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Widow inheritance and HIV/AIDS interventions in sub-Saharan Africa: Contrasting conceptualizations of 'risk' and 'spaces of vulnerability'

EVELYNES KAWANGO AGOT

A dissertation submitted in partial fulfillment of the
requirements for the degree of

Doctor of Philosophy

University of Washington

2001

Program authorized to offer Degree: Geography

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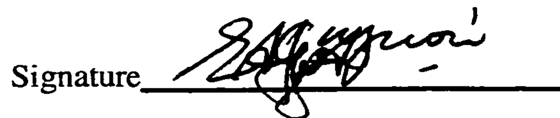

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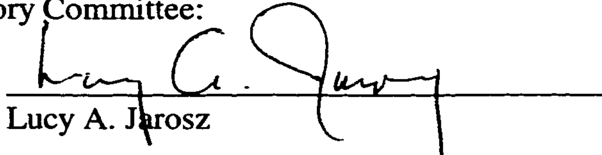

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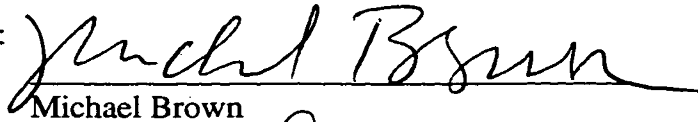

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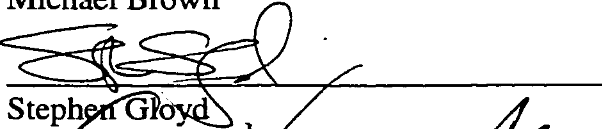

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Abstract

Widow inheritance and HIV/AIDS interventions in sub-Saharan Africa: Contrasting conceptualizations of 'risk' and 'spaces of vulnerability'

Evelynes Kawango Agot
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Fourteen percent of Kenya's adult population is currently living with HIV. Of the 43 ethnic communities in the country, the Luo has been disproportionately affected by the epidemic, accounting for 32.8% of the national HIV caseloads in 2000, but comprising only 13% of the population. To check the rapid spread of the virus, one of the risk behaviors targeted for change is the cultural practice of widow inheritance. Yet despite close to 15 years of campaign and 99% 'AIDS awareness' in the community, several studies conducted between 1991 and 2000 show that the trend has remained consistent over the years, with over 50% of the widows in the rural countryside getting inherited within a year of widowhood.

Using primary data from 66 focus group discussions, 161 open discussions, and 11 key informant interviews, and secondary data from various publications of the Kenyan government, the international and local agencies involved in HIV/AIDS prevention activities, and the local newspapers, I explore why intervention programs have had little success in changing the attitudes and behavior of the Luo people towards widow inheritance. The study found the main reason to be the fact that the providers and the recipients of the intervention programs are defining the 'risk' associated with the practice differently. While to the former, widow inheritance is a risk behavior for HIV acquisition and transmission and should be discarded, to the latter the practice is protective against the spread of the virus and should be revamped. As such, campaigns geared towards changing the attitudes and behavior of the

community towards inheritance without addressing the disparate perceptions will continue to be ineffectual.

In this dissertation, I provide a compromise between the two stakeholders--the providers and the recipients of the programs--by proposing a strategy that would reduce the risk for HIV in ways that are feasible and culturally appropriate. The proposed strategy takes into account the contextual milieu (cultural, social, economic and religious) within which widows get inherited and within which HIV can potentially be acquired or transmitted within the relationship. In the framework provided by these contexts, the following recommendations are suggested: going for HIV testing prior to inheritance, practicing symbolic inheritance without the component of sex, abstaining from sex or remaining mutually faithful, using condoms, and bolstering support for widows within their respective churches.

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Glossary

HIV: Human Immune Deficiency Virus

AIDS: Acquired Immune Deficiency Syndrome

***Chira*:** A wasting disease believed to result from breaching certain taboos, such as participating in certain community activities without observing the sexual rituals associated with them, or failing to adhere to stipulated sexual norms of the society (see footnotes 9 and 35). Besides weight loss, *chira* also presents with diarrhea, vomiting, thinning of hair, persistent cough, and general lethargy. Because the symptoms are similar to those of AIDS, the study participants often conflated the two terms.

Widow inheritance: When a man dies, his brother or cousin is expected to 'take care of' his widow (see footnote 1 for the various reasons why the practice is carried out). Part of the contract involves sexual cleansing after burial and during various other events when sexual rites are required, for example to usher in or to conclude farming seasons, rites of passage, or building of homes. The main consequence of not observing the tradition is affliction by *chira* (discussed above).

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Auma nyar Odera ka Odiedie gi Domtila Ogendo, in paragraph ni obed mana mari! Tho, oromogo jowadwa! Awuoro chuny mane Nyasaye mani e polo omiyi. Asedwaro chuny machal gi mari no to aneno mana achiel achiel (Akinyi nyar Otedo, iwinja?). Ichiwri ok ni nikech in gi geno mar yudee gimoro; en mana kiti mane Nyasaye ochweyi go. Asebedo kapimo joma ogena nikech an; ok nikech kony ma anyalo chiwo to ji oselwar achiel ka achiel. Kuom jok mane apimo, Auma ema aneno ka odong kochung'. Kuomi ok an VAT (Value Added Tax) ma berne luwore gi kony ma onyalo chiwo; kuomi an mana Nguono nyar Jaduong' Agot gi Mama Sipporah--ok ni ka ok anduso gimoro to berna be orumo gi kanyo, tinda! Onge kaka anyaylo

goyoni erokamano ma dirom gi chiwruok ni; ringo ni koni gi koni--in gi joodi pep--ema omiyo 'otheso' ni ochopo kama entieree ni. Nyasaye ema ong'eyo erokamano mani e chunya. Ruoth Yesu omed gwedhi kendo jiwi idhi nyime gi chuny machalo kamano!

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And now to the one closest to my heart, my daughter Gift-Noelle Wango (*Gibude*), thanks for your patience, understanding, support, and for working so hard in my absence! I always thank God for the gift of Gift!

With these FEW☺ remarks--I could go on and on but because I've run out of space☺--I say, from the bottom of my heart: *God bless you one and all.*

Dedication

✝ To the Lord Jesus Christ ✝

☺And to my daughter, Gift-Noelle Wango (*Gibude)*, my mother, Zipporah Wango Agot, and my sister, Margaret A. Onyango, for being pillars of support through it all☺

Also to you dear friends--you were all there when I left home 4 years, 10 months and 24 days today; none of you will be there when I return.....hard to accept....

☹ Caren Atieno nyar Nyalala: My dearest friend and 'twin-sister' (Died Feb., 1997)

☹ Prof. Isaac Sindiga: My friend and mentor in Medical Geography (Died May, 1999)

☹ Gregory Maitha: Exemplary Tech. who performed the lab analysis (Died Apr., 2001)

☹ Mical Awino Ogoma: My sister in the Lord and partner in Ushindi (Died May, 2001)

Introduction: Overview of the dissertation

In this dissertation, I provide a critique of the current intervention programs that aim at changing sexual behaviors that are deemed to be providing conducive environments for the acquisition and transmission of HIV/AIDS in sub-Saharan Africa. The dissertation is based on a case study of the practice of widow inheritance[1] among the Luo ethnic community of Kenya. Its overarching purpose is to identify the reasons behind the dismal performance of the current intervention programs in convincing members of the Luo community to change their behavior towards the practice. Subsequently, it suggests safe alternatives that would reduce the risk for HIV while at the same time fulfill the cultural functions associated with the practice. I have organized this *Introduction* in three parts. In part one, I provide a synopsis of the current HIV/AIDS situation in sub-Saharan Africa, in Kenya, as well as in Luo Nyanza, as a way of demonstrating the magnitude of the problem. Secondly, I discuss the objectives and rationale of the dissertation. And thirdly, I provide an outline and discuss the structure of the dissertation.

Overall, the dissertation makes both theoretical and methodological contributions to social science in general, and to human geography in particular. In terms of theory, I demonstrate that behaviors that are observed and classified as risky for the acquisition and transmission of HIV are not isolated factors that can be

---

[1] This is a practice where a widow is 'taken care of' by a brother or a cousin to the late husband. Respondents cited five main reasons why widows are inherited, namely, to discourage widows from abandoning their marital homes and their children; to restrain widows from seeking sexual liaisons outside the husbands' clan; to give childless widows, especially those without sons, an opportunity to get children who would continue the lineage of the deceased; to entitle the widow to social and economic support from the inheritor; and to enable her to participate in certain social events for which sexual rite is a component, such as during farming seasons (cultivating, planting, weeding, and harvesting), during ceremonies associated with rites of passage of close family members (birth, marriage and death), and when establishing homes (see Chapters Two and Four for details).

successfully targeted by interventions. Rather, they are culminations of interactions between and among various factors and situations that underlie what we are able to see and quantify. Hence, defining 'risk' and 'vulnerability' for HIV does not start and end with the behavior which we are able to observe; it goes beyond it and beneath it to incorporate unseen factors that codetermine the magnitude of risk and vulnerability that different people are exposed to given their individual circumstances. This framework is built upon the theoretical underpinnings of 'risk' and 'vulnerability' proposed by Watts & Bohle (1993) and expounded by Delor & Hubert (2000). Basing the dissertation on the cultural practice of widow inheritance among the Luo community, I use the background characteristics of a widow, her social relations, as well as her religious affiliation as the three principal factors underlying the practice. Different components of these factors combine to produce situations that may predispose certain widows to increased likelihood of being inherited in a manner that puts them at a higher risk for HIV compared to those who are not inherited.

In terms of methodology, this dissertation underscores the importance of using ethnographic method in studies that seek to place participants at the center of research activities with respect to setting the agenda for the study. The approach also enabled me as the researcher to understand the full depth and context of the phenomena under study, and throughout the dissertation, I show how powerful ethnography is in erasing barriers between the researchers and the participants, as well as among participants of different socioeconomic backgrounds, especially when discussing sensitive topics such as sex and sexuality and their relationship to the various cultural practices. The interactive nature of the method made it possible for the participants to grapple with

complex issues around HIV/AIDS and widow inheritance, and to negotiate a compromise between the hitherto disparate cultural and biomedical conceptualization of 'risk' and 'vulnerability.'

HIV prevalence updates: The latest HIV epidemic report released by UNAIDS in December 2000 indicates that 36.1 million people in the world are currently living with HIV/AIDS, 25.3 million (70.1%) of whom are from sub-Saharan Africa--home to 13% of the global population. The global prevalence of HIV/AIDS currently stands at 1.1% of the population, while in sub-Saharan Africa, 8.8% of the population is infected. Except for the Caribbean with 2.3% prevalence, all other regions of the world still have a prevalence of less than 1%. At present, HIV/AIDS is the fourth leading cause of mortality worldwide and the number one killer in sub-Saharan Africa, where at least sixteen countries have an adult prevalence of over 10% (UNAIDS, 2000). In the year 1999 alone, for example, the region was also home to 71.1% of 5.3 million new infections in adults (15-49 years of age) and children (<15 years of age); 81.9% of the 15,738 women infected; 91.7% of the 13.2 million AIDS orphans; and 80% of the 3.0 million AIDS-related deaths. The sub-continent is also the only region in the world where more women than men are infected (55% of all infections in Africa are in women compared to 47% globally), and where heterosexual mode of transmission is still by far the most dominant. This last characteristic of the epidemic makes it necessary to involve both men and women in intervention programs addressing changes in sexual behavior.

Kenya is one of the 16 countries with a high prevalence in the sub-continent (see footnote 36), where about 14% of all adults (2.2 million people) in the country were infected with HIV by the end of 2000 (UNAIDS, 2000). The current prevalence is 15% in the two major cities of the country (Nairobi and Mombasa) and over 20% in most medium-sized cities (Busia, Kisumu, Meru, Nakuru and Thika). Overall, 17-18% of the urban population and 12-13% of the rural population are infected (NASCOP, 2000; Government of Kenya, 1999). It is estimated that a cumulative total of 1.1 million people in the country have died from AIDS since the epidemic began, with current occurrence of reported fatality of 700 daily, and the number is increasing.

Within Kenya, the epidemic is more prevalent in Nyanza province of Western Kenya (Figure 1), contributing 28.8% of all the cases in the country in 1999 and 32.8% in 2000 (NASCOP, 2000). Within the province, the districts occupied predominantly by the Luo ethnic community account for 85.1% of the provincial totals but under 68% of its population (NASCOP, 1999; Government of Kenya, 2001). HIV seroprevalence of women attending antenatal clinics in Luo-occupied districts in 1999/2000 ranged between 30.1% and 43.5% (CDC-KEMRI, 2000).

Several reasons have been advanced to explain the disproportionate prevalence of HIV in the Luo community, one of which is societal beliefs, practices, and norms promoting sexual networking, such as widow inheritance. This practice has subsequently been targeted with intervention programs but with little success. My task in this dissertation is to investigate why this is so, and I accomplish this through the five objectives outlined below:

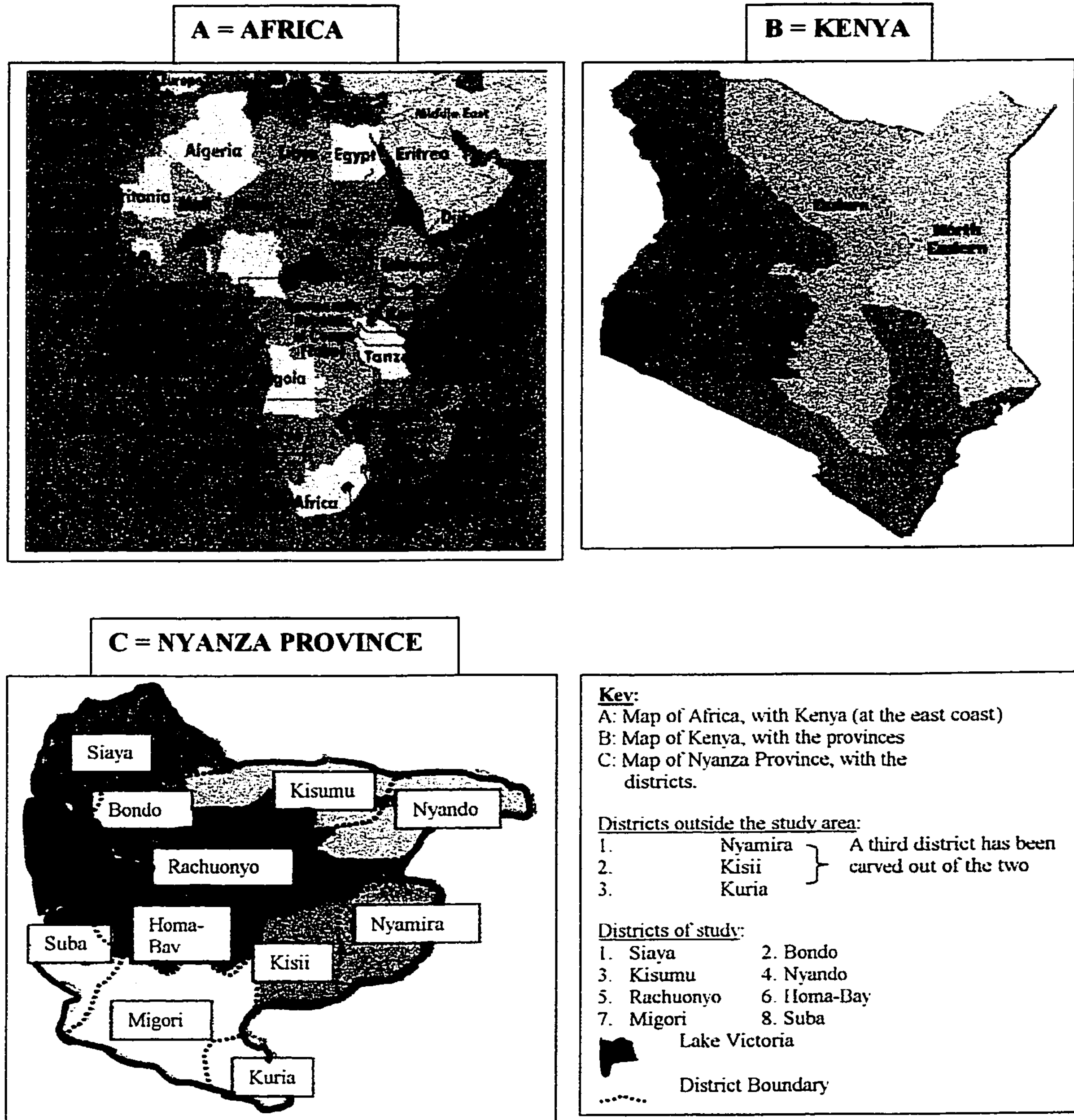

Figure 1: **Map showing the study districts.**

Source: http://www.kenyaweb.com/regions/index/html

Study objectives: First, I examine whether or not the participants consider widow inheritance as a risk behavior for the acquisition and transmission of HIV. The objective is important because the first concern for any intervention program aiming at behavior change should be to ascertain that the recipients have conceptualized the potential association between the behavior of interest (e.g., widow inheritance) and the health risk (e.g., HIV). Otherwise, expecting people to change a behavior that they have not yet associated with the risk in question is unrealistic.

Second, I identify and discuss the main factors that determine 'vulnerability' of widows for HIV within the context of inheritance. The objective is premised on the fact that vulnerability to being inherited, and to acquiring HIV through the relationship, is not uniform for all widows. Depending on which factors are at play, different widows in the same life circumstance may experience similar types and magnitudes of vulnerability, while the same widow may experience different levels of vulnerability at different points in time or in different places. To address this objective, I borrow the framework of tripartite relationship first proposed by Watts & Bohle (1993) and later expanded by Delor & Hubert (2000) to frame my description of how the different factors intersect to produce different 'spaces' within which widows become either more or less vulnerable for HIV, depending on their particular circumstances.

Third, I analyze the appropriateness of using the concept of 'risk' in describing the association between HIV/AIDS and widow inheritance as practiced by the Luo ethnic community. In this objective, I specifically examine the components of the

current practice that can potentially increase the risk for HIV, and suggest that these, rather than the practice in its entirety, should be the targets of intervention.

Fourth, I assess how effective the current intervention approaches are in responding to the contextual milieu (cultural, social, economic, and religious) within which widows get inherited, and within which HIV could potentially be contracted or transmitted. I then provide highlights of selected case studies of interventions targeting female genital cutting in sub-Saharan Africa to demonstrate that in culturally-embedded practices (such as widow inheritance), approaches that compromise between culture and health, in which both stakeholders achieve their respective goals, have been applied elsewhere with success.

And fifth, the dissertation aims at reconciling biomedical and cultural perceptions of widow inheritance and the risk for HIV by providing alternatives in which the goal of public health of minimizing the risky components of widow inheritance can be achieved in a manner that is also culturally acceptable. The structure and content of the dissertation presented below are based on these objectives.

Dissertation layout: In **Chapter One**, entitled *Readying the reader: negotiating the research process*, I first give highlights of globalization and the political economy of health in sub-Saharan Africa, particularly how global forces have undermined efforts of many African governments to carry out effective interventions. I then use case studies of on-going HIV prevention strategies in Senegal and Uganda to demonstrate that despite the global agenda shaping much of AIDS activities in Africa, political will and foresight, in partnership with the local population, can turn around support from

foreign donors into programs that are relevant to the needs of the people. Secondly, I describe the procedures I used in planning for and conducting the dissertation fieldwork, in organizing and analyzing the data, and in interpreting and presenting the results. I specifically point out the reasons why I selected widow inheritance among the Luo ethnic community as a representation of other cultural practices in sub-Saharan Africa. The main point the chapter conveys is the importance of making field studies flexible to accommodate the needs of the respondents and to give them voice in influencing the agenda for the study.

Chapter Two, *Giving voice to the subaltern: Negotiating cultural and medical discourses around widow inheritance and its status as a purported 'risk' factor for HIV*, contains three main parts. First, I present highlights on cultural studies and HIV/AIDS in sub-Saharan Africa as a way of providing a basis for understanding widow inheritance, which is the theme of the dissertation. Secondly, I give background information about the practice of widow inheritance across the subcontinent. This is done to 'ready the reader', whereby I provide an outline of the geography of the widow inheritance and a description of different scenarios in which the practice can both increase and decrease the risk for HIV. And thirdly, I present part of the results from fieldwork. I use responses from the participants to show their level of understanding of basic facts about HIV/AIDS and how it relates to the practice of widow inheritance. This information gives an indication of the level of success of the current interventions in creating awareness about HIV and AIDS and in influencing the community to change their behavior towards the tradition.

In **Chapter Three**, entitled *HIV/AIDS in sub-Saharan Africa: re-constructing 'spaces of vulnerability' within the framework of widow inheritance*, I accomplish three tasks. First, I examine the utility of the concept of 'space' as a framework for understanding and organizing the geography of HIV/AIDS in general, and in sub-Saharan Africa in particular. Second, I provide a background to the personal, social, economic, and religious environments within which the practice of widow inheritance is carried out. And third, I examine how the different characteristics of these environments for widow inheritance intersect to create different 'spaces of vulnerability' for widows in different circumstances, in different geographical locations, or at different time periods. My argument in this chapter is that unless 'vulnerability' for HIV is constructed within the frameworks of social, cultural, economic, and religious contexts of the practice of inheritance itself, intervention programs targeting the practice will continue to remain ineffective. And I maintain that the only source from which to obtain better and more valid information regarding such contextual issues are the practitioners of the tradition themselves. I present the contrasting scenarios to show how the practice has been modified over time (starting long before the onset of the epidemic) and the impact these changes have had on the potential risk of HIV associated with inheritance.

In **Chapter Four**, which I title: *Querying the utility of 'risk analysis' in HIV/AIDS intervention in sub-Saharan Africa: Does widow inheritance constitute 'risk'?* I discuss the different usage of the concept of 'risk', such as risk group, risk behavior, and risk situation and examine their relevance in framing the geography of HIV/AIDS in general and in designing intervention programs to check the spread of

the disease, in particular. In this chapter, I also discuss the theoretical underpinnings framing the different uses of the concept of 'risk', contrasting individual-based and relational-based approaches to 'risk analysis', and to intervention programs arising therefrom. I assess circumstances when widow inheritance would constitute 'risk behavior' for HIV acquisition and transmission in the Luo community, as well as circumstances when the practice would, in fact, check the spread of the virus.

In **Chapter Five**, *HIV/AIDS and widow inheritance in Luo Nyanza: Whose agenda are interventions addressing?* I first present highlights of the interventions for HIV/AIDS in sub-Saharan Africa and in Kenya, then zero in on Luo Nyanza where I discuss at length some of the current interventions targeting behavior change. Specifically, I use responses from the participants to demonstrate the ineffectiveness of the intervention education programs targeting widow inheritance among the Luo community. There are two main arguments I advance in this chapter: one, that the heavy dependence on foreign funding for HIV prevention activities in most sub-Saharan African countries has compromised the autonomy of respective countries in charting out the type and direction of the interventions.

And two, that having not taken into account the various contexts within which widow inheritance takes place, these interventions have, consequently, made dismal impact in changing the attitude of the community towards 'eliminating' the practice. I use case studies of interventions that have been mounted in Mali, the Gambia, and Kenya to change people's attitudes towards the practice of female genital cutting to demonstrate that if collaboration with the practitioners of the culture under review is sought, interventions targeting sensitive issues are received more favorably.

My aim in **Chapter Six**, *Widow inheritance and HIV/AIDS interventions in sub-Saharan Africa: Bringing program designers and recipients into a dialogue*, is to demonstrate a disparity in the conceptualizations of 'vulnerability' and 'risk' between the Ministry of Health (who are the designers of the interventions) and the members of the Luo community (who are the recipients of the interventions), and to show that the differences in the viewpoints of the two groups has led to ineffective interventions being designed and disseminated that are neither understood by nor practical to the targeted recipients. I use the metaphor of a tree and the relationship between the leaves, the branches, the trunk, and the roots to demonstrate how superficial the current interventions--which are targeting the 'leaves' independent of the rest of the tree--are in addressing the underlying determinants of inheritance. Through the metaphor, I illustrate that, just as chopping off the leaves would barely eliminate the whole tree, targeting widow inheritance in isolation from the context in which it is contracted cannot lead to a lasting impact in changing behavior regarding the practice. The metaphor serves as a framework to show the different forces behind the practice that must be addressed by the interventions, and subsequently, provides a basis for making suggestions to reduce both the proportions of the widows being inherited and the prevalence of the risky component of the practice. Interventions drawing from this framework will have better chances of being both acceptable to the community, and effective in reducing the risk for HIV.

At the close of the dissertation, *In lieu of conclusions: dissertation recap and recommendations*, I reiterate the key findings of the study, highlighting the shortcomings of the current interventions and providing recommendations to policy

makers and implementers on how to be sensitive to the needs of the community. And, I maintain, the only way they can achieve this is by framing their policies on information obtained from those who 'live' the lives that they are targeting for change. By this I mean that the ultimate argument for sensitivity to community needs and perspectives is not just that it is informative and the 'politically correct' thing to do; it is that it will greatly improve our ability to achieve the public health goals of increased well-being and decreased suffering.

Chapter One:

Readying the reader: negotiating the research process

Chapter overview: In this chapter, I briefly situate the issue of HIV/AIDS in sub-Saharan Africa within the larger framework of global economy, focusing particularly on the structural political economic change in sub-Saharan Africa over the last two decades and how the change has impacted the epidemic at the national and local levels. I then narrow down my attention to the description of the procedures I used in planning and conducting the dissertation fieldwork, in organizing and analyzing the data, as well as in interpreting and presenting the results. I have divided the contents into four parts. In part one, I give an overview of the political and economic structures that frame the understanding of HIV/AIDS in Africa as a way of situating my work within the prevailing global processes that influence health even at the most local level. While I show how changes wrought by these processes have suppressed the efforts towards HIV/AIDS interventions overall, I also provide examples from Senegal and Uganda that demonstrate that with political will and prudent decision-making, it is still possible to collaborate with foreign donors and mount successful interventions in Africa.

In the second part, I discuss the activities carried out prior to the field data collection phase. These include a brief introduction of how the study emerged, a description of the process of selecting the study population, the research sites, and the study topic, a presentation of the purpose and significance of the dissertation, and an

outline of the study questions and hypotheses. In part three, I describe the process of field data collection, including set-up activities, collection of primary and secondary data, and the major study limitations encountered during fieldwork and with data management and analysis. And finally, part four covers the activities carried out after the data collection exercise and include management and analysis of field data, as well as interpretation and presentation of results.

The political economy of health in Africa: implications for HIV intervention

In developing countries where contagious diseases are still more prevalent, low health status is an accurate proxy for poverty. There are many facets of poverty, such as low income, lack of sufficient food, insufficient housing conditions, lack of infrastructure and social facilities, illiterate population, and so on, and none of these is isolated or ahistorical reality; each has been shaped by numerous external factors and global historical processes (Knauder, 2000:219). Even though the focus of my analysis is on cultural processes and how they impact HIV transmission and prevention at a local level, I recognize that these processes cannot be fully understood unless they are positioned within structural political economic change that countries in sub-Saharan Africa have gone through since the advent of the disease. This is especially so given that in day-to-day decisions by both men and women I worked with, particularly in relation to their susceptibility to HIV, the effects of global structural forces may not be directly visible (and thus are not highlighted in my local level analysis), but they are still central in shaping both the environments that predispose populations to the disease, and the options of interventions available to them.

In this section, I briefly review the impacts of some of the conditions set by international donor organizations (notably the World Bank and the International Monetary Fund – IMF) on the health status of sub-Saharan African population in general, and HIV spread and prevention in particular. This background provides an important context for understanding some of the key arguments I advance in the main case study informing this dissertation (in Chapters Two, Four, Five, and Six), and is another critical link to a holistic view of HIV prevention.

In showing how the imbalanced global power relations have configured the level of well being of sub-Saharan African populations and compromised their ability to meaningfully combat the HIV/AIDS epidemic, I start with a brief historical analysis of selected events in the region. The 1950s, 1960s, and early 1970s were periods of steady economic growth in most of sub-Saharan Africa (Asthana, 1994; Knauder, 2000); however, the modernization strategies adopted by the newly independent governments locked their respective economies into the unequal trading relations that lie at the root of the current economic crisis (Edwards & Kinyua, 2000). A report by the Development Research Bureau (DRB, 1993) outlined the 'problems' in Africa since the late 1970s as follows: persistently rising rates of inflation, deteriorating terms of trade, shrinking capital inflow, a decreasing attention to agriculture, high population growth, famine, natural disasters, and bureaucratic structures invariably plagued with corruption (See also Wai, 2000; Serri, 2000; Helleiner, 2000). The advent of the HIV/AIDS Africa in the 1980s thus found the ground ripe with enabling factors that acted in synergy to allow it to find root easily and quickly and then fueled its spread towards the current epidemic proportions.

It would be insightful, as a way of providing background, to trace some of the antecedents of the current situation of health status in the region. And a good place to begin is by considering how the colonial legacy served to sow seeds of today's global processes in Africa, that is, how the legacy not only initiated and nurtured the imbalanced power relations that continue to exist between Africa and the West; but how it also shaped the trend of the health care provision that today characterizes much of the region. The first and perhaps most significant change during the colonial period was the introduction of biomedicine in Africa, alongside or in place of ethnomedicine (Good, 1985; Mbiti, 1990).

During this era, the colonial administrators concentrated better health facilities in urban and mining areas where most Europeans lived (Ulin, 1981; Khtar & Izhar, 1994; Okuonzi & Macrae, 1994), while the missionaries, on the other hand, provided care mostly to the rural populations where most of the consumers of the health care were Africans (Khtar & Izhar, 1994). Overall, both providers emphasized institution-based curative care, and there were varying degrees of racial segregation in the consumption of different quantities and qualities of biomedical services, with the indigenous African having the least entitlement particularly in government-run institutions (Okuonzi & Macrae, 1994). By independence, the provision of health services had become a significant political issue in many African countries.

But, just as the colonial administrators were the principal decision-makers in the location and running of the health care facilities prior to independence, African political leaders too began to dictate the location of the same largely on the basis of personal preferences rather than need, and economic status (and sometimes ethnic

background) replaced race with respect to access to health care (Okuonzi & Macrae, 1994). Thus, the inequalities in the distribution of health services and their curative orientation created by the colonial administrators have persisted (Iyun, 1994).

In what has been marketed as a response to counter the deteriorating status of health and other social services in Africa (and other parts of the developing world), the World Bank and the IMF have instituted a set of strategies collectively referred to as Structural Adjustment Programs (SAPs)[2]. It is not within the scope of this dissertation to delve into a detailed discussion of SAPs outside what is outlined in footnote 2. In what follows, I show ways in which SAPs have impacted the provision of health care in Africa and how some of the effects have led to the inability of many African states and individuals to cope with HIV/AIDS.

The African states began to adopt the programs outlined in footnote 2 in the late 1970s and through the 1980s, and currently, all countries are in various adjustment levels in which budgetary reforms play a central role (Monekoso, 1993; Navaro, 2002; Knauder, 2000). However, the extent to which SAPs are working towards what the World Bank and IMF promised, namely, balancing the economic disequilibria and

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[2] The main features of SAPs (Knauder, 2000:238; Navarro, 2002) include the following:

i. Reduction of state expenditure--which has resulted in the cancellation of unproductive projects so as to reduce national budget deficits.
ii. Provision of incentives to increase traditional export and develop new export activities in order to gain more foreign exchange and improve the balance of trade. For example, the debtor countries were forced to lower trade barriers by removing import controls and export taxes as part of the incentives to attract private foreign investment. The result is that local producers have become exposed to foreign competition, and many have been driven out of business. Governments were also mandated to reduce or eliminate subsidies and price controls over goods (including food) and services and adhere completely to open door policy.
iii. State intervention had to be minimized in the management of the economy, including major cutbacks in the provision of social services such as health and education.
iv. Governments were required to freeze wages and salaries, to retrench workers in the public sector, to devalue local currencies, and to limit the amount of money in circulation in order to fight inflation.
v. In addition, control of capital movement was to be abolished and state owned enterprises privatized.

turning around the faltering economies into a state of sustainable growth and development, is contested (Okuonzi & Macrae, 1995; Knauder, 2000; Navarro, 2002; Kolko, 2002; Serri, 2000). Although some evidence might suggest that reforms and adjustments have generally led to better economic performance as assessed by the World Bank and the United Nations Development Program (DRB, 1993; Wai, 2000), there are variations in the way different sectors have been affected. The most fundamental objection to adjustment relates to its impact on health and welfare (Serri, 2000; Laurell & Arellano, 2002). The two social sectors have suffered more shocks as a result of cutbacks in public expenditures, both directly and indirectly, as I outline below.

In many African countries, total health budgets have remained nearly at the same low level (of about 5%) over many years, or have declined, leading to lower per capita health spending (Laurell & Arrelano, 2000; Cornia & Mwabu, 2000). Cuts in public spending and the emphasis on cost-recovery have made vital public services increasingly inaccessible to those who need them most--the urban poor as well as the landless and the small landholder rural population. The revenue base for the public health sector in most countries in the sub-continent is unable to generate enough finances, despite instituting cost-recovery measures, for the provision of public health services (Collins, Quick, & Musau, 1996; Knauder, 2000).

To exacerbate the problem, most of the resource-consuming facilities are urban-based, serving only 10-15 percent of the population in many countries (Knauder, 2000; Cornia @ Mwabu, 2000). In Malawi, Sierra Leone, Cote d'Ivoire, Togo, and the People's Republic of the Congo, for instance, over 80 percent of the

health expenditure goes to finance expensive hospital services which are often accessible to only a small proportion of the population in the urban areas (DRB, 1993; Cornia & Mwabu, 2000). And even in the rural areas, the bulk of the allocation goes to staff salaries and wages, and little is left for maintenance, recurrent costs, and disease prevention campaigns--the domain of primary health care. In Kenya, resource allocation for health promotion and disease prevention is only five percent of the total allocation on health, yet majority of the conditions which present themselves for curative purposes are potentially preventable (Lore, 1993; see also Sahn & Berner, 1995; Israr et al., 2000). Prevention activities for HIV fall under the same impoverished sector of primary health care (PHC), adding further burden to this department. As such, the initial optimism associated with the PHC strategy as the panacea to health problems in developing countries (See WHO, 1981; Agot, 1994; 1995) has been countered by a number of events arising from cutbacks in public spending precipitated by SAPs. At the consumption level of healthcare services, the poorest strata of the society has been hit hardest--their real income and subsequent living standards have been lowered, decreasing their ability to access heath care.

At the provision level of health care, there are two features of the effects of SAPs. First, the adverse economic conditions created by SAPs have demoralized health staff who have had to face cuts or stagnation in wages and salaries and inadequate medical supplies (Watts & Gilson, 1994; Israr et al., 2000; see also Knauder, 2000). In most countries in the region, real salaries have not kept pace with inflation, and some workers have resorted to illegal selling of the few drugs available in public health care facilities or to charging extra for services. Others have quit public

service or supplement their income by opening private practice while they are still in government service (Asthana, 1994; Israr et al., 2000). The dual practice provides an ideal opportunity for siphoning of medicines, drugs, equipment, and productive time out of public health institutions.

The second feature is seen in the staff who stay on and who are forced to make do with inadequate supplies and poor maintenance of buildings, equipment, vehicles, and so on. The apathy of such staff is seen most acutely when patients are sent back because they have not brought with them a sheet of paper on which their case histories, diagnoses and prescriptions can be written, or when they have no bottles for their medicines, or when most of the prescriptions of essential drugs cannot be filled at the centers (personal observation in several health centers during my dissertation fieldwork). The result of reduced performance and productivity is that the standard of care in public facilities has plummeted, especially since the mid 1980s, just at the time that the devastating impact of HIV/AIDS was also starting to manifest. In summary, the advent of HIV/AIDS coincided with an overburdened and low-performing health care delivery, particularly primary health care--the sector responsible for HIV intervention activities.

Given the background highlighted above, it would appear difficult, as I have alluded to, for African states to contain the pandemic, and this may partly explain why the disease has spread so fast in the region. However, Auerbach and Coates (2000:1029) believe that HIV prevention can work in Africa and elsewhere in the world. They cite evidence from places as diverse as Senegal and Uganda (as well as Thailand and Australia) to support their view,--places where concerted HIV

prevention efforts at the national level have resulted in the maintenance of low seroprevalence where they otherwise would have been expected to rise (e.g., Senegal), and declining prevalence and incidence in places and populations with historically high rates (e.g., Uganda). Before presenting an overview of the strategies that Senegal and Uganda have used, it is beneficial to mention some of the current discourses around AIDS prevention in Africa.

In countries where the epidemic is widespread (See footnote 36), the governments are realizing that many of the causes and consequences of HIV are beyond the scope of health ministries; that HIV/AIDS is not a health problem per-se since factors that facilitate the spread, such as sex work, casual sex, certain cultural practices, poverty, and so on are beyond the scope of health administrations (UNAIDS, 2000). Campbell and Williams (1999), for example, suggest that there is need for a shift in the discourses that shape sexual health promotion campaigns away from biomedical and behavioral interventions and towards what Tawil (1995, in Campbell & Williams, 1999:1636) refers to as 'structural interventions' and 'enabling approaches'. Enabling approaches are "those where, rather than trying to *persuade* people to change their behavior through educational programs or through encouraging them to attend clinics for Sexually Transmitted Infections (STIs), sexual health promoters turn their attention to the possibility of creating circumstances that *enable* behavior change to occur". Such approaches focus on the social and environmental determinants that facilitate or impede behavioral choice and aim to remove structural barriers to health-protective action and to construct barriers to risk taking. In the context of HIV in developing countries, enabling approaches should focus on the

economic development of at-risk groupings (e.g., economic and policy strategies that empower women and enable them to be self-reliant would be more far reaching than enrolling them in workshops and teaching them how to negotiate safe sex with their partners) (Campbell & Williams, 1999).

Thus, the authors suggest, prevention approaches should move away from viewing HIV/AIDS as a medical/behavioral problem whereby governments are allocating primary responsibility to the health departments and should instead involve a much broader range of departments in multisector approaches that recognizes that many of the contextual factors leading to HIV/AIDS lie outside the province of health departments and outside the reach of biomedical behavioral interventions.

While I support the perspective that conditions and circumstances that predispose individuals to behaviors that expose them to HIV acquisition often transcend medical and behavioral contexts, I also recognize that they still remain critical not just in understanding the nature of the disease and the course of the epidemic; but also in being useful (even though not sufficient) in informing and guiding interventions in many parts of Africa. I demonstrate in the case studies of Senegal and Uganda which I highlight here below that in many instances, integrating all the three contexts--biomedical, behavioral, and enabling environments--provides a more comprehensive approach to dealing with a disease as complex as HIV. For example, there are instances when 'quick fixes' in terms of medical interventions (such as treatment of STIs in populations where the diseases are prevalent) are needed; there are times when not-so-quick-fixes in terms of behavior change interventions (such as encouraging condom use in men who have sex with sex workers) are the only

feasible options available *in the interim*; and there are times when the larger political and economic structures (such as State changes in labor regulations to allow couples to live [and work] together so as to reduce risk of HIV transmission associated with spousal separation) must be addressed before genuine change can be expected.

In the first example, long-term interventions that predispose people to acquiring STIs can be addressed concurrently with, or subsequent to, but not in place of, short-term treatment. In the second example, designing strategies that increase condom acceptance, training men on how to use them, and increasing their supply and accessibility would contribute to a more immediate reduction of risk to men who visit sex workers, as well as to their spouses or sexual partners whom they would subsequently infect. However, this should be done hand-in-hand with changing the political, economic, and societal forces encouraging women to join the sex industry, spouses to be separated, or men to visit sex workers and/or fail to use condoms.

Thus, while in the long run enabling environment is a key element in preventing further spread of HIV, it needs the support of other shorter-term program activities and strategies. In other words, addressing larger political and economic structures cannot, for example, compensate for inadequate understanding of the epidemiology of HIV/AIDS and the forms of behavior linked with it. According to WHO (1989), enabling environments alone cannot solve all health care problems; an integrated approach is necessary, as the Senegal and Uganda cases I outline below demonstrate.

Senegal: Meda and colleagues (1999) have shown that in West Africa countries, less than 1 per 1000 of the population was infected with HIV before 1985, and in 1999 the seroprevalence had risen to 6.44% in Burkina Faso, 5.06% in Nigeria, and 10.76% in Cote d'Ivoire. In Senegal however, the seroprevalence has been relatively contained at around 1% (Meda et al., 1999). These authors, as well as Lagarde, Pison and Enel (1998) and Spira et al., (2000), attribute this success to several factors, including: 1) prevention of transmission through blood by means of systematic HIV screening of blood before transfusion, 2) prevention of sexual transmission through awareness campaigns for responsible and safe sex especially through radios, televisions, and in ante-natal clinics, 3) widespread screening and treatment of sexually transmitted infections, 4) promotion of condom use and provision of affordable, good and quality condoms, 5) special interventions for groups at high risk of HIV infections, such as female sex workers. Senegal is one of the few countries in the world where sex work has been legal even before the advent of the HIV epidemic--a move which is reported to have brought sex workers 'out of hiding' and allowed them to be registered and to benefit from programs such as treatment of STIs and condom distribution.

Other factors that have been associated with reduced risk for infection include male circumcision (See Chapter Two for information on the association between circumcision and HIV) and a strong cohesion around religious values which have contributed towards control of sexuality and alcohol consumption. The authors conclude that concentrating on prevention at the outset of the epidemic--by political,

religious, and community leaders--is believed to be responsible for controlling the spread in the country.

Uganda: In citing Uganda as an example of 'how to do things right' in the area of HIV intervention, American Health Consultants (1999) and UNAIDS (2000) give the first credit to President Yoweri Kaguta Museveni and his wife Janet. Both have taken a personal and active stance on HIV prevention, care, and treatment and encourage people to know their serostatus. When Uganda's president began to talk about HIV in 1986, soon after taking over the country's leadership, there were not many other leaders in the world at the time who had the courage to do so. The President encouraged all top officials to talk about AIDS every time they spoke publicly (American Health Consultants, 1999).

Following the leading of their president and top political leadership, other sectors of the Ugandan society began to apply strategies to address concerns specific to their situations, and before long, the epidemic was being attacked from all directions. So far, the following strategies have been adopted in the fight: One, the population is offered a health care package if they voluntarily receive confidential HIV counseling and testing. As we found out in our study, people are reluctant to be tested or, if they are tested, to come back for results, if there is nothing to offer them. And studies have found an association between being tested and change in behavior--notably a reduction in risky sexual behavior by those who test negative--UNAIDS, 2001)

Secondly, social support networks have been set up for people living with HIV/AIDS, such as the world famous TASO (The AIDS Support Organization). This has boosted the willingness of people to be tested since they know that if they turn out to be seropositive for HIV, they have somewhere they can fall back to for care. Third, communities are encouraged to support people with HIV and to raise children left behind because of the epidemic. A growing area of concern is the increasing number of AIDS orphans who are joining the sex industry as a means of survival and who are further fueling the epidemic (Levine, Michaels & Back, 1996).

Fourth, following the example of political leadership, the business community has recognized the need to provide access to information and services to employees, their families, and the communities they serve. Fifth, support has also been provided for the control of sexually transmitted infections by subsidizing treatment as well as by distributing free or inexpensive condoms (See Chapter Two for further discussion on the association between STI and HIV). Sixth, religious and community leaders have addressed the problem of HIV among the youth by promoting the concept of delaying first sexual encounter. This has contributed to the greatest change in sexual behavior being observed among the youth between 15 and 19 years of age. Seventh, billboards have been used to disseminate messages of AIDS and *care* for people living with the disease. Having the component of care as part of a message is important because people learn to associate AIDS with care, not just with death (See Chapter Five for the contrast in Kenya's approach).

Eighth, there have been impressive achievements in building the capacity of, and aggressively using leaders and volunteers from, the local communities to reach the

otherwise hard-to-reach rural population. The account given by Luba (1998, cited in the next paragraph) demonstrates that if recognized and tapped, community leaders and volunteers have the potential to make a cheaper, far-reaching, and more sustained impact in the fight against HIV/AIDS than institution-based health-care personnel. And nine, a regional center specializing in treatment of patients with HIV and training of African doctors on HIV-related management is currently being set up in Uganda (Wendo, 2001). The goal of the center is to strengthen medical infrastructure, replicate it across Africa, and counter the most cited constraint to accessing antiretroviral therapies in Africa, namely, lack of expertise and infrastructure in the region. Being a center for the entire sub-continent, the mission and vision, according to Wendo's description (2001:1957) is that "the hundreds trained at the center will then train thousands who will train millions."

I have isolated one of the strategies--equipping and using community leaders and volunteers--to show how all-encompassing the activities are. In a report that depicts what is happening in many parts of rural Uganda, Luba (1998) outlines several actions that have been taken in response to the Presidential initiative, that HIV/AIDS intervention requires teamwork and when each one plays a part, the epidemic can be brought under control. Community leaders such as Chiefs, Elders, and other volunteers have been recruited, trained and mobilized in AIDS work. The approach is simple and takes the form of learning how to identify cultural practices influencing HIV infection and how to promote behavior change. Strategies used as entry points into the community include home-to-home visits, schools, funerals, churches, markets, and other places and forums. The leaders are involved mainly in three activities:

giving basic information about HIV/AIDS, distribution of condoms, and advising on referrals to testing, counseling and medical services. As part of an education campaign for example, causes of death are announced at funerals (to discourage potential inheritors of widows), and families are encouraged to take care of widows and orphans. This example is typical of what is taking place at the rural community level in many parts of Uganda.

Uganda's top-down approach that started with political leadership and the subsequent multisectoral commitment of other departments and the business world, as well as the involvement of leaders and volunteers from the local communities, have resulted in a drop of HIV seroprevalence from 30% in 1992 to 15% in 1998 and to 8.3% at present (UNAIDS, 2000; Wendo, 2001; Opio et al., 2000). As I mentioned already, the biggest change is in the 15-19 age group, which shows that improvement is not merely that of an infected population dying off; but in preventing new infections (American Health Consultants, 1999).

There are two things I want to point out about the prevention activities going on in Senegal and Uganda. One, that with political prudence and foresight, the epidemic can be contained or even reversed. Uganda has amply demonstrated that being sensitive to local needs and recognizing that there is great potential in the people themselves, and using it, the fight against HIV can be won. Both Senegal and Uganda have shown that foreign funding for HIV activities can be used efficiently if it is directed at the needs that are relevant to specific countries and specific communities within those countries. As such, it is not just the quantity of material resources that is key to containing the HIV/AIDS epidemic in Africa; it is also the ability of political

leadership to use the resources efficiently. And the greatest potential is with the people themselves, both in terms of finding out what needs to be done, and in involving them in doing it. By giving them an opportunity to identify with and 'own' the projects, the community feels motivated and empowered to take responsibility for their own health.

The second point I want to note regarding these case studies is that biomedical, behavioral, and enabling environments are all necessary and should be used in combination to fight the disease, especially at the state level, because of the diverse backgrounds of the populace. However, each approach should be tailored to the needs of the people in their respective local circumstances. In Senegal for example, making sex work legal is reported to have provided an 'enabling environment' towards condom use and STI treatment, while in Uganda, 'enabling environment' has taken the form of providing social support and network at the national and community levels that made people come to terms with the disease, accept testing and/or take responsibility in the AIDS fight. In addition, building the capacity of members of the rural communities to address cultural practices that increase the risk for HIV (such as funeral rites that involve sex) has been more successful than bringing in outsiders, such as health personnel, to urge the people to stop the practice.

In the rest of the dissertation, I use the practice of widow inheritance as carried out by the Luo ethnic community in Kenya as a case study to support the position that to tailor interventions to the needs of the practitioners, it is necessary to identify the needs of the people from the people themselves and then to involve them in planning and executing the programs that target changing their behavior. In the section that

follows, and for the remaining part of the dissertation, I describe the processes that led me to hold this position.

Background of the study: Ideally, the procedural way to plan for a study is to start with a proposal. Indeed, the proposal writing stage is one of the most essential phases in research design and execution; one where logistical decisions are made about the *what* of the study (topic, objectives, questions, and theories), the *why* of the study (rationale, significance, and potential application of the findings), the *where* of the study (study site and populations), and the *how* of the study (approaches to data collection, analysis, interpretation, and presentation) (Creswell, 1998). In essence, a proposal is a mock situation in which the "field" is simulated in the mind of the researcher in a way that compels him/her to take a mental journey through the anticipated research steps, and then design the most effective and realistic strategies to address in advance issues that are likely to arise in the course of executing the study.

Important as proposals are, the component of the field study informing this dissertation was conceived of, in its entirety, during the phase of data collection for a study that was designed to investigate a different question (See Agot, 2001). Having emerged as an unplanned offshoot of another study[3], it did not enjoy the advantages associated with having a clear-cut blueprint of directions to follow. While this presented some drawbacks, especially in terms of not being able to put to use much of the reviewed literature and the other activities in the protocol, the uniqueness provided

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[3] This was not a natural consequence. Rather, it was a methodological reality in conducting participatory action research. In fact, I did not go to the field with the intention of opening my research process to incorporate the agenda of the participants. What I took to the field was flexibility, keen observational and discernment skills, and an open mind.

an unprecedented strength to the study as I entered into my fieldwork having given myself the freedom to adjust my initial plan and respond to the situations that were emerging when I embarked on my study. As I discuss in further detail later in the chapter, the main reason for adjusting my approach was after realizing that male circumcision, which was my initial topic of study, was not even considered a significant 'risk factor' for HIV by the respondents. They pointed out that they had more serious issues to discuss about AIDS than circumcision.

Thus, the first and main adjustment was to bring the participants on board by providing them with an opportunity to define the needs that they wanted to see addressed in the study. I did this by converting the first several field visits into 'needs assessment' sessions--a process that led to a redefinition of the study orientation, setting anew the research goals, questions, and hypotheses, and reworking the data collection strategies. I became less of a victim of what Janesick (1998) termed *methodolatry* (method + idolatry), that is, an over enthusiasm for methods, sometimes in oblivion of the substantive needs of the study participants. Even though I have said that making such spontaneous decisions was not my original intention, the flexibility allowed by this approach made it possible to integrate the needs identified by the participants and the research plans that I had in my prior agenda.

While I also agree that preparing for a study and laying down a procedure is important, I suggest the need to recognize when it becomes more beneficial to step out of methodological and/or theoretical enclosure(s) to view the research questions through the lens of the participants in addition to, or instead of, the lens of pre-set methodology and theory (what I term *metheodolatry* = methods + theory + idolatry).

However, I realize that this approach may be considered rather unorthodox by methods-bound and theory-bound researchers, but for this study, it gave participants an (rare) opportunity of setting the agenda for the study themselves and for placing what they considered important to them at the center of the whole exercise rather than (imposing on them) only what I had planned for.

For the next several sub-sections, I describe the procedures I followed to plan for and carry out the study, including how and why I abandoned or modified some of the initial procedures. I have reported most of the changes in the order in which they were made, and because these were done as the study was underway, some of the components (of the study) may appear inappropriately placed in terms of the conventional sequence. For example, I selected the study population and research sites before selecting widow inheritance as the topic to focus on.

Selecting study population, sites, and topic

Study population: The study was carried out among the Luo ethno-linguistic community in Nyanza Province, Western Kenya, along the shores of Lake Victoria (Figure 1). The Luo is the third largest ethnic community in the country, representing 13% of the country's population after the Agikuyu (21%) and the Abaluyia (14%). (http://travel.discovery.com). The community was selected for this study mainly because, in my mind as a Luo, it represents a paradox in the HIV/AIDS epidemic that I have found difficult to understand. On the one hand, it has almost always accounted

for the highest prevalence of the disease in the country since the late 1980s when complete data became available (Table 1)[4].

Within Nyanza province, there are four ethnic communities: the Luo, Abagusii, Abakuria, and Abasuba. The Luo ethnic community, which forms approximately 68% of the province's population, accounted for 85.1% of the provincial HIV prevalence in 1999 (NASCOP, 2000). By comparison, the Kikuyu of Central Kenya (forming 21% of the national population) and the Luyia of Western Kenya (accounting for 14% of the national population) (http://travel.discovery.com) accounted for 10.6% and 9.1% of HIV cases, respectively, in the same year (NASCOP, 2000).

On the other hand, the Luo community is the most researched ethnic group in terms of identifying risk factors for HIV (Government of Kenya, 1998), and is also the

Table 1: Percent AIDS cases in Kenya by province of birth, 1991-1999

Provinces	1991	1992	1993	1994	1995	1996	1997	1998	1999
Nairobi	7.5	1.9	2.8	13.6	4.8	5.7	3.6	4.1	4.7
Central	8.5	7.8	9.2	11.1	15.3	10.7	18.4	11.4	10.6
Coast	11.7	9.0	6.8	5.5	3.3	4.0	3.9	2.7	7.9
Eastern	13.3	15.2	16.2	21.0	22.7	23.0	24.0	24.9	18.3
North Eastern	0.3	0.3	0.3	0.5	0.6	0.3	0.4	0.8	0.4
NYANZA	**29.0**	**34.7**	**30.2**	**21.9**	**24.3**	**21.9**	**19.8**	**28.4**	**28.8**
Rift Valley	8.3	7.0	9.4	19.0	14.9	17.2	18.8	14.9	10.8
Western	6.7	6.2	8.6	7.5	9.7	12.7	8.5	7.8	9.1
Unspecified	14.8	17.9	16.2	3.3	4.4	3.8	2.6	5.0	9.1

Source: Kenya National AIDS and STD Control Programme (NASCOP), 2000 database.

[4] Table 1 shows the latest trend in HIV/AIDS cases in the eight provinces of Kenya. Nyanza has been leading consistently for most of the years, including the period prior to 1991 (data not shown). Within the province, the districts occupied by the Luo community (Bondo, Siaya, Kisumu, Nyando, Rachuonyo, Homa Bay, Migori, and Suba – see Figure 1) accounted for 85.1% of the reported cases of HIV/AIDS in 1999 [NASCOP, 2000] but only 68% of the population [http://travel.discovery.com]).

highest recipient of some of the most intense interventions in the country to date (see Chapter Five for details). The explanations offered by the government for the disproportionate prevalence of HIV in Luo Nyanza include the following: (i) the geographical proximity to the earlier epicenters of the disease in Uganda and Central African countries--an important factor especially considering the long periods of political turmoil in these countries which led to an upsurge of refugee population in Kisumu (the provincial headquarter of Nyanza) and its environs; (ii) an earlier onset of the disease in the region, mostly as a result of the refugee population, that contributed to the initial repository for the virus in the population; (iii) the fact that Kisumu is a major city along a trucking highway from Central African countries to the Kenyan Coast thus serving as a popular stop-over for the highly sexually mobile truck drivers and loaders; (iv) the absence of male circumcision; (v) endemic ulcerating STDs (also associated with lack of male circumcision); (vi) the labor outmigration and the resultant spousal separation in which men, especially, serve as bridge population linking originally core transmitter groups in cities to their spouses and other sexual partners in the rural countryside; and (vii) the societal beliefs, practices, and norms promoting sexual networking, such as widow inheritance (See footnote 1), polygyny[5], and other more subtle endorsement of sexual multipartnership for men (NASCOP, 1999; Government of Kenya, 1997; 1998; 1999; Lavreys et al., 1999; Rakwar et al., 1999; Okeyo & Allen, 1993; Agot, 1996; Odiwuor, 2001).

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[5] A marital union in which a man has more than one wife concurrently living with him under recognized customary or religious laws.

Three of these factors--lack of male circumcision, high prevalence of genital ulcer disease, and cultural beliefs and practices that encourage sexual networking--have been the focus of most current research and therefore merit further discussion. One of the important cultural identifiers that set the Luos apart from most of the communities in Kenya is that they do not practice male (or female) circumcision, except for pockets of followers of Islam and of a few African instituted churches[6]. There is also sporadic research showing that a few Luo men who are not affiliated with these religious groups are now choosing to get circumcised mainly for reasons related to health and genital hygiene (Lavreys et al., 1999; Bailey et al., 2001; Auvert et al., forthcoming; Agot, 2001). For instance, Auvert and colleagues (forthcoming--information obtained from Robert Bailey of the University of Illinois at Chicago) found that 11.5% of the study subjects who were Luos were circumcised. However, the authors did not disaggregate the respondents by church membership and some of the circumcised men could have been circumcised because they were members of churches that advocate the practice. In our study (Agot, 2001), only 5.6% of the men in non-circumcising churches had been circumcised, citing health reasons for doing so.

As such, the community is still considered largely non-circumcising, a factor that is believed to be contributing to the high prevalence of HIV among them, especially given the increasing evidence that it is relatively easier for non-circumcised

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[6] These are churches founded in Africa, by Africans, as opposed to those introduced by missionaries. Nine of them advocate circumcision of male members, namely: Nomiya Church (the first independent church in Kenya which began in 1907), and eight denominations which have broken away from it over the years--Nomiya Roho Sabato, Nomiya Church of Gospellers, Nomiya Luo Sabato, Nomiya Fweny Maler, Nomiya Roho Sabato Mowar, Yie Nomiya Roho Sabato, Nomiya Sabato Church, and Nomiya Luo Roho Sabato.

men to both contract and transmit HIV[7]. For instance, to date, at least 54 studies have been conducted to assess the potential association between male circumcision status and HIV. Thirty-nine (72%) of them have reported increased prevalence of HIV among those with intact foreskin ranging from 1.5-fold (Agot, 2001) to 8.1-fold (Cameron, et al., 1989) compared to circumcised men. Thirteen percent of these studies have shown trends towards an association (e.g., Mehendale et al., 1996), 13% have found no association (e.g., Barongo et al., 1992), while only one study (2%) in which women reported on the circumcision status of their spouses found a negative association (Chao et al., 1992). As a result of these findings, there is growing pressure to consider male circumcision as one of the strategies to curb the spread of HIV/AID in non-circumcising populations in sub-Saharan Africa (Moses et al., 1998; Weiss, Quigley & Hayes, 2000; Gray et al., 2000), and among the Luo specifically (Bailey et al., 2001; Auvert et al., forthcoming; Agot, 2001). For instance, in Luo Nyanza there is an on-going circumcision services being provided in the clinics in Siaya district (Bailey, Muga et al, 2001) while preparation for a randomized controlled trial (RCT)

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[7] In theory, male circumcision could act either to increase or decrease the prevalence of HIV-1. On the one hand, there is a possibility that if performed under unhygienic conditions, circumcision could actually be responsible for transmitting the infection. On the other hand, several physiological and biological processes have been suggested to explain the mechanism for the association between an intact foreskin and HIV-1 acquisition: 1) The HIV-1 virus targets the Langerhans cells and macrophages in the inner mucosal surface of the foreskin, both of which are coated with CD4 receptors (Szabo and Short, 2000; Jessamine et al., 1990). Most cases of primary HIV-1 infection are thought to involve HIV-1 binding initially to CD4 positive cells, making them the primary point of viral entry into the penis of an uncircumcised man. This is particularly important because during sexual intercourse, the foreskin is pulled back down the shaft of the penis, and the inner surface of the foreskin is exposed to vaginal secretions, providing a relatively large area where HIV-1 transmission could take place (Szabo and Short, 2000, Moses et al., 1999; Nasio et al., 1996). Male circumcision therefore would provide protection by removing most of the vulnerable mucosal lining. 2) The mucosal lining of the foreskin may be susceptible to minor injuries during intercourse, given that in uncircumcised men the epithelium lining the glans penis and preputial sac is thinner and less cornified than that of circumcised men (Szabo and Short, 2000; Lavreys et al., 1999). And 3) the warm and relatively moist environment under the foreskin may act as an incubator and thus facilitate replication of the virus, in addition to allowing longer viral persistence and offering greater exposure time and opportunity for viral penetration (Szabo and Short, 2000; Kelly et al., 1999).

is underway in Kisumu district. Actual intervention study for the RCT in planned for beginning in January 2002 (Bailey, Moses, et al, 2001).

Many studies have also found a positive association between sexually transmitted infections (STI), especially genital ulcers, and a higher prevalence of HIV (Lavreys et al., 1999; Nasio et al., 1996; Jessamine et al., 1990; Cook et al, 1994; Seed et al., 1995). The ulcers provide portal entry points for the virus, thus increasing the chances of infection. For the same reasons as described in footnote 7 in the previous page, the association is found especially in males who are not circumcised (Tyndall et al., 1996; Weiss et al., 2000), indicating a synergistic effect because those who are not circumcised are at increased risk for genital ulcers (Greenblatt et al., 1987; 1988; Lavreys et al., 1999). However, absence of circumcision is also an independent risk factor for HIV (Tyndal et al., 1996; Jessamine et al., 1990; Lavreys et al., 1999). Presently in Luo Nyanza, the Ministry of Health and several international donor agencies (especially United States Agency for International Development--USAID, 1996, and the Belgium Administration for Development Co-Operation--BADC, 1997; 1998; Meester et al., 1998) are providing essential drugs for STI as an intervention to reduce the infections in the region, and in so doing, to check the spread of new HIV infections in the community.

Since the advent of HIV/AIDS, cultural beliefs, norms, and practices of the Luo community have been studied and/or publicly debated more extensively than of any other group in Kenya (Government of Kenya, 1998; 1999). Of particular concern are those traditions that lay ground for multiple sexual partnerships, notably polygyny and widow inheritance. Polygyny can be 'official' (when a man is legally married to

more than one wife), clandestine (when a monogamous man has extramarital sexual relationships), or both (when a polygynous man has sexual affairs besides his lawful wives). Research evidence is building to show that 'official' polygyny poses less HIV transmission risk than having other sexual affairs outside in a monogamous marriage (Agot 1996; Oppong, 1998; Meda et al., 1999). It may therefore be safer to have more than one wife and be mutually faithful to the relationship than to be monogamous but have outside sexual affairs.

Kenya's Ministry of Health believes that the practice of widow inheritance is associated with increased risk for HIV acquisition and transmission (NASCOP, 1999; Government of Kenya, 1998; 1999). However, even though awareness campaigns have been going on since the late 1980s urging the Luo to stop the practice as one of the strategies to check the rapid spread of HIV among them, the potential association between the two variables (widow inheritance and HIV) has not, to date, been verified empirically[8]. Instead, the Ministry has based its interventions on plausibility of such an association, that is, that widow inheritance implies multiple sexual partners, which increases the risk for HIV infection. At this point, therefore, the proportion of HIV among the widows or among the general population that is attributable to the practice is still unknown. Nevertheless, there are three scenarios in assessing the potential risk that could be associated with the practice--what I have labeled the biomedical, the cultural, and biomedical-cultural (or in-between) perspectives. I highlight the perspectives below; but a more detailed exposition is in Chapter Four.

[8] To my knowledge, there is no study that has examined widows and actually found those who are inherited to have either higher incidence or prevalence of HIV relative those who are not. The current interventions are basing their activities on the biological plausibility of an association (additional details in Chapters Two and Four)

In terms of biomedical explanation, the practice of widow inheritance can be a 'risk behavior' for HIV. For instance, at the start of a relationship of inheritance, there are four possible circumstances that would affect the risk of acquiring or transmitting HIV: 1) when both the widow and the inheritor (and his sexual partners, if applicable) are seronegative for HIV (and remain mutually faithful to the relationship afterwards) and therefore pose no risk to each other; 2) when the widow is positive for HIV and transmits the virus to the inheritor (who in turn may infect his wife or wives or other sexual partners); 3) when the widow is negative for HIV and acquires the virus from the inheritor (and may infect subsequent sexual partners); and 4) when both are positive for HIV and re-infect each other, potentially leading to a faster progression to AIDS and death.

In terms of cultural explanation however, many subjects endorsed a very practical means by which widow inheritance can actually reduce the spread of HIV. To them, an uninherited widow is 'free', meaning she is not under the control of a father, brother, husband, or any male person. Thus, they argued, a widow who is not inherited, regardless of her serostatus, would be more inclined to be involved with multiple sexual partners and would consequently pose a greater danger to herself (if she is seronegative) or the community (if she is positive for HIV) by transmitting HIV to an unknown number of people. But if she were inherited and positive, she would affect only one man and his wife/wives (or one man *at a time* even when she divorces and acquires other inheritors). In this hypothetical scenario, the virus would be relatively contained. Thus, to them it makes intuitive sense to argue for inheritance as a public health strategy to check the rapid spread of HIV/AIDS within the community.

Another way to conceptualize the cultural perspective to the relationship between widow inheritance and risk for HIV is in terms of *chira*[9]. *Chira* is a wasting condition believed to be brought about by breaching of taboos, especially sexual taboos associated with declining to be inherited, or having sexual affairs outside marriage at certain periods such as during mourning, lactation, or in events where sexual rite is required between spouses (See sub-section on "Cultural Perspective" in Chapter Four). Besides wasting, *chira* also presents with persistent cough, persistent diarrhea, thinning and loss of hair texture, loss of skin luster, and generalized malaise. Given the association of both AIDS and *chira* with someone (in the relationship) having contravened some sort of sexual contract, and also given the similarities in the signs and symptoms, most participants conflated AIDS with *chira* during the discussion. It is important to note therefore that inheritance performed according to the traditional prescriptions is perceived to protect against the potential risk of acquiring *chira*--even though this was frequently conflated with AIDS--hence while 'risk' in biomedical framework is defined in terms of being inherited, in cultural framework, 'risk' is defined in terms of failing to be inherited.

In combining both cultural and biomedical terms (what I refer to as biomedical- cultural or 'in-between' position) however, the risk does not depend on whether or not a widow is inherited, but on whether or not she abstains from sex after her husband dies. If not, it would be safer for her (regardless of her serostatus) and for

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[9] Belief in *chira* has always been with the Luo and is traceable to the first ancestor of the community (Ramogi). *Chira* was instituted primarily to guard against potential misbehavior towards elders as well as around sexual norms. Due to the similarities in the 'clinical' manifestation between *chira* and AIDS, there was a tendency to view AIDS not as a new disease but as something that has always been with the people. Examples of such attitudes are presented in Chapter Four.

the community at large, if she were inherited. This was premised on the understanding that women who reject inheritance may have more sexual partners than those who accept to partake of the relationship. And since many men who die from HIV are young, women are entering widowhood at a much younger age, and abstinence from sex may not be an easy option to select and comply with. In this respect, widow inheritance in itself does not constitute risk for HIV; it is the sexual activity in widowhood that should be addressed by intervention programs, particularly the elements that increase vulnerability of the widows and the community (discussions on the current components of inheritance is in Chapter Four). In a way therefore, avoiding 'indiscriminate sex' would fulfill the cultural requirement of avoiding *chira,* and in so doing, protect against HIV at the same time.

Overall, it is important to point out two things. One, that the practice of widow inheritance could, in fact, be more dangerous to the male inheritors because an increasing number of widows who are eligible for inheritance are also seropositive for HIV. However, as I discuss in Chapter Two, there is more social pressure for the widow to be inherited and as such, most interventions target the women rather than the inheritors. And two, none of the practices discussed above (lack of male circumcision, widow inheritance, or polygyny) is a preserve of the Luo community alone. The Luo just happen to be the only community that has had their cultural practices studied to any extent (Government of Kenya, 1998). Similarly, sexual rites are not limited to this community, and the Government of Kenya is sounding a call for studies to be carried out in other communities as well (Government of Kenya, 1999).

However, there is still significant disparity in HIV prevalence between the Luo and other communities who are sharing similar cultural practices. For instance, the Teso of Western Province and the Turkana of North-Eastern Province of Kenya do not practice male circumcision yet had lower prevalence of HIV in 1999 relative to the Luo (4.2% in Kakamega, and 0.3% in Turkana, respectively – NASCOP, 2000). Also, the Abagusii, the Abaluyia, and the Miji Kenda communities, to name but a few, practice widow inheritance (Okeyo & Allen, 1993; Agot, 2001; Mahindu, personal communication, May 17, 2001) but accounted for a prevalence of approximately 4.2%, 9.1%, and 3.0%, respectively in 1999 (NASCOP, 2000). Polygyny is also widespread and common to nearly all communities in Kenya (NCPD/CBS/MI, 1998).

However, the relatively higher prevalence of these practices among the Luo, as well as the meanings and specific activities associated with some of them (such as sexual rites forming an integral part of widow inheritance), are believed to be partly responsible for the relatively higher prevalence of HIV/AIDS in the Luo community (Government of Kenya, 1998; 1999). Despite the many 'risk factors' and 'risk situations' (both concepts defined in Chapter Four) that have been identified in the community, this dissertation focuses only on the practice of widow inheritance, its perceived risk for HIV, and the interventions that have been designed to address it. In the next two sub-sections, I discuss the process of selecting research sites and topic.

Research sites: Subjects were drawn from eight of the twelve districts in Nyanza Province (Figure 1), seven of which are occupied by the Luo community (Bondo, Siaya, Kisumu, Nyando, Rachuonyo, Homa-Bay, and Migori) and one

occupied by the Abasuba[10] community (Suba). The initial study was designed to examine the association between circumcision status and the seroprevalence of HIV-1. I used African instituted churches as entry points into the community, and compared 398 circumcised and 447 non-circumcised men from these churches[11]. In all, my research team and I visited 39 of the 43 divisions of Luo Nyanza, reaching leaders of 66 denominations and 399 congregations in 161 venues (further details in Agot, 2001). At each venue, we met between 17 and over 200 participants (depending on whether we went during a normal church service, a special church function, or a weekday) and discussed the issues of the study with a cross-section of close to 12,000 people. The participants comprised of men and women 15 years or older, even though most of them were women and older men. For most part, both church leaders (clergy and administrators) and members of the general congregation participated in the discussion sessions together. During the discussions, we also identified and followed up eleven key informants for in-depth interviews on the origin of the practice of widow inheritance and the changes that have been made over the years. Further discussion on the specific activities carried out at the sites comes later in the chapter.

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[10] The Abasuba is a Bantu ethno-linguistic group (whereas the Luo is a Nilotic ethno-linguistic group), but the generations of living among the Luo has left relatively few traces of their uniqueness as a group, except for those in the Islands such as Mfangano. For example, most of the Abasuba speak mainly the Luo language (*Dholuo*) and practice many of the cultures, including widow inheritance, in exactly the same format and for exactly the same reasons. As such, 'Luo Nyanza' is used in this dissertation to refer to all the eight districts.

[11] The Luo ethnic community does not traditionally practice male circumcision. Most Luo men are Christians, some of who are members of African instituted churches (churches founded in Africa, by Africans, as opposed to those introduced by missionaries). A subset of African instituted churches advocate circumcision as part of their religious teachings. Among the minority of Luo men who are circumcised, the practice is often linked to membership to such a church (The churches are listed in footnote 6).

Selection of the research topic: As mentioned previously, the part of the study that eventually informed this dissertation was not conceived of prior to the data collection phase; it arose during a study investigating the association between male circumcision and HIV-1 seroprevalence (Agot, 2001). My interest was drawn to HIV/AIDS in sub-Saharan Africa largely because of the continuing rapid spread of the disease despite the numerous intervention programs that have been going on to address it (UNAIDS, 1997; 2000; USAID, 1996). With respect to the Luo specifically, my initial hypothesis was that the main reason why HIV continued to ravage the community despite interventions addressing sexual behavior change was because men were not circumcised. I was particularly intrigued by the close spatial correlation that had been shown by Moses and colleagues (1990; 194; 1998) between regions in sub-Saharan Africa occupied by ethnic communities which do not practice circumcision and those that had high prevalence of HIV/AIDS. My initial study was designed to test the hypothesis that HIV was associated with lack of circumcision. I hoped that by conducting an individual-level (rather than ecological) study that controlled for a number of key alternative explanatory variables such as other cultural practices and status of other sexually transmitted infections within a single ethnic group, I could provide what I considered would be once-and-for-all evidence supporting the 'overdue' need to introduce circumcision in the community as an intervention strategy to stem the spread of the epidemic.

The initial study was thus a highly structured person-to-person survey. Given the focus on male circumcision and the prevalence of HIV-1, only males aged between 15 and 59 years were eligible to join. All women as well as men outside this age range

had no part in the initial study. However, the only time we could meet with the potential participants was during normal church functions where, ordinarily, women and older (60 years and over) men were disproportionately represented relative to eligible men (i.e., 18 – 59 years old), often in a ratio of over 15:1. Even though this group was 'irrelevant' as far as our 'main study' was concerned, we could not simply dismiss them without raising suspicion about our research agenda. I was therefore compelled to devise an impromptu plan to engage them in something--anything--while we waited for the 'eligible men' to go through what to me constituted the *main* study. For lack of anything 'substantive' to do, it made sense to talk with them to find out how much they knew about HIV and AIDS in terms of its definition, routes of transmission, risk factors, and prevention strategies. In addition, I thought it would be interesting to open up the discussion for questions, and this way, I could obtain additional information that could provide useful background for the dissertation.

As it turned out, what was initially planned as a non-substantive 'pass-time' with *ineligible* subjects yielded the most valuable insights about the HIV/AIDS situation in the community. After a few visits, it was becoming increasingly clear that participants were concerned with bigger and more urgent issues than the male circumcision in our agenda--issues that they felt had hitherto been bypassed by the interventions. It was clear, for example, that basic knowledge about HIV/AIDS was desperately inadequate. Yet at the time of the study, Nyanza Province was boasting a 99% public awareness of HIV/AIDS (Government of Kenya, 1999; NASCOP, 1999). It was true that everyone we met had *heard* of AIDS but few of them knew what it really was (i.e., as distinct from *chira*), fewer knew how it was transmitted or

prevented (as separate from sexual taboos associated with *chira*--see Chapter Four), and fewer still had conceptualized the biomedical link between widow inheritance and HIV acquisition and transmission. Overall, it was evident that participants had different conceptions not just of what AIDS was and how it was transmitted; they also had different definitions of what constituted 'risk' for HIV (discussed further in Chapters Two and Four), as well as what they felt needed to be done to improve the effectiveness of the interventions (Chapter Six). Even though circumcision status was our main focus, this did not feature as priority in their list of concerns. In fact, it hardly featured at all in most of the sites we visited--including the churches where the practice was recommended--until we brought the topic up ourselves.

Although I went ahead with the circumcision component of the study (See Agot, 2001), I had to redefine my research goal (and attitude) to convert what started off as a pass-time activity into a core component of the study. The change in the approach allowed participants, as Spivak (1988, in Craddock, 2000) would say, to re-define risk as they saw it, to challenge official discourses about the 'riskiness' of the behavior of widow inheritance, to question the appropriateness of the intervention programs targeting the practice, and eventually, to chart out what they felt should be done to make the intervention programs more responsive to the needs of the community. These are the tasks I address in the rest of the chapter.

Purpose and significance of the study

Since the late 1980s, the Ministry of Health in Kenya, supported by several international donor agencies, has targeted the Luo community with educational

campaigns through print and electronic media, workshops, and politic rallies aiming at eliminating the practice of widow inheritance, among other factors (Government of Kenya, 1997; 1998; UNAIDS, 2000). Yet, according to studies conducted in the community in 1993 (Okeyo & Allen, 1993), in 1996 (Agot, 1996), and in 2000 (Field data), 51%, 55.2% and 57.1% of the widows, respectively, were inherited at the time of the study. Almost all those who had been widowed for at least one year reported having been inherited at least once during the entire period of their widowhood. The purpose of this study was to work *with* study participants to identify where the current interventions have failed to address their needs and to make recommendations that can both fulfill the goal of the interventions in reducing the risk for HIV for the widows and the community while at the same time effectively fulfilling the cultural requirements of the practice.

Research questions

The questions that follow are drawn from the five objectives of the dissertation, namely: i) an assessment of knowledge level of the participants in linking widow inheritance to the risk of HIV/AIDS (Chapter Two); ii) a construction of the concept of 'spaces of vulnerability' in understanding the relationship between widow inheritance and HIV (Chapter Three); iii) an evaluation of the concept of 'risk' and its utility in the study of HIV/AIDS in sub-Saharan Africa (Chapter Four); iv) an examination of the appropriateness of the current interventions programs aiming at eliminating the practice of widow inheritance (Chapter Five); and v) a reorganization of the intervention strategies so as to be more responsive to the needs of the

community while also fulfilling the goals of state interventions in reducing the risk for HIV (Chapter Six).

Question on labeling widow inheritance as a risk behavior: Do the participants consider widow inheritance as a risk behavior for the acquisition and transmission of HIV? A primary concern for any intervention program aiming at behavior change should be to ascertain that the recipients have conceptualized the potential association between the behavior of interest (e.g., widow inheritance) and health risk (e.g., HIV), otherwise expecting people to change a behavior that they have not yet associated with the risk in question is unfeasible. Either due to genuine misconception or deliberate attempt to take refuge under the 'façade' of *chira*, respondents in individual interviews attributed the deaths of their siblings to causes other than AIDS, even when their description of conditions preceding these deaths was highly suggestive of the disease. However, the general trend, especially arising from the discussions, was that AIDS was still being conflated with *chira* (see Chapter Four). As such, it should only be after ascertaining that the practitioners have linked their practice to HIV that interventions should then proceed to ask why the behavior continues to be upheld despite this awareness.

Question on 'vulnerability': What factors increase the vulnerability to HIV for widows who are inherited relative to those who are not? In brief, I have presented 'vulnerability' as resulting from an interaction of three factors, namely: a widow's background characteristics (e.g., whether or not she is educated and how this translates

into her belief in taboos associated with inheritance); her relationship with other members of the society (e.g., if, as a mother, her children would expect her to be inherited); and her religious affiliations (e.g., whether or not her faith supports the practice).

For instance, a widow who is educated (and who may therefore not believe in *chira*) and who is employed away from the rural home (and for whom certain requirements for inheritance, such as 'taking care of the grave' for a specified length of time, may not be feasible) may personally not wish to be inherited. But because she is also a mother, her children may expect her to be inherited in order for them to be 'protected' against possible affliction by *chira* (see Chapter Four for further discussion). Her other subject identities, such as being a mother-in-law, or a co-wife, or a sister, and so on, may also put additional pressure on her. In other words, in deciding whether to be inherited or not, a widow has to consider not only how compatible her social standing (her background characteristics) is with the various requirements of the practice; she would also take into account trade-offs, for example, between her own risk for acquiring HIV and the perceived misfortunes that may befall her family if she is not inherited, or what this decision would cost her in terms of relationship with her family. Given these concurrently competing interests in her decision towards the practice, widows experience varying 'spaces of vulnerability' for inheritance, and subsequently for HIV, in the course of their widowhood.

<u>Question on 'risk' for HIV</u>: Does widow inheritance constitute 'risk' for HIV? In terms of risk, I stated earlier that widow inheritance as an institution does not

automatically pose risk, and that not all widows face similar magnitude of risk when they are inherited. The reason of raising the issue of 'risk' is to examine the components of the current practice that would pose higher risk for the practitioners within different scenarios, such as by being inherited by men who have inherited other widows, or by strangers whose background behaviors are unknown, or by divorcing and acquiring a series of inheritors.

Question on current interventions: How appropriate are the intervention methods and messages in responding to the concerns raised by the participants regarding their conceptions of 'risk' and 'vulnerability'? In other words, do the intervention designers and providers conceptualize the two terms in the same way as the recipients of these interventions? And are the interventions designed to respond to the contextual milieu (cultural, social, economic, and religious) within which widows get inherited, and within which HIV could potentially be contracted or transmitted? As I alluded to in the previous question, a widow's decision about whether or not to be inherited is dependent also on her relationship with her immediate and extended family members.

Thus, by working with communities in health interventions rather than with individuals alone, intervention programs would be focusing on changing policy, social structures, social norms and cultural practices that surround widow inheritance as a risk behavior, not just the widows by themselves, or the practice by itself. It has been reported that community-based changes working at the level of changing local cultures and sub-cultures have potential to effect long-term maintenance of changed behaviors by changing the environment surrounding the individuals to support safe behaviors

(King, 1999). As Ulin (1992, in King, 1999) suggests, when interventions have enabled the participants themselves to take part in mobilizing and setting their own goals, efforts to change behavior have been highly successful (in King, 1999:35). In setting this question, I am proposing that designing appropriate interventions without genuine involvement of the community in which they will be implemented will produce dismal results. My point is that effective interventions are not just what make biomedical sense with regards to the association between sexual behavior and disease transmission; they must make cultural sense as well. In other words, they must be both biologically and culturally competent.

Question on reconciling biomedical and cultural agendas: Are there ways in which the public health goal of minimizing the risky components of widow inheritance can be achieved in a manner that is also culturally appropriate and effective? Are there, in other words, safe alternatives to widow inheritance that also fulfill the perceived cultural functions of the practice? Two levels of effectiveness are implied by this question, one, whether or not the alternatives are effective in minimizing or eliminating the chances of the widows to acquire or transmit HIV, and two, if the alternatives can fulfill, sufficiently well, the original functions of the practice. For instance, if sex is left out of the practice (See requirements for sexual rites in Chapters Two and Four, and suggestions of how to exclude sex from the contract in Chapter Six), are the substitutes still perceived to be sufficient to ensure protection and safety for the widow and her family against affliction by *chira* or other misfortunes in the

same way as she would have been 'protected' had she followed all the recommended procedures that involve sex?

Assumptions of the study

a. The study was set on the premise that state-initiated interventions to reduce or eliminate widow inheritance are ineffective because the widows (and the community at large) have not labeled the practice as a risk factor, and also because the perceived cultural consequences of not being inherited balance or outweigh the fear of AIDS. In this dissertation (in Chapter Five), I am arguing that the current interventions are addressing neither of these shortcomings.

b. Basing interventions on information derived from members of the Luo community would be more effective in inducing behavior change than when the cultural, social, economic, and religious contexts of the practice are ignored.

c. When widows are able to perceive that certain components of inheritance may pose increased risk for HIV, they would be more likely to change their behavior if they were provided with safe alternatives to inheritance to choose from; if they believe in the efficacy of the alternatives to perform cultural functions similar to those provided by inheritance; and, especially, if they have support from their family, clan, and church members for their decisions to practice safe alternatives.

For the remainder of this chapter, I present the actual data collection exercise, and the subsequent management and analysis of data, as well as the interpretation and presentation of results.

Setting up: obtaining permits and approvals

Before embarking on the study, I obtained ethical approvals from the Human Subjects Review Board of the University of Washington, from Kenyatta National Hospital in Nairobi, and from the Provincial Internal Review Board (IRB) in Kisumu. In addition, I also visited the Provincial AIDS/STD Coordinating Officer (PASCO) of Nyanza province, as well as the Medial Officers of Health (MOH) and the District AIDS/STD Coordinating Officers (DASCO) in all the eight districts of Luo Nyanza to inform them of the study and to obtain information on the activities that they are involved with in addressing the epidemic. I also obtained research permits from the Office of the President, from the Nyanza Provincial Commissioner, from the eight District Commissioners, and from a number of local chiefs with jurisdiction over the study area.

Finally, because of my initial interest in male circumcision, and because among the Luo community the practice is performed as a church requirement rather than a cultural requirement, I visited both the Africa and the East Africa head offices of an organization that brings together most of the non-missionary denominations[12], the Organization of African Instituted Churches (OAIC). Among these denominations,

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[12] In this dissertation I use the term 'denomination' to refer to the main groping of the Christian religion, such as Episcopal or Roman Catholic; 'church' is used to refer to the local worship places belonging to the denominations; and 'congregations' to denote members of these local 'churches'.

a few advocate circumcision of males (footnote 6) while the majority does not. The purpose of my visit was to obtain lists of member and non-member denominations and to get someone to guide me to the leaders. We (my guide and I) visited leaders of all 63 denominations on the list, as well as five others whom we identified during the set-up phase. During our visit, we obtained the lists and physical locations of local churches for each denomination, and also conducted focus group discussions with the leaders about their teachings on, among other factors, widow inheritance.

Altogether we contacted 68 denominations and obtained permission to carry out our study from leaders (Archbishops, Bishops, Archdeacons, and Deacons) of 66 of them. Two declined to join the study. From the 66, we selected only eighteen denominations for purposes of field visit; nine that advocate circumcision and nine that do not[13], matching them on the basis of, among other factors, geographical proximity (churches with congregations in the same district) and teachings on polygyny and on the practice of widow inheritance. The nine circumcising denominations compiled a list 448 local churches across Luo Nyanza, while the selected nine non-circumcising churches had 505 local churches. We eventually met with leaders of 399 local church congregations for purposes of setting up research dates and venues and for mobilizing church members to turn up to participate in the study. I selected members of these denominations to serve as field guides to the study

[13] At this point of selecting participating churches, the study was still proceeding as initially planned; hence I based the selection criteria on the practice of male circumcision. The selected denominations that do not advocate circumcision included: Church of Peace in Africa, Church of Christ in Africa, Voice of Healing and Salvation Church, St. Meshack, Mercy and Holy Ghost Church, Church of Mercy, Church of Savior, Coptic Orthodox Church, and Israel Nineveh. Also in attendance in a few discussion sessions were members of New Church of Savior, Holy Ghost Orthodox, Musanda Holy Ghost, and New Pentecostal Evangelistic Church.

sites and as links with the study participants. The procedure of selecting participants is presented in Figure 2 below.

From the figure, 208 of the congregations we met belonged to denominations that supported the practice of widow inheritance, 142 were neutral, and 49 opposed the practice. The wide difference in the number of congregations recruited in the study resulted from the fact that at least one-fifth of the members of denominations that recommend circumcision for their members were not circumcised, forcing us to select more congregations from them so as to obtain comparable sample size. It turned out that eight of the nine denominations which advocate male circumcision supported widow inheritance while one was neutral, hence selecting more circumcising congregations yielded more supporters of the practice. Four of the denominations that do not recommend circumcision for their male members opposed widow inheritance, one supported the practice, while four were neutral.

After selecting the 399 local congregations for field visit, the leaders, the guides from respective denominations, and I selected those that were centrally located to serve as venues for meeting with the participants. During these visits, we also set dates for the visits and made arrangements for passing on information to prospective participants.

However, I was not able to enumerate the actual number of participants or record the sociodemographic characteristics of the respondents for two reasons. 1) Because the initial plan of the study did not involve open group discussions, and also because the focus groups discussions with denominational leaders were conducted for

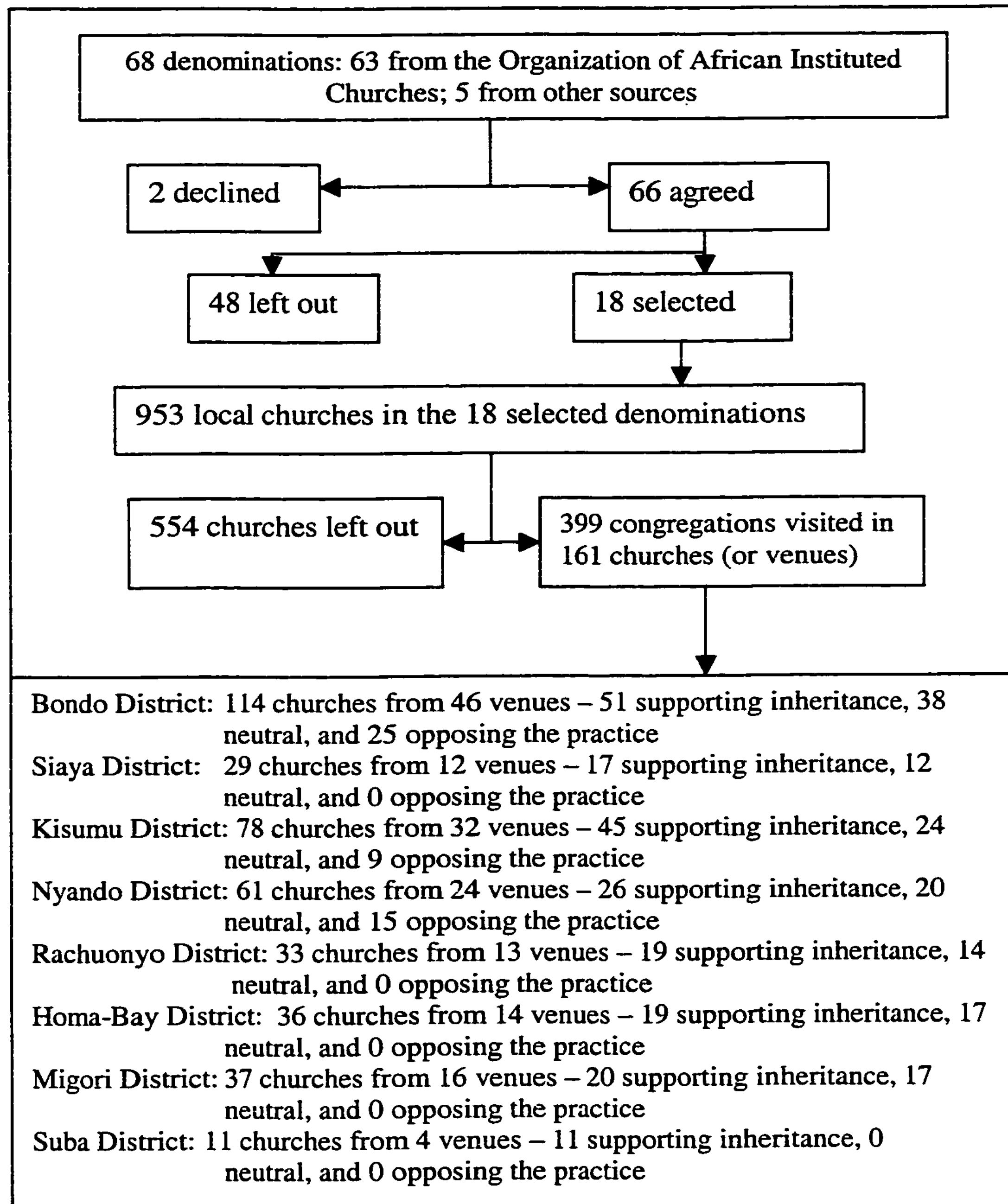

Figure 2: **Participant selection procedure**

purposes of selecting churches with comparable teachings on widow inheritance and polygyny, background characteristics did not constitute the criteria for selecting participants. And 2), attendance ranged from 17 participants when we visited during weekdays to over 200 when several churches came together to participate in the study or when our visits coincided with a major church function such as during ceremonies associated with circumcision or ending of mourning periods. As such, it was not feasible in many instances to obtain background information on such large number of participants. The only characteristics that I was able to obtain from video taped recordings and field notes were the sex and estimated age of participants who spoke up during the discussions.

The research team and their responsibilities

The research team comprised of 13 members--11 males (10 of whom were from the Luo community) and two females (both Luos). There were four male nurses (two alternating on a monthly basis and each with a substitute), two male interviewers, two male field guides (one was a member of a circumcising denomination and the other belonged to a non-circumcising denomination), three laboratory technologists (two in Nyanza Provincial General Hospital in Kisumu and one--the only non-Luo--in the Department of Medical Microbiology, University of Nairobi[14]), one data clerk, and I (the research leader). The nurses were in charge of interviewing male participants about their medical history, conducting pre-HIV test counseling, taking blood specimens, and observing both circumcision status and genital hygiene. When time

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[14] The technologist, Mr. Gregory Maitha, passed away in April, 2001 during the write-up of this dissertation.

allowed, they joined me in the open discussions and responded especially to the sentiments expressed towards the way the Ministry of Health is carrying out the interventions. In addition, they provided post-test counseling and gave back HIV results at subsequent visits. The interviewers were in-charge of conducting confidential oral interviews with male participants using a prepared standard schedule, while the guides took charge of setting up research dates and venues, arranged for passing on the announcement to potential participants about our visits, guided the team to the sites, and introduced them to the congregation. Both the guides and the interviewers assisted me with video and audio recordings of the focus groups and open discussions. The two laboratory technologists in Kisumu were in charge of separating the serum from the plasma and for storing it in readiness for bi-monthly transportation to Nairobi for HIV-1 analysis.

As the research leader, my responsibilities were multiple. Besides obtaining all the permits from relevant authorities and sending introductory letters to all leaders, I was also in charge of the following during the visits: 1) explaining the purpose and procedures of the study to the entire congregation; 2) obtaining consent and issuing confidential identity cards to the men who were participating in the individual interviews; 3) facilitating both focus and open group discussions, taking field notes, and occasionally audio and/or video recording the sessions; 4) assisting with computer data entry of data from individual interviews, transcribing discussion sessions from video and audio recordings, and typing field notes; 5) conducting key in-depth interviews with selected participants; 6) coordinating the activities of the rest of the team members, including procurement of medical supplies, attending to subjects'

confidentiality during releasing of results, and making all payments, and 7) analyzing the data .

To accomplish all these tasks, I brought into the study four main advantages. One, as the leader, being a member of the Luo community helped the team to gain trust from participants who welcomed us as insiders (even though having lived away from my rural home since 1980 except for periodic visits, I was actually an insider-outsider). In fact, being a Luo was the main reason why I was allowed, as an educated and working *woman*, to venture into a study such as AIDS and male circumcision which not only touches on sexuality, culture, religion, and AIDS, but which was also very private and intrusive[15]. Being from the community and speaking *Dholuo* fluently enabled me both to facilitate the discussion sessions and to respond to questions and issues of concern comfortably. This was particularly useful in understanding the figurative speech often used when talking about issues such as sexuality in public.

Two, my dual training in both public health and social sciences armed me with adequate information about HIV/AIDS and the strategies to deliver it. I was thus able to respond to participants' questions and engage with them in discussing topical issues such as condom use and sexual abstinence. Three, I had previously conducted other public health-related studies in the same community (See my Curriculum Vitae at the end of the dissertation) and was thus aware of, and prepared for, some of the sentiments potential participants would have regarding a study such as ours. And finally, being a Christian (although not from an African Instituted Church) prepared

[15] Part of the procedures the nurses undertook were to physically verify circumcision status and genital hygiene level of the male subjects. Blood specimens were also collected for HIV-1 screening, and interviews covered sensitive questions such as a description of washing the genitals, methods of foreplay before sex, and extra-marital sexual affairs. This, however, was done in confidence by the male clinicians.

me to respond to issues that were based on *The Bible* and to comfortably attend and sometimes participate in certain church functions, for example, giving short sermons, presiding over fundraising, addressing church women groups on matters of reproductive health and *The Bible*--all of which I was requested to do from time to time.

In addition, to demonstrate that our interest was not just in obtaining data, we attended all the church functions that were taking place during our visits, from the weekly sermons, to the circumcision, wedding, burial, and baptismal ceremonies. During these occasions, we joined their agenda and did what everyone else was doing, such as removing shoes when entering the church, covering hair as required of women, singing and giving offerings, sitting on mats on the floor with women on occasions, and so on. We introduced our agenda only after the activities of the day were over; when we were given permission to proceed.

Methods of collecting data.

Data collection lasted between April 1999 and June 2000 and was conducted in *Dholuo,* the local language. As I stated previously, my original plan was to conduct a quantitative study using survey technique (for detailed procedure, see Agot, 2001). When widow inheritance was incorporated as the second main part of the study (rationale for selection of study topic is discussed earlier in the chapter), a second methodology was adopted. For this component of the study, primary information was derived from three sources: 1) Denomination-level focus group discussions with leaders of different denominations during the set-up phase of the study. However,

during this time our study was still focusing on male circumcision, and discussion on widow inheritance did not receive very prominent attention, except as one of the factors we planned to use in selecting participating denominations. 2) Open group discussions at the church congregation-level, focusing on widow inheritance and other cultural practices. Both the clergy and the congregants participated in the discussions. And 3), individual-level in-depth interviews on the origins of widow inheritance, conducted with selected community elders. Secondary information on intervention policies and activities was obtained from archival data from various government publications, official reports from international and nongovernmental organizations, as well as from local newspapers.

Primary Data

Denomination-level Focus Group Discussions: For six months prior to visiting local churches, I met with the top leadership of 68 denominations (Archbishops, Bishops, Archdeacons, Deacons, pastors, and various leaders at middle level and junior ranks) to, among other things, discuss their doctrines regarding widow inheritance. Because the topics of HIV/AIDS and widow inheritance were both sensitive and embedded in cultural and religious traditions, the focus group approach allowed us the flexibility of making adjustments whenever we detected lines of discomfort from the respondents during the sessions. The interactive nature of this approach also provided an opportunity to identify issues that the community found most problematic in accepting the intervention to modify the practice. We dealt particularly with the teachings of the denominations regarding inheritance--whether or

not they condoned the practice and the reasons and bases for their position. Those who opposed it were further questioned regarding their rules about members who join the church when they were already inherited and those who got inherited after joining the church, while those who supported or were neutral about the practice described how their churches got involved in such arrangements. Altogether, the discussions took an average of three hours. Details of discussion guidelines are in Appendix 1.

Congregation-level Open Group Discussions: Because the research activities were carried out in churches, most of the time we reached participants only during normal church functions. As such, discussion sessions comprised of everyone 15 years or older who was in the church on the day of our visit and who wished to join the discussion. The sessions were divided into six related parts (outlined below), altogether taking between four and six hours at each venue.

Part I: After introducing the study and the research team, and outlining the eligibility criteria and participation process for the circumcision component, those who were ineligible (all women and men under the age of 18 years and over the age of 59 years), as well as eligible men who declined to join individual survey, were divided into four groups comprising of younger men, older men, younger women, and older women. Following their suggestion, the removal of six lower teeth[16] was used as the

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[16] In addition to non-circumcision of males, removal of six lower teeth was another marker of identity for the Luo. However, the practice is almost extinct, and at present, those without the six lower teeth belong to at least two generations ago (mostly those above 60 years of age; age 50-59 form the transition). In many ways, it is accepted as the beginning of the separation between traditional and modern life--hence a divide between those who would

divide between older and younger subjects. Each group was then asked to discuss and subsequently present to the combined forum their understanding of HIV and AIDS, mechanisms of transmission, and to give suggestions for possible strategies for prevention. In addition, they were asked to give their position on the functions of widow inheritance in the present-day Luo community, its potential association with HIV, and whether the practice should be preserved or eliminated. Each group was responsible for selecting a recording secretary and a representative who would report the views of group at the combined meeting. While this was being facilitated by the nurse and the field guide, I obtained informed consent and registered eligible subjects for the circumcision component of the study (for detailed process, see Agot, 2001).

Part II: We then reconvened in one forum and heard reports from the small groups. Next, we followed up the concerns raised in these reports, particularly those that related to the various constructions of HIV and AIDS, as well as the mechanisms of its transmission. Specific effort was made to ensure that participants were able to draw a distinction between AIDS and *chira,* which appeared to be the most problematic to conceptualize (See Table 2 in this chapter).

Part III: We moved on to discuss the (perceived) functions of widow inheritance to the community; comparing how it was carried out in the past and how it is done

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continue to support traditional practices such as widow inheritance, and those who have begun to relax some of the rules.

presently, including the new types of risk that have been introduced by the changes. We particularly focused on the role of sexual rites in the present-day inheritance.

Part IV: Participants were asked to draw a possible link between HIV and AIDS (as discussed in Part II) and the current components of the practice of widow inheritance (as discussed in Part III). This allowed them to conceptualize the possible association between the practice and risk for HIV besides the link with *chira,* which is what emerged as most problematic to grasp from almost all small group discussions. We then discussed the specific sexual behaviors in the current elements of inheritance that would increase the chances of acquiring or transmitting HIV (such as the upsurge of serial inheritors), distinguishing them from those that would lead to affliction by *chira* (such as sharing an inheritor with someone with whom it would be taboo to share a sexual partner, for example, between a mother and a daughter, or a mother-in-law and a daughter-in-law). Consequently, most participants were able to distinguish, by themselves, AIDS from *chira.*

Part V: Whenever time allowed, participants were asked again to get back to their original small groups (or if there was no time, to work together in one group) and make recommendations of possible safe alternatives for widows, paying particular attention to widows who may still want to observe the traditions without risking contracting or transmitting HIV through the practice.

Part VI: To conclude, we compared the key recommendations provided during the initial group presentations and those provided at the end of the discussion (to assess the level of understanding and possible change of attitude towards the need to eliminate the risky components of the practice). As a 'take home message' from every venue, participants summarized their position and recommendations regarding whether or not the practice of widow inheritance should continue, and if so, the manner in which it should be carried out so as to preserve the traditions while at the same time reducing the risk for acquiring or transmitting HIV. Discussion guidelines for open discussions are in Appendix 2.

Overall, we observed a general change of attitude in many respondents, from being resistant at the start of the study about changing the practice, to voluntary acquiescing that there is actually an association between HIV/AIDS with certain components of the practice that need to be changed (this is the topic of Chapter Six). I believe that this was made possible mainly because of our approach in which we were using, as the starting point, whichever position the majority of the respondents supported and gradually leading the proponents (of widow inheritance) to identify how specific elements of the practice would increase the risk for HIV. Giving participants voice in the study and allowing them to identify their needs and to chart out a course of action they deemed suitable for themselves paid an important dividend because they were able to draw, on their own, the link between inheritance and risk for HIV, and to debate as a group about possible safe alternatives to the practice.

Individual-level in-depth interviews: Primary data were also collected through individual in-depth interviews. During discussion sessions, we identified eleven participants who demonstrated more knowledge about the origins of the widow inheritance practice but for whom the limited time could not allow to delve into an exhaustive account of the custom. We obtained their permission for follow-up visits. They comprised of eight males and three females: two males each from Bondo and Nyando districts, one male each from Siaya, Rachuonyo and Migori districts, one female each from Suba and Homa Bay districts, and a male and a female from Kisumu district. From this exercise, we were able to obtain additional complementary information on the origins of the practice, such as who conceived of it and how and why it was instituted, the significance of the sexual component, why it is linked to certain social events such as farming seasons and rites of passage, and how it has been modified to accommodate the changing socio-demographic characteristics of the practitioners, as well as the changing social structure of the community in general. Interview guidelines for individual in-depth interviews are in Appendix 3.

Secondary data: Information on current interventions was obtained from the official policy document of the Government of Kenya (*Sessional Paper No. 4 of 1997 on AIDS in Kenya*--Government of Kenya, 1997), and complemented with other reports from the Government (National AIDS Control Council, 2000; NASCOP, 1999; Government of Kenya, 1998, 1999). In addition, information on public attitude towards the disease, as well as towards widow inheritance and Luo Nyanza as the perceived epicenter of HIV/AIDS was collected principally from the main local

newspaper (*The Daily Nation* and *The East African Standard*). Reports on interventions being carried out or supported by international organizations and non-governmental organizations were obtained from publications from respective agencies or their consortiums (e.g., UNAIDS, 1997; 2000; Belgium Administration for Development Cooperation – BADC, 1997; 1998)

Information obtained from these literature include the types of HIV/AIDS interventions that target behavior change among the Luo and who was providing it, the state response to the epidemic in Kenya overall, and in Luo Nyanza in particular, as well as the public debate about the practice of widow inheritance among the Luo and the general sentiments about the situation of AIDS in the community.

Limitations of the study

Besides the difficulties in physically accessing the study sites, the main limitation was the initial suspicion by the participants towards the purpose of the study. They were wary about the intentions of outsiders labeling their tradition of inheriting widows as a risky behavior for HIV without taking the time to listen to their perception of the practice and of AIDS. In many places, it was made clear to us at the outset that we were wasting time if that was our mission. This attitude was evident despite having obtained permission from the leaders of each denomination and also sending letters of introduction to the local churches. To recognize and incorporate this sentiment in our research strategy, and to show that we were not visiting and studying the community to denounce inheritance but to understand the practice, our first task was to get a consensus on whether or not they wanted inheritance to continue. Except

for 6% of the dominations that openly condemned widow inheritance (even among them there were dissenting views), participants in all the other venues voted (by a show of hands) by a big majority to support the continuation of the custom.

That being the case, we endorsed the position of the majority and used that as our starting point (but also acknowledged, and benefited from, views expressed by dissenting respondents). The initial tension in the participants dissipated somewhat when they realized that I as the research leader, as well as all members of the entire research team, were from the Luo community. And also that the field guide was in fact a member of their denomination. They referred to us from then as 'our own people coming to help us', and were willing to give us the chance to delve into and understand the issues surrounding AIDS among them.

Another limitation arose from the way the discussion sessions were set up. When we reconvened in one group, all participants--clergy and congregants, men and women, young and old people, educated and uneducated people, husbands and wives, and sometimes parents and children, shared their ideas and debated and raised issues on the same platform. On the one hand, this inhibited free contribution from those who may have felt uneasy discussing intimate issues such as sex and sexuality in the presence of the clergy or other family members. But on the other hand, some of the ice we had set to break (especially between spouses, and between parents and children) was the taboo of silence and to demystify the beliefs that have been created around HIV/AIDS and issues of sexuality. This was an important aspect of the study since one of the suggestions was to encourage spousal and parental dialogue on such hitherto prohibited topics. Our agenda notwithstanding, we followed the preference of the

participants--for either joint or separate forums--and in all places, they opted for joint platform--especially at the start of the sessions. However, whenever there were participants under age 24 years, we would hold a joint session to discuss general issues of AIDS, widow inheritance, and other cultural practices, and then follow by a separate forum for the youth to address issues specific to them. On a few occasions, the youth were further separated by gender whenever such need was expressed. Adopting such multiple approaches permitted us to address issues pertaining to the community at large without compromising those that were relevant to the youth, or to the young girls and boys specifically.

In addition, as a member of the Luo community, my positionality as a researcher studying widow inheritance helped to resolve some of these limitations. I was already conversant with some of the issues around the practice and even though I preferred to leave the discussion sessions open and free flowing, my background enabled me to grasp the hidden meanings and innuendos that often characterize topics around sex and sexuality, especially in forums where men and women of mixed ages and church positions sat and debated on issues together. I was thus able to identify and probe issues that were not clear or were misrepresented during the discussion and to facilitate problem-solving exercises about the alternatives to inheritance that would be safe and feasible.

Another shortcoming is that our data are limited in their scope of generalizability because of the focus on men alone in the individual survey. Although the women were in the majority, many of whom were asking to be screened for HIV, our permit allowed us to enroll only men and as such, the responses we obtained

during the groups discussions could not be linked to specific female respondents and their personal characteristics. This was with the exception of age and gender of those who volunteered to speak during the discussion and were either video taped and/or recorded on field notes. Hence, I cannot make inferences based on individual widows on other categories of respondents. However, since societal support remains one of the most critical determinants in a widow's decision in matters of inheritance, information obtained through focus and open group discussions is still useful in designing interventions that address the social structure of the practice.

There was also another limitation with respect to the generalizability of findings. Participants were selected from denominations that broke away from mainstream missionary churches because of the latter's uncompromising position on African traditions such as widow inheritance (Further discussion in Chapter Two), and majority of these churches support the practice. As such, our information is more likely to be biased towards support for the practice whereas in the general population comprising also of members of the missionary churches, more respondents would either be opposed or neutral to the practice.

Recording data: In each discussion session, three methods were used to record information: Field note-books and video recording were used to record both verbal contributions during focus group and open discussion sessions, as well as during individual in-depth interviews. Field note-taking was carried out by myself for the most part, while video and audio recording was done mainly by the field guides and assisted by the interviewers after they had completed their sessions. I also helped

occasionally when they were committed in other places. In all the sessions, audio recording was also used as back up for the video and field notes, especially when we ran out of battery power. In addition, whenever we split into two groups and went to different sites, my research assistant recorded the discussion sessions which I later compared with his field notes.

Managing and analyzing data:

Data management: For this exercise, Atlas.ti software (Scientific Software Development, Muhr, 1997) was used to carry out textual management and analysis. However, as I have mentioned earlier, the information was drawn from discussions and as such, could not be linked to individual participants. Given this limitation, I grouped the data based on two criteria: One, the position of the denominations (of the respondents) concerning the practice of widow inheritance--whether they were from churches that supported the practice, were opposed to it, or were neutral, and two, the districts where the respondents' churches were located. The results of the groupings are discussed under the subsection on "Primary Documents" below. The rest of this section describes the specific procedures of data management and analysis using the guidelines provided in the User's Guide for Atlas.ti (Muhr, 1997), and the subsequent interpretation and presentation of the results.

1. Hermeneutic Unit (HU): This is the initial process in preparing data for Atlas.ti and involves creating a folder-like 'container' for all the data, and of assigning codes (or identifiers) to be used to perform text retrieval and analysis. To create the HU, I typed the filed notes and transcribed the recorded

information--both of which were obtained from focus group discussions, open discussions, and in-depth interviews--as Word Document and copied into the Atlas.ti program.

2. Primary Documents: After creating the HU, I grouped the textual information into eighteen main or Primary Documents. For each of the eight districts, I divided the information from the respondents into three categories as follows: responses from members of denominations that support widow inheritance; responses from those that do not have a clear doctrinal policy on the practice and where widows are left to make their choice about the issue; and responses from those that oppose the custom. Altogether, members of denominations that supported inheritance were found in all the eight districts (forming eight Primary Documents); members of denominations with a neutral stand towards the practice were found in all districts except Suba (forming seven Primary Documents); and members of denominations that opposed the practice were found only in Bondo, Kisumu, and Nyando districts (forming three Primary Documents).

3. The textual working phase: In this phase, I read, selected, and assigned codes to the passages on the bases of the objectives of the dissertation, as follows:

    i. Labeling of widow inheritance as a risk behavior: codes were assigned to capture respondents' views especially on how AIDS was

constructed, as well as its transmission mechanisms and conflation with *chira*.

ii. Conceptualization of 'vulnerability': coding was focused on discussions on widows' perceived social responsibility to the wider community by being (or failing to be) inherited, including how the community gets involved. Also included here were discussions on the dilemma between getting inherited and risking HIV, as well as the issue of sexual rite and the role it plays in different social events.

iii. Conceptualization of 'risk': coded under this category were responses that touched on the following: different scenarios on how widow inheritance might constitute risk, suggestions provided at the beginning of the discussion sessions on how to address the epidemic, and the views on the current components of inheritance that can potentially increase risk for HIV.

iv. Appropriateness of current interventions: Here, I included opinions about the role of the government in checking/exacerbating the disease, issues about condom distribution, and whether or not interventions are targeting the actual (underlying) reasons behind inheritance as it relates to HIV.

v. Reconciling the goal of interventions and the needs of the community: Responses coded under this objective were those focusing on suggestions of safe alternatives to current inheritance and debates around feasibility, acceptability, and resolving competing choices.

In addition to the coding procedures outlined above, being assigned to each Primary Document also meant that responses were automatically categorized according to the respondent's denominational teachings regarding inheritance and the locational districts of their churches. This is because the two criteria were the bases for assigning the Primary Documents (See above). Also, the gender of respondents were coded, as were their approximate ages (categorized as under 20; 20-29; 30-39; 40-49; 50-59; 60 and above) to allow analysis by these variables.

Data analysis: This stage consisted of comparing responses using the assigned codes to capture the required interrelationships. The following example demonstrates the type of analysis performed. Using 'text retrieval' tool in Atlas.ti, I 'pulled out' responses that I had assigned the code of, for example, "AIDS and *chira* conflated--'A&CC'." Through this operation, I was able to refine my analysis as follows: i) retrieved everything that was said about the topic of "AIDS and *chira* conflated" to get a general view on what respondents felt about the issue; ii) used 'women' from the 'sex' code to retrieve only what was said by *women*--this operation excluded what was said by men on the topic; iii) used 'women' and 'age 20-29' to retrieve only what was said by women between ages *20-29*. I then refined the analysis further by defining only women between ages 20-29 from *Bondo district*, followed by women between 20-29 in Bondo district from *churches that support widow inheritance*. This way, I was able to call up and examine responses that were defined and refined according to my specifications. Such cross-referencing was made possible by the Boolean operation

provided in Atlas.ti, and allowed for combinations of different variables in a single analysis without necessarily having to re-code the responses. The italicized codes show the progressive refinement in the selection of responses. For example, my final retrieval above only brought out what *female* respondents between *ages 20-29* from churches in *Bondo district* that *support widow inheritance* said about "*AIDS and chira conflated*".

Interpreting and presenting the findings

The interpretation, which I describe below, was based on the five objectives of the study and the questions that arose from them:

i. Have people labeled widow inheritance as a risk behavior? Responses that conflated AIDS with *chira,* or gave other misconceptions about HIV/AIDS and/or its transmission mechanisms were taken to be indicative of pre-labeling stage, and demonstrated that people were not ready for intervention messages requiring them to stop the practice.

ii. What are the factors that co-define 'spaces of vulnerability' for HIV for widows? The interpretation of this question rests on the importance of contextual understandings of widow inheritance--how widows' societal expectations either reinforce or counteract their positions on inheritance as individuals and how the interaction between these positions (personal, societal, and religious) produce different levels of vulnerability for widows in different circumstances.

iii. How do the participants define risk with respect to widow inheritance? My concern was with issues such as the various components of inheritance that can potentially increase the (biomedical) risk for acquiring HIV for widows who are inherited, or the (cultural) risk for *chira,* and the ability to tell the difference. This revealed the difference between the 'biomedical' and the 'cultural' perception of widow inheritance as risk behavior.

iv. How appropriate are the current interventions in bringing about change in behavior? The appropriateness are interpreted at two levels. One, where responses are taken to be indicative of the level of success in the performance of the intervention programs, for example, by creating awareness not just about the existence of AIDS, but where respondents also have the correct perception of the disease, as well as its transmission channels and prevention strategies. And two, appropriateness is also viewed in terms of how the interventions are responsive to the social, religious, cultural, and economic contexts of the practice of widow inheritance.

v. Are alternatives available that can both reduce the potential risk for HIV inherent in the practice of widow inheritance, and also preserve the cultural functions of the practice? Suggestions demonstrated that the goals of the Ministry of Health (of reducing the risky components of widow inheritance) and of the community (of protecting the family from *chira,* etc) are not necessarily antagonistic; they can be achieved

concurrently. In the next chapter, I present the first part of the results to show the position of the participants with respect to the questions raised above. The rest of the results are discussed in Chapters Four, Five, and Six.

Chapter Two:

Giving voice to the subaltern: Negotiating cultural and medical discourses around widow inheritance and its 'risk' for HIV

Chapter overview: In this chapter, I present part of the main findings of the study--the other results are presented in Chapters Four (those concerning different conceptualizations of 'risk'), Five (those related to the ongoing interventions) and Six (those addressing safe alternatives to inheritance). The chapter is divided into three parts. In the first part, I give a brief overview of cultural studies on AIDS in Africa. I then provide background information about the tradition of widow inheritance, beginning with a critique of the appropriateness of the terms 'widow' and 'inheritance' (or other terms that have been used in reference to the practice) in adequately describing the nature of the relationship between the 'widow' and the 'inheritor'. In addition, I give a brief geography of the practice, and describe a background to the prevailing gendered-power relations in marriage which, I argue, have served as the precursors to the practice in many communities in sub-Saharan Africa, as well as among my study population, the Luo of Kenya. I also highlight some of the modifications that have been made in carrying out the practice and the impact they have had on the potential risk for HIV associated with inheritance

The second part focuses on the main findings of the study while in the final part, I discuss the role of the church, both as a custodian of the tradition of widow inheritance and as an agency for its elimination. The main thrust behind this part is to use responses from the participants to determine whether or not they have labeled

widow inheritance as a 'risk behavior' and to examine how they negotiate their perceptions of the practice and of HIV/AIDS between the cultural and biomedical worldviews.

Cultural studies on HIV/AIDS in sub-Saharan Africa: An overview

> **"When tradition and health of our people are in conflict, it is tradition we must sacrifice"** (A Traditional Medical Practitioner in South Africa, when asked about cultural resistance to male circumcision--Green et al., 1993:183)

The fight against AIDS in Africa is often presented as a fight against 'cultural barriers' that are seen as promoting the spread of the HIV virus. According to Gausset (2001), a Danish anthropologist who conducted a study on HIV/AIDS intervention among the Tonga of Zambia, this attitude is based on a long history of Western prejudices about sexuality in Africa which focus on its exotic aspects only (such as polygyny, circumcision, dry sex, widow inheritance, sexual cleansing, etc.) with the assumption that the practices are invariably incompatible with a safer behavior and that their eradication would ensure protection of the people. The author begins his soul-searching article by reporting how, while they were doing a study in Zambia, a Danish journalist interviewed them about their work and weeks later, he (mis)reported the interview in a major newspaper in Denmark, which he titled, "The fight against AIDS is the fight against culture", transforming it to fit what he (and the readers) expected the situation to be in Africa regarding AIDS and sexuality.

Gausset (2001) cites several examples in scientific literature, including those by supposedly-nonjudgmental anthropologists, in which he shows that placing the

blame on 'African cultural practices' is part of a widespread discourse of accounting for the epidemic in the region. For example, in what he aptly termed "AIDS and the study of African sexuality", the author argues that AIDS has made it legitimate once again to study sexuality in Africa, and since lives are at stake, anthropological research on sexuality can no longer be accused of being motivated by exoticism or an interest in 'ethnopornography'.

Just as in the past when international interest in African sexuality and prejudices arising therefrom were based on compilation of anecdotes, rumors, unresearched media reports, and decontextualized data gathered mainly from travelers, missionaries, or colonial administrators, much of the current 'scientific' data, particularly in the early years of the epidemic, has revived the hitherto thinly veiled prejudices (See also Chirimuuta & Chirimuuta, 1989; Jarosz, 1991). Focusing on cultural practices as barriers to HIV prevention which must therefore be eliminated once again, the said practices become ethnocentrically described either as irrational (lacking any cultural or social explanation) or as immoral, and little effort is made to understand the broader socio-cultural context in which they are embedded (Gausset, 2001; Jarosz, 1991; Chirimuuta & Chirimuuta, 1989; Schoepf, 1991). In fact, Gausset (2001:510) points out that 'African sexuality' has more often than not been studied only in as far as it was different from 'European sexuality' (See also Wilton, 1997:45).

What this boils down to is that to present AIDS prevention in terms of culturally defined 'risk groups' may divert attention from the most fundamental problems. First, it may transform the fight against AIDS into a fight between cultures, with one culture trying to impose its own conditions on the others. What is at stake

then becomes cultural practices instead of AIDS. Secondly, it may have counterproductive effects of creating an imagined immunity for those who are not members of the perceived 'risk group' and also alienating members of the risk group into a stigmatized "Other" (see Chapter Four for a detailed discussion).

In what Gausset (2001) refers to as 'the double discourse on [HIV] prevention', he brings to the attention of the reader that when a correlation is found between HIV and the use of modern facilities, the facilities have to be improved and made safer; but when some correlation between HIV and an African cultural practice is found, the practice is to be eradicated. The author particularly singles out that today in the West, AIDS prevention campaigns do not suggest that sub-populations initially associated with high risk have to stop their practices; rather, they advice them to make these practices safer. Yet the same understanding is lacking in Africa; the cultural practices (such as circumcision, polygyny, inheritance, dry sex, and so on) which are seen as barriers to AIDS prevention are completely decontextualized, and their importance for people's identities is overlooked. For example, in the West, one respects different cultural and sexual behaviors, and one tries to make them safer without fighting against them; in Africa, one adopts the opposite attitude, and one tries to eradicate what are identified as 'cultural barriers' to AIDS prevention.

I am not denying the fact that there are ways in which many of the cultural practices that have been studied *may* pose risk for HIV. In fact, this dissertation is based on how one of the practices--widow inheritance--could potentially pose risk for acquiring or transmitting the virus to the widow or to the inheritor. My argument supports Treichler (1999:161) when she calls on those of us involved with HIV

research to recognize the "rare moments when medicine's narration of the *real* is interrupted long enough to glimpse other narratives; when social and cultural questions are periodically allowed to disrupt the tidy biomedical narrative". This is when a researcher or observer gets close enough to the cultural practice of interest to glimpse its true character, because "getting a good hard look requires uncovering the (biomedical scientific) rules of everyday practice and attempting to capture the meanings in what is being observed". Unfortunately, there has been a lot of what Treichler (1999) refers to as 'textual cleansing and fortification', 'smoothing data' or 'omitting untidy anomalies' when our research does not conform to our theories (and prejudices) about African cultural practices and HIV.

What the authors referenced above (Chirimuuta & Chirimuuta, 1989; Treichler, 1999; Jarosz, 1991, Scheopf, 1991, Craddock, 2000, Gausset, 2001; Wilton, 1997) are calling for is that AIDS prevention campaigners should rethink their approach of telling people that they should be monogamous, *stop inheriting widows*, stop practicing dry sex, etc; instead, they should endeavor to make behavior and practices safer in ways that are culturally acceptable to the practitioners. Otherwise, when the fight against AIDS is approached as the fight against culture, and when intervention providers are more bent on eradicating cultural practices than on eradicating HIV, then it is a small wonder that results from the massive prevention efforts are nowhere commensurate with the resources and expertise expended on them. I take the same position in this dissertation and use the cultural practice of widow inheritance as a case study to demonstrate that sustaining cultural practices and reducing HIV transmission need not be mutually exclusive.

Widow inheritance: its meaning and geography in sub-Saharan Africa

Widow inheritance: what and why is it? 'Widow inheritance' is a practice where a widow is taken care of by a brother or a paternal cousin to her late husband (see footnote 1). It serves well to start by challenging the appropriateness of the terms 'widow' and 'inheritance' in describing the relationship contracted between the widow and her brother-in-law. Since the advent of HIV/AIDS and its assumed association with the practice, there have been public debates challenging the appropriateness of the two terms (Agot, 1996).

More recently, Burudi (2000) argued that the term 'widow' is inappropriate, claiming that to an African, the Christian marriage vow, "till death do us part", is not only strange; it is also utterly meaningless. Among the Bukusu sub-group of the Luyia ethnic community[17] about whom the author referenced his argument, when a man dies, his wife is called *namulekhwa* (literally meaning 'a woman left behind by her husband') to imply that the husband has just gone ahead of her in the next world of the departed. If the husband was called Wafula, for example, the woman is still referred to as *khwa-Wafula* (the wife of Wafula), not the "widow" of Wafula. Among the Luo also, a woman whose husband has died is referred to as *chi liel* (literally, the wife of the grave), to imply that she continues to be officially married to him even after his death (Mboya, 1997; Field data). In both Luo and Luyia cultures, as in many others in sub-Saharan Africa (Awusobo-Asare et al., 1993), the term 'widow' is not entirely appropriate to describe the state of the woman who has lost a husband.

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[17] The Luyia ethnic community is the second largest in the country and lives in Western Kenya, a neighboring province to the Luo (Figure 1). Those living along the border share a number of traditional practices with the Luo, including most of the rituals associated with widow inheritance.

Some writers, such as Omolo (2000) and Chikovore and Mbizvo (1999), have used the term 'wife' instead of 'widow', to emphasize situations where the inheritor relocates the woman to his farm. Among the Luo community however, an inherited 'widow' continues to stay on the farm of her late husband, and children born from this union belong to the deceased rather than to the inheritor, take on the name of the former, and continue his lineage (Mboya, 1997; Field data). Even in the very rare circumstances when the inheritor would relocate the widow to his farm, this would be on a temporary basis, and once her children were grown, he would return them, together with the mother, back to their own farm. As one respondent explained:

> The reason why an inheritor cannot move and stay with the widow, and why he must have his family is that he must have his home and his gate; he cannot stay in the home where another man had died and call it his home. A woman cannot bury two men on the same compound.

The requirement that widows do not abandon their marital homes is also reported among the Teso, the Marachi, the Abagusii, and the Maragoli (Personal communication with members of the respective communities—Echessah, Isoe, and Mahindu, May 15 – 17, 2001 in Nairobi, Kenya). In all these communities, there are similarities with what is done among the Luo. For example, the inheritor should be a brother or cousin to the deceased, and except for the Maragoli (a sub-ethnic community of the Luyia), the widow is required to remain in the home of her late husband. Also there is sex involved between the widow and the inheritor, and the children born out of this relationship continue the lineage of the dead man. As such, the term 'wife' is inappropriate to describe the relationship, except, perhaps, for the

Maragoli where the woman can decide to relocate to the inheritor's home and where the widows' children belong to their respective biological fathers.

Another reason why the term 'wife' is inappropriate is because the inheritor retains his own wife and children, and if he is single, he is expected to marry and raise a family he calls his own. Among the Luo, his duty as an inheritor is to take care of *(rito),* and not to take over *(kawo)* his brother's home and family. The widow refers to him as the one/brother in-law "I live with" or "who takes care of me" rather than "my husband" because, officially, she remains the wife of the late husband. Under this arrangement, such a relationship may not be traditionally counted as a true marriage because the woman was not divorced (see also Awusobo-Asare et al., 1993). As such, the term 'wife' in not appropriate for this contract[18].

This brings into question, as well, the appropriateness of the term 'inheritance'. As Oriang' (2000) points out, the very term "inheritance" is a misnomer; it does not describe adequately the type of contract made between the widow and the inheritor. The writer points out that in the Luo traditional society, a brother in-law stepped in to provide guardianship for his deceased brother's family, but the woman never became known as "Mrs. Inheritor." She kept hold of the family's land, and the family unit remained a tight-knit part of the wider clan, while at the same time retaining their own unique identity as the family of the dead man. And, as I stated before, since the 'inheritor' does not 'take over' the widow, her family, or her late husband's property, the term 'inheritance' is not an appropriate description of the arrangement. With

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[18] An interesting observation is that while as a 'wife', a Luo woman is relatively dependent on the husband (explanation later in the chapter); as a 'widow' she gains a certain amount of autonomy and can actually send the inheritor away without having to obtain approval from other members of the family--even when her children or in-laws may have been the ones who initially forced her into being inherited.

respect to taking over family property, respondents acknowledged that there are abuses of this pact with many cases where brothers-in-law have confiscated family property from widows, especially those who decline to be inherited by a family member or to stay in her matrimonial home even if she 'decides' to be inherited by someone outside the family.

An alternative term that has been used in a report describing the practice in several communities in Uganda is 'remarriage' (Ntozi, 1997). The term 'remarriage' may be somewhat appropriate for what is going on in Uganda, where a widow without a son who can inherit his father's property will be left without any physical asset such as cattle or land because she is supposed to be looked after by the brother, or close male relative of the husband who inherits her. But since Ntozi also reports that children born from this relationship belong to the deceased, it if difficult to envision how the term 'remarriage' would apply to a relationship where the children born into a 'marriage' belong to someone else. What does seem clear, however, is that since in many cultures the women are never 'divorced' nor 'set free' by the death of the husbands, they cannot, technically, 'remarry', for they are still married. And as a number of respondents pointed out, bride wealth cannot be paid for the same woman twice, and without giving bride wealth, customarily one cannot (re)marry.

Nonetheless, I do recognize that these terms possibly imply variations in the specific details of how the practice is contracted and the meanings attached to them in different communities across the sub-continent. I also acknowledge the limitations inherent in the terms that have been used to describe this relationship. The bottom line of my argument is to point out the inadequacy of using a foreign language to describe

a practice that is instituted in a culture different from where the language originates. At best, we can only settle for closest substitutes, which must be taken with a grain of salt because of their insufficiency in describing accurately the practice. Hence, I choose to use 'widow inheritance' for two reasons: 1) because it is more popular that 'remarriage', and 2), for lack of a more fitting term or phrase to describe the type of contract made by the Luo whereby the inheritor is performing (or expected to perform) economic, social, and conjugal duties on behalf of the deceased. The terms 'support' or 'guardianship' have also been suggested (See Agot, 1996) and would have been more appropriate instead of 'inheritance', but the *mandatory* sexual component in the relationship instituted by the Luo makes me somewhat uneasy with using either of them. In what follows, I discuss briefly the geography of the practice in parts of sub-Saharans Africa, identifying some of the characteristics that qualify it to be classified as a risk behavior.

The geography of widow inheritance: The practice of widow inheritance has been reported in many parts of sub-Saharan Africa (Ntozi, 1997; Okeyo & Allen, 1993; Agot, 1996). The practice is particularly strong in Kenya (Okeyo & Allen, 1993; Agot, 1996; Burudi, 2000; Oriang', 2000; Odiwuor, 2001), Uganda, Mali, Burkina Faso, Sierra Leone, and Botswana (Ntozi, 1997), Zambia, (Nkunika et al., 1998), Zimbabwe (Chikovore & Mbizvo, 1999), Rwanda (Bartley et al., 1994), Ghana (Awusobo-Asare et al., 1993), Cameroon (Sonkey et al., 1998), and Namibia (Andima, 1997). The practice has also been reported in India (Crossette, 2000) and Bangladesh (Caldwell et al., 1999), among other non-African countries. It is more

prevalent in patrilineal systems (where ancestry is traced through the father's lineage, and where inheritance of property passes from father to son), most of which are also patrilclan systems (where the wife relocates to the husband's home upon marriage and becomes a part of his clan--even after he dies) (Ntozi, 1997; Agot, 1996; Okeyo & Allen, 1993; Awusobo-Asare et al., 1993; Mbiti, 1990).

Even though the practice has been reported in various countries, it is important to point out early that neither the procedures followed, nor the meanings attached to the practice are universal across communities or cultures. For instance, while part of funeral rites in many societies in Kenya (Agot, 1996, Okeyo & Allen, 1993; Odiwuor, 2001), Zambia (Kunda, 1996), and Rwanda, (Burtleys et al., 1994) require a widow to have sexual intercourse with one of her male in-laws as a ritual to get rid of the husband's ghost, there is no element of sexual ritual cleansing of widows which involves obligatory sexual intercourse in the Ghanaian situation reported by Awusabo-Asare and colleagues (1993). The practice varies within the same communities as well. For example, among the Luyia in Kenya, the Samia sub-tribe, and several other groups sharing their border with the Luo perform the practice in an almost identical manner to the Luo style (including sexual ritual cleansing). But among the Maragoli subgroup of the same community, the brother in-law provides social and economic support, and the sexual component is only introduced into the relationship with mutual consent (Herman Mahindu, personal communication, Nairobi, Kenya, May 17, 2001). What this means is that widow inheritance does not translate into uniform risk for all the practitioners; it depends largely on whether or not sex is part of the arrangement, and if so, whether it is mandatory or consensual.

In our study among the Luo ethnic community, respondents cited five main reasons why widows are inherited: one, to discourage widows from abandoning their marital homes and their children. Because the Luo community is organized around patrilineal kinship system where children belong to their father and his clan (see also Mboya, 1997; Okeyo & Allen, 1993), a widow who leaves her late husband's home would risk leaving her children behind. Two, the practice restrains widows from seeking sexual liaisons outside the husbands' clan which, in cultural perceptions, could bring misfortunes to the widow and her family (see discussion on *chira* in Chapter Four). Three, through the practice, widows without children (especially sons) can have an opportunity to get children to continue the lineage of the deceased, hence the requirement that an inheritor should be his blood relative. The requirement underscores the fact that a child born with an inheritor who is not a relative does not biologically share any blood relationship with the deceased and cannot, technically, be considered eligible to continue his lineage. Four, by being inherited, the widow acquired (or was expected to acquire) some rights for economic and social support from the inheritor. And five, inheritance enables the widow to participate in certain social events for which sexual rite is a component, for example, to mark the start of farming seasons (cultivating, planting, weeding, and harvesting), to put up or refurbish the home, or to mark the rites of passage of loved ones (birth, marriage, or death) (more detailed explanation on footnote 21; see also Mboya, 1997; Okeyo & Allen, 1993; Agot, 1996; Ntozi, 1997; Odiwuor, 2001).

In several Ugandan communities, Ntozi (1997) found that widows were being inherited whether or not it was known that one's husband had died of an AIDS-related

disease, and that these relationships were being consummated. The same survey also found that non-AIDS widows who refused to be inherited either because they suspected the men to be HIV-infected, or because they did not want to risk contracting HIV, were left to fend for themselves and their children, forcing some of them to rescind their decision. The situation was worse for AIDS widows who were shunned by in-laws and who, in addition to facing social stigma and hostility, had to support themselves and their children single-handed through the course of their disease. However, the worst scenario reported was that AIDS widows, some of whom were HIV-positive and knew it, were more likely to remarry than those whose spouses died of other diseases. Ntozi (1997) attributed such behavior to two factors: an attitude of not wanting to die alone and thus knowingly attracting new partners to infect with HIV, and also because the custom which requires widows to be inherited by their late husband's male relatives was still alive in many societies of Uganda despite the AIDS epidemic and the awareness of its dangers.

Both reasons came out in our study as issues of concern. For many respondents, the fear of AIDS emerged, by and large, as secondary to, or at par with the fear of the consequences of not being inherited, whether or not a widow was positive for HIV. The two quotes (immediately following) represent the views of most respondents regarding the dilemma faced by an HIV-positive widow.

Female respondent in her late 20s:

> If it is known that you have the big disease [AIDS], your brother-in-law cannot live with you. So you can just keep quiet so that no one [outside the family] knows, and then your in-laws [will] quietly go to

> look for someone along the beach [of Lake Victoria] to inherit you and relieve you from the taboo you are facing. (From a church in Bondo district that supports inheritance).

Female respondent in her early 30s:

> If you have AIDS, then either look for someone who also has AIDS to inherit you because you *must* be inherited. If not, then you can pay for the services of a professional inheritor, and because he has been bought with money, let him go ahead and die. (From a church in Migori district that supports inheritance).

It is important to point out that such opinions were expressed at the start of the discussions, and as the sessions progressed, many respondents reconsidered their initial positions (In Chapter Six, I discuss the process through which this was made possible).

One of the reasons cited for the high rate or 'remarriage' in Uganda was because widows and widowers looked healthy (Ntozi, 1997). Schoepf (1991) obtained similar results in the Democratic Republic of the Congo and linked the confusion to a number of factors, including the fact that some men known to be in multiple partnerships have remained healthy, and also that in some circumstances, people get sick but their spouses remained healthy. In our study too, there was also a misunderstanding of the period between infection and visible symptoms, and respondents associated pre-AIDS stage with being disease-free. They cited several examples in their neighborhoods where either widows or inheritors have out-survived several partners, as many as eight inheritors to one widow were counted--and the widows were still looking healthy and still being inherited. Explaining the rationale

behind such 'implausible' outcomes in simple and easy-to-grasp terms was rather tricky, particularly given that their argument was based on the fact that there is contact between vaginal and semenal fluid during intercourse. We used risk for known diseases such as diarrhea and contaminated water--why people would drink the same water and some get sick while the others do not--to give a sense of the meaning of probability. We also used local diseases such as malaria to introduce the concept of "incubation period" in the explanation--how long it takes between a mosquito bite and coming down with malaria.

Additionally, in Ntozi's (1997) and Schoepf's (1991) studies, widows were desperate for economic assistance and without being inherited, they were likely not to receive support from their in-laws. They would also risk being thrown out of their husband's property and forced to leave their children behind. Our study found mixed results. A small proportion of respondents voiced fears about the potential economic loss as a major issue of concern. Women were, however, more concerned with the 'dependency syndrome' of today's inheritors. While, as I mention earlier in the chapter, providing economic and social support to the widow was one of the key reasons for the institution of inheritance in the past, most of the inheritors of today have instead become liabilities. As Oriang' (2000) observed about inheritance among the Luo community, "the new form of widow inheritance ranks among the most coercive and exploitative relationships--where the inheritor lives like a king and demands only certain kinds of food and sulks and threatens to leave if his every wish is not met. Omollo (2000) also noted that today's inheritors in the Luo community live

on the sweat of the widows, providing no material or financial assistance; theirs is a world of romance, exploitative sex, and lavish food.

Most respondents felt that this has been triggered by several circumstances, including the diminishing relations between the in-laws and the widows, or for fear of contracting HIV, or just because of the low regard the practice has come to assume lately. There is also the fact that a number of widows--a significant proportion who had hitherto been living with their husbands in their places of work--are financially better-off than potential inheritors in the rural countryside. Thus, more and more widows are turning to professional inheritors who have grown to know they are in demand and hence expect to be treated well, or else they threaten to abandon the widows before accomplishing the rites for which they were contracted (See footnotes 21 and 32). The quotation below is a sentiment typically expressed by most women:

Female respondent in her 60s:

> What is 'spoiling' inheritance is that even with an inheritor you are still on you own. He does not help you--he only wants to eat what you have worked for. Won't you send him away? [Other women chorused: "Yes, send him away".] She continued: "He is a burden; he does not want [to eat] vegetables, he only wants sweet food, [yet] he does not even bring sugar; he does not go to the farm; [so] why keep him after he has completed the task [of observing the sexual rite] for which you brought him?"

It appears that there are deeper forces driving widows into inheritance over and above (or sometimes besides) reasons related to economic and social support, and while raising women's income levels, for example, would be an appropriate intervention for those who get into such relationship to secure economic support, it

may not be adequate for those represented by the above quote who provide for the inheritors instead. Mason (1994) provides an interesting way, which, I think, can give insight into the understanding of a situation such as this. Writing on HIV transmission, the use of condoms, and the balance of power between women and men, the author warns that cross-cultural generalizations about the distribution of sex motives, such as economic dependence of women on men, are hazardous. Arguing that in certain settings, gender inequality may create other gender differences in the distribution of sexual motives, she presents a case that challenges the popular paradigm that men do not like using condoms, thus putting their wives at risk for contracting STDs. In the highly patriarchal family systems in parts of South Asia, women were heavily dependent on their sons for their current and future welfare, making procreation a stronger motive for having sexual relations among women than among men. This motive conflicts with the use of condoms and represents a situation where women are, in fact, less motivated to use condoms than men.

Similarly, respondents in our study cited more cases where, because of social obligations, widows had a stronger motive to be inherited and were the ones who consequently supported the inheritors economically and not the other way round, as expected. Thus, linking inheritance among the Luo to the economic dependence of widows on their inheritors tells only part (or sometimes none) of the story. Thomas (2000), Hernlund (2000) and Shell-Duncan, Omolo, & Muruli (2000) make similar conclusions regarding female genital cutting, that in many instances, the women were, in fact, the perpetrators of the practice (See the end of Chapter Five for further discussion on this topic).

Another reason why inheritance continues to be practiced in many communities in Africa can be linked to desire for (more, or male) children. According to the official policy paper in Kenya, *AIDS in Kenya, Sessional Paper No. 4* (Kenya, 1997:14), "the status of the African woman within the society is contingent on child bearing, with preference of male offspring, hence some women will continue bearing children even with the knowledge of their HIV positivity." Schoepf's (1991) study in the Democratic Republic of the Congo reached a similar finding, that women are torn between motherhood and risk because childbearing is central to the female role and enables her to have sense of self. Whether widowed or married, HIV seropositive women continue to become pregnant despite counseling. Ntozi (1997), for example, reported that 60% of the widows surveyed in Uganda have produced additional children with the inheritors. While having children as a reason for being inherited was supported by respondents in our study, there were a few dissenting voices challenging this notion as a key rationale for the practice. They argued that if this were the case, only women of childbearing age would be eligible for inheritance, and furthermore, only those without children, or those without sons. But this did not feature as the main reason why Luo widows get inherited, because even those who were past childbearing age were still inherited. In fact, it was pointed out that even women who had long stopped having sex with their husbands before they (the husbands) died were inherited and resumed sex all over again, in the name of observing customs.

Here too, having children is an important pull-factor towards inheritance; however, its significance is apparently dimmed by other forces that compel widows, even those past childbearing age, or those with children, to be inherited. My point is

that no single factor can be sufficient to explain why these widows do what they do. As Livingston (1992) argued, it is only by appreciating what the individuals know (and tell) can we understand why they chose to follow certain routes and reject others. I recognize, as did Livingston, that knowing what participants know is an interpretative exercise, so I do not claim to present unequivocal objective knowledge here because, as any other interpreter, I am conscious that the information I collected from the study was constrained by the limits of language or discourse used by the participants to describe AIDS, inheritance, and their potential relationship. It is also partial because I am in a privileged position to select from the information the participants provided what to present and what to leave out. Nevertheless, I still claim, as I did at the start of this dissertation, that I am genuinely responding to Spivak's call (1988, in Craddock, 2000:163) for "studies that give voice to the subaltern rather than speak for them." I did research *with* rather than *about* people who have been classified as vulnerable because of their custom of inheriting widows. My aim in the rest of the dissertation is to demonstrate this commitment.

The discussion in the next section centers on the reasons why the practice is still prevalent in sub-Saharan Africa, and among the Luo, drawing especially on how gendered-power expectations in marriages lay groundwork for inheritance in widowhood. I argue that although widowhood begins at the death of one's husband, its conception and the conditions that nurture it start long before the death of the spouse. I am particularly focusing on gender relations and sexuality in marriage, which, I maintain, are the two main forces that continue to nurture and sustain inheritance in this day and age.

Gender relations in marriage: a precursor to widow inheritance?

The dynamics of gender relations in marriage and their association with the spread of HIV has been a subject of much research (Mason, 1994; Treichler, 1999; Wilton, 1997; Craddock, 2000; Bajos & Marquet, 2000; Rakwar et al., 1999; Odiwuor, 2001). Although I do not want to fall victim to painting women as passive recipients of, and participants in, suppressive patriarchal traditions that put their lives at risk for HIV acquisition, it is my opinion, as I will demonstrate using views from the respondents, that a significant proportion of women can still be rightfully classified as 'unwilling' or 'ignorant' participants in such traditions. As such, in this section, I aim to highlight some circumstances that underlie the current status between men and women in marriage (and subsequently, in widowhood), and how the relationship translates into differentiated vulnerability between genders.

Studies are consistent in their finding that by and large, men have higher mean number of sexual partners and wider sexual networks than women, and consequently, that being married can rightfully be used as a proxy for 'risk' for many women (See Figure 5). This conclusion has been supported by studies in Nigeria (Osho & Olayinka, 1999; Orubuloye, 1992; Caldwell, Orubuloye, & Caldwell, 1997), Ghana (Awusobo-Asare et al., 1993), Indonesia (Ford et al., 1994), Belgium (Bajos & Marques, 2000), Bangladesh (Caldwell et al., 1999), Tanzania (Setel, 1999), and Kenya (Hunter et al., 1994; Rakwar et al., 1999; Odiwuor, 2001), to cite but a few. My task in this section is to shed some light on how inheritance is related to gendered-power imbalance in marriages and how the resultant sexual relations between spouses

impact women's vulnerability to HIV/AIDS in marriages, and subsequently, in widowhood.

In many patrilineal societies of sub-Saharan African ethnic communities, marriages, particularly those sealed by bride wealth, are often perceived to give the man exclusive rights over his wife's sexual services, but not the reverse (Awusobo-Asare et al., 1993; Orubuloye, 1992; Boroffice, 1995). In such marriages, sexual intercourse is seen as a marital duty and a woman who refuses to have sex with her husband, except during menstruation and postpartum periods, is seen to be signaling to her husband to have extramarital sexual relations. Such differential expectations between men and women have also been reported in several other studies in sub-Saharan Africa, for example, in the Democratic Republic of the Congo (Schoepf, 1991), Nigeria (Orubuloye, 1992; Boroffice, 1995), Ghana (Awusobo-Asare et al., 1993), Tanzania (Setel, 1999), and among the Luo of Kenya (Agot, 1996b).

In these studies, it is shown that men's sexual polypartnerships have always been considered normal, and even encouraged, while the case is different for females, who are expected to be faithful and to be good wives and mothers. Male respondents in our study remarked often that "women have less energy [for sex] compared to men because they get older and tired quickly"; or that *kama iluokrie ok ituoyie* (you don't stay on to dry where you bathe) to denote the casual 'hit and move on' nature of sexual liaisons; or that a man "needs a change of 'diet'" because the same type of meal (his wife/regular sexual partner) becomes monotonous. In Ghana, for example, the term 'adultery' is reserved for a married woman who indulges in extra-marital sex,

whether the man is married or not; but a man is considered to have committed adultery only if he has sex with a married woman (Awusabo-Asare et al., 1993).

Women interviewed in the Democratic Republic of Congo (Schoepf, 1991), in Nigeria (Boroffice, 1995), and in Tanzania (Setel, 1999) concerning their attitude towards men's extramarital sexual affairs were reported to have accepted the double standard as the status quo. In their opinion, it was hopeless to expect men, married or unmarried, to be faithful, and so no matter what women did, men would uphold the culture of polygyny, formally or clandestinely. Forty per cent of women in Ghana, for instance, felt that a woman does not have a right to refuse sex with a promiscuous partner even for perceived health risks because of several reasons, including marital duty, dictates of tradition, religious reasons, and for fear losing the partner (Awusabo-Asare et al., 1993). In Northern Tanzania, Setel (1999:82-83) reports that a woman felt that knowing her serostatus would not change her life because she would have to repeat the process after each visit from her husband. Other women who expressed fear of being infected were even more afraid of confronting their husbands. They said they would rather remain silent, risk death, and preserve the marriage than risk the stigma and upheaval of trying to refuse sex or demand the use of condoms. Most of the women in these studies argued that promiscuity cannot be used as an excuse to refuse sex, because it was futile to expect fidelity from male partners.

There was a general feeling that it was not a woman's right or business to be inquisitive, because ignoring the social pact (i.e., hiding under the façade of ignorance) by asking questions, complaining, or protesting, tended to terminate marriages and to incur the wrath of the husbands, his relatives, and even the woman's

own relatives (Orubuloye, 1992). In Kenya, for example, Rakwar and colleagues (1999) reported that 80% of the women felt they were at risk for HIV because of the behavior of their partners, but knew they would be blamed for introducing the infection into the relationship in the event of a positive HIV test result.

In individual interviews in the Democratic Republic of Congo, Schoepf (1991) presented a case where a woman accepted her situation as a co-wife, arguing that her husband always respected her as the first wife, and, in any case, he kept his other women away from the house as a sign of discretion. To her, the position of a wife--particularly a first wife--was more honorable than that of the other women who settled for being either younger co-wives or concubines. In essence, the woman was saying that since she had been the chosen one among many to be married, and hence was in the privileged position relative to others, complaining would be tantamount to ingratitude towards her husband's 'generous gesture'.

One of the factors playing a part in the disempowered status of women is that in many communities, there is hardly any communication between partners about sex-related issues, and women may not even know that their husbands are infected with an STD or HIV (Awusabo-Asare et al., 1993; Gillies & Parker, 1994). But even if they did, and brought it up, they may face violence or risk being accused of infidelity (See also Rakwar et al., 1999). As Schoepf (1991:113) reported, a woman in the Democratic Republic of Congo who suspected that her husband was HIV-positive suggested the use of condoms or abstinence from sex, both of which he declined. His family joined in and threatened to throw her out and to confiscate her youngest child, so she acquiesced. Following her husband's death, her in-laws accused her of infecting

him and disinherited her. She died two years later, and the author observes that had he agreed to use condoms or had she the resources to leave him, she might still be alive (See also a similar feature by Orlale & Otieno in *Daily Nation,* March 30, 1999).

This indicates that the woman's economic dependence on her husband meant a lower bargaining power in the marital and sexual transactions, and puts her under economic pressure to stay in the relationship against her will. In addition, being in a patriarchal family system, she would be expected to leave her children behind if she were to leave the marriage. This case demonstrates the compromised position obtaining in patrilineal family systems where some married women find few outlets to exercise autonomy over their sexuality with their spouses. Without rights over her children or family property (and among the Luo, rights of burial place as well, which I shall discuss later), staying in marriage in many cases is the only 'honorable' way to ensure familial, social and economic security. In contrast, married couples in matrilineal societies continue to belong to their matriclans where wives are more likely to exercise some authority over their status in marriage, or to divorce and remarry when necessary, compared to those of patrilineal groups (Awusobo-Asare, et al., 1993).

Among the Luo ethnic community, I argue that gendered-power dynamics in marriages serve to sustain the institution of widow inheritance. The community is patrilineal in kinship system, which, as I have highlighted in the examples above, encourages official and/or clandestine polygyny. In Kenya, Nyanza province reported the highest proportion of polygynous relationships (at 18.3%), compared to 8.4% nationally (NCPD/CBS/MI, 1998). In our study, 18.4% of the men were polygynous

while 78.8% of all men reported extramarital sexual affair over the course of their married life. This can be attributed, in part, to societal endorsement of polygyny, which comes with a covert (sometimes overt) culture of multiple sexual partnerships (See also Awusobo-Asare et al., 1993; Anarfi & Awusabo-Asare, 1993; Orubuloye et al., 1991; 1992).

The polygynous nature of Luo men has been cited as a cause of marital insecurity for several reasons (Agot, 1996b). One, respondents expressed concern that women fear denying their husbands sex, or questioning or disapproving their husbands' infidelity, even at the risk of contracting HIV. Similar to what Awusobo-Asare and others (1993) found in Ghana, this strategy only gives the husbands justification not just to have extra-marital sexual affairs, but also to marry other wives. Two, the women would also risk losing their rights over their children in the event of divorce or separation, because as a patrilineal society, children and property of a Luo, including the wife herself, belong to her husband's clan. References such as *dhako mwandu dala* (a wife is the wealth of a home) or as one put it, "A wife is a family thing; a woman is a wife of a family and cannot be married afresh" were not uncommon among our study respondents.

Such claim of 'ownership' continues after the death of the husband, and the wife would claim custodial inheritance (have a right to use the husbands property as long as she is alive) only if she remains in the home. The property customarily belongs to her sons, and without sons, the brothers-in-law would repossess everything if she leaves, or when she dies. Having daughters could not guarantee her ownership of the property. Even though property inheritance and lineage are still almost exclusively in

the domain of male members of the community, the 'ownership' of women themselves is less strict since women are increasingly becoming self-reliant. In bereavement however, some of this autonomy wavers, and the widow is often urged (sometimes forced) to follow the norms set by the in-laws (See Appendix 4).

One channel through which family ownership of property, wife, and children had been enforced was the paying of bride wealth. Traditionally, the extended family members of the groom, particularly his father and uncles, were expected to contribute towards the bride wealth, and in so doing, the in-coming wife would belong not just to the husband; she was also a wife to his family and to the clan as a whole (Mboya, 1997). Terms and phrases used in reference to a wife by extended family members include *chiwa* (our wife), or *chi dalawa/gweng'wa* (a wife of our home/clan). The implied communal 'possessiveness' and 'ownership' (at this point, this referred to social, not sexual relationship) does not terminate with the death of a husband, and as I shall demonstrate later, has served as a strong precursor to the cultural tradition of inheriting widows.

And finally, among the Luo, as in many African communities, ancestral land is highly valued as a permanent home[19] and a final resting place upon death. Because the customary laws of property inheritance are drawn along male lineage, girls do not have property rights in their parental homes, and upon marriage, they also relinquish any claims for burial. Many times they do not re-claim this right even when they

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[19] To the Luo (and within many other communities in Kenya and in sub-Saharan Africa) a 'home' refers to the permanent rural residence. Residential places in cities and other work places are considered 'houses', even if they have been passed on in the same family for generations.

separate or divorce from their husbands[20]. In such circumstances, their cortege would often be returned to their husbands' homes for burial, often after much negotiation, persuasion, and pleas. To forestall such incidents, parents often urge their daughters to stay and work out their marriages, hence some women remain in relationships that they would otherwise quit, or agree to be inherited against their choice, just to maintain burial rights in their marital homes.

The place of sex in Luo marriage: a precursor to widow inheritance?

Another factor that is not directly tied to polygyny, but which, nevertheless, plays a key role in ensuring the continuation of family involvement in the life of the widow is the role of sex in marriage. The respondents identified three main functions of sex in marriage, namely, for procreation, to cement spousal relationship, and for purposes of ritual cleansing or other observances associated with social events[21]. The

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[20] In fact, a single girl of marriageable age would be buried outside the fence at the back of the her father's home to indicate that once a girl attains marriageable age, she no longer has a place in her father's household, whether or not she decides to marry. She is referred to as *migogo* (a term reserved for a married woman by her family of birth) whose ghost would haunt the family if she were buried within the homestead. At times, a married sister or cousin would claim her body and bury her. Once women lose burial rights in their homes of birth upon marriage, they would not want to lose the rights again in their matrimonial homes, and therefore must remain married (for those with husbands) or inherited (for widows).

[21] Some of the additional requirements of widow inheritance are that the practice must be observed in a pecking order, meaning that before an elder person is inherited, anyone younger than she should not overtake her. For example, if a mother or a mother-in-law is widowed and has not been inherited, her daughter or daughter-in-law cannot be inherited either, lest she brings *chira* to herself and/or her family. The elder woman's children, daughters-in-law, or younger co-wives would also not participate in events where sexual rite is required until after she observes the ritual herself. For example, they should not cultivate [*golo pur*], plant [*golo kodhi*], or harvest [*kelo/bilo cham*]; they should not participate in marriages and burials of some of their loved ones; and they should not construct [*goyo dala*] or repair [*loso/loko ot*] their houses. (Some of these functions are discussed further in this chapter as well as in Chapter Four.) There are two important things to add in discussing this process, one, that these rules are effective only if the elder woman is still sexually active--the idea being that that the younger woman can still go ahead and participate in the events as long as the elder woman remains sexually abstinent during the event and for a while after. And two, that these rituals were easier to carry out in the past because people were living together, and it was easy for the community to monitor what was going on. It was also practically possible for couples, who were then living together, to observe the required sexual rites.

discussion that follows focuses on the perceptions of the respondents regarding the third function of sex--sexual rite--in sustaining the practice of widow inheritance.

The origins of making sex into a component of farming seasons, of rites of passage, and of establishment of homes, is traceable to the eldest wife of *Ramogi*--the first ancestor of the Luo. The key informant interviewees reported that she initiated rules governing sex in marriage as a way of ensuring that, after her husband married younger wives, she would still be entitled to some share of conjugal rights. Introducing sex into activities that sustain daily life (i.e., food and shelter) or into those that give the community its identity (i.e., rites of passage) has, for example, given it (sex) the powerful hold it continues to have among the Luo. In fact, regardless of gender, church affiliation, or district of residence within Luo Nyanza, we found this hold to be still strong among the respondents. However, there was a tendency for those who were younger, especially male respondents, to question the rationale for some of the practices, and to suggest need for change, especially in the era of HIV/AIDS. The following views from the discussions attest to this observation (the first quote was a reaction to a group of women who were voicing their disapproval of today's version of inheritance):

Male respondent in his 20s:

> The way I see it is that [these] women are supporting [the idea] that widow inheritance should be abandoned, but as I see it, they are supporting what they don't know. Because it is women who come to you when their husbands die, [saying] that their sons want to marry and there is nothing they can do. [As such] if we stop inheritance, then they will kill all their children. [The 'killing' being referred to is through *chira* arising from breaching taboos associated with a son marrying and consummating the marriage when his widowed mother

has not been inherited. The respondent was a member of a church in Suba District that supports inheritance].

Male respondent, under 20 years:

> How come the Luo people insisted that only contact between blood and blood can release someone from taboos? Aren't there other means to counter the taboos? Why [must it be] flesh to flesh? [Member of a church in Siaya District that supports inheritance].

The following quote is excerpted from a rather heated discussion where different views were being expressed centering on some of the cultural beliefs around sex in marriage:

Female respondent, under 20 years:

> The way I see it is that the rules [taboos] instituted by the Luo [ancestors] are responsible for most of the [AIDS] problems that we have--everything must be sealed through sexual intercourse. It is this tradition that should be eliminated. [What is required is that] People should teach themselves to have nothing to do with such traditions.

Male participant, over 60 years (respondent visibly upset):

> Can't you [all] see that this girl is now coming [here] with wisdom of education and of Christianity."

Male respondent, in his 20s, in evident exasperation:

> Where did this Luo tradition start; that the only way to free oneself from taboos is to have sex?

Male respondent, in his 40s:

> The Luo elders introduced this custom to institute faithfulness [between couples] so that one would fear bringing wrath to himself/herself by being unfaithful to the partner during certain events. It is also to ensure respect in polygynous marriages so that a man who would otherwise not perform his conjugal duties with certain wives would be under obligation to do so [This is illustrated in Figure 3 later in chapter]

Male, in his 20s, responds again:

> Then let's ask the elders of today to sit again and undo some of these mandates and take another oath that revokes the [old] tradition and release the community from such taboos

The excerpts reveal two things of interest for this dissertation, one, that people feel collectively bound to the tradition following the original oath made by their ancestors, and two, there is some indication that younger members of the community are beginning to question some of these assumptions and to call for change. Interestingly, many of them were not pressing for radical changes, such as overhauling the entire custom (as required by the interventions initiated by the Ministry of Health), but that whatever components are not viable in this day and age need to be reconsidered. This is what Treichler (1999) would identify as diverse voices, which, she argues, represent not diverse accounts of reality but significant points of articulation for ongoing social and cultural struggles. In the case where a woman is deciding whether to be inherited or not, the 'choice' process must be viewed as ongoing religious, traditional, historical, personal, and relational interactions in the production of their vulnerability (See Chapter Three for further discussion on the theme of 'vulnerability').

As I have already mentioned (see footnote 21), most of the events that are accompanied by sexual rites are expected to follow a pecking order, from the eldest to the youngest woman. For instance, in observing sexual rite before starting a given farming cycle, a polygynous man would begin with the first wife and follow the order in which he married them. Similarly, a mother-in-law would be required to partake of the practice before her daughter in-law, and the younger sons will follow the first-born son. Figure 3 shows the order to be followed in a typical polygynous Luo homestead. This scenario poses serious implications for the spread of HIV, because if one wife is infected, the virus could be passed on to everyone else during a single event as the

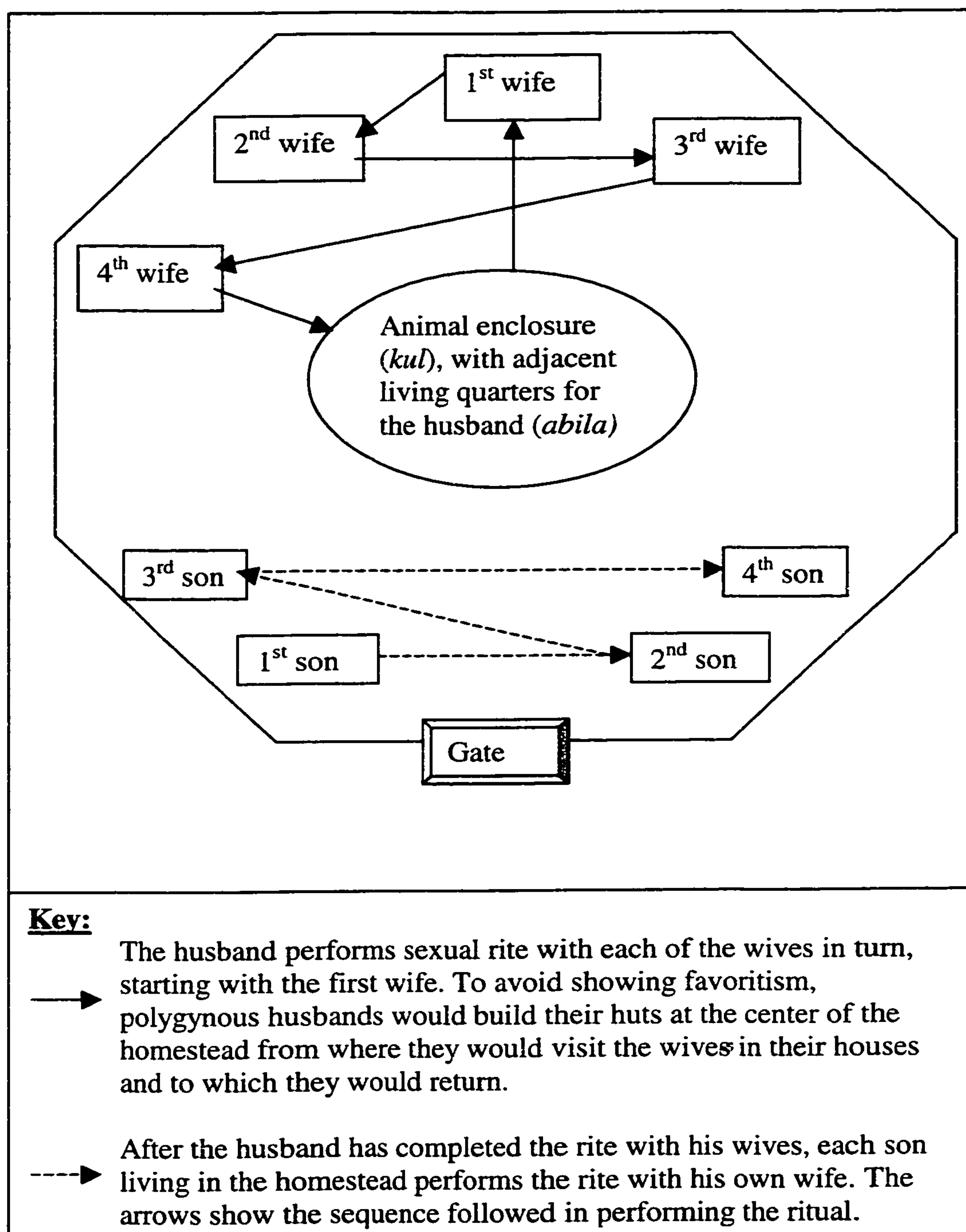

Figure 3: A Luo homestead: order of sexual rite to mark the start of planting season.

husband fulfils the requirement of sexual rite with each wife in turn. Once this is done, then married sons who are still living in their parents' homesteads will also follow suit in order of birth. If, for any reason a woman has no husband/inheritor at the time she is required to observe a ritual that involves their children, such as those associated with marriage and funeral ceremonies, she may be expected to either go back to her husband (if separated) or get someone else with whom to have sex (if divorced or widowed), because, unless she observes the ritual, younger wives and/or sons cannot fully participate in the event. Anyone who breaches this rule would risk experiencing misfortunes, and so, inheritance becomes a family and clan affair, rather than an individual's decision. For instance, if a son and his wife become the first in the homestead to plant [*golo kodhi*], then the mother-in-law must refrain from sex totally until the planting season is over, otherwise it is believed that the son, and especially the grandchildren, would die in mysterious circumstances. The excerpts below illustrate this dilemma.

Male respondent, in his 30s:

> [It is believed that] If a mother-in-law is not inherited, she would 'kill' her son's children [through *chira* or other misfortunes], and so, many children force their mothers to get inheritors. [As a son] Your wife considers your [uninherited] mother a witch who is killing her children and as a result may go back to her parents and refuse to return until your mother has been inherited, has died, or you have moved out of your father's homestead. [Member of a church in Bondo District that holds neutral position about inheritance].

Female respondent, in her 20s:

> Children get support from other family and clan members [telling them], that 'You see, it is your mother [who is] killing your children.' So the old lady surrenders and is given 'some shepherd full of disease'.... Women now [in this meeting] are putting a 'tick' [an okay] to stop inheritance, but when there is death, then clan members

or family members make it impossible for us to refuse to be inherited. They tell your children that "If your mother is not inherited, then there will be misfortunes in your family". So they [the children] force you, or else they abandon the home and rent a place at a market center [and live there] until you are inherited or until you die. It forces you to look for a man and in the process, collect AIDS and bring home. [Member of a church in Kisumu District that does not support inheritance].

Female respondent, in her 40s (expressing another dilemma):

Without being inherited, you cannot attend any funeral where your daughter is married, or visit her or else you are accused of [having an intention of] killing your son-in-law. Your married daughters cannot step in your home [either] until you are inherited. So, what can we do? I don't have a choice but to look for whomever I can find--even in a *Kajater Market* [A local market place. The name has been changed to protect the identity of the venue, hence of the respondent. Respondent was a member of a church in Nyando District that supports inheritance].

As I have mentioned now and again, and as shown in these views, to enforce the custom, rules were made and consequences were pronounced by the clan elders, under oath, to govern the procedure of the ritual. The most well-cited consequence of breaching taboos around inheritance is affliction with a health condition called *chira*. Because there is still a very strong belief in *chira* (Subsection on *chira* in Chapter Four), decision-making in matters of sex is quite complex, and even if they may appear voluntary, in effect the woman may be responding to outside forces, and many times the risk to self becomes secondary to the 'survival' of members of her immediate and extended family, as well as of her clan.

Many respondents, both in the open and focus group discussions were unable to trace the origin of the institution of widow inheritance independent of these activities. It was simply accepted as a mark of community identity that had been passed on over generations and to which the present day people were custodians. They

saw the practice as a way of ensuring that the role of sex in holding the family and community together continues to be observed after the demise of a husband. Because, even if one is widowed, her obligation as a mother, a mother-in-law, a sister, a daughter, or a co-wife requires of her to continue observing sexual rites during farming seasons or rites of passage so as to 'protect' herself and her family from being affected by *chira*. Having highlighted the role of (keeping) traditions as a force behind the continuation of the practice, I now turn to the second most important force--that of the church.

Enforcement of the custom of widow inheritance: who is responsible?

As I mentioned in Chapter One, the study participants were members of various African instituted churches drawn from the Luo ethnic community. They reported that both the Luo 'elders' (both men and women who are conversant with the tradition) and the church traditions are serving as custodians of the practice, reinforcing each other, to ensure that the custom continues to be upheld. In my discussion earlier in the chapter (see 'gendered-power relations in marriage' and 'the place of sex in marriage'), I explained how the Luo traditions act as an enforcing agency to keep the custom alive. In this part, I now turn to the role the church is playing in either promoting or discouraging the practice, concluding with an interpretation of the sort of impact different church doctrines would potentially have on widowed members of their congregations regarding the likelihood of being inherited and of risking HIV in the relationship.

<u>Church traditions as an enforcing agency of widow inheritance</u>: It has been estimated that upwards of 80% of Kenyans are active members of organized religious groups and that these institutions enjoy high degree of credibility among communities in which they operate (Government of Kenya, 1998; See also Luba, 1998; Nicholas & Durrheim, 1995; Lagarde et al., 2000). They also have a unique infrastructure that has sustainable human resources and divergent focus groups such as the youth, the women, the men, and the children in their formative years. Consequently, there is increasing recognition of the potential these organizations have in the fight against the spread of HIV. For purposes of this dissertation, my interest in churches is two-fold: one is that the church has a role in perpetuating the practice of inheritance (discussed below), and secondly, that it has potential contribution in changing the behavior of its members towards widow inheritance (discussed briefly in this chapter, but mainly in Chapter Six).

One of our goals for visiting leaders of various denominations was to obtain information on their teachings regarding widow inheritance, among other customs. Of the 66 denominations whose leaders consented to joining the study, only four (6%) totally condemned the practice, while the position of the remaining 62 ranged from being partially supportive (giving parishioners the freedom to decide, while prohibiting the clergy), to being neutral (giving both the clergy and the rest of the parishioners freedom to decide), and to fully supporting the practice. For this last group, the culture (of inheritance) itself is one of the key doctrinal teachings of the church. As such, the church is fully involved in the events preceding, during, and following the burial ceremony of its adherents, including those around inheritance.

To examine whether the church is a barrier to or an enhancer of the practice of inheritance, I have chosen to present only the two extreme positions--positions representing total rejection of the practice and those representing total approval. It is important to mention that each of the 66 denomination leaders used various sections of the Bible to reference their position on the subject (of inheritance), some of them further reinforcing their stand with customary requirements of the Luo concerning the practice. It is also beneficial to reiterate what I pointed out in the subsection of *Limitations,* that only African Instituted Churches were selected in the study, and that this may have biased the results towards widow inheritance. Mainstream churches, such as the Anglican, Roman Catholic, and the Mission-based Pentecostals are more strongly opposed to the practice, and, in fact, many independent churches broke away from the missionary-based churches because of the latter's stand on African traditions such as widow inheritance. Thus including them in the study could have shifted the results more towards opposition to the practice. However, because many widows still uphold the tradition despite the teachings of their churches, the expected effect of conventional churches in dissuading adherents from partaking of the practice could have been lowered.

Opponents of inheritance: All the four denominations that oppose widow inheritance were first or second generation breakaways from the Anglican Church of Kenya, a mainstream Missionary church introduced to Kenya in the late 19th century from the Church of England (Mboya, 1997). Their main reason for breaking away was the rejection of the Anglican stance of excommunicating polygynous men and their

younger wives, as well as inherited widows and their inheritors. These churches argue that these are European cultures being imposed on Africans by the white missionaries, who, they claim, were (mis)using the Bible to promote their own foreign culture. Drawing from two of these leaders, the Archbishop of Church of Peace in Africa (*Hera*), The Rt. Reverend Dr. Matthew Ajuoga, and the Archbishop of The Voice of Salvation and Healing (*Duond Warruok)*, The Rt. Reverend Silas Owiti, I discuss the grounds for their opposition, citing some of the Biblical Scriptures they had used in support of their stance that women should be free to marry whomever they choose after the death of a husband (all quotations are from *The New King James Bible*; their emphases are italicized).

I Corinthians 7:8-9

> But I say to the unmarried and the widows: It is good for them if they remain even as I am; but if they cannot exercise self-control, *let them marry. For it is better to marry than to burn with passion.*

I Corinthians 7:39

> A wife is bound by law as long as her husband lives; but *if her husband dies, she is at liberty to be married to whom she wishes, only in the Lord.*

Romans 7:2

> *For the woman who has a husband is bound by the law to her husband as long as he lives. But if the husband dies, she is free from that law*, so that she is no adulteress, though she has married another man.

The leaders supported their position by arguing that according to the New Testament, the vow "until death do us part" given at Christian marriage ceremonies holds true for all professing Christians--whether European or African--and that the death of a

husband releases the surviving widow from all the vows and sets her free "to be married to whom she wishes", except "in the Lord." The only brother-in-law who would be eligible to marry her is one who is not married. Being inherited by a married brother-in-law would result in polygyny which the church opposes for those who are members.

An issue that the opponents of inheritance were unable to defend convincingly, and which was the major source of contention by the proponents, was the fate of the children should the widow decide to marry elsewhere. This is because the Luo community is a patrilineal system where children belong to the father's family and where leaving one's marital home would imply leaving the children behind. As I mentioned earlier, one of the reasons why women remain in turbulent marriages or why some widows agree to be inherited is to avoid parting with their children. When such a conflict arises, women have to choose which of the two traditions to uphold: Christian or cultural. Because many women in such circumstances chose to stay behind, one of the leaders from the churches that condemn inheritance referred to it as a time of reckoning--whether one is a "Christian who is a Luo" (which he defined as "when Luo traditions take precedence over Christian traditions") or a "Luo who is a Christian" ("when Christian traditions override Luo traditions"). This is a case of having multiple loyalties. As one female respondent observed:

> Refusing to be inherited because you have Jesus before your son builds his own home cannot work out. You'll be forced to get someone when his time comes to build. Luo customs must be honored first and that is what sets you free to observe Jesus' customs

Many pastors conceded to the fact that the biggest challenge is to enforce the church teachings in a community that still holds the tradition of inheritance very strongly. For instance, the following quotation represents what most pastors reported about their dilemma when they preside over burials:

> A common circumstance is usually when, just before lowering the coffin to the grave, community members ask you whether, as the pastor who is presiding over the burial ceremony of the man, the church approves inheritance. My usual response is that "What brought me here is the one who has died; the woman is yours and you are the ones to pass the verdict.

Widow inheritance is thus one area where competing cultural and religious interests get played out, and although the role of the church in reducing the practice was acknowledged (See Chapter Six), in many instances the Luo culture overrides the Christian culture.

Proponents of inheritance: On the other hand, for the denominations that condoned the practice, I will cite the Scriptural references and justification provided by two of the archbishops to represent this position--The Reverend Archbishop Gideon Charles Owalo of *Nomiya Church* (who is a son of the founder of the first African Independent Church in Kenya [founded in 1907], and himself a self-confessed product of inheritance), and The Reverend Archbishop Zebulon Were Ndiege of *Nomiya Luo Roho Sabato*[22]. Their position is drawn largely from three Scriptures, one from the Old Testament and two from the New Testament:

[22] The Archbishop passed away during fieldwork, and we attended his funeral as a (research) team to convey our condolences.

Deuteronomy 25:5-10

> *If brothers dwell together, and one of them dies and has no son, the widow of the dead man shall not be married to a stranger outside the family; her husband's brother shall go in to her, take her as his wife, perform the duty of a husband's brother to her.* And it shall be that the first born son which she bears will succeed to the name of his dead brother, that his name may no more be blotted out of Israel. But if the man does not want to take his brother's wife......Then the elders of his city shall call him and speak to him......

I Timothy 5:9, 14

> *Do not let a widow under sixty years old be taken into the number...* Therefore I desire that the *younger widows marry*....give no opportunity to the adversary to speak reproachfully.

I Corinthians 7:3, 4

> Let the husband render to his wife the affection due her, and likewise also the wife to her husband. *The wife does not have authority over her own body, but the husband does. And likewise the husband does not have authority over his own body, but the wife does.*

These clergy argued that widow inheritance is sanctioned both by the Luo traditions and the Bible, and the procedure described by both custodians, independently of each other, is so similar that, to them, "God must have endorsed the Luo culture long before Christianity and *The Bible* were ever introduced to the community". (However, this was rebuffed by other respondents, for example, that "Luos are like Israelites, but given the current trend in the practice of inheritance, they are like Israelites who have lost direction".) The argument of the proponents is that, given that no one has authority over their own bodies, they felt that any widow under 60 years of age is too young to abstain from sex, and rather than leave her to succumb to temptations, it would be better for her and for the community if she were inherited.

<u>The two positions compared</u>: The point of divergence between the two positions is the emphasis of the Old versus the New Testament references. Those who opposed the practice depended more on the New Testament, arguing that:

Colossians 2:20

> **Therefore, if you died with Christ from the basic principles of this world, why, as though living in the world, do you subject yourself to its regulations?**

II Corinthians 5:17

> **Therefore, if anyone is in Christ, he is a new creation; old things have passed away; behold, all things have become new.**

To the respondents therefore, following traditions compromises their faith, and being tied to one's culture is an indication of spiritual immaturity. In fact, passing this, and similar hurdles, was cited as proof of their Christian growth. Proponents, on the other hand, base their support on the Old Testament, and argue that Jesus Himself said He did not come to abolish but to fulfill the law of the Old Testament, that:

Matthew 5:17

> **Do not think I came to destroy the Law or the Prophets. I did not come to destroy but to fulfill**

Hence, fulfilling the law of widow inheritance, drawn from the prophets (see earlier reference to Deuteronomy 25:5-10), is acting in accordance with what Jesus Himself said He did not come to destroy. Their position was also challenged, especially by those who argued that they were misapplying the Bible. One of the examples proponents were using was from the Book of Ruth Chapters 2-4 where the widow on whom the story is based did not have sons. To this widow, the quotation from

Deuteronomy 25:6 "And it shall be that the first born son which she bears will succeed to the name of his dead brother" was relevant. On the contrary however, the practice was being recommended for all women under 60 years of age, with or without children. For the critics, this was one area where, although *The Bible* was being used, the traditions remained more prominent and where more people were potentially being exposed to HIV unnecessarily in the name of misrepresentation of Biblical teachings.

Implications of the positions of the churches for HIV 'risk' and 'vulnerability': In the entire dissertation, I present the church as one of the trio (besides personal background characteristics of widows and their social relationships) that influences a widow's decision to get inherited, and the level of risk for HIV she would be exposed to in the relationship. What is emerging is that for each widow, being a member of a given denomination would play a part in defining the magnitude of risk she is exposed to, or how vulnerable she is. For instance, it would make intuitive sense that a widow from a church that allows her the choice (to be inherited or not) would be more amenable to intervention messages advocating for change compared with those from churches where the practice is encouraged. The latter group would therefore be more vulnerable. I argue that this need not necessarily be the case, especially because, as I have pointed out already, the cultural requirement of *tieko chik* (see footnote 32) is still quite strong so that widows from churches that do not condone the practice may still partake of the tradition, but go underground to avoid moral disapproval. And as mentioned previously, one of the current components of the practice that were cited

by the respondents as increasing the risk for HIV for the widows is performing the rite in secret.

In essence therefore, churches that condone the practice do, in fact, encourage a more open, and probably safer and less risky behavior, than those that oppose it. But, on the other hand, it is also possible that being assured of support from one's church, it becomes easier for the widow to decline to be inherited because the church would 'bail her out' in events where she would otherwise be expected to observe the sexual rite. Respondents agreed that an increasing number of widows are nowadays relying on support from their churches rather than being inherited. This has also provided an avenue for interventions (discussed further in Chapter Six).

What this chapter has demonstrated is that the practice of widow inheritance is so fully intertwined in culture and religious beliefs that to address it in isolation from these factors is to leave significant structures that produce and sustain it still intact. Moreover, labeling the practice only in terms of biomedical risk perception is inadequate to address the different ways in which the practitioners conceive its association with HIV--ways of which interventions must take cognizance (See subsection on "Cultural perspective" in Chapter Four). However, the current situation is one where the concepts of 'risk' and 'vulnerability' are defined differently between those designing and implementing the interventions and those to whom the interventions are targeted. In the next chapter, I describe how the widow's background characteristics, social relations, and religious beliefs interact to define her level (or space) of vulnerability to HIV through the practice of inheritance.

Chapter Three:

HIV/AIDS in sub-Saharan Africa: re-constructing 'spaces of vulnerability' within the framework of widow inheritance

Chapter overview: In this chapter, I demonstrate that when 'spaces of vulnerability'[23] for HIV are constructed within the framework of widow inheritance, the social, personal, and religious contexts of the practice are integral in the construction process. By paying attention to these contexts, we can understand why similar life events produce different 'spaces of vulnerability' for different widows at the same point in time, or for the same widow at different points in time. I have selected the practice of widow inheritance among the Luo as a case study to represent other areas, other communities, and other cultural practices across sub-Saharan Africa which have also been associated with a higher prevalence of HIV/AIDS and which have consequently been targeted by interventions for behavior change.

The goals of the chapter are threefold. Firstly, I very briefly examine the utility of the concept of 'space' as a framework for understanding and organizing the geography of HIV/AIDS in general, and in sub-Saharan Africa in particular. Secondly, I provide a background to the personal, social, economic, and religious environments within which the practice of widow inheritance is carried out, highlighting its function for the practitioners and the community at large. Lastly, I discuss how the intersections of the different characteristics of the 'environments' for widow inheritance provided in

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[23] In a manner of brief introduction to the concept, I define 'space of vulnerability' as where different combinations of factors underlying the practice of widow inheritance, namely, widows' personal background characteristics, relations with immediate and extended family members, and religious affiliation, intersect and define the type and level of vulnerability that widows in those spaces experience (further elucidation is provided later in the chapter).

the second objective (above) produce varying 'spaces of vulnerability' for widows in different circumstances, in different geographical locations, and at different time periods.

When is 'place' relevant in explaining the geography of HIV and when is it not?

The two key concepts that define the discipline of geography are 'space' and 'place' (Massey 1999b, Agnew, 1989; Unwin, 2000; Johnston, 1997). Even though it is beyond the scope of this dissertation to theorize the concepts in and of themselves (except for the brief highlights footnoted below[24]), I however delve further into the

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[24] Several terms and phrases have been used to elucidate the different meanings that have been attributed to the concepts of space and place, for example, absolute and relative (Blaut, 1961, in Johnston, Gregory, & Smith, 1994; Cofey, 1981), relational (Harvey, 1969; Gillian, 1999; Agnew, 1989), discursive (Massey, Allen, & Sarre 1999; Allen, Massey, and Sarre, 1999; Gillian, 1999), container (Massey, 1984, Kearns & Gesler, 1998), objective and social (Johnston et al., 1994; Unwin, 2000; Sack, 1984), location, context, and process (Massey, 1984; 1999a; Thrift, 1999; Gillian, 1999). The term locational refers to 'space' as absolute, objective, or container; discursive refers to discourses that prompt the formation of mental maps characterizing and labeling certain regions as, for example, HIV/AIDS-prone; while context denotes 'space' as relative, relational, process, or social.

'Space' as context can be conceptualized at two levels: At one level, 'context' can be thought of as synonymous with a set of attributes or processes, and implies a coalescence of these attributes or processes that give a particular space in a particular location its uniqueness and distinction from other spaces. An example would be that Luo Nyanza is characterized by 50% of inherited widows. Although less narrow than the locational or discursive concepts, Thrift (1999) and Unwin (2000) argue that conceptualizing space as context at this level is somewhat limiting because used this way, space assumes its definition from the aggregate representation--the sum total of a phenomenon (e.g., 50% prevalence of widow inheritance in Luo Nyanza)--rather than from the process that produce/constitute the phenomenon. Lately, phrases like "construction of space" or "space as socially constructed" (Unwin, 2000; Agnew, 1989) are increasingly being used. However, even the phrase 'construction of space' does not imply the dynamism of the processes themselves; instead it focuses on the dynamism in the formation of the pattern. Similarly, the conception of "space as socially constructed" stresses more the processes of constructing a particular space, rather than how the processes themselves are constructed. In this context, our understanding of widow inheritance would end with the prevalence of the practice itself, not the process that produce it.

The second level--one that is more relevant to my dissertation--is where space as process is used to denote the inherent dynamism of the processes themselves. This arises from the fact that the social relations constituting space are experienced differently and are variously interpreted by those holding different positions as part of it. For instance, social relations that may produce one type of inheritance in some widows (e.g., being inherited by professional inheritors) would result in a different response by other widows (e.g., being inherited by brothers-in-law). Such a way of conceptualizing the spatial implies the existence in the lived world a simultaneous multiplicity of spaces produced when different processes intersect with one another, some of which pose higher risk for widows than others. For purposes of this dissertation, conceptualization of space at this level implies that the practice of widow inheritance can only be fully grasped by paying attention to the processes that are associated with its production (i.e., widow's background characteristics, her social relations, and the doctrines of her church towards the practice), how the processes themselves have changed over time, and how the changes continue to redefine spaces within which widows find themselves vulnerable for HIV.

contextual understanding of the terms because such grasp provides a framework to the concepts of 'risk' and 'vulnerability', both of which are central to this dissertation. I point out that places are defined by processes that are both contextual (combination of processes that give a specific place its character and distinction) and dynamic (ever-changing nature of the processes that lead to ever-changing character of a place).

The whole essence behind the dynamism of the processes is that as they interact, they construct new spaces either by deconstructing current ones and/or reconstructing old ones. At the same time that a given place is changing through the interactions of the different processes, the processes themselves are also changing. For instance, when relations between widows and their brothers-in-law deteriorate (See Chapter Four for explanation), the landscape of inheritance increasingly becomes dominated by professional inheritors. This has led to more 'demand' for this type of inheritors who, in turn, are inheriting more and more widows concurrently. In addition, the increasing 'demand' reduces the likelihood of the inheritors to agree to go for the HIV test or their willingness to provide material or other support to the widows. In this regard, the context of the practice is changing (from predominantly brothers-in-law to predominantly professional inheritors), and the character and behavior of the professional inheritors are changing as well (from inheriting a single widow for her entire widowhood and from providing material support, to inheriting multiple widows concurrently for short stints, upon whom the inheritor then relies for his upkeep without giving much in return).

Even though I have argued in support of place as a dynamic process, I do not imply that by being dynamic, places must be seen only as transitory and must pass on

(See also Thrift, 1999). I argue, rather, that in any given place, many processes are going on concurrently, and it is the impressions of the dominant process that become conspicuous. When this happens, we see (even so, only momentarily) distinguishable patterns that we then call the geography of a place. What this means is that whatever becomes dominant when a given combination of processes interact in a given way in a given place or at a given time will constitute the defining feature of the place. Butler (in Gillian, 1999) summarized this position by observing that particular relational performances produce a specific space; other performances of other kinds of relationality will produce other spaces.

One thing this dissertation underscores is the fact that because geographies are unfixed, concern with the geography of a phenomenon, such as the geography of HIV/AIDS, can sometimes be a fleeting illusion. In this regard, I suggest that spatial correlations that are presented on maps, for example between HIV prevalence and different risk factors, should be treated as clues rather than as confirmations of possible associations. The maps should trigger empirical investigations at the local level to ascertain the relationship on the ground. In short, I argue that maps (and patterns) are necessary geographic tools for justifying further HIV/AIDS research, but not for justifying HIV/AIDS interventions.

Given this argument, does it mean therefore that place matters only to the extent that it triggers our inquisitiveness about possible spatial associations and that it should be laid aside to allow for a discernment of a more genuine relationship of phenomena? Would places with high prevalence of HIV/AIDS provide useful frameworks to characterize specific regions or whole countries in terms of risk and to

justify blanket interventions targeting these geographical units? Or would place only matter at the map level, so to speak, because it is at that scale where the spatial patterns and associations may appear intact? In other words, at what point should geographers lay aside the spatial patterns of HIV/AIDS presented on maps, take steps towards the actual people about whom HIV/AIDS and widow inheritance, for example, have been mapped, and begin to look for explanations from the people themselves? Maps, like aggregates, are important, but understanding a more comprehensive relationship requires going beyond them.

Having said this, my main concern is how to then strike a balance between keeping away from labeling and stigmatizing places as risky for HIV on the one hand, and recommending place-specific understanding of vulnerability and of setting intervention programs, on the other. That is, when should we claim sufficient homogeneity in a place, without collapsing too much, to provide a basis for designing place-specific intervention programs that are, for example, responsive to the Luo culture of widow inheritance? For me, the major thrust behind the discourse on place is that spatializing AIDS may be useful only in so far as it serves to homogenize a people into a category in terms of HIV/AIDS prevalence for purposes of designing locality-specific interventions. However, using such categorization as justification to classify a place as being AIDS-prone is erroneous and does not serve any purpose except to fuel the existing stereotypes of places being intrinsically associated with risk, as I highlight in the next subsection. In other words, categorizing places helps only in decision-making about *where* to invest resources but not *how* to invest them.

HIV/AIDS research in sub-Saharan Africa: Spatializing culture into "Us" versus "Them".

In this section, I present examples of what I consider erroneous conceptions of 'space' in depicting HIV/AIDS in sub-Saharan Africa, and how these misconceptions have sidetracked pressing issues relevant to designing and/or executing effective interventions. First and foremost, it is important to keep at the back of our minds that when we talk about sub-Saharan Africa, we are talking about forty-six[25] different countries (classification by UNICEF, 2000), with at least nine hundred ethnic communities and close to 2,000 sub-ethnic groups and three hundred language families (Treichler, 1999:124). Zambia alone, for example, has more than seventy languages, while Kenya has 43 ethnic communities with distinct languages (Government of Kenya, 2001). In Kenya, for example, the Luyia and Kalenjin communities comprise of nine or more relatively distinguishable sub-groups who not only have different linguistic dialects, but among whom certain cultural traditions, such as widow inheritance, are carried out differently (Burudi, 2000; Personal communication with Isoe and Mahindu, May 2001). As such, the conception of sub-Saharan Africa as a single entity obscures salient features specific not just to different countries or different ethnic communities within each country, but even within a single community as well.

[25] Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Democratic Republic of Congo, Cote d'Ivoire, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia, Zimbabwe

There are three main ways in which the situation of HIV/AIDS in the sub-continent of Africa has been perceived (and given meaning), especially by those in the West, from where most funding come. One way has been through the lens of the historical legacies (and attendant stereotypes) which view difference as a temporal concept in which the sub-continent is a backward version of the West (or, at a local level, where the Luos are perceived as backward compared to other ethnic communities which *claim* not to practice widow inheritance [I say *claim* because as I pointed out in Chapter Two, most ethnic communities in Kenya practice some form of widow inheritance; only they have not been studied or the practice has not received much public and media attention]).

The construction of the so-called "African AIDS" by proponents of "Africa-as-backward" paradigm build their position on what Wilton (1997:3) describes as the intersection of a range of pre-existing discursive 'packages' about the sub-continent as a single spatial entity, such as in terms of darkness, sexuality, disorder, barbarism, wild, insatiable, animal-like, exotic, and cultural backwardness (See also Watts, 1999; Jarosz, 1992; Wilton, 1997; Setel, 1999; Gausset, 2001). Chrimuuta & Chirimuuta (1989), Schoepf (1991), Jarosz (1992) and Gausset (2001) also observe that Western popular and biomedical accounts of AIDS contain numerous examples of racist discourse about African culture, and with Africa designated as the source of AIDS, exotic customs have been held responsible, and the sexuality of Africans has been characterized across the board as irredeemably oversexed, abnormal, untamed, dangerous, and different from that of other peoples elsewhere. Jarosz (1992) uses the metaphor of Africa as a Dark Continent to depict how Europeans remade and

represented the continent as "Other". The author adds that the metaphor homogenizes and flattens places and people, and denies the actualities and specificities of economic and social processes of the 46 countries and over 900 ethnic communities transforming the continent. As Farmer and others (1996) and Gausset (2001) have argued, African culture is now being taken up wholesale to explain, justify, and excuse nonexistent, inadequate, or failed intervention campaigns. Yet, Wilton (1997:45) observes that lay beliefs about health and illness vary widely between cultures and, *even in industrialized Western cultures, seldom conform to allopathic medical understandings* (my emphasis).

A second way to interpret the disparate statistics of HIV/AIDS between sub-Saharan Africa and the West is through the spatio-temporal lens. In this category are those who view Africa not just as a 'temporal other', but (and also) as a 'spatial other', where differences between people have led to a social exclusion that is spatially enforced (Massey 1985). In his extensive research among gay men in British Columbia, Brown (1995) argues that the type of focus given to this group "both reveals and erases" them--reveals them as 'important' enough to warrant being studied, but erases them as not important enough to be allowed into the mainstream discourse of the disease (except as carriers of the virus who should be kept at bay in order to *block* HIV from diffusing into the 'rest of the population'). Massey and others (1999b) describe this type of position as reminiscent of those who display at one and the same time a familiarity with and a distance from peoples (on the other side of the globe) and to pass judgments on their actions and lifestyles (Similar argument is also found in Sibley, 1999 and Smith, 1999).

A classic example in this category would be Gould (in Treichler, 1999:253-4) who, dismissing the documented heterosexual transmission of HIV in Africa, sought familiar 'explanation' of the "African AIDS" in what Treichler's refers to as 'the cultural practices of "the Other"', in which he listed the following 'causes': unadmitted homosexual or quasi-homosexual transmission, unadmitted drug use, *the practice of anal intercourse as a method of birth control*, the widespread use of unsterilised needles, a history of immune suppression and infectious diseases, scarification, clitoridectomy, circumcision (its presence in female and absence in males), and violent, excessive, or exotic sexual practices" (my emphasis at the absurdity).

In this dissertation however, I take the third position, that of spatial difference. This is a spatial recognition of difference and vulnerability which acknowledge that sub-Saharan Africa may not just be following the West (in the sense of temporal perspective), but might actually have its own story to tell. As Massey (1999a) argues, spatial differences as a matter of being advanced or backward deny the possibility that there might be alternative stories and trajectories emanating from different regions that might explain why they appear different and unfamiliar to us, as indeed, we too appear different and unfamiliar to them. In other words, the position challenges us to go beyond simply the desire to understand or to describe the 'Other' culture, and to let its practitioners (of the culture) speak, and then give voice to the story they tell (See also

Spivak, [1988] in Craddock, 2000). It is only then can we displace Western interpretations[26] that focus on Africa and Africans as backward or as "Other."

This whole attitude behind assuming expert knowledge about Africa but not wanting to verify certain assumptions is what I refer to as selective visibility. Brown (1995) would call it 'revelation and erasure' or 'social distancing.' It is a situation where, on the one hand, Africa is brought into international focus as home to 70% of the global HIV, therefore 'qualifying' the continent as a convenient laboratory for AIDS research and a flood of intervention activities, while on the other hand, the continent is many times left out of the picture when it comes to benefits accruing even from studies conducted among them. For instance, a recent study between British and Kenyan researchers using a group of sex workers in Majengo, Nairobi, who had been resistant to HIV infection despite repeated exposure, turned sour when, after seven years of collaboration, the British rushed to register the patent for the vaccine that was developed from the study without as much as mentioning either the Kenyan researchers (who can also be viewed as a privileged group "Othering" the subjects) nor study participants (Okwemba & Makokha, 2000).

Yet one of the three international ethical principles in conducting medical research is that of justice--the principle that therapeutic investigations should not

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[26] My reference to "Western" should not be understood to imply that African researchers, other professionals, politicians, and those with the 'power' to collect and disseminate information about "others" are exempt from giving such interpretations. In fact, I have amply demonstrated this in Chapter Four where I explore how Kenyans who are non Luos are also "Othering" Luos and associating them with traditions and behaviors that inherently qualify them as AIDS-tropic. "Others" include also those in different--often lower--socioeconomic strata than the privileged writers. My unease with whole interpretive discourse is what Hill-Collins (1998) refers to as the growing commodificaton and consumption of the "different" in the scholarly market, especially since the advent of HIV/AIDS. I have deliberately chosen to use "Western" because they have better means to collect, interpret, and disseminate information about the "Other" than Africans writing about Africa, for example, and hence command a wider sphere of influence in readership about their depiction of "Other", and the perceptions arising therefrom.

unduly involve persons from groups unlikely to benefit from subsequent applications of research (Emanuel, Wender, & Grady, 2000). In another example, reasons such as inadequacy of infrastructure in Africa, or that "Africans lacked a requisite 'concept of time'" and would not benefit from HIV drugs that must be administered on tight time schedules, have been used to justify not providing HIV/AIDS drugs to Africa (New York Times of April 29, 2001; Wendo 2001).

In my view, the most important 'take home' message about HIV/AIDS *is not* so much to look for spatial or behavioral commonalities that tie together what Treichler (1999) refers to as white or black AIDS, gay or straight AIDS, European or African AIDS, East or West German AIDS, Central or West African AIDS, foreign or native AIDS, or guilty or innocent AIDS; *it is not* to look for (or 'force', like Gould [1988, in Treichler, 1999] did) a familiar explanation either; *it is not* even to search for a coherent "rationale" explaining the AIDS that 'makes White or Western sense' to the Western professional and technological agencies. Rather, *it is* to learn to listen to multiple voices of population groups most directly affected, and, ultimately, to challenge the entire discursive formation of international AIDS discussions that are often applied unthinkingly and in some sense, imperialistically to diverse cultures--in what Jarosz (1992) would call "flattening places and people." As Kalipeni (2000) and Oppong (1997) argue, there is need to change our attitude towards HIV in sub-Saharan Africa, and to bolster our approach to interventions that incorporates the larger context of the epidemic.

In the next two sub-sections, I highlight the social environment within which widow inheritance takes place, to bring out the complexities around the practice that

make a single approach to interventions ineffectual. Secondly, I have used the social environment of the practice of widow inheritance to discuss the changing 'spaces of vulnerability' to HIV in the Luo ethnic community. I argue that because the constructions of widow inheritance are multiple, assuming a single biomedical explanation to justify interventions targeting its elimination (or even modification) is shortsighted.

The sociocultural and religious environment for widow inheritance

As I mention in Chapter Two, respondents reported that the practice of widow inheritance has been observed by the Luo community as far back as the first ancestor of the Luo--*Ramogi* (Mboya, 1997). Prior to the advent of HIV/AIDS, the practice was perceived of as an embodiment of order and normality to the community; a practice through which the community was biologically and socially reproduced[27] as individuals and as a collective. The Luo, like most of the communities in Kenya, is an agricultural community, deriving their livelihood principally from subsistence farming. The types of social organization around production and consumption are therefore closely linked to farming activities, that is, how labor is organized and how activities such as cultivating, planting, weeding, and harvesting are carried out. Given the centrality of agriculture for the Luo, any rule or practice that is tied to activities around food production or consumption would have a critical and direct hold on the

[27] The term social reproduction has been used to refer to the reproduction both of social relations within which, and the materials by which, social life is premised (Johnston, Gregory, and Smith, 1994). I use it in this dissertation to refer to the continuity of the social organizations around food production and consumption, around the establishment of homes and of other living arrangements, around rites of passage (birth, initiation, marriage, and death), around property inheritance, and around general patterns of conducting 'business as usual', such as conforming to expectations of gender roles, or of observing societal moral codes of conduct.

survival of individuals and families, and consequently, on the perpetuation of their community.

As I discussed in Chapter Two, it is a customary expectation for Luo widows (or any woman who had been married in her life, whether divorced, separated, widowed, or still married) to partake of sexual rites preceding the onset of each farming season (See footnote 21). For many widows, this requirement influences their choice to be inherited. One of the reasons why the community endorses inheritance is precisely for the purpose that the tradition may provide means by which widows, like married women, would continue to participate in the food production process without inhibition--meaning she would have a male partner with whom to observe sexual rites whenever occasions call for such. In this respect, the decision of a widow is central to the social survival of individuals, and ultimately, of the community.

Furthermore, the existence and perpetuation of a community is dependent upon the birth of individual members and upon their initiation, marriage, and even death. These are collectively referred to as 'rites of passage'. For a widow to fully participate in ceremonies to mark any rite of passage for her parents, married daughter, or son-in-law, she must be inherited so as to observe the accompanying sexual requirement. As I have shown, activities around food production and consumption, and around the rites of passage, are performed principally to ensure the continuity of the community, both in biological and social contexts. And since widow inheritance revolves around these two activities, the practice is viewed in cultural terms as critical to the community's reproduction as a social group. In biomedical perspective however, widow inheritance is viewed as a possible conduit for the spread of HIV even though there are some

ways--some of which I pointed out in Chapter Two--that it may serve to protect women and communities from HIV.

In widow inheritance therefore, we see a practice rife with tensions that signals a mismatch between its role as perceived by the practitioners (cultural explanation) and by the health officials providing and delivering the interventions (biomedical explanation). As I mentioned earlier, prior to the advent of HIV/AIDS, widow inheritance was practiced to maintain social and biological reproduction. By participating in the custom, individual widows not only get an opportunity to get inherited; they are also seen to be fulfilling responsibilities to other relatives (children, parents, co-wives, siblings, and in-laws), and in doing so, they work to maintain harmonious social relations.

Since the onset of HIV/AIDS, however, the practice has come to be considered a risk behavior that is providing a favorable environment for the acquisition and transmission of the virus. In other words, as a result of HIV/AIDS, the practice of widow inheritance that had hitherto been perceived as cementing the community is now considered as a behavior that is tearing the group apart. For instance, from a cultural perspective, one of the major dilemmas faced by the widow is that if she is not inherited, then her (in)action would threaten her health and that of her other kin, but from a biomedical perspective, getting inherited may expose her to HIV. Such is the paradox between cultural explanation (belief that being inherited *controls* the spread of HIV/AIDS--See Chapter Four for detailed discussion about the association between AIDS and *chira*, as well as reasons for conflating the two) and the biomedical explanation (teachings that being inherited *exacerbates* the disease). To those who

believe in the cultural explanation, eliminating the practice is tantamount to passing a death sentence on the whole community[28], and to those who believe in biomedical explanation, eliminating the practice is one of the strategies that would save the community from potential decimation.

The point I want to illustrate by these examples is that the arrival of HIV/AIDS has heralded a reversal in the roles and perceptions about the functions of widow inheritance and in the subsequent messages relayed to the practitioners about it. Almost 'overnight', AIDS has changed these perceptions, from a symbol of life, continuity, coherence, which was encouraged, to a symbol of gloom, sickness, and death, which must now be discarded. My usage of the terms 'dilemma' and 'tension' implies that those who design and deliver interventions and those who are targeted as the recipients are interpreting the association between HIV/AIDS and widow inheritance differently. Given these examples, and also as I demonstrate in Chapters Two and Four, most practitioners have not yet labeled the practice as a risk behavior for HIV, and an intervention that does not start and build from this premise is bound to be inappropriate for such an audience.

Thus far, I have presented the expectations for widows with regards to the practice of inheritance as if they were passive adherents. This, however, is not the

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[28] As I mention in Chapter Four, widow inheritance has the potential to both control and exacerbate the spread of HIV. In biomedical context, participants argued that a widow who is not inherited would be more likely to have multiple sexual partners and be at a higher risk for acquiring or transmitting the virus than one who is inherited and who may be more likely to remain faithful to one partner. According to their argument, the bottom line is whether or not a widow abstains from sex--with an inheritor or anyone else--not whether or not she is inherited. In the cultural context too, a widow who is not inherited and who contravenes sexual norms (i.e., does not abstain from sex when she is expected to) would risk being afflicted with and/or afflicting her children with *chira* (translated as, or conflated with, AIDS). To these participants therefore, any plan urging them to stop the practice could well be a calculated malice to decimate them as a community.

case. Even though the practice is still favorably held across Luo Nyanza, there are many forces that are acting to counter or modify the expectations and/or actual practice. The result is that it has neither remained static, nor has it cracked under the stress of HIV or of interventions. Instead, is has been adapted in ways that make widows be more vulnerable than before (See Chapter Four for detailed chronicle of the changes). It is important to point out that the practice has changed mostly in the light of changes in educational, economic, and social conditions, not in response to the health crisis. In the next sub-section, I discuss how the changes have redefined 'spaces of vulnerability' for widows.

Constructing 'spaces of vulnerability' to HIV through widow inheritance

The concept of 'vulnerability' has been discussed in ecological terms, in relation to political economy and class structures, and as a reflection of social relations, including ethnicity, caste, generation, and gender (Watts & Bohle, 1993; Delor & Hubert, 2000). Vulnerability can be expressed spatially (from the local, to the regional, and to the transnational scales) and temporally (as a long-term or short-term condition). But whatever the particularities of these different approaches, vulnerability is a multilayered and multidimensional social space defined by the prevailing political, economic and institutional capabilities of people to secure basic needs in specific places at specific times (Watts & Bohle, 1993).

In recent literature, the concept of vulnerability has been attributed to the work of Watts & Bohle on hunger and famine (See Oppong, 1998; Delor & Hubert, 2000; Kalipeni, 2000). The two authors view vulnerability to famine and hunger through an

intersection of three coordinates: the risk of *exposure* to crisis situations; the risk of inadequate *capacities* or resources to cope with these situations; and the potential risk of being subjected to *severe consequences* as a result of being exposed to the crises. Thus, the most vulnerable individuals, groups, classes, and regions are those most exposed to perturbations, who possess the most limited coping capability, who suffer the most from crisis impact, and who are endowed with the most circumscribed capacity for recovery (Watts & Bohle, 1993:45). This implies that the magnitude of vulnerability is subject to an interaction among the three coordinates. Or put differently, understanding vulnerability demands an understanding of specific realms of choice and constraint which determine exposure, capacity and potentiality--of the individual's own command over basic necessities (such as household income or food); of the rights and entitlements provided by the immediate society (such as availability of land or food); as well as the presence of supporting structural properties of the political economy itself. As such, approach to vulnerability must go beyond the individual to the conditions of the immediate society of which vulnerable individuals are members and ultimately to the larger structures of which the individual's society is part.

The concept of vulnerability has been applied to the study of HIV/AIDS by several scholars, for example, Mann and Tarantola (1996), Oppong (1998), Delor and Hubert (2000), and Kalipeni (2000). Mann and Tarantola (1996) define vulnerability as the extent to which the individuals are capable of making and effecting free and informed decisions about their lives. It is an analysis that recognizes how broader contextual issues such as government structure, gender relations, attitudes towards

sexuality, religious beliefs, and poverty influence decision-making behavior, as well as the subsequent capacity to reduce personal vulnerability to disease that may arise from these decisions (of lack thereof). Such influence can be meted out directly or be mediated through (intervention) programs. Following this definition, they identify three levels of vulnerability, namely, personal, programmatic, and societal.

Personal vulnerability is comprised of three elements: *informational needs* (e.g., about HIV, sexuality, and services) for reducing vulnerability to HIV infection; *personal characteristics* such as emotional development, perception of risk and attitudes towards risk-taking, and personal attitudes towards sex and sexuality; as well as *personal skills* such as the ability to negotiate sexual practices, including safe sex and condom use (Mann & Tarantola, 1996). The approach to reducing personal vulnerability often focuses on providing information and education to the individual, counseling and peer support, and skills training. However, an intervention strategy to reduce personal vulnerability is inadequate to address behavior change, which is more complex and goes beyond the capacity of the individual, as I demonstrate in Chapters Two, Four, and Five.

Programmatic vulnerability, according to the authors, focuses on the contributions of HIV/AIDS programs toward reducing or increasing personal vulnerability. Programmatic vulnerability has been defined by the WHO (in Mann & Tarantola, 1996) in terms of three major prevention elements: (i) information and education, (ii) health and social services, and (iii) non-discrimination towards HIV-infected people and people with AIDS. Efforts to reduce programmatic vulnerability has been to strengthen the availability and accessibility of key program elements, the

quality and content of each, and the process through which the element is designed, implemented, and evaluated. Although an important component of improving the health status of affected populations, simply improving program elements does not address the critical issue of health care delivery, namely, access to the services by the individuals whose vulnerability the programs seek to minimize.

Finally, there has been recognition of the need to go beyond individual and programmatic vulnerability to address societal vulnerability as well. As Mann and Tarantola (1996) observed, research and empirical observation had demonstrated that personal behavior is so profoundly influenced and conditioned by broader societal factors that focusing on change in personal behavior without influencing the relevant societal factors could never be sufficiently effective. It has become evident that HIV/AIDS programs are created within, and therefore constrained by, the larger society. Hence, the concept of societal vulnerability builds upon the insight that collective social factors strongly influence both personal vulnerability and programmatic vulnerability.

Both Oppong (1998) and Kalipeni (2000) also used the concept of vulnerability to frame their analysis of HIV/AIDS. Their findings supported the conclusion of Mann and Tarantola (1996), that both individual and programmatic vulnerability are constrained by the society of which the individuals are members and in which the programs are implemented. Oppong, for example, found that high rates of HIV in rural Ghana relative to urban areas seem directly related to the movements of vulnerable social groups, particularly female sex workers who, because of economic vulnerability, were found in rural places with high proportions of migrant labor. Both

Oppong (1997) and Kalipeni (2000), as well as Craddock (2000), reported that programs such as condom distribution targeting female sex workers and male migrant workers failed to be effective because they ignored why women go into sex work or the contexts of migrant mine labor that preclude them from using condoms (See also Campbell & Williams, 1999). The authors criticized approaches that focus on the peculiarities of individual sexual behavior rather than the social, economic, and political contingencies which make certain social groups vulnerable. They call for prevention measures to deal with underlying structures of vulnerability.

Delor and Hubert (2000) have used the concept of vulnerability to explain the prevalence of HIV/AIDS in men and women in Belgium. Proposing what they term as a heuristic framework to the study of vulnerability, the authors designed 'spaces of vulnerability' based on three components. The first is what they referred to as the social trajectory, which constitutes the individual and her/his sexual behavior. The second one is the level where two or more trajectories intersect. Sexual transmission of HIV requires at least two people, each of whom is coming into the relationship with specific sexual histories (See Figure 5 in the next chapter). Finally, they recognized the importance of the social context which they envisioned as the effects of certain cultural or social norms concerning sexual behavior--which can either enhance or inhibit transmission. According to the authors, the three components--identity vulnerability (of individual trajectories), relational vulnerability (of intersection between two or more trajectories), and contextual vulnerability (of social and cultural contexts of behavior at different points or in different circumstances)--often intersect

in the life course of an individual and may either increase or reduce their degree of vulnerability.

What all these authors are arguing for is that vulnerability (whether for natural disaster or for HIV infection) identified with only one of its causes (whether it is poverty, certain lifestyles, or any other factor) is incomplete, thus cannot explain why certain sections of human groups are more vulnerable than others. A linear approach to defining vulnerability obliterates the fact that all of the people who feel the influences of the same factors do not suffer the same way. As such, attention must be paid to people's actual living conditions in order to discern the potentials and weaknesses that could make individuals particularly vulnerable if an adverse event occurs. And even more importantly, the authors emphasize the fact that various spaces of vulnerability intersect and often reinforce each other in what Chambers (1983) referred to as 'clusters of disadvantage'. As Delor and Hubert (2000) point out, superimposing spaces on each other reinforces the person's vulnerability, since several, possibly synergistic processes often criss-cross.

With regard to widow inheritance, I pointed out in the previous chapter and also earlier in this chapter, that not all widows eventually get inherited and that even for those who do, the manner in which it is done varies from widow to widow in a similar life circumstance, or for the same widow in different time periods. In the remaining part of this chapter, I discuss the main determinants of vulnerability for widows, both for inheritance and for HIV acquisition. Following the tripartite framework provided by Watts and Bohle (1993) and expanded on by Delor and Hubert (2000), I also envision vulnerability of widows to being inherited and hence to

acquiring HIV in the relationship through another tripartite relationship--one that comprises the widow's background characteristics, her relationship with family and other members of the society, as well as her religious affiliation. In the same way that Watts and Bohle (1993) and Delor and Hubert (2000) conceptualized 'spaces of vulnerability' as arising from intersections among the three coordinates or dimensions, I also envision the three aspects defining a widow's vulnerability to inheritance (i.e., personal background, social or relational, and religious factors) as intersecting in different ways and producing, as a result, varying 'spaces of vulnerability' for widows to acquire HIV.

First and foremost, the widow's personal background characteristics would either enhance or inhibit her likelihood of being inherited. For instance, it is relatively less likely, at least theoretically, for widows with the following characteristics to be inherited compared to their counterparts: those with children, especially sons who can perpetuate the lineage of their father; those who have reached menopause and are less sexually active; and those with a higher level of education and who are likely to have been exposed to other cultures and worldviews and whose regard for inheritance may have diminished. Also less likely to be inherited are those who are independent economically, as well as those who live away from the rural homes, and therefore away from the eyes of the community that would disapprove their action. Even though I demonstrated in Chapter Two that the decision of whether to be inherited many times falls in the hands of other family members besides the widow herself, personal background characteristics are still a significant force of either resistance or compliance to the practice.

Secondly, the widow's relationship with other members of the society is an important factor in her decision-making. She relates to different members as a mother, a mother-in-law, a sister, a sister-in-law, a daughter, a daughter-in-law, or a co-wife. As I mentioned previously (See footnote 21), in all the identities listed above, inheritance or sexual ritual follows a pecking order, and a widow's decision not to be inherited may prevent those younger than her (younger sister, daughter, daughter-in-law) from being inherited as well, or from participating in certain social events. To complicate matters, many widows have multiple identities (e.g., they are mothers, daughters, and mothers-in-law at the same time) for which the different roles they assume reinforce each other in influencing their decision regarding inheritance. The nature and magnitude of influence from all these relationships are dependent also on how strongly the relatives themselves adhere to the practice (see Appendix 4).

And thirdly, a widow's vulnerability depends also on the religious denominations to which she is a member. As I discussed in Chapter Two, the churches we visited can be grouped into three categories with regards to their position on the practice of widow inheritance: those that support the practice, those that are neutral and leave the decision with the widow, and those that oppose it. As such, the position of the widow's church may also influence her decision to be inherited, because she may consider the support (or loss of it) a significant factor in her decision.

As I discuss in more detail in Chapter Four, there are at least five reasons why widows chose (or are sometimes mandated) to be inherited. Briefly, these include: to keep them in their marital homes, to restrain them from seeking sexual liaisons outside the husbands' clan, to enable some of them to get children, to entitle them to social

and economic support from the inheritor, and to enable them to participate in social, agricultural, and home building events for which sexual rite is mandatory. As I show in the next chapter, this last reason appeared to be the most critical determinant of widows' decision on whether or not to partake of the practice. For such widows, the need for inheritance is often made necessary by events in which these rites are required, such as in observing rites of passage (birth, marriage, death), during farming seasons (cultivating, planting, weeding, and harvesting), or when constructing a new home or house. In my analysis below, I discuss how the different components of the tripartite relationship of inheritance interact to produce different 'spaces of vulnerability' for widows. In the analogy, I use the events cited above in which widows are required to observe sexual rite as the *potential* 'space''[29] upon which vulnerability is defined. I refer to it as potential because until such an event occurs, there is no taboo that would be invoked; hence there is no reason for a widow to be inherited for purposes of *tieko chik* (See footnote 32). In other words, she is not vulnerable, yet (although she may be vulnerable for any of the other four reasons).

The custom of sexual rites practiced as a prerequisite for the onset of farming seasons, during ceremonies associated with rites of passage of loved ones, and when constructing or repairing homes, are examples of events that often serve to bring forth the need for inheritance for those who are not in a sexual relationship with a man at the time. What I envisage is a situation where a widow who wants to build a home for her family may seek sexual 'services' of an inheritor for fear that failing to do so

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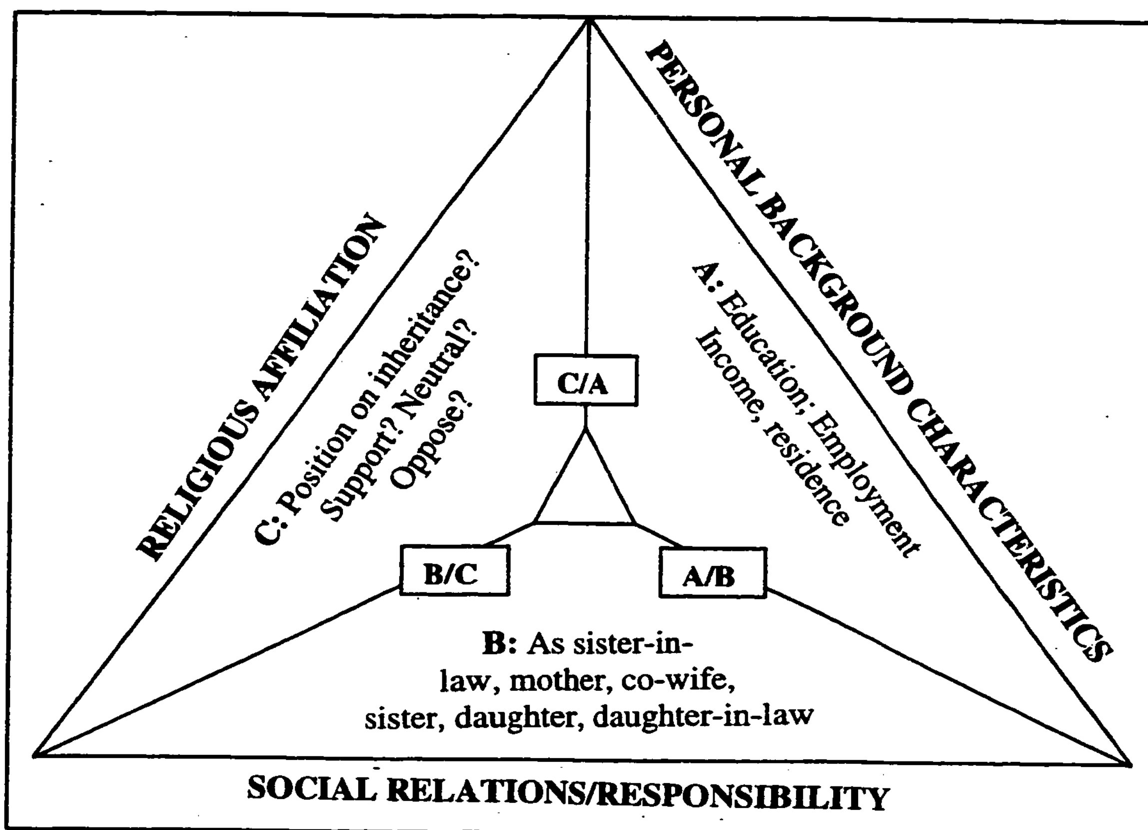
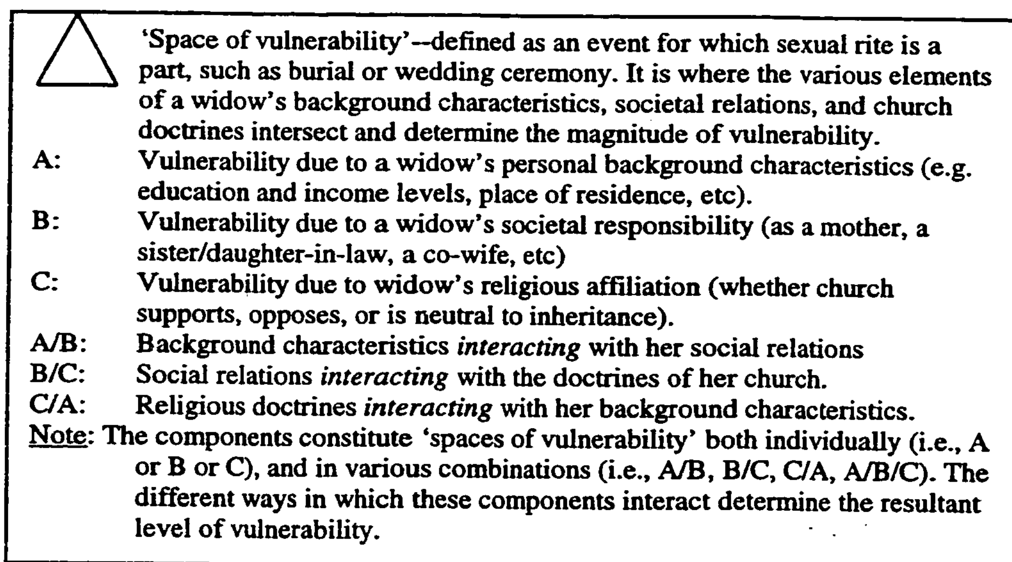
[29] Any of the five reasons why widows get inherited can be used to define the 'space' where different factors intersect to produce different levels of vulnerability for HIV for widows in those circumstances.

would bring wrath to her and her immediate family and also because her children and/or in-laws may not allow her to disregard the custom (See Appendix 4). In this example (from the appendix 4), the need to be cleansed was the immediate event that prompted the incident, but the underlying reason may have been the fear by the in-laws that the widows' failure to be inherited could impact negatively on the larger family as well.

Also influencing a widow's likelihood to be inherited is the position of her church with respect to the practice. It may be easier to decline to take part of the practice if she would count on support from her church. Overall therefore, if an event happens, the vulnerability arising would then depend on the intersections in the three components of the tripartite relationship: the widow's background characteristics, her relationship with members of her family and the larger society, and the position of her church regarding practice of widow inheritance.

In Figure 4a, the scenarios A, B, and C represent competing or reinforcing interests arising from background characteristics, types of social responsibility, and religious doctrines. The information used to construct the conceptual frameworks of variations in vulnerability (depicted in Figures 4 a-c) is derived from respondents' description of how the level of 'risk' for widows is determined by who the widow is (personal characteristics), as well as what is expected of her by the family, society, and religious institution of which she is a member. Thus, in each of the figures, I have presented differential impacts on widows in terms various aspects of their identities and their positions within the web of social relationships. Background characteristics that were cited to influence vulnerability for being inherited include income,





△	'Space of vulnerability'--defined as an event for which sexual rite is a part, such as burial or wedding ceremony. It is where the various elements of a widow's background characteristics, societal relations, and church doctrines intersect and determine the magnitude of vulnerability.
A:	Vulnerability due to a widow's personal background characteristics (e.g. education and income levels, place of residence, etc).
B:	Vulnerability due to a widow's societal responsibility (as a mother, a sister/daughter-in-law, a co-wife, etc)
C:	Vulnerability due to widow's religious affiliation (whether church supports, opposes, or is neutral to inheritance).
A/B:	Background characteristics *interacting* with her social relations
B/C:	Social relations *interacting* with the doctrines of her church.
C/A:	Religious doctrines *interacting* with her background characteristics.

Note: The components constitute 'spaces of vulnerability' both individually (i.e., A or B or C), and in various combinations (i.e., A/B, B/C, C/A, A/B/C). The different ways in which these components interact determine the resultant level of vulnerability.

Figure 4a: The determinants of 'vulnerability' of widows to inheritance

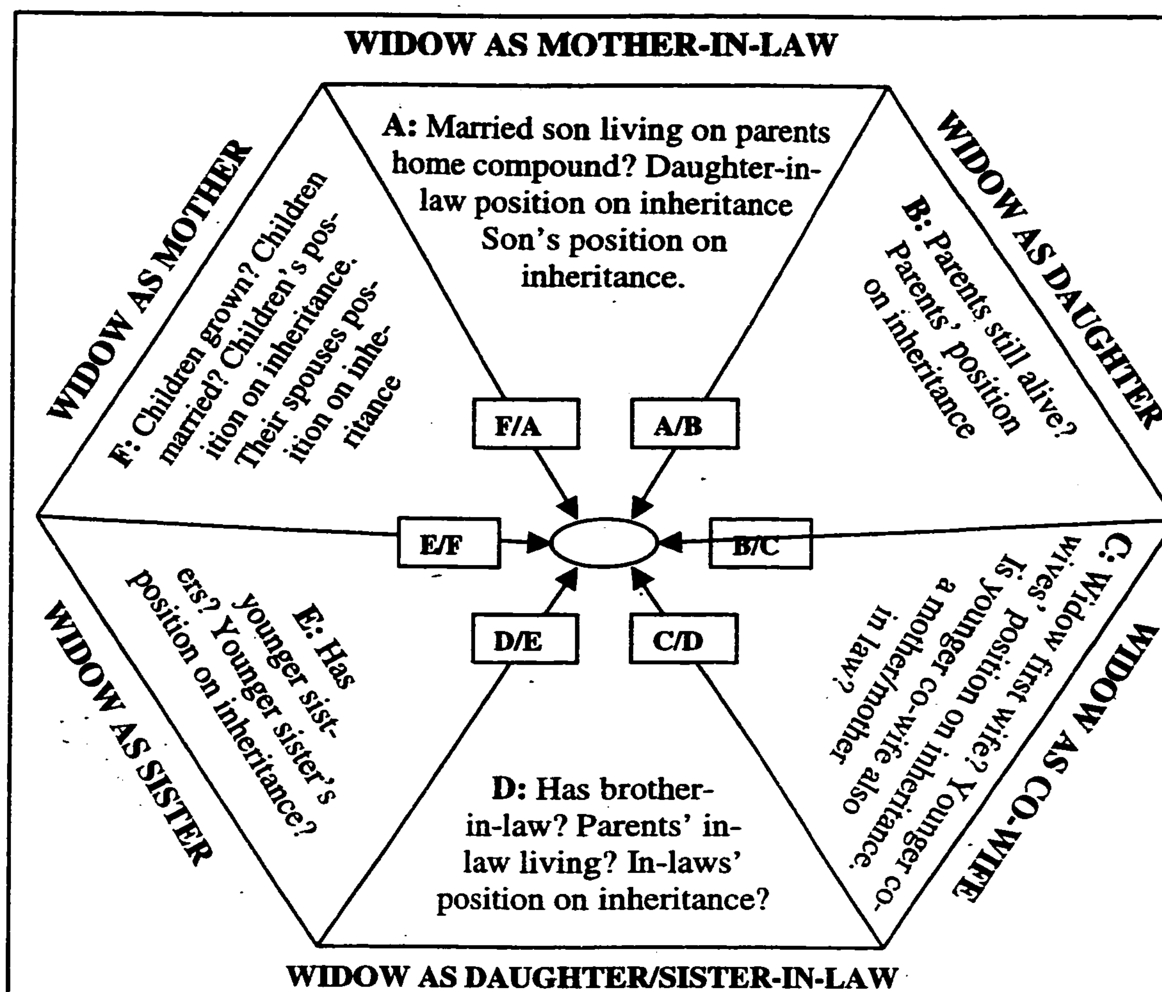
Source: Adapted from Watts & Bohle (1993)

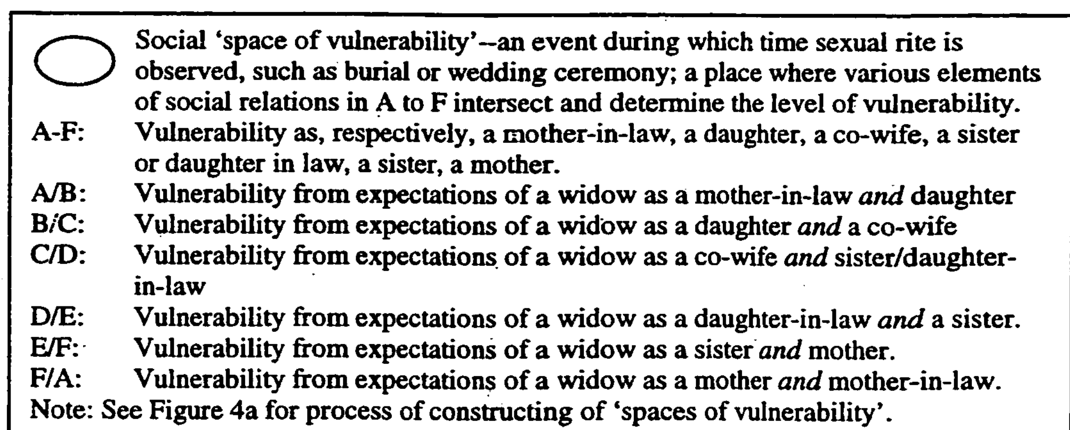
education, employment, and residence. These characteristics are in turn influenced by societal expectations of the widow, for example, in her role as a mother, a daughter, and so on. The interaction between the background factors and societal relations can either reinforce or inhibit her likelihood to partake of the practice.

Either or both of these determinants of vulnerability (background characteristics and societal relations) are also influenced by the doctrines of the widow's church towards inheritance, and how strongly she personally believes in them. An interplay between and among the three sets of factors define the space within which widows then become more or less vulnerable to inheritance, and in so doing, to risk acquiring or transmitting HIV. It is usually in situations where factors supportive of the practice reinforce each other (and are also counter to her own decisions) that a widow becomes more vulnerable because she may be forced to be inherited against her wishes or else resort to a type of inheritance that would expose her to more risk for HIV, such as being inherited by a serial inheritor.

In Figures 4b and 4c, I have extracted and expanded on two of the components of the tripartite relationship to demonstrate that there are even finer strands of underlying forces that interact to condition the vulnerability that the widows find themselves in with regards to their participation in inheritance. For example, in Figure 4b, the most vulnerable group would be widows with identities that combine the following:

a. A *mother-in-law* with a married son who still lives with her on her compound (See Figure 3) and whose wife supports the tradition is likely to be expected to





<u>Figure 4b</u>: The social space of vulnerability: mapping the 'space of vulnerability' through social relations.

observe ritual sex during certain events (e.g., farming seasons) so that the son's family is protected from *chira.* Also, having a married daughter whose spouse and/or in-laws support the tradition may pose another source of pressure.

c. An elder *wife* in a polygynous home whose younger co-wives fear the consequences of failing to be inherited, especially if the latter are also mothers and/or mothers-in-laws with children who support the tradition. This way, the co-wives may be responding to pressure from their children instead of or in addition to their own fears.

d. As a *mother*, whether or not she has grownup children who would put pressure on her, and whether or not her children are married to spouses who support inheritance.

e. As a *daughter/sister-in-law*, she would be more vulnerable if she has in-laws who expect her to be inherited to ward off potential misfortunes that may befall the family of the deceased. Or if they want her to get children to perpetuate the lineage of their brother/son.

f. As a *sister*, because inheritance is expected to follow a pecking order, her vulnerability would depend on whether she has younger sisters who support inheritance.

g. A *daughter* whose parents are still living would be under pressure to be inherited if the parents believe in and fear the consequences of potential *chira* for their grandchildren. And depending on the position of the widow's siblings and other relatives on inheritance, having living parents may imply that their

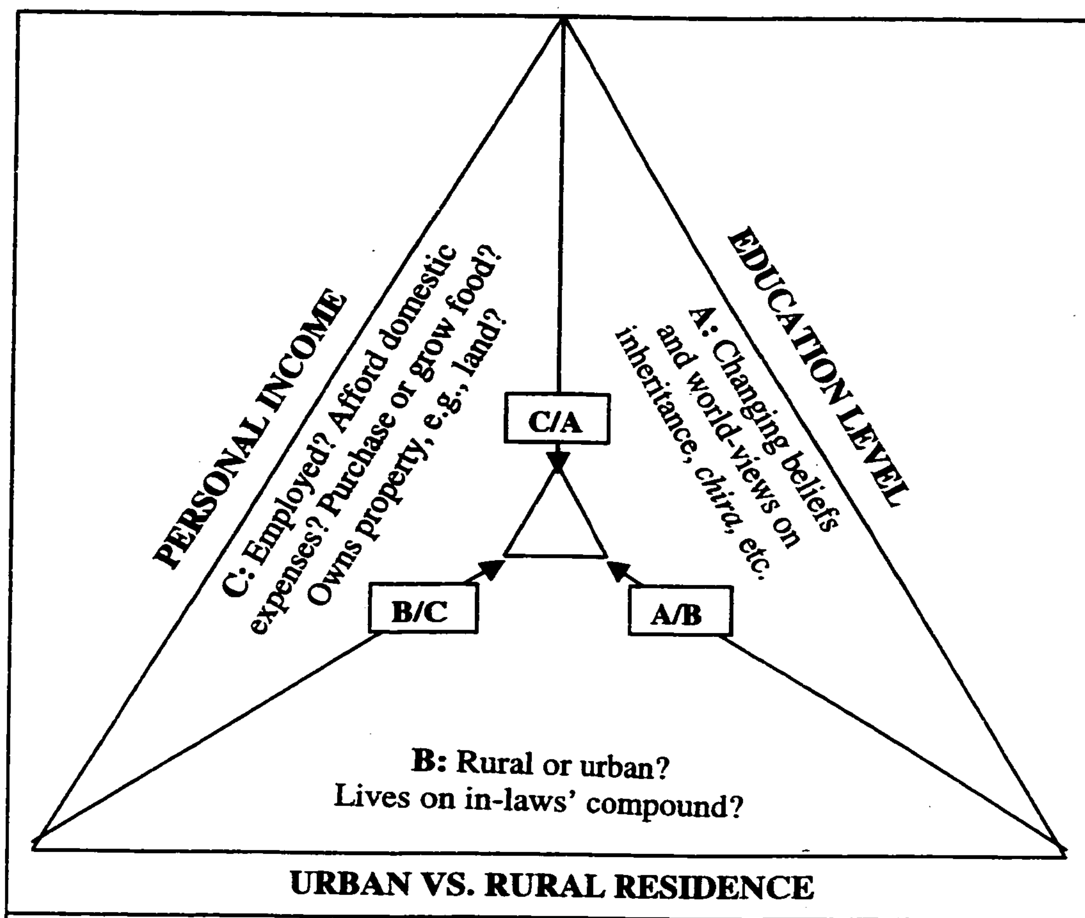
death may occasion a need for her to be inherited before she can be allowed to fully participate in the funeral and burial ceremonies.

In reality however, a number of these expectations are concurrent, reinforcing each other, and intensifying a widow's vulnerability to succumb to the practice even in situations when personally she would have contrary wishes.

In figure 4c, the most vulnerable group of widows (to inheritance) in terms of background characteristics would most likely be those with the least education, the least personal income, and who live in the rural countryside where the tradition is observed more strictly (i.e., poor rural widows). With respect to education level, there is the changing worldview and perceptions that come with exposure to other cultures in schools and through literature. It is likely that the higher the level of education, the less likely the widow will believe in the effect of *chira* (See Chapter Four for discussion on this concept), and the less likely she would accept being inherited.

In terms of income (and employment), one of the reasons a widow who may otherwise not personally desire be inherited do so is so that she and her children do not risk being disinherited by the family of the late husband. She may also participate in the tradition in exchange for economic support. Thus, a widow who is economically self- reliant would be less inclined to renege on her decision not to be inherited, because she would be able to buy her own property and take care of her children.

Place of residence is important for two reasons. Firstly, relative to one living in the city or in other work place, a widow living in her rural home would be more vulnerable to inheritance given the continuous presence of societal surveillance and pressure. Secondly, relative to one living on her own plot, she would be more



'Space of vulnerability'--defined as an event for which sexual rite is a part, such as burial or wedding ceremony. It is the space where a widow's background characteristics--education, income, and residence--intersect and hence determine the magnitude of vulnerability

A-C: Vulnerability due to, respectively, widow's level of education, place of residence, and income.
A/B: Vulnerability due to widow's level of education (e.g., belief in *chira*) interacting with place of residence (e.g., live in urban or rural; on her farm or with in-laws)
B/C: Vulnerability due to widow's place of residence *interacting* with her level of income (e.g., self sufficiency, property ownership)
C/A: Vulnerability due to widow's level of income *interacting* with her education level

Note: See Figure 4a for process of constructing of 'spaces of vulnerability'.

Figure 4c: Self as space of vulnerability: Mapping the space of vulnerability through personal background characteristics

<u>Source</u>: Adapted from Watts & Bohle (1993)

vulnerable if she lives on the same compound with her parents-in-law, and especially with younger brothers to her husband who may prevail upon her to partake of the practice (See Figure 3 and Appendix 4).

Depending on a number of factors, including the urgency with which the event must be executed and the number of stakeholders affected by her decision, these interactions and intersections in Figures 4a-c may create new elements of the practice, with varying potential for vulnerability. For instance, unlike in the past when the inheritor was required to be a brother-in-law whose background behavior was known, presently, because of deteriorating relationships between widows and their in-laws (discussed in Chapter Four), there is an influx of 'professional inheritors' whose backgrounds are unknown and who make a living by moving from one widow to another. Other changes that have also been precipitated by this single move from brothers-in-law to professional inheritors are that unlike in the past, the contracts are now made hastily, often in secret, and are short-term. The bottom line in all these changes is that they allow little or no time for background check on the inheritor or for HIV testing prior to starting a relationship. The 'spaces of vulnerability' resulting from these relations become even more risky (for HIV) in these circumstances. From the foregoing discussion, it would be simplistic and misguided to design intervention programs that draw borders and boundaries around widow inheritance as *the* target behavior to be eliminated, leaving out consideration of the determinants of their vulnerability.

The goal of this dissertation is not to provide a 'cook book' or prescription for intervention policy makers to follow; rather, it is to challenge them to rethink their

intervention strategies and to incorporate factors that predispose widows to inheritance. I have, in the hypothetical example presented below, used examples raised by the study respondents that highlight how complex and varied 'spaces of vulnerability' for a single widow may be determined by life circumstances around her.

Achieng' is a 31 year old mother of two boys, aged nine and six years. She has just buried her husband of 10 years, having lived most of her married life in the city. As such, she was hardly acquainted with her in-laws prior to the funeral. Married at 21 years of age at the beginning of her career as a nurse, she was lucky to have a husband who supported her professional development. Although she does not work directly with HV/AIDS, she is fully aware of the situation in different parts of the country. For example, in the last workshop she participated in, the prevalence of reported HIV/AIDS cases in the general population in her husband's home district was almost 25%, with over 30% in males aged 30-39 years among whom her potential inheritor is likely to fall. Feeling very sensitized by the activities at the workshop, she led a group of other equally enthusiastic women in passing a resolution to say that none of them would succumb to the family pressure to be inherited. A record of this workshop and this resolution had already been sent to the donors as an indicator of the willingness of women to denounce the practice, and to demonstrate the 'success' of the intervention program.

Hardly a year after she made the pledge, she is faced with the reality of being a widow. The workshop excitement has long since subsided, and there are no more charged supporters rallying around her and urging her on. There are no more pledges to be made. Instead, here she is, bereaved, vulnerable, and largely at the mercy of in-

laws, most of whom she is meeting for the first time and who have no idea that she made such a pledge. All said, however, Achieng' is actually not a typical widow. But the point of this is that if the issues raised below apply to a widow in her status, how much more would they apply to a typical widow who has little or no education, no steady source of income, and no career? Thus, Achieng's dilemma as outlined below, depicts only part of the complexity of decision-making in matters around the practice.

- Achieng' has sons who will eventually need a place they can call home, and being in a patrilineal family system, this is their home. To maintain her children's right over their father's property, she would have to comply with what the in-laws expect her to do. Perhaps if she had daughters, she would stay with them in her city house until they are old enough to get married. But again, having daughters would strengthen the reasons why her in-laws would want her to be inherited because in this way, she can get sons to perpetuate the lineage of their brother.
- With a single income now, she would have to live even more modestly. But when her children go to high school, she would not be able to pay for their education and that is in a matter of two years for her first child. Which brother-in-law would agree to assist her in educating her children without expecting any sexual favors?
- Having spent most of her life in the city, she does not fully grasp the idea behind, nor the perceived seriousness of the concept of *chira*. But her belief, pertinent though it may be, is not the only relevant factor to be considered. She may not believe in *chira*, but her in-laws, her parents, and siblings do. Her

children might come to believe as well when they grow up, most likely through the influence of their paternal uncles. She has heard many incidents of children, alone or with in-laws, ganging up against their mothers and forcing inheritors on them.

- She would not be able to participate in many functions for some close family members, such as burials or marriages. She may not even be allowed in the homes of some of her family members. Those who believe that her uninherited status may bring misfortunes would bar her from such ceremonies or visits. She is lucky that she was in a monogamous marriage, otherwise having a younger co-wife may have forced her to consider being inherited so as to allow her (the co-wife) to be inherited as well. In all, does she care less enough about these social relationships to break ties completely with her relatives?
- Achieng' just discovered that her house, which was still in her father-in-law's homestead, needed repair although she would have preferred to build a more permanent structure on her own plot. However, according to traditions, she would require a man, an inheritor, to start the foundation of the new house. And men are very reluctant to perform this task to an 'unclean' widow who has not been inherited unless part of the arrangement includes inheritance. But she is not planning on relocating to the countryside any time soon so it may be pointless to plan on putting up a house yet. But she is faced with another dilemma. Her husband was the first-born, and the second son had already expressed a wish to move out of the father's homestead and put up a home on his plot. But being the wife to the first-born son, Achieng' has to move out first

before the younger brother-in-law can be permitted to follow suit. However, she cannot move out without an inheritor because there is sexual rite associated with this event. But because the church she attends does not approve of the tradition, she hopes the leaders would prevail upon her relatives to allow her the freedom to choose.

- Her children are still young so she does not have to worry about the practice now. But what would happen when they grow up and marry? She would not attend their weddings without being inherited because, as a norm, she would have to have sex first before her son and his wife can also consummate their marriage. And should her daughter-in-law believe in *chira,* it is likely that she (the widow) would be held responsible for sicknesses and other misfortunes befalling the son's family. She knows of cases where children have moved out of their parents' homesteads when their mothers are not inherited to 'avoid' misfortunes.

This scenario and the entire discussion in the chapter have demonstrated two things: one, that each of the different demands in Achieng's life spells out a single 'space of vulnerability' and different combination of these factors results in different 'spaces of vulnerability'. And two, that the practice of widow inheritance is often deeply embedded in a widow's personal background characteristics, in her relationship with other members of the society, and in whether the church to which she is a member supports the tradition or not.

The overall picture one gets from Achieng's dilemma is that even though she has most of what it takes in terms of her personal background characteristics to resist

inheritance, she is torn by competing interests in her decision. Thus a 'panacea' solution often provided in similar circumstances, namely, that of 'women empowerment through education and raising of income' (see for example, Kenya, 1998; 1999; World Bank, 1997, 2000; Adeyi et al., 2001; Mason, 1994) may not be so pertinent in her eventual decision. It appears that societal forces (i.e., relationships with other members of the family) may override intellectual and economic empowerment for Achieng'. Thus, addressing the practice as the risk behavior to be eliminated without taking into account these underlying factors is shortsighted. This argument is the basis of the next chapter.

Chapter Four:

Querying the utility of 'risk analysis' in HIV/AIDS intervention in sub-Saharan Africa: Does widow inheritance constitute 'risk'?

Chapter overview: In this chapter, I discuss when and how the concept of 'risk' has been used in framing the geography of HIV/AIDS in general, and in designing intervention programs to check the spread of the disease, in particular. Using what I refer to as 'risk analysis' models (i.e., 'risk group', 'risk behavior', and 'risk situation'), I present circumstances where the use of such analytic models have facilitated a better understanding about HIV/AIDS, on the one hand, and where they have concealed or sidetracked pertinent issues about the disease, or where their use have fueled the stereotypical labeling of populations or geographical areas with 'risk' for HIV, on the other. I have addressed these concerns under three broad goals.

First, I discuss the contexts in which the concept of 'risk' (and its extensions, such as risk groups, risk behavior, and risk situation) has been used as a framework for guiding studies and interventions about HIV. The debates that the applications have generated are also highlighted. Secondly, I discuss the theoretical underpinnings framing the different uses of the concept of 'risk', contrasting individual-based and relational-based approaches to 'risk analysis', and to intervention programs arising therefrom. In the third and final goal, I assess circumstances when widow inheritance would constitute 'risk behavior' for HIV acquisition and transmission in the Luo community, as well as circumstances when the practice would, in fact, check the spread of the virus. For each of these circumstances, I have made suggestions that may

benefit intervention policy makers designing programs to reduce the potential risk associated with the practice.

Definition of 'risk': The term 'risk' is probably used in epidemiology and environmental health more than in any other academic discipline. Epidemiologists use the term to refer to defined groups at demonstrably increased probability of acquiring particular medical conditions compared to the rest of the population (Watney, 1996). Risk for a disease represents the probability of becoming infected by that disease pathogen through being exposed to conditions or behaviors that have been associated with its infection or transmission compared with those who are not exposed. For example, the risk of HIV associated with having sexual intercourse with an infected person without a condom would be higher relative to those using condoms, or the likelihood of contracting HIV in multiple sexual partnerships would be increased relative to those with single partners (Mann & Tarantola, 1996; Rothman & Greenland, 1998; Hennekens & Buring, 1987). For purposes of this dissertation, widow inheritance would constitute risk for HIV if those who are inherited are more likely to acquire the virus relative to those who are not inherited. Even though men who do the inheriting are also exposed to risk, it is the women who are under societal obligation to be inherited and who have therefore been targeted by interventions (see subsection on the different perspectives on widow inheritance and the risk for HIV later in this chapter).

It is important to define two variants of the concept of 'risk' that are often used to justify and guide most public health interventions. The first concept, 'attributable

risk percent' or 'attributable fraction', is a measure of additional occurrence of disease among those who are exposed to a given health risk compared to those who are not exposed. For instance, among widows who are inherited, attributable fraction would be how much of the new HIV infections which they experience is due to being inherited, and consequently, how much of the HIV could be prevented if they were not inherited. Attributable fraction measures the potential for prevention of HIV by eliminating the practice among widows. The main assumption here is that even those who are not inherited can still acquire HIV through other means. Hence, stopping widow inheritance would not, on its own, totally eliminate HIV among widows. The second concept, 'population attributable risk percent' or 'population attributable fraction', is a measure of the additional proportion of the disease in the general population (everyone, not just widows) that is attributable to the practice of inheriting widows. For instance, of all the HIV-positive people in the Luo population, what proportion is being contributed by the practice of widow inheritance? In other words, it is the proportion of HIV in the general population that could be eliminated if inheritance was stopped (Hennekens & Buring, 1987; Gordis, 2000). It assumes that even those who are not directly involved in inheritance may also get infected, such as the wives and sexual partners of the inheritors, and the partners of these partners, and so on.

I would like to point out that even though awareness campaigns have been going on since the late 1980s urging the Luo to stop the practice of widow inheritance as one strategy to check the rapid spread of HIV among them, the potential association between the practice and HIV has not, to date, been verified empirically. Instead,

Kenya's Ministry of Health is justifying their interventions on grounds of biological plausibility of such an association. At this point therefore, the proportion of HIV among the widows, or among the general population, that is attributable to the practice is still unknown. However, it is not the task of this dissertation to ascertain whether or not an association does exist; my goal is just to offer a critique of the ongoing interventions addressing the practice. In all my discussions, and especially in my usage of the term 'risk', I am also assuming, as do the intervention providers, that widow inheritance is associated with a higher incidence of HIV.

Because most public health interventions are derived from epidemiologic studies, and because epidemiologists have been at the forefront of HIV/AIDS intervention programs since the onset of the epidemic, it suffices to define the discipline (of epidemiology) in order that we may see its approach to disease analysis which has been adopted in public health interventions. It would also be beneficial to view epidemiology as the basis of focusing on the individual as the unit of analysis, as well as in providing the origin and justification of 'risk analysis'.

Epidemiology is the study of how a disease is distributed in populations, and of the factors that influence or determine this distribution (Gordis, 2000). It seeks to answer the questions of *who, where, when,* and *why* with respect to the acquisition and transmission of a given disease. Its major goal is to identify sub-groups in the population who are at high risk for disease, to identify specific factors or characteristics that put them at high risk, and also to suggest how these factors can be alleviated. The main reason for identifying such populations and the underlying

factors is to prevent ill health by targeting interventions appropriately (Gordis, 2000; Rothman & Greenland, 1998; Hennekens & Buring, 1987).

With this mandate, epidemiology has provided a powerful tool for understanding the dynamics of HIV transmission (e.g., *who* = sub-groups with the highest number of infections; *where* = parts of the world/country/state [or whatever geographic scale] where the disease is most frequently occurring; *when* = whether the number of infections are increasing or decreasing over time; and *why* = whether there is any special characteristics or behaviors about those infected which may explain why they are disproportionately affected by the disease). And true to this definition and to the role of the discipline, epidemiological studies identified the modes of HIV transmission and the specific behaviors associated with increased risk of acquiring/transmitting the virus even before it (the virus) was identified (Mann & Tarantola, 1996).

From the definition and task of epidemiology, it is clear that concern is with the individual. Application of the methods of epidemiology to guide public health interventions has thus predetermined that our understanding of 'risk' is focused on individual behavior with little attention to the context within which a given behavior occurs. What follows below is a critique of the concepts of 'risk groups' and 'risk behavior'. I have reserved the discussion on 'risk situations' for later in the chapter because it forms the basis for my suggestion of an effective framework for HIV intervention.

'Risk group': The phrase 'risk group' is used to refer to disproportionately affected populations, whatever defines them as a group, or whatever their ground for social identity and organization is. As I have mentioned already, one of the key goals in epidemiological analysis is to identify particular groups (i.e., based on age, sex, ethnicity, race, education, income, occupation, etc) that have high concentrations of a health problem at any point in time. The identification is done for purpose of taking public health action. Depending upon which part of the world and/or historical time period one is interested in, mentioning the phrase 'risk group' with respect to HIV/AIDS would more often than not elicit labeling certain populations as AIDS-prone. For example, the concept of 'risk group' has been used in the past to designate whole populations such as Haitians (See Chirimuuta & Chirimuuta, 1989), Africans (Gould, 1988, in Treichler, 1999), or, members of the Luo community in Kenya (See for example Amendi, 2000; Omolo, 2000; Tuju, 1996; Government of Kenya, 1998) with 'risk' for HIV. Similar labeling has also been directed to sub-populations such as adolescents (Craddock, 2000), women (Bajos & Marquet, 2000), minorities in Western countries (Cohen, 1999; Hill-Collins, 1998), non-circumcising populations (Moses et al., 1998; Bailey, 1999; Caldwell et al., 1995), gay men (Brown, 1995; 1997; Cohen, 1999; Treichler, 1999), intravenous drug users (Wilton, 1997; Des Jerlais & Friedman, 1996), as well as other groups characterized by occupation, like sex workers (Craddock, 2000), mineworkers (Campbell & Williams, 1999; Craddock, 2000), or long distance truck drivers (Lavreys et al., 1999).

On the one hand, it has been argued that the usefulness and practical application of data that define 'risk groups' provide fundamental bases for rational

prevention that are targeted to those in greatest need in the shortest time (Mann & Tarantola, 1996; Gordis, 2000). However, this position is not necessarily held by all. For example, the use of the concept of 'risk group' in the early years of the HIV/AIDS epidemic was associated with two interpretations that challenged the claimed usefulness. First of all, the phrase was used, especially by the mass media, in such a way that the named risk groups were seen as those who posed risk to the rest of the population, which consequently contributed to prejudice and discrimination towards them (Brown, 1995; Treichler, 1998; Litva a& Eyles, 1996). Secondly, a focus on risk groups sends a message to those outside of the specified categories that they are not at risk of infection (Watney, 1996; Setel, 1999; Wilton, 1997; see also Craddock, 2000). In the sections that follow, I discuss the three claims: that identifying 'risk groups' is beneficial to the groups as they are more likely to receive targeted and prompt intervention, that associating specific social groups and their behaviors with risk elicits stereotyping and discrimination, and that those who are outside the groups or behaviors so designated as 'at risk' assume insulation from the disease.

Identifying a 'risk group' is useful for targeted interventions: It has been argued that attention to 'risk groups' makes it easy to know where a disease is concentrated as well as who is most affected so that scarce resources can be used efficiently (Mann & Tarantola, 1996; Gordis, 2000). Watney (1996:432) has claimed, for example, that the discourse of 'risk behaviors' as a preferred concept to 'risk group' has contributed to a widespread international "de-gaying" of the HIV epidemic, especially in countries where gays and bi-sexual men continue to make up the great majority of cases

cumulatively and of newly diagnosed HIV and AIDS. Due to this concern, there has been a widespread revival of the use of the term 'risk group' since 1990 in order to help target intervention at those in demonstrably greatest need (Mann & Tarantola, 1996). While it is clear that not all members of named 'risk groups' are at identical risk from HIV, the term is necessary and helpful in drawing attention to certain needs and may, according to Watney (1996), actually serve to counter the exaggerated notion of risk which is latent in the concept of 'risk behaviors'.

In support of a revival of the term 'risk groups', a British reporter (in Watney, 1996) noted in 1991 that failure to recognize that, in some instances, the use of the term 'risk group' may be valuable, is a major barrier to assigning appropriate priorities in health promotion actions. According to the report, avoiding the notion of 'risk groups' has failed to prevent stigmatization and instead has prevented effective targeting of different groups. Using gay men and other men who have sex with men as examples, the report charged that if this omission is not addressed immediately (i.e., if these groups are not treated as 'risk groups' and given the necessary attention), then many more gay men will become infected with HIV.

<u>Identifying a 'risk group' elicits negative labeling</u>: As Chirimuuta and Chirimuuta (1989) and Craddock (2000) argue, the way in which sex workers, for example, are publicly discussed and officially depicted cannot be disaggregated from pervasive understanding of the AIDS epidemic--an understanding where public discourses have melded social identity (sex workers, or for our purposes, widows) with infectious status under the label of risk. Furthermore, individual-oriented 'risk analysis' in which

sexually transmitted diseases, including HIV, have been framed through the trope of sexual deviance by the 'at risk' individuals, has brought purported 'risk groups' such as sex workers (or widows) into the punitive spotlight with the pathologization of their sexuality and the conflation of their social identity with infectious status.

Making a similar observation with respect to gay men, Brown (1995) argues that what is often being mapped across the geographies is the virus rather that the people living with it and their various contexts. He adds that this approach brings the virus (rather than the people) closer into the research spotlight for purposes of labeling rather than for sincere understanding of their plight, because the social distance continues to be maintained. Craddock (2000) also observes that the higher seropositivity rates in some sex workers underscores the culpability behind the association of identity and serostatus rather than legitimizing an investigation into the causes of that association (See also Wilton, 1997; Litva & Eyles, 1996). For example, sex workers are easily construed as responsible for the transmission of disease because the power relations preventing them from demanding condoms are completely left out of the picture.

Also, such focus on 'risk groups' leaves little room for a flexible definition of identity categories. As Craddock (2000) further argues, such inflexible boundaries on identity overlook the fact that individuals assume a multitude of identities at various points in time and space. As I discuss later in this chapter and as I did in greater detail in Chapters Two and Three, a widow facing decisions of whether or not to be inherited does not just assume the single identity of being a widow. Rather, she at the same time is a mother, a sister, a mother-in-law, or a co-wife; or educated and professional; or a

member of a church with a given doctrine towards inheritance. The possible combination of these identities will directly influence her decision. In the view of Delor and Hubert (2000), the 'risk group' approach is just a way of avoiding such nuanced analysis of individuality and hence disqualifies and stigmatizes the individual understood as indistinguishable from the group. As Hartshorne (1959) once observed, it is 'putting boundaries that don't exist around things that don't matter'

<u>Identifying a 'risk group' gives false security</u>: In Kenya, the Luo ethnic community accounted for 28.8% of the country's reported HIV/AIDS cases in 1999 but only about 13% of the population (NASCOP, 2000). For most of the years, the community has had the highest HIV/AIDS seroprevalence in the nation, prompting and fueling a public perception that if non-Luo were infected with HIV, it was whispered that she or he must have had sex with a Luo partner. Letters to the editor in local newspapers contained remarks depicting such a mind-set. For instance, "Outlaw polygamy and begin circumcising males to reduce AIDS in Nyanza" (*Daily Nation*, June 17, 2000), or "Western Kenya leads in AIDS because they are stuck with archaic cultures" (*Daily Nation*, October 19, 2000), or "How to end Nyanza AIDS plight" (*Daily Nation,* October 2, 2000; See also *Daily Nation,* February 19, 2001). A number of young respondents in the study also reported that in the schools that they attend, non-Luos boys refer to them as AIDS-prone because they are not circumcised.

Writing from personal experience, it has for a long time been usual to overhear casual remarks in public places referring to the Luo as "people of AIDS", or in trying to explain deaths of non-Luo colleagues, family members, or friends by searching for

some form of link with a Luo or with having been to Luo Nyanza. To the extent that this belief was taken seriously, members of other communities probably felt 'protected' by virtue of being non-Luos or of living outside Luo Nyanza. Although at this point it is still conjecture, part of today's high or growing HIV seroprevalence among non-Luos in Kenya (34% in Thika district among predominantly Kikuyu ethnic community, 23% in Meru district among predominantly Embu and Meru communities, and 26% in Nakuru district among Kikuyu and Kalenjin communities – NASCOP, 2000; Kamau, 2000) could, at least in part, be a result of this fallacy.

In a study conducted in Kenya in the early 1990s, for instance, only 30% of respondents engaging in unsafe sexual behavior thought that they were personally at risk for HIV (Hunter et al., 1994). The authors report that although by the early 1990s all the men at an STD clinic in Nairobi had heard of AIDS, only 8% thought they were personally at risk. This was a period when sex workers and truck drivers were the groups identified with risk in urban settings (Cameron, et al., 1989). In this example, an exclusive focus on the two groups as if they were the only ones at risk, could have been (mis)interpreted by these subjects to mean that they could not be 'at risk' because they belonged to neither of the groups. And even as recent as 1999, men within 'stable' marital relationships but with multiple sexual partners refused to accept that their sexual behavior can occasion the introduction of HIV infection into the relationship (Rakwar et al., 1999).

In his study in Northern Tanzania, Setel (1999) also reported the perception that AIDS is a disease of bachelors who engage in sex for pleasure (*starehe*), thus married men felt they were not at risk. In fact, in her book on *EnGendering AIDS:*

Deconstructing Sex, Text and Epidemic, Wilton (1997:xiii) purposely declines to use the term 'risk group' for the same reason, that categorizing certain groups of people as 'at risk' implies that those outside such groups are somehow not at risk. But even more than that, she argues that such accepted taxonomic conventions whereby individuals are assigned to such 'risk groups' are misleading. For example, injecting drug users will be presumed to be 'at risk' from their drug use rather than from sexual transmission, and if HIV-positive, will go on record as having been infected through drug use, not through sex. And in this vein, interventions targeting them would be geared more towards needle exchange than safe sex, instead of providing a multifaceted approach comprising of both, as well as other 'risk behaviors'.

In my study, respondents were emphatic about the fact that it is not inheritance that puts women at risk; it is their sexual behavior in widowhood. They were in a way warning that a focus on inheritance sends a message to those outside of the specified category that they are not at risk of infection and those inside the specific category that they are doomed regardless of their sexual behavior within those categories. Yet, as I pointed out in the previous chapter, the principal determinant of vulnerability for widows is the type of sexual relationship they are engaged in for both those who are inherited and those who are not.

'Risk behavior': Following a widespread reaction against the notion of 'risk groups', especially when more information about HIV was being discovered and relayed to the general public, it was becoming clear that risk for HIV did not come from who people were, but from what they did (Watney, 1996). A new emphasis was

subsequently placed on 'risk factors', and particularly on behaviors potentially facilitating the transmission of HIV. Thus, between 1988 and 1990, the concept of 'risk behaviors' became increasingly used in public health, in HIV/AIDS education, and in prevention policies.

However, as Mann and Tarantola (1996) and Watney (1996) argue, the shift of terminology introduced as many problems as it seemed to resolve. For instance, while it is true that unprotected sexual intercourse is a risk behavior which may increase the likelihood of contracting HIV, it is also clear that not everyone engaging in this risk behavior is at equal risk. This discursive shift from 'risk groups' to 'risk behaviors' suggested that every participant of a given behavior is at equal risk from HIV, which is not the case. HIV is not an 'equal opportunity' disease, and even for a given behavior, many factors co-determine who gets infected and who does not. As such, replacing the 'risk group' category with 'risk behavior' category corresponds to the tendency to make the risk universal by defining society as a whole as the threatened social entity by virtue of supposedly engaging in the said behavior.

My position in this debate is that the two conceptions of 'risk' are still useful, but only in so far as they help to draw attention to where health problems are or are likely to be. They also prompt further research where those designated as 'at risk' are allowed to tell their stories about their perception of 'risk'. In addition, their description of the conditions in which they live and act are equally valuable in broadening and deepening understanding of why people get sick. Eventually, I argue, it is around these interpretations that interventions should be designed, and not around 'risk behaviors', or 'risk groups' per-se. For instance, interventions should not be

addressed to the widows as the risk group or to inheritance as the risk behavior. Rather, they should address the components of inheritance that have been identified by respondents as having potential to expose widows to risk for acquiring HIV and the underlying factors that predispose widows to engage in them (I discuss these further in the final section of the chapter).

It has been reported that quite often, failure of interventions designed around such narrowly conceived 'understanding' of behavior is quickly justified by invoking cultural differences (Barnet, 1996). But as Schoepf (1991), Prual and others (1991), and Gausset (2001) observed, there are wide variations in attitudes towards sexual behavior and practices between the various ethnic groups and regions of sub-Saharan Africa. Even when some of these communities engage in practices that may appear similar, the manner in which they are carried out and the meanings attached to them are often very different. Such differences challenge standard interventions and, instead, call for programs that are place- and group-specific, but which do not, at the same time, perpetuate the stigma of labeling places as essentially 'risk-prone' or associating whole groups with 'risk'. My point is that the concept of 'risk' must be contextually interrogated and retold by those who (or whose behaviors) are labeled, rightfully or otherwise, as 'risk'.

Hence, I support Massey (1999b) in her challenge to researchers, policy makers, and other stakeholder groups, not just to think through such imaginary constructions (e.g., of 'risk'); but rather, that they should think with scientists, contest the authority of their evidence and point out their provisional character. They are provisional especially because the identity boundaries defining 'risk groups' are

challenged by the multiplicity of subjects' identities of individual members who subsequently experience risk differently. For instance, using widow inheritance as the identity boundary defining risk, as the current interventions are assuming, ignores the fact that some widows are mothers and get inherited for the sake of their children, which put them at a higher risk than those without children. Or that a widow who does not depend on farming directly for her family upkeep would be at less risk because she would not experience periods when she is expected to observe sexual rite associated with farming seasons. As such, for different widows, or even for the same widow but in another place and/or at another point in time, some of the identity boundaries would dissolve.

Hunter and colleagues (1994) illustrate this point in what they suitably refer to as 'beyond risk groups', that in studies performed in more general populations, it is clear that HIV can be efficiently transmitted and the epidemic sustained beyond readily identifiable 'risk groups' because once the epidemic reaches a certain size (a population prevalence of 10% has been suggested), the concept of 'risk groups' ceases to be of much public health importance[30]. In the next section, I discuss how both concepts of risk provide the framework for individual-based interventions, and how these interventions have turned out to be ill-prepared and ineffective in addressing the complexity of HIV acquisition and transmission.

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[30] This could partly explain why in our findings (Agot, 2001), circumcised men were only at marginal advantage over their non-circumcised counterparts (a 50% reduction compared with 800% reduction in the study by Cameroon et al., 1989 in Nairobi, for example). The overall prevalence of HIV-1 was 25.5% in our study population.

Approaches to intervention: There have been four periods through the history of HIV/AIDS, with corresponding shifts in approaches to prevention. Mann and Tarantola (1996) outlined the first three periods as follows: Between 1981-1984 when much was still unknown about the disease, public health efforts focused more on providing information about known and assumed risk behaviors to stimulate individual behavior change independent of the environments in which these behaviors were carried out and acquired meaning. During the period between 1985 and 1988, individual risk reduction became codified as the central goal, and there was more concerted effort to address behavior change which was supported by certain health and social services, such as management of opportunistic infections, distribution of condoms, and care for People Living With HIV/AIDS. The third period (1989-1997/8) marked the recognition of the importance of societal dimension to the risk reduction approach, which I have discussed in further detail below. Finally, the current period from about 1998 to present has been characterized by the development of anti-retroviral therapies, particularly the Highly Active Antiretroviral Therapy (HAART) available mostly in the developed world. This development is estimated to prolong the lifespan of HIV-positive people from an average of 15 years to over 30 years. However, it is only the developed countries that have mostly reached this period; developing countries are still straddling the second and the third periods. (But this is likely to change following the current pledge by major pharmaceutical companies to avail antiretroviral drugs relatively cheaply to the developing world.)

Individual-based approach: In this section, I have identified the shortcomings of individual-based strategies to HIV/AIDS intervention and have examined, in the subsequent subsection, how relational-based approaches can alleviate some of the shortcomings identified here and provide a more encompassing framework for AIDS interventions.

In an individual-based approach to HIV prevention, the decision to protect oneself depends on his or her risk perceptions--how an individual assimilates information about the risk of transmission and behavior in the face of risk. Protecting oneself is thus seen as an individual, voluntary act, influenced only slightly by the social environment (Bajos & Marquet, 2000; Fisher & Fisher, 2000). And so, if the individuals deviate from protective behavior and expose themselves to risk (i.e., do not act rationally), it is supposedly because they fail to evaluate the risks inherent in a given situation correctly (Bajos & Marquet, 2000). Implicit in this type of approach is the hypothesis that protecting one's own health is the overriding priority of any individual and that the individual is empowered to enact those priorities.

Similarly, King (1999), Fisher and Fisher (2000), and Rosentock, Stecher, and Becker (1994), for example, maintain that in terms of individual-based models, health behavior is largely seen as a function of the individual's socio-demographic characteristics, personal intentions, knowledge, and attitudes rather than the social context within which the behavior is enacted. Such assumption is suggestive of *Theory of Reasoned Action* (King, 1999; Fishbein, Middlestadt, Hitchcock, 1994), which is also based on the assumption that human beings are rational and make systematic use of the information available to them. It thus assumes that they consider the

implications of their actions in a given context at a given time before they decide to or not to engage in a given behavior. According to such theory, most actions are under volitional control of the individual.

As I have shown in the preceding discussion, 'risk group' or 'risk behavior' analyses focus on individuals presumed to be at risk given membership in a given group or participation in a given behavior. Many activists have criticized governmental and other AIDS programs as being too 'risk group/risk behavior'-oriented (Cohen, 1997; Treichler, 1999). They (the activists) view institutional responses to the HIV scourge as shortsighted because they are derivations of narrow traditional public health strategies (education and awareness campaigns, condom distribution, voluntary counseling and testing services, and treatment of STDs) which focus on behavior change at individuals presumed to be 'at risk' (O'Malley, 1996:457). This approach is not surprising, however, given that most official AIDS programs are organized by institutions with a public health mandate. Even nongovernmental efforts heavily emphasize information and education to change human behavior. And because epidemiological analysis that has guided most of these interventions involves collecting information from individuals and seeking associations between behaviors and the likelihood of HIV infection, the ability of the interventions to identify and examine broader contextual issues (e.g., social attitude towards sexuality or gender relations) is limited (Mann and Tarantola, 1996). Such strategies, according to Craddock (2000), are predicated upon assumptions of individual agency divorced from social context, such as economic contingencies, inequitable power relations, cultural production of meanings of AIDS, and so on.

As Schoepf (1991), Asthana (1998), Oppong (1998), and Kalipeni (2000) also argue, by focusing predominantly on HIV transmission at the individual level, epidemiological research has reduced sexuality largely to a question of coital frequency and condom use. Questions are not asked about the situations that lead to multiple partners or unsafe sex nor about whether individuals have the power to resist unwanted sexual activity or to modify their sexual practices. Thus, subjects are treated in a social vacuum and as a result, very little is known about the social construction of a given behavior that may predispose them to HIV. Yet the choice of whether to have protected sex or not or to have sex at all, as we have seen with regard to widow inheritance, may not lie with the individual subjects who are targeted by interventions. According to Craddock (2000), in the situation of most sex workers, the decision to use condoms lies overwhelmingly with their clients who, as Asthana (1998:186) observes, do not constitute a readily identifiable "community" for outreach efforts.

Also, individual-based interpretations of, and interventions towards, a behavior designated as risk for HIV acquisition assumes several things. Using the campaign for the elimination of widow inheritance as an example, a number of assumptions come to mind. The first is that the role inheritance plays in the lives of the widows, and for the broader community, is assumed to be insignificant and can therefore be dispensed with easily without need for substitution. The second assumption is that the practitioners clearly see the association between the practice and HIV infection, and have thus labeled it as 'risk behavior'. The third is that the fear of AIDS outweighs the fear of the potential consequences of abandoning the practice, and so people would be more

inclined to choose the latter. And finally, that the widows are empowered to say no to being inherited if this is in their best interest.

An intervention policy that does not question these assumptions while promoting behavior change will remain ineffective in addressing the complex social and cultural environments within which the tradition is carried out. For instance, how can condom promotion be effective in reducing the risk of HIV to a widow or to her inheritor if her reason for getting involved in such a relationship is to get children to continue the lineage of the deceased? Or how can a campaign to eliminate the component of sex from the practice appeal to the practitioners when sex remains a central seal in many events governing food production and rites of passage for the widow and her family? As Mann and Tarantola (1996) have also pointed out, the rather exclusive focus on individual risk reduction is too narrow and unable to deal concretely with the lived social values of those who may be exposed to HIV.

From the foregoing, and as I have mentioned previously, it is evident that interventions based on the individual's ability to affect behavior change ignore the complex interactions between the contextual factors of inheritance and individual behavior. Instead, they rely on the assumption that giving correct information about transmission and prevention of HIV/AIDS will lead to behavior change. However, our study, as many others before it (See, for example, Rakwar et al., 1999; Campbell & Williams, 1999) has shown that health education is necessary but not sufficient to induce behavior change among most individuals.

In the next section, I discuss how individual-based approaches to interventions would benefit by widening their scope to incorporate external factors that condition

and shape behaviors. Specifically, I examine both intra- and inter-personal factors which condition the widows' choices regarding whether or not to be inherited, and how a consideration of these factors and their interactions provides a more encompassing framework. Such a framework is relational-based and, I posit, can inform the interventions more effectively than the current focus on individuals. As Mann and Tarantola (1996) observe, individual capacity, whether involving people trying to change risky behaviors or scientists seeking research support, is strongly influenced and sometimes dominated by the community and societal context.

Relation-based approach: The relation-based approach, on the other hand, considers conceptual frameworks that focus on interactions between partners themselves, as well as with their social networks. Each of these interactions is also influenced by aspects of personal identities of the respondents such as education and income levels, occupation, and so on (Bajos & Marquet, 2000). The approach is attributed to Van Campenhoundt et al. (1997, in Bajos & Marquet, 2000:1534) who presented it as a new conceptual framework that focuses on interactions between partners and among social networks to which each partner belongs. The basic idea is that the interactive behaviors and meanings of sexual partnerships, and sometimes of the others they relate to within a wider society rather than their own characteristics alone, constitute the building blocks in risk-taking or risk-avoiding behavior in a relationship. These behaviors and meanings are incomprehensible if they are considered separately from each other.

For instance, a woman cannot be just a widow, period, so that it is only her widowhood that is invoked, as it were, in interventions to eliminate the practice of inheritance. Instead, she is a widow who earns 'X' amount of income, has 'X' level of education, is also a mother or a sister, and so on. All identities play important roles in defining 'spaces' within which a particular widow finds herself 'vulnerable' to be inherited (and to acquire or transmit HIV in the relationship), and consequently, determine her eventual behavior choice. As Bajos and Marquet (2000) suggest, women's social status in society, for example, should be used as an interpretative framework in order to help us understand a given behavior as risk-related.

In this respect, Parker (1996:137) calls upon sexual behavior researchers to go beyond numerical aggregates representing particular attitudes or sexual practices to examine the contexts in which sexual activity is shaped. Parker wants his readers to consider, in other words, the social, cultural, political, and economic systems in which a behavior occurs and becomes meaningful. This is particularly so because it is becoming increasingly clear that a range of contextual factors such as the structure of gendered power relations and the formation of sexual identities play a fundamental role in shaping both sexual behavior and behavioral responses to HIV/AIDS.

In their study of sexual behavior and preventive patterns using Belgian data, Bajos and Marquet (2000) point out that men and women self-reporting sexual behavior and preventive behavior appeared to be aligned with social standards that value diversified male sexuality and tend to limit women to sentimental, conjugal sexuality in keeping with their reproductive role. The authors noted that deviations from this norm were associated with the widow's higher social status. They found that

the higher the status, the more women were able to stray from their traditional social roles, such as sexuality aimed primarily at reproduction in a steady couple relationship, and the freer they were to report sexual activity that departs from these social scripts, such as using condoms. In this example, an effective intervention must take into account, besides promoting condom use, the social structures providing imbalanced gender and power relations.

With regard to widow inheritance for instance, in some cases a woman gets inherited for economic support, while in other situations, inheritance enables her to ensure that her children do not lose inheritance of their father's property. In these instances, instead of (or in addition to) persuading the widows against inheritance through awareness campaigns, improving their income-generating capacity, or instituting legal protection over property rights could be more effective strategies in changing the behavior.

An important recognition in relational-based models of HIV prevention is that sexual transmission of HIV requires at least two individuals whose different sexual histories such as multiple partnerships, define their 'space of vulnerability.' Thus, the vulnerability of the index person is determined by the risk factors and the different sexual histories of their partners. In much of multipartnership in sub-Saharan Africa, men are expected, even encouraged, to have multiple sexual partners, while women are expected to remain virgins until marriage and to be faithful to their husbands thereafter (Orubuloye, 1992; Awusobo-Asare, et al., 1993; Anarfi and Awusabo-Asare, 1993; Ntozi, 1997). In Figure 5, I visually depict a hypothetical scenario where,

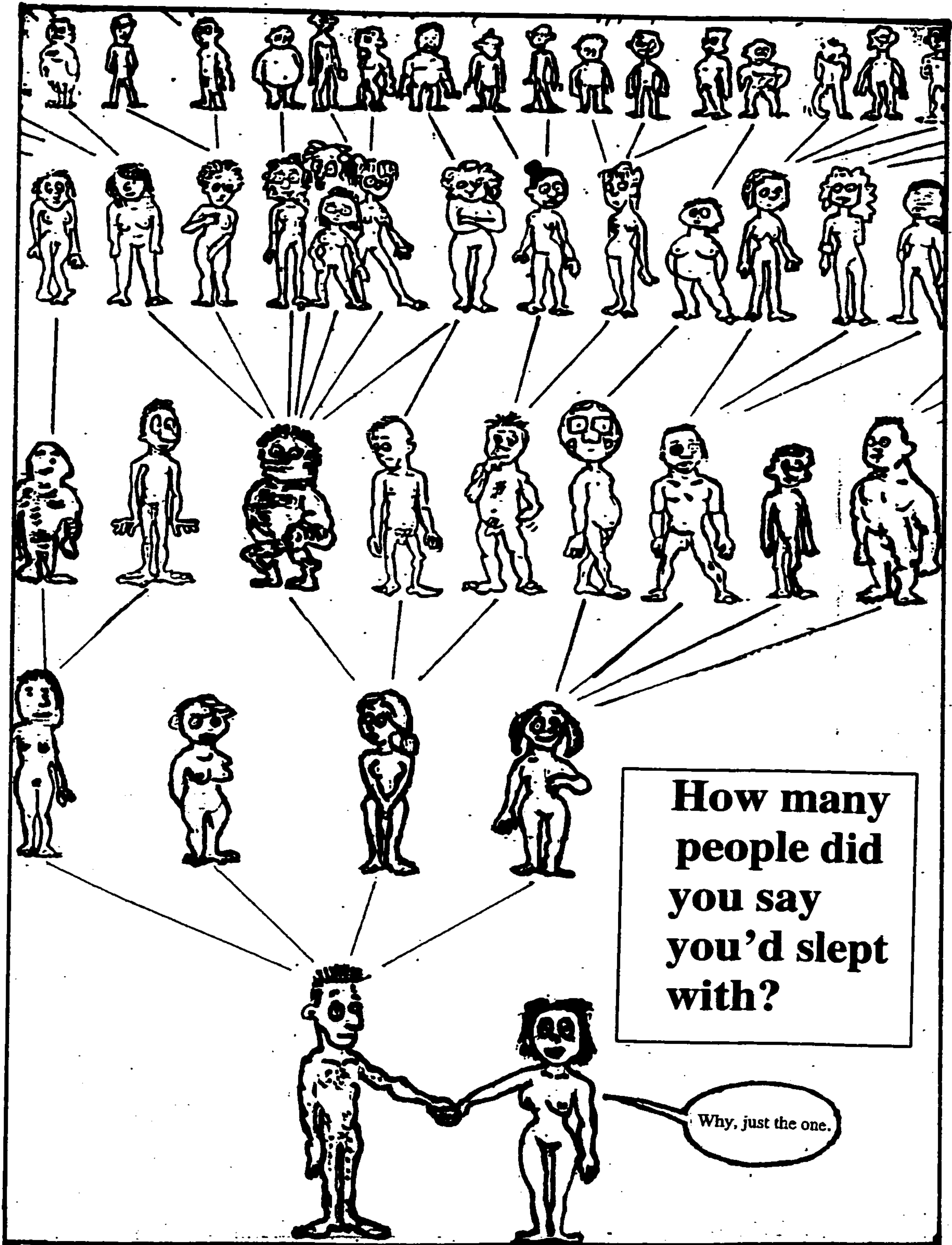

Figure 5: 1*1 = 44-plus: A Conceptual scenario of risk in sexual networking

Source: Unknown (obtained from Mr. Ephraim Odeny of Nyanza Provincial General Hospital)

unknown to the woman, she is linked to an infinite number of sexual partners. Her faithfulness to her partner is virtually irrelevant in assessing her risk for HIV. In an epidemiologic study, having one sexual partner would accord her a measure of false security, which would, of course, be completely misleading, both to her and of the results based on her "ideal situation" as the model reference person. This is the situation of populations where concurrent multipartnerships are prevalent.

As implied in Figure 5, even sexual networking (defined as the number sexual partners of the index subject) should not be the final outcome of interest to researchers. Sequential (serial) and concurrency (overlapping) are both forms of sexual networking, but each has markedly different implications for HIV diffusion (Morris, 1995; 1997; Aral, 1999; See also Orubuloye et al., 1991; 1992; Laumann & Youm, 1999). For instance, in a sequential pattern of relationship where one relationship is terminated before another one is initiated, an index partner can only infect other partners acquired subsequent to his or her infection. In a concurrent relationship however, infection of any one member of the network can potentially be passed on to others in the network within a short span of time. This is especially so because individuals are highly infectious when they first acquire HIV (during the period of primary infection) and are thus more likely to infect concurrent partners.

I am arguing that with regards to sexual partnerships, risk is exacerbated by the type and extent of sexual networks rather than just the number of sexual partners. If, for example, the index person has three sexual partners who are all faithful to the relationship, s/he would be at a lower risk compared to one with one sexual partner who has other sexual partners, and whose partners also have partners *ad infinitum* (i.e.,

where 1 * 1 = 44 to infinity, as hypothesized in Figure 5). Therefore risk must be conceived of in terms of factors that may predispose an individual or her/his partner in a given community or sub-population to concurrent sexual networking with individuals who are likely to carry the AIDS virus (See also Setel, 1999).

In other examples, Gillies (1996), Craddock (2000) and Campbell & Williams (1999) observed that since migrant laborers in South Africa were separated from their wives, earned low wages, and lived and worked in harsh conditions, they were inclined to have more contact with sex workers or casual encounters. This system created geographic networks of sexual relationships between urban (mostly male) and rural (mostly female) communities and a market to sustain prostitution in mining towns. In this population, effective preventive efforts would need to address the economic system itself, for example, the low wages that cannot allow men to support their families in their places of work, or to make more frequent visits to their spouses. Also, being able to economically support their families in their home areas would reduce the temptation by their spouses to enter into sexual relations as a means of survival (See Craddock, 2000). Alternatively, it would also be important to address societal structure that requires women to remain in the rural countryside and take care of family property while their spouses go to work in distant places.

Furthermore, the relationship between poverty and HIV/AIDS should also be seen as multi-tiered in a manner reminiscent of that of multipartnerships. O'Malley (1996), for example, proposes two levels of perceiving poverty in most sexual relationships, namely, in terms of absolute and relative poverty. In absolute terms, the simple linkage between poverty and the epidemic is that AIDS costs money, both to

affected individuals and their families (e.g., on prevention, care, and consequences of death), as well as to the state programmatic response (e.g., in treatment of opportunistic diseases, in the distribution of condoms and other intervention programs, and in the institutional care of people with HIV/AIDS). In relative terms, which, to the author are more important because of their subtle but far-reaching and lasting impact, poverty is viewed in terms of the gap between the rich and the poor. This gap generates the conditions in which people adopt survival strategies which amplify their vulnerability to becoming HIV infected. Providing unprotected sexual intercourse in return for more money or other favors, for example, is a manifestation of relative poverty. For such people for whom sex without a condom would be acceptable, maybe even preferred if it pays more, they may react to interventions about condom use differently from those whose economic stake in having unprotected sex is lower. As such, when we focus our interventions more on the number of clients seen by sex workers and the degree of condom use in sexual transactions than on the reasons why women enter into commercial sex, or why men visit sex workers or refuse to use condoms, we miss the big picture--the root cause of the problem.

In the famous "100% Condom Program" introduced in Thailand in 1991, it has been found that women who began sex after the condom promotion campaign had been implemented were still at high risk for HIV infection (Klimarx, et al., 1999). In this study, veteran sex workers who had learned to negotiate condom use with their clients prior to the intervention benefited from the program. However, novices who joined the program after it had started did not benefit, as they had not polished their prowess in negotiating condom use with their clients. For the men and the long-term

sex workers, STD and HIV infections declined markedly, while for those relatively new in the profession, the infections have in fact increased. These findings call to questions the efficacy of condom distribution campaigns--even if made mandatory by the state, as in the case of Thailand--at the exclusion of women's empowerment. Craddock (2000) points out that studies on high condom use and low HIV seropositivity among some sex workers have found that it is not prostitution per se that poses risk. Rather, it is the power relations governing the terms of its practice.

So, to continue to ignore the complex social context of which AIDS is a part, such as gender roles in patrilineal kinship systems or the relationship between poverty and HIV/AIDS, is to continue to generate inappropriate and ineffectual prevention policies (see also Oppong, 1998; Kalipeni, 2000). The processes which endeavor to account for why some are more likely to acquire HIV rather than others go beyond, for example, the epidemiologic approach of predicting the odds of having HIV given that one has a particular number of sex partners (other factors, such as being inherited, having genital ulcers, being uncircumcised, and so on, can be substituted for multiple partnerships). As such, the complexity of the social contexts of HIV acquisition or transmission demands, as Craddock (2000) argues, an equally encompassing framework because 'risk', as the prologue to disease, must be seen as contextually situated rather than taken as a given. The examples show that there are times when strategies to mitigate vulnerability to AIDS do not have to focus on the disease itself or to the population 'at risk', but on the structural socioeconomic and other conditions providing and/or sustaining the behavior in question.

Ultimately then, a relational-based model provides a critique of individual behavior change as undermining the overall research capacity to understand the complexity of HIV transmission and control. As I have alluded to, health behavior is a socially situated phenomenon shaped by a range of forces, some which lie primarily in the individual, others in small groups, and still others in communities, and so on (Friedman, Jarlais, & Ward, 1994). Hence, to focus only on the individual's psychological process of behavior change is to ignore the interactive relationship of behavior in its social, cultural, and economic dimensions, all of which are crucial determinants of behavior being manifested. This means that themes of health behavior need to be far-reaching and able to synthesize different levels of analysis, such as socio-cultural norms, religious doctrines, and gender-power relations that infuse meaning into the behavior that we see in people. Taking these concerns into account addresses the societal structures that produce and sustain widow inheritance.

Even though I have presented individual-based and relational-based approaches separately, I want to conclude by stressing that the two approaches must be seen to complement each other, keeping in mind that the individual is part of the whole, and the whole is made up of individuals. Because an individual feeds into the collective, the two approaches are not antagonistic. Both must be taken into account if behavior is to be explained more fully. The fusion between the individual and the collective can be conceptualized in a way similar to Mbiti's description of the philosophy behind the African social system, about which he writes, "I am because we are, and since we are, therefore I am" (1990:106). Participating in the practice of widow inheritance, for example, affects the individual "I" (the widow) which, in turn,

affects the collective "we" (the family, clan, and community) by checking or exacerbating the spread of HIV, as well as of *chira*. Hence, personal thoughts, actions, experiences, and ascriptions of meaning by the individual widows are constantly influencing and being influenced by their involvement in the relational workings with other members of the society and other events in the society, both past and present. Hoping to understand widow inheritance outside these relations is simply impossible, and interventions that treat the practice (of inheritance) independently of the processes that give it meaning can only yield dismal performance.

'Risk situation': Given the shortcomings I have highlighted in applying the concept of 'risk groups' or 'risk behavior' in understanding the geography of HIV/AIDS interventions, I want to second a proposal by Zwi and Cabral (1991, in Asthana, 1998) that a more comprehensive model of understanding risk to individuals without labeling population groups or behaviors as risk-prone is the concept of 'risk-situations'. A risk-situation, according to these authors, considers individual risk factors, but also takes into account the forces/situations that shape these factors as they intersect and reinforce each other. Intersections of different factors which *put people at risk*, or more specifically, which predisposes them to behaviors that increase their likelihood of being infected with HIV, would constitute 'risk situations'. For instance, many Luo widows choose to be inherited because of their fear of losing burial rights, or rights over their husbands' property, or that they and/or their children would be inflicted with misfortunes. This means that these conditions, and the intersections between and among them, produce situations that either support or discourage

inheritance. For example, a widow who depends on her late husbands' property for survival and who also believes that failing to be inherited would inflict her children with *chira*, would be more inclined to be inherited than one who is economically independent, or who does not believe in *chira*. Thus, it is the convergence of different situations that places different widows in different types and levels of risk for acquiring HIV. Because 'risk situations' denote circumstances that may predispose a widow to inheritance, they underlie the concept of 'vulnerability' that I discussed in the previous chapter.

As such, the concept of 'risk situation' is particularly useful because it allows for a shift from risk reduction framework (where specific people or behaviors are identified and targeted by interventions) to vulnerability reduction framework (whereby interventions take cognizance of the interactions or intersections of political, economic, social, cultural, and religious forces that reinforce each other to predispose an individual to engage in activities that would increase their chances of acquiring HIV--further elucidation of vulnerability reduction framework (or what Tawil, 1995, in Campbell & Williams, 1999 referred to as 'structural interventions' or enab;9ng approaches'). is inferred in the discussion on political economy approach to HIV intervention found in Chapter One). The overall goal of interventions should therefore be how the different risk situations can be minimized so as to reduce risk to individuals, and in so doing, control the epidemic. As Mann and Tarantola (1996:463) also point out, the future of HIV prevention and control will depend on our ability to understand, at the deepest possible level, the nature of individual and collective vulnerability to HIV. As I demonstrate in the next section, the only way to understand

the true nature of vulnerability is by seeking out, listening to, and incorporating perspectives of those who have been accorded the 'at risk' label.

Does widow inheritance constitute 'risk' for HIV?

Given the discussions earlier in the chapter on how problematic it is to get a clear definition of 'risk' or to derive from it a useful application, in this section I address the question of whether or not the practice of widow inheritance has the potential to increase the spread of HIV in the Luo community. As I mentioned at the beginning of the chapter, there is no empirical evidence yet linking the practice to elevated risk for HIV. Nonetheless, Kenya's Ministry of Health has been campaigning to reduce or eliminate the practice since the late 1980s, justifying their action by the biological plausibility of the association. Here I address the issue of whether or not participants too felt that inheritance increases widows' risk for HIV. I have categorized the responses into three perspectives. First is when inherited widows would actually be at a higher risk for acquiring HIV (where I discuss the biomedical perspective of widow inheritance as a 'risk behavior'). The second one is when it would depend on whether or not the widow remains sexually abstinent; if not, then her risk would depend on the type of sexual liaisons she is involved (in this part I discuss the community's view on the biomedical perspective). And the last scenario is when inherited widows are perceived to be at a reduced risk for HIV relative to those who are not inherited (where I discuss the cultural perspective of widow inheritance as a protective behavior).

Biomedical perspective: inheritance increases the risk for HIV/AIDS

As I mentioned, to my knowledge no study has been conducted to investigate whether the prevalence of HIV among widows who are inherited is significantly greater compared to those who are not inherited. Nine criteria have been suggested for assessing whether a disease is related to a risk factor, such as widow inheritance, in epidemiologic investigations (Rothman & Greenland, 1998). One of the conditions is 'biological plausibility' or 'biological credibility', which is the belief that the existence of a cause and effect relationship is enhanced if there is known or postulated biologic mechanism by which the said risk might increase the chances of getting a disease (Hennekens & Buring, 1987; Gordis, 2000). As Rothman and Greenland (1998) point out, biological plausibility is an important concern but one that is far from definitive, because some associations which could be considered biologically plausible can be mere coincidence.

For purposes of this dissertation, the biologically plausible phenomenon is that a widow being inherited means that she probably has sexual intercourse with a new partner who may have additional partners. HIV is transmitted through sexual contact between humans, and the occurrence of HIV infection is related directly to the number of opportunities for transmission one has, such as having multiple partners and unprotected sexual contacts. In the light of this reasoning, the current interventions are based on the assumption that at the start of a relationship of inheritance, there are four possible scenarios in terms of HIV acquisition or transmission: one, when both the widow and the inheritor are seronegative for HIV; two, when the widow is positive for HIV and can transmit the virus to the inheritor (who in turn infects his wife or wives

or other sexual partners); three, when the widow is negative for HIV and can acquire the virus from the inheritor; and four, when both are positive for HIV and can re-infect each other, potentially leading to a faster progression to AIDS and to death. Interventions are particularly targeting the second and third scenarios. And, in a community where close to one-third of the adult population (15-49 years of age) has HIV (NASCOP, 2000), both the widows and the inheritors would pose risk to each other, justifying the labeling of the practice as a risk behavior.

Thus, widow inheritance as a practice does not constitute risk for HIV in its entirety; what matters is the sexual activity in widowhood. As such, an intervention that aims at eliminating the practice instead of targeting only the components that increase the risk for widows will continue to be resisted by those who view the practice as having a prophylactic effect for HIV acquisition, and also because of other compelling social benefits.

Community's view on biomedical perspective: inheritance can both increase and reduce risk for HIV/AIDS

Our respondents argued that while it is feasible that widow inheritance would pose risk to both the widow and the inheritor, they also pointed out that a widow who is not inherited, regardless of her serostatus, would be more inclined to be involved with multiple sexual partners. She would consequently pose a greater danger to herself (if she is seronegative) or to the community (if she is positive for HIV) by transmitting HIV to an unknown number of people. But if she were inherited, she would affect only

one man 'at a time'[31]. In a hypothetical closed system consisting of the inheritor, his wife, and the widow, the virus would be contained among the three people for an average of 8-10 years (the current incubation period for HIV in Kenya [NASCOP, 1999]). If this is maintained, the only way through which the infection could spread is after the inheritor dies and his wife or the widow (assuming he is outlived by both or either of them) becomes eligible for inheritance. In so doing, the wife or the widow would infect another man who would in turn infect his wife; thereby starting off another closed system for another eight or more years. Even with leakage outside the system (maybe where one of the trio has an outside sexual relation) the spread would be relatively slower.

The likelihood of this scenario occurring would be increased, insofar as, upon inheritance, the widow's social and sexual behavior immediately becomes under routine societal surveillance. This ensures a measure of sexual restraint. The turnover of male partners in the first scenario (where a widow is not inherited) has the potential to be more frequent, much faster, and to result in a more far-reaching spread of HIV than in the second scenario (where a widow is inherited and possibly infects only the inheritor and his wife/wives). Hence, to many study subjects, it makes intuitive sense to argue for inheritance as a way of checking the rapid spread of HIV/AIDS within the community. To understand how the practice of inheritance has the potential to both exacerbate and check the spread of HIV, it is important to draw from the manner in

[31] Male respondents were adamant that no one can sacrifice his life and the future of his family by knowingly inheriting a widow who is HIV-positive. However, because of the fear of going for HIV test (See discussion in Chapter Six), most men enter into inheritance relationships with widows without knowing their serostatus.

which it was carried out in the past and how it has changed over time in ways that now make it be classified as 'risk behavior'.

Widow inheritance in the past: To understand the cultural perspective of the potential association between inheritance and HIV, it is worthwhile to highlight some of the characteristics of the practice as it was originally instituted. Traditionally, a widow was supposed to be inherited by a brother or a cousin to the late husband. Among the Luo (Okeyo, 1995; Agot, 1996; Field data; Mboya, 1997), as in many ethnic communities in Uganda and other countries in sub-Saharan Africa (Ntozi, 1997), the status of widowhood starts the day the husband dies. During the mourning period which lasted for at least one year, sometimes two or longer, respondents reported that the widow would leave her hair uncombed. And to make it easy for the public to identify her as an uninherited widow and as unclean [*ogak,* or she has *okola/kode*], she would also be required to carry her husband's walking stick and to wear some of his clothing on which she would sew another identification label. In doing this, she was announcing to the general public that she was in mourning and was therefore a 'no-touch' zone. She was a pariah of sorts; her movements were severely restricted. She was prohibited from, among other things, going to public places (such as markets or domestic water sources) where she could mingle with and possibly touch people, she could neither prepare nor serve food to her grown children, and was restrained particularly from visiting her married daughters--not even in bereavement.

One to two years later, her male in-laws would call a meeting to decide who should inherit her, although some respondents maintained that it was the widow's

responsibility to approach a potential inheritor and his wife and initiate the process. Whichever approach was used, if the selected man obliged, which he would sometimes be prevailed upon, but not forced to do, the sexual consummation that followed was believed to cleanse the widow and to release her from the uncleanliness which 'tied' her to the ghost of her husband. The act is referred to as *chodo* [cutting off] *okola* or *kode*. Respondents were not clear about what *kode* precisely referred to, but *okola* is the dry back of a banana stalk that can be used as rope if moistened. It is symbolic of an inextricable link to traditions--past and present. Most respondents concurred that the reference to "cutting off of *kode*" meant that for the first time since the death of her husband, someone would remove the husband's pants that she had been putting on as a mourning sign and a symbol of celibacy. During this first sexual intercourse, the inheritor symbolically cuts off [*chodo*] the widow's connection to her late husband and releases her to be reabsorbed back into the mainstream activities of the society. After this event, she shed her husband's clothing, staff, and any other symbol that designated her 'unclean' status. The following day, an old woman from her husband's clan was called to shave her head. These acts together officially marked the end of the mourning period, the incorporation back into the society fully, and the resumption of a normal life.

The extended family members were fully involved in the whole event to vouch for the behavior both of the inheritor and the widow and also to ensure the ceremony was performed according to the customs. Inheritance performed this way was intended to be permanent, and the man was to be responsible for the economic, social, and conjugal duties that ordinarily come with an official marriage, and for all practical

purposes, he was the new 'husband' of the widow and the 'father' to her children. However, he was not recognized as an official husband or father given that in doing all these he is but 'taking care' of his brother's family [*rito ka owadgi*]. The openness, the background check, the familiarity of the two involved, and the permanency of the relationship that were characteristic of inheritance in the past ensured that the practice would pose relatively lower risk for the widow or the inheritor in the event of a disease such as HIV/AIDS (relative to today's inheritance practices discussed below).

<u>Widow inheritance now</u>: Like many cultural practices by different ethnic communities in sub-Saharan Africa, widow inheritance has evolved over time, and some of the characteristics discussed above have become unviable. Some have been discarded and others modified. In this section, I report some of the changes that have taken place, including why they have occurred and the implications they have for the spread of HIV for the widow, and for the community in general.

With the coming of formal education and migrant labor, it is no longer feasible to fully partake in the customs detailed in the previous section. Because some widows must return to their places of work, businesses, or other engagements after taking their husbands to their rural homes for burial, it is no longer to possible to observe long mourning periods, or to put on their husbands' clothes, or to leave their hair uncombed in public, and so on. Additionally, in today's marriages, many husbands and wives do not live together most of the time, and observance of sexual rite during farming seasons, for example, is not often feasible. Hence, women take part in these activities

without the component of sex--something that would have elicited intense public wrath in the past.

Other changes in the practice have been prompted by the deteriorating relationship between widows and their in-laws and by the advent of Christian churches that denounce the practice (discussed under 'the role of the church as an enforcing agency of the practice' in Chapter Two). As a result of the changing circumstances, many features have emerged about the practice that have the potential to increase widows' vulnerability to HIV. Respondents cited five major changes that have occurred, each of which could potentially pose increased risk for the acquisition or transmission of the AIDS-virus. These include the proliferation of professional inheritors; the increasing practice of soliciting the services of 'interim' inheritors; inheritance occasioned only by specific events when sexual rite is required; inheritance contracted in secrecy; and the increasing rate of inheritors being divorced. In what follows, I expound on these features, relating each of them to the potential risk they pose for HIV for the practitioners and for the society in general.

As I mentioned previously, in the original institution of the practice, the inheritor should be a brother or a cousin of the late husband, one whose background was well known to the widow, and one who also knew the widow's past behavior relatively well. However, it was noted that the relationships between widows and their in-laws are not as strong nowadays and that the widows sometimes shun their in-laws and remain formally uninherited (though not necessarily sexually inactive) or else look for inheritors outside their husbands' families. In other instances, the in-laws themselves decline to inherit the widow, mainly for fear of contracting HIV and also

because inheritance has assumed a derogatory connotation. Other reasons given for this strained relationship include the fact that some women feel reluctant to be tied down by the traditions, or else if they choose to observe the custom, they want to choose the man they would enter into a relationship with. Male respondents pointed out also that the relationship is weakening because widows use them as door mats "to 'help' them clean up the ritual uncleanliness and then dump them soon after". The quotation below illustrates this view:

Male respondent in his 20s:

> You take your sister-in-law, but after two days [used figuratively to emphasize the shortness of the period] she begins to make a plan of how to chase [send] you away. Which means that [all] she wants me to do is to *tieko chik* (for explanation, see footnote 32) for her to release her so that she can move around [have affairs] easily. Widows of today have men inheriting them, while they keep others--better suitors--pending at the same time

Another reason for the strained relationship is because marriages are contracted and lived in cities where most of the couples work. Consequently, some women get acquainted with the husbands' family members only upon their bereavement (See the case of Achieng' at the end of Chapter Three). Older female and male respondents lamented that women just come home to bring the bodies of their husbands and leave for the city soon after--before observing the rituals associated with the funeral and are therefore responsible for the AIDS plaguing the community (the respondents used the term 'AIDS' even though they were referring to *chira)*. There is also less involvement of the extended family in marriage arrangements, thereby reducing their traditional authority to demand total compliance from the widows, especially because payment of bride wealth through which extended family members

were traditionally involved is on the decline due to, among other things, the rising cost of living.

Shifts in the gender roles in inheritance was also cited as one of the reasons for deteriorating relations between widows and their in-laws. Whereas the norm was that the widow would be provided with economic and social support by the inheritor, the reverse is becoming more and more common. I have explained previously why most of today's inheritors live off the sweat of the widows.

The overall effect of the deteriorating relationship between widows and their in-laws is that many of those who end up being inherited (voluntarily or otherwise) are forced to, or prefer to look outside the husband's family for an inheritor, because in so doing, they can exercise personal choice. It also becomes easy to terminate such relationships with less societal disapproval. An inheritor who does not belong to the husband's clan goes by the term *jakowiny* (sing. j*okowiny*, pl), loosely translated as "professional inheritor", and for reasons that are linked to the instability in the relationship between widows and their in-laws, what respondents referred to as *jakowiny*-phenomenon, or *jakowiny*-epidemic, is on the rise. Increasingly, most 'professional inheritors' move from one corner of Luo Nyanza to another inheriting one widow after another, many times being paid to perform the cleansing rites, or else are attracted to the wealth left behind by the deceased. As Oriang' (2000) puts it, as more and more people are educated, they shun the inheritance rites, and widows resort to forking out tidy sums from their own pockets to buy the services of inheritors from other clans, from neighboring ethnic communities, or even from as far as Uganda or Rwanda. The migratory behavior of these inheritors, coupled with their tendency to

keep several widows concurrently, and moving back and forth among them, was cited in every venue as ***the*** most dangerous twist in the current version of widow inheritance that would exacerbate the vulnerability of widows to HIV.

Another phenomenon on the rise is the soliciting of services of what respondents referred to as 'interim' inheritors, that is, those who inherit widows briefly so as to 'break the link' between the deceased and his brother or cousin who would subsequently take over from him. This is made necessary when a brother in-law would be considered ineligible to perform the initial 'cleansing' rite (*chodo okola/kode*). Three reasons were mentioned to explain such ineligibility, including: if the surviving in-law was born a twin, or born immediately after twins, or if he was the first to survive following serial deaths of older siblings (this was collectively referred to as ineligibility associated with 'special' births); if the widow and the proposed brother-in-law had been sexually involved prior to the death of the husband; and if the brother-in-law does not want to risk being infected with HIV, or if the practice is just not attractive to him. Incidentally, the HIV serostatus of the inheritor did not feature in the discussion as a major concern.

In the first two circumstances, it would be culturally improper for the selected in-law to be the first to have sex with the widow and to cleanse her, and because sex is a mandatory component of inheritance, not being able to engage in sex technically disqualifies such 'suitors' from being eligible. It therefore becomes necessary for the widow to get someone from outside the extended family network to perform this initial cleansing ritual of *chodo okola/kode* before it would be safe for the brother-in-

law to 'take over'. (This is how the *jakowiny* concept began, and as they said, 'to take away the curses and uncleanliness associated with death'.) Such an arrangement is referred to as *kadhna* (literally translated as 'pass through for me'), and is a procedure designed to cleanse the widow in readiness for the official inheritor--the brother in law. What this arrangement implies is that in the same 'cleansing' process, the widow might instead become infected (instead of being cleansed) and subsequently infect the brother-in-law.

The requirement of *kadhna* has been further intensified by the potential inheritors' fear of contracting HIV. Those who 'pass through' are now used as baits and are monitored for signs of AIDS before brothers-in-law feel safe to take over. The reported period for monitoring ranges between one month and one year, indicating ignorance concerning the incubation period of the AIDS-causing virus. Since this is a one-time (or short-time) circumstantial arrangement, it does not provide enough time or the right environment for background check on the inheritors' past sexual behavior, or to even suggest, let alone insist on, going for HIV test. Such 'interim' inheritors are also aware of their temporary and risky roles in the overall plan and often dictate the conditions of the contract.

As I have mentioned previously, the contract of inheritance was intended to be a permanent and serious relationship. However, because of the weak foundation on which inheritance is contracted nowadays, and for various other reasons, few of them last longer than one year (Okeyo & Allen, 1993). They are becoming shorter stints, with increasing number and frequencies of 'divorces'. Another reason why

participants also felt that inheritance arrangements are increasingly becoming shorter stints and also why there are more and more serial 'divorces' was because many of them are contracted solely for purposes of fulfilling sexual rites for specific social events, such as during a farming season or a funeral. Hence, every time a widow would be faced with a situation where she is mandated to observe sexual rite, she would look for someone just for that purpose, many times ending up with different partners for each occasion.

To conclude this section, I turn to what respondents felt was the main reason for inheritance nowadays. This was over and above the need for children, because even widows who are past childbearing age or who already have children are still being inherited. The reason is also over and above the need for economic support because many widows nowadays provide for the upkeep of the inheritors. The reason is that widows feel they owe it to their children and other members of the extended family (e.g., sons-in-law, daughters-in-law, sisters, or co-wives) to observe the sexual rules stipulated by the society. In a way, they feel they have a responsibility--a duty, in fact--to be inherited in order to 'protect' their family from possible affliction by *chira* and/or other misfortunes. (The concept of *chira* is discussed more fully later in the chapter under the subtopic on 'Cultural perspective'.) To illustrate this point, I introduce three phrases that were used by respondents in almost all the venues to underscore the deep cultural embeddedness of the practice, namely, *chik omake*,

tieko/chopo chik, and *rieyo dala/pacho*[32]. I will use these phrases from time to time to illustrate why many times widows who are inherited do so for fear of breaching taboos, or for purposes of 'straightening their homes'. The exchange reported immediately below, and others earlier on in the Chapter, demonstrate how the practice of inheritance is deeply rooted in the belief of *tieko chik* and *rieyo dala* in the life of a woman, and how everything, in turn, is tied back to *chira*—and in a sense, to ritual sex

Traditionally, a woman above 60 years old was not formally inherited (i.e., sexual relations was not part of the arrangement); she was given some item by a brother-in-law (a coat, a traditional stool, a pipe, and so on) as a symbol to designate that he has symbolically inherited her. His role would be to preside over social issues and to be called upon for advice. Wherever there was an event that would require sexual rite, he would simply go to her house, eat (sometimes, but not necessarily, sleep over), but there was no sexual contact involved. The excerpt below is part of a discussion to decide whether, in case of illness such as HIV, people can resort to similar symbolic sex to reduce the risk of transmitting the disease, while at the same time not abandoning the practice altogether for those who may not wish to do so.

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[32] *Chik* means a rule, law, forbidden act, a restraint, or more precisely, a taboo (and the 'don'ts associated with it). *Omake* literally means "to catch; to lay a hold on; or to tie to", and *tieko* or *chopo* is to finish, complete, or put behind. *Chik omake* would mean that someone is tied by certain taboos and is restrained from performing a given role before the taboo is lifted, while *tieko chik* is the process of complying with the procedures required to address the said taboo, hence 'lifting' its hold over a person. The taboos are lifted for purposes of *rieyo dala* or *pacho*. *Dala* or *pacho* is a homestead (See Figure 3) and *rieyo* literally means 'to straighten'. It refers to 'putting the house in order'. It is believed that if *chik* is left unresolved, it would bring a number of misfortunes to those residing within the home, or to a lesser extent, those with continuing ties to the home, such as a married daughter (See footnote 21). Invariably, the taboos around inheritance were believed to be lifted only through sexual rites.

Male respondent, in his 20s:

> If your first wife is sick and it is planting season, what does the man do? Can he just 'take the seeds out' [*golo kodhi*, i.e., plant or cast the seeds] without going to the house [fulfilling the sexual rite] of the first wife?

Female respondent in her 40s:

> He cannot! Otherwise how will this sick one *golo kodhi* later on? [Meaning if she has been bypassed by those younger than her.]

Several voices of women at background:

> It is not possible. If you [the man] *golo kodhi* without going into her house, how will you come back to this house later? In that case, planting for that season has by-passed her.

Male respondent in his 60s:

> If the woman is just sick and not old and [therefore] does not qualify for the symbolic gesture of being given a stool, etc. [meaning if she is still otherwise sexually active], you must go with her--even if not 'all the way'--because your other wives as well as daughters-in-law will wait for a signal from you [that you have observed the tradition] before they can take their turn and proceed with planting

Female respondent in her 40s, explaining further:

> In case any one of the women in this home goes ahead and plants, the crops cannot be brought back home. She would be forced to sell them and buy others, or to exchange them with a willing neighbor, because someone's *chira* cannot affect you. [This is excerpted from a discussion with members of a church in Kisumu District that, interestingly, does not approve inheritance.]

Another characteristic of the present day inheritance is that many widows are at cultural cross-roads because of education, Christian beliefs, wage employment, and contact with other cultures and worldviews. On the one hand, some widows are somewhat skeptical about the whole purpose of inheritance and the associated taboos, yet, on the other hand, they still have some residual doubt whether abandoning the

practice altogether is safe, especially for their children. As such, they prefer to be inherited in private rather than go through a more public and elaborate procedure. At other times, some widows prefer to be inherited soon after the burial of their husbands so as to avoid potential confrontation with their in-laws or with their own families and then have nothing further to do with the inheritor or the practice. Because *chira* resulting from breaching taboos affect the children as well, family members are often very keen in ensuring that the tradition is observed[33]. A private or hasty inheritance, in the view of the respondents, would not provide a conducive environment for background check of the inheritor's past behavior, or for pre-contractual HIV-testing for both.

While biomedical and perspective and community's view of it are in agreement that these practices pose risk for HIV, the former assumes a simple cause-effect relationship, and therefore their solution is to eliminate the practice. However, the respondents provided a richer analysis of the situation. First, they concurred with the biomedical position, that these behaviors have the potential to increase a widow's vulnerability to HIV. But they argued also that a widow who is not inherited would, in fact, be at a greater risk for HIV because she is more likely to be involved with multiple sexual partners than one who is inherited. They maintained judging the potential risk associated with inheritance should therefore not be a straight forward 'yes' or 'no', but rather, that 'it depends'--not on whether or not a widow is inherited,

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[33] The Daily Nation reported on March 24, 2001 an incident where brothers-in-law forced two widows to be inherited. Here are a few excerpts: "[The Provincial Commissioner--PC] said widows were being forced to undergo 'traumatizing and barbaric sexual cleansing rites at the hands of hired drug addicts or wife inheritors, known locally as *jokowiny*...On Thursday, a notorious inheritor had been arrested in connection with an incident where two widows were forced into sex by in-laws. The PC said the two widows, who had buried their husband a few days earlier, were locked up, tied with ropes and forced into sex with the hired man after refusing to be inherited" (Full report in Appendix 4)

but on whether or not she abstains from sex after her husband dies. If not, they argued, it would be safer for her and for the community at large if she were inherited (whether she is HIV-positive or –negative). And since many men who die from HIV are young, women are entering widowhood at a much younger age at which abstinence from sex may not be an easy option to comply with. In other words, for the respondents, widow inheritance per-se does not constitute risk for HIV; rather, it is the current components, such as the involvement of professional inheritors, the practice of having 'interim' inheritors, having serial 'divorces' of inheritors, and so on, which have introduced 'risk' into the practice. Hence, it is these components that should be addressed by intervention programs and not the practice itself in its entirety.

Cultural perspective: inheritance reduces the 'risk' for HIV/AIDS

To understand the basis for conceptualizing inheritance as a practice that has the potential to reduce the risk for acquiring or transmitting HIV, it is beneficial to also draw upon the cultural perceptions of AIDS as *chira*. In what I consider as a discursive framework of HIV/AIDS in which AIDS and *chira* are perceived as one and the same thing, I specifically address the question of whether or not the respondents have labeled widow inheritance as a risk behavior for acquiring or transmitting HIV (although the entire dissertation is actually framed to examine this relationship). As I mentioned in Chapter One, in order to avoid a given risk behavior, an individual must first label his or her actions risky for contracting HIV before making a commitment to reduce the risk behavior and to increase safer behavior (Fisher and Fisher, 1999; King, 1999). Throughout the study (see excerpts quoted

previously in the chapter, as well as later on), it is evident that there was a widespread confusion between AIDS and *chira*. Yet as seen in Table 2 below, the two conditions are different, and there is no biomedical explanations or support for the ideology of *chira* that I am aware of.

As the most frequently cited consequence of not being inherited at all, or of being inherited improperly[34], the word *chira*[35] is derived from the verb *chiyo,* which means to drain, siphon, waste away, or thin very slowly. As a culturally perceived health condition (although without biomedical explanation or equivalence), *chira* is used to describe an unexplained wasting away of the body that is associated with breaching of taboos, especially sexual taboos, including those around inheritance. For instance, to share an inheritor with someone with whom it would be incestuous to share a man sexually, such as a mother and a daughter, or a mother-in-law and a daughter-in-law, would be tantamount to breaching a serious taboo and of bringing the curse of *chira* upon oneself and/or her children. Some major *chira* are perceived to be irredeemable. However, if addressed in time, most *chira* can be reversed, or even averted, using a special concoction (*manyasi*) assembled by traditional medical practitioners for that purpose.

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[34] As I already mentioned, if a widow decided not to be inherited but remained celibate, she would not be afflicted by *chira*. The whole idea about *chira* revolves around breaching of sexual taboos, such as when a younger woman (e.g., daughter or daughter-in-law) takes the lead and engages in the sexual rites during an event in the home (such as farming), she would be 'safe' as long as the older woman (i.e., mother-in-law) remains abstinent for that period.

[35] Beside physical illness (and sometimes death), other perceived effects of *chira* in adults include mental illness, not being able to marry or live with a spouse, and miscellaneous other misfortunes. In children, *chira* also manifests itself as distended stomach and paling skin (this has been conflated with Protein Energy Malnutrition, especially kwashiorkor, and has sometimes inhibited effective interventions to reduce child malnutrition in the community – Agot, 1995). *Chira* in children is often seen as an indication (or more precisely, a public manifestation) that one of the parents had secretly contravened some sexual norm.

Table 2: Similarities and differences between AIDS and *chira*

Similarities
i. Contracted though sexual intercourse, where at least one of the partners is believed to have contravened certain sexual pact, such as having an affair outside a regular relationship (leading to AIDS) or engaging in sex inappropriately in widowhood (leading to *chira*). ii. Several signs and symptoms are also believed to be similar to both, for example, wasting, vomiting, persistent cough, persistent diarrhea, thinning and loss of hair texture, loss of skin luster, and generalized malaise.
Differences
i. Symptoms that were identified as associated with AIDS but not *chira* included boils, herpes zoster, tuberculosis, and cancers. Other differences are that: ii. AIDS is caused by a virus in the blood that can be detected through a laboratory test, while the cause of *chira* cannot be verified by any test. iii. HIV can be spread through blood products (transfusion, injections, and through other body piercing) while *chira* can only be transmitted by disregarding sexual taboos, and never through blood contact. iv. HIV still has no cure while *chira* can be averted or reversed if discovered (diagnosed) in time. A traditional remedy--*manyasi*--is used for this purpose. v. Anyone with HIV can infect others she or he has sex with, while one's *chira* is only 'infectious' to those related to her or him by blood or marriage. The potency of *chira* decreases outwards from immediate family. For example, there is *chira* for immediate family (*chich dala*) that does not affect anyone else outside the family circle; there is *chira* that can only affect members of a single clan (*chich gweng'*); and there is *chira* that can affect only those who are members of the Luo community (*chich oganda*) and not other communities. In other words, while *chira* is person-, group-, or place-specific, AIDS is a worldwide pandemic. vi. If a widow is inherited in the recommended manner, having observed all procedures associated with the tradition, she cannot get *chira*. However, if her inheritor has HIV, then she can get infected whether or not she followed all the traditional rules required in inheritance. vii. HIV is passed on from mother to child; *chira* might only affect children who are already born, but cannot be transmitted in-utero or at delivery.

Source: Complied with information from the respondents.

The similarities between *chira* and HIV/AIDS with respect to sexual transmission and the clinical signs and symptoms (See Table 2) led many respondents to conflate AIDS and *chira*, and to argue that AIDS has always been with them and was not a new disease as people were saying. To them, AIDS is just the English term for *chira*, and they used the terms 'AIDS' and '*chira*' interchangeably, slipping back and forth between them. For most respondents, this finding was similar irrespective of age, gender, church affiliation, or place of residence. The quotes below demonstrate the extent of conflating the two terms:

Female respondent, in her 40s:

> When a woman is not inherited, this brings *chira* which is also called AIDS. A woman must be inherited so that she can 'open' for her children such that if her son wants to marry, to straighten the 'things of the home', the mother must be inherited before he can go ahead with his marriage plans. Failure to observe this tradition will kill the son with *chira* which people will 'change' and call AIDS. [In response to my question whether what she was describing was *chira* or AIDS, she said] *Chira* is AIDS due to loss of traditions; we Luos call it *chira* and it is the AIDS in your [we, the research team] language. [From a church in Rachuonyo District with neutral stand on inheritance].

Female respondent, in her 50s:

> "Let us treat *chira* before it grows--if we leave it [to grow] until it turns into AIDS, then we won't be able to treat it.... [pointing at young widows] They don't follow traditions these days; they go to *tieko chik* in towns where they work. Whomever she *tieko chik* with [has sexual relations with first following her husband's death], when he goes back to his house carrying the 'shadow of impurity' with him [and sleeps with his wife], can he escape from being infected with AIDS? If this is not AIDS, then what is? How does it look like? Isn't that [referring to the case of a widow rushing back to the city and having sex with unsuspecting man who does not realize that he is, in fact, inheriting

> her] a big *chira* that cannot be treated? *Chira* for *okola* [uncleanliness associated with widowhood, before one is properly inherited] is fatal" [From a church in Homa Bay District that supports inheritance).

Male respondent in his 40s:

> "Some [widows] these days are being inherited by people they call fathers-in-law; for others, those they would call their grandchildren, and then she goes to eat in his son's house, can the son survive? This will wipe away his entire house [kill him and his children]. Sometimes someone who can marry your daughter--such a son-in-law inherits you…." [shakes his head to demonstrate the utter confusion at the abominations going on in the name of inheritance, yet thoroughly conflating AIDS and *chira*. He was making his contribution to the reasons why AIDS is spreading fast among the Luo. The respondent was a member of a church in Nyando District with a neutral stand on inheritance].

This dialogue, and those before it, demonstrate what Pred (1986) would call internalized power relations, whereby individuals frequently come to think of the detailed situation and social order characterizing their participation as natural rather than humanly created and culturally arbitrary. To the extent that the institutional control mechanisms such as the position of a widow, or of sex in marriage become taken for granted, unmentioned or unexamined--what Pred (1986) refers to as being "apart from themselves and incapable of being otherwise"--most participants did not feel that the rules were imprisoning, especially when a significant part of their lives seemed to consist of avoidance of one taboo after another. However, the apparent 'no-way-out' situation implied here is not the case. This is the central theme of Chapter Six where I suggest how interventions should proceed to provide widows with potential 'escape routes'.

Many of these accounts I have presented so far try to make sense of AIDS by building on known facts. This being the case, they suggested that AIDS was rampant among the Luo because the people have abandoned the customs around inheritance. Hence the solution to the rapid spread of HIV in Luo Nyanza is to revive the proper practice of inheritance (and other sexual norms), not to eliminate it lest the whole community is decimated. However, it is these very traditions that the state interventions have designated as risk behaviors for HIV and which are being targeted for elimination. When intervention providers and recipients define risk within widow inheritance differently as these illustrations demonstrate, it becomes rather premature to expect the practitioners to abandon the practice just because the intervention message labels it as risk.

In this section, I have shown how the Luo community is trying to make sense of their world within the era of HIV. What comes to mind especially from the quotes is the idea of cultural construction of AIDS and of widowhood. According to Treichler (1999), the concept of cultural construction refers to the process of how knowledge is produced and sustained within specific contexts, discourses, and cultural communities. In the context of this dissertation, AIDS as a disease is socially constructed by the Luo community as *chira*, which is as real to them as the virus is to the biomedical mind. However, a constructionist framework does not make AIDS just a discourse (of *chira*) in the mind of the Luo; it is a disease that also kills, and one that had claimed friends, relatives, and acquaintances of virtually everyone in the community.

But even with so many sicknesses and death around them as a result of HIV/AIDS, what I see demonstrated in the results presented so far in this chapter (as well as Chapter Two) is the difficulty people are still having in trying to understand AIDS in relation to widow inheritance, as well as to *chira*. As Treichler (1999) notes, a number of factors contribute to the process by which a given meaning may be transformed--or fails to be transformed--into an official definition. This is a case in point where the 'apparent' harmony (or similarities) between *chira* (cultural meanings) and AIDS (biomedical meanings) impedes rather than enhance understanding of AIDS. I argue that unless the custodians of the custom of inheritance--members of the larger community and the church--are genuinely involved in defining and setting up interventions, singling out the practitioners (widows) independent of their social contexts will remain ineffectual in addressing the forces that are responsible for the continuation of the risky components of the practice.

Chapter Five:

HIV/AIDS and widow inheritance in Luo Nyanza: Whose agenda are interventions addressing?

Chapter overview: Overall, Chapter Five presents a situation analysis of the interventions for HIV/AIDS in Kenya and in Luo Nyanza. In the chapter, I address four specific objectives. First, I present highlights of the epidemic, as well as some suggestions that have been proposed to address the situation. Secondly, I discuss how Kenya has responded to the epidemic, focusing specifically on foreign-initiated and foreign-supported interventions. In this part, I also present some of the shortcomings arising from over-reliance on outside support. Thirdly, I discuss the approaches to, as well as the inefficiency of the current interventions aiming at behavior change towards the practice of widow inheritance among the Luo community. My main argument is that for the most part, the ineffectiveness arises from neglecting to incorporate information from the practitioners in designing the interventions, as well as failing to involve them in carrying out the program activities. And fourthly, I present examples of public health interventions that have achieved a good measure of success because of involving the community in their activities. I use highlights from three strategies addressing female genital cutting as a risk behavior for reproductive health problems--from Mali, the Gambia, and Kenya--to show different levels of community involvement and how potential for success is related to the type and magnitude of involvement.

HIV/AIDS epidemic: Highlights and suggested solutions

The first three sentences of the latest UNAIDS report on HIV/AIDS provides a succinct situation analysis of the epidemic.

> The human immunodeficiency virus (HIV) which causes AIDS has brought about a global epidemic far more extensive than what was predicted even a decade ago. UNAIDS and WHO now estimate that the number of people living with HIV or AIDS at the end of the year 2000 stands at 36.1 million. *This is more than 50% higher than* what WHO's Global Programme on AIDS *projected in 1991 on the basis of the data then available* (my emphasis) (http://www.unaids.org/).

This extract reveals at least two pertinent issues about the past, the present, and the future of the epidemic. First, it challenges our ability to make predictions about a disease whose transmission and acquisition is as complex as HIV. I am reminded of Levins (1994:xvii) who made the following remark about man's inability to predict disease patterns: "The accumulation of 'exceptions' and the frustrations of the efforts by the medical community forced a new awareness of the fact that diseases rise and fall, evolve and spread, and retreat and spread again, and as a result, we have to prepare for a more complex tomorrow than naive progressivism and simple extrapolation would have us anticipate." But more importantly, the trend has brought to question issues about the (in)efficiency of our interventions, particularly those targeted at the current epicenters of the epidemic. In the next part, I revisit the main highlights of the current situation of HIV/AIDS epidemic in sub-Saharan Africa, Kenya, and Luo Nyanza, and provide examples of some of the suggestions that have been put forward to address the situation.

The latest global statistics (http://www.unaids.org/) show that 8.8% of sub-Saharan African adults are currently living with HIV/AIDS. This constitutes 70.1% of the 36.1 million global cases. AIDS is presently the fourth leading cause of mortality worldwide and the number one killer in sub-Saharan Africa, where at least sixteen countries have an adult prevalence of over 10%[36]. *Time Magazine* website (http://www.time.com/aidsinafrica/cover.html) has a very vivid depiction of the situation. Under a very telling title "Death stalks a continent" is written "Every 25 seconds another person in Africa gets infected with HIV. You are now looking at the number of people infected." Next to the message is a digital counter adding one (person) to the total every 25 seconds 'while you watch'.

According to the list in the footnote 36 below, Kenya is one of the 16 countries in the sub-continent hardest hit by the epidemic, with 14% of adults currently infected and over one million having died since the virus was diagnosed in the country in 1984 (http://www.unaids.org/). As in many countries in sub-Saharan Africa, heterosexual contact is the main mode of transmission, accounting for up to 90% of the infections in adults. Between 2-5 percent of the infections are transmitted through contaminated blood, and the remaining portion gets transmitted through miscellaneous other means (Government of Kenya, 1998; 1999). Bisexual contact has been reported in some parts of the country, particularly in Coast Province and among confined groups such as the convents, army, prisoners, and tourist resorts, but the degree of the spread of the virus by this route is still unknown (Government of Kenya, 1997; 1998).

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[36] Botswana (35.8%), Swaziland (25.25%), Zimbabwe (25.06%), Lesotho (23.57%), Zambia (19.95%), South Africa (19.94%), Namibia (19.54%), Malawi (15.95%), Kenya (13.95%), Central African Republic (13.84%), Mozambique (13.22%), Djibouti (11.75%), Burundi (11.32%), Rwanda (11.21%), Cote d'Ivoire (10.76%), and Ethiopia (10.36%) – these are December 2000 estimates of HIV prevalence from UNAIDS

Among the eight provinces of Kenya (Table 1), Nyanza is disproportionately affected, contributing 28.8.% of all the cases in the country in 1999 and 32.8% in 2000 (NASCOP, 1999; 2000). Within the province, the districts occupied predominantly by the Luo community account for 85.1% of the provincial HIV prevalence but under 68% of its population (NASCOP, 2000; Government of Kenya, 2001). Also, a sentinel survey carried out by CDC-KEMRI (2000) of women attending ante-natal clinics in Luo-Nyanza showed even a higher prevalence of between 30.1% to 43.5%.

Given the continuing rise in the epidemic in sub-Saharan Africa, Kenya, and Luo Nyanza, several suggestions have been put forward on how to best bring the spread under control. I have selected four viewpoints to illustrate what is considered to be the main problem with the current interventions especially in sub-Saharan Africa, and upon which I will frame my recommendations of strategies that might be more promising in effecting change.

Viewpoint 1: From **UN Press release, April 30, 2001**

i. April 26, 2001. Abuja, Nigeria. Speaking at the Summit of African leaders, the UN Secretary-General Kofi Annan called for a new global AIDS campaign and a renewed commitment to AIDS activities. He concluded his speech by making the following appeal:

> Finally, we need money. The war on AIDS will not be won without war chest, of a size far beyond what is available so far. Money is needed for education and awareness campaigns, for HIV tests, for condoms, for drugs, for scientific research, to provide care for orphans, and of course to improve our healthcare systems. (http://www.unaids.org/).

ii. April 30, 2001. Philadelphia. In his address to the annual meeting of the Council on Foundations, an association of some 1800 US-based foundations, Mr. Kofi Annan made a second appeal (four days after the Abuja appeal) for increased commitment and resources for an expanded worldwide campaign against HIV/AIDS. One of his key messages was that:

> The world has the (financial) resources to defeat this epidemic, if it really wants to. Following this appeal, the United Nations set up a Global Fund for AIDS prevention and treatment with a price tag of 7-10 billion dollars per year. By the end of July 2001, $1,394,041,068 had already been pledged by various governments, foundations, other organizations, and private individuals (http://www.unaids.org/).

Viewpoint 2:

> The general ineffectiveness of AIDS prevention programs in Africa does not just stem from lack of funding, but from an unwillingness (of program designers) to look beyond simplistic approaches that focus on the peculiarities of individual sexual behavior rather than the social, economic and political contingencies which make certain social groups vulnerable. The realities of sexual behavior is much more complicated (Kalipeni, 2000:967).

Viewpoint 3:

> Expecting people to abandon behaviors that bring pleasure and immediate gratification is unreasonable, especially when it gives them power or income, even while posing unacceptable risks to personal, family, and community health (Oppong, 1997, in Kalipeni, 2000)

Viewpoint 4:

> Sexuality and sexual behavior are extremely complex and must be placed in their social, historical, economic, and cultural context. In practice, however, little attention has been paid to the ways in which sexual behavior varies across space and time. Focusing predominantly on HIV transmission at the individual level, epidemiological research has reduced sexuality to a question of coital frequency and positions. Questions are not asked about the situations that lead to multiple partners or unsafe sex nor about whether individuals have the power to

> resist unwanted sex activity or to modify their sexual practices. The tendency to view AIDS as a behavioral problem and the subsequent neglect of the sociocultural and economic context of HIV transmission has left planners poorly equipped to design and to implement HIV prevention strategies (Asthana, 1998:169-70, 172).

The four viewpoints show, on the one hand, that to the Secretary General of the UN, the most effective tool available to us to address the pandemic lies in getting more resources. On the other hand, the other three viewpoints[37] seem to suggest that the solution is not *just* more resources, but a re-evaluation of current strategies towards intervention.

I am using these four representative viewpoints to anchor my discussion of the current interventions. While I recognize that additional funds are necessary to improve the overall ineffectiveness of the intervention programs in Africa, my position deviates from that of the U.N. Secretary-General. Instead, my argument supports the last three views, that what we need, at least at this point, is not just additional resources pumped into the interventions within the framework in which they currently are designed and operate. Rather, we need to rethink (and revamp) the framework itself, particularly its content and approach. For the rest of the chapter, I endeavor to provide evidence to justify my position.

HIV/AIDS interventions: Kenya's response

HIV in Kenya was first reported in Kisumu in 1984 in a patient of Ugandan origin (Government of Kenya, 1998; 1999). By the end of 1999, it was estimated that

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2.2 million people were infected and 1.1 million had died from the disease (UNAIDS, 2000; NASCOP, 2000). Currently, the Kenyan National Aids Control Council estimates that the country spends $3 million (about Kenya Shillings 231 million) everyday to treat people with AIDS-related illnesses (*Daily Nation* May 12, 2001). In the following paragraphs, I highlight the chronology of specific responses to the epidemic which the Government of Kenya has put into place from the time HIV was detected to the present. Unless otherwise referenced, statistics and factual information presented in the subsequent paragraphs are compiled from historical accounts of HIV in Kenya as documented by the Government (Government of Kenya, 1997; 1998; 1999), NACC (2001), Odindo, 1998, and UNAIDS (1997).

The increasing number of reported HIV/AIDS cases prompted the Government of Kenya to set up the National AIDS Committee (NAC) in 1985 to provide advice on all matters relating to the prevention and control of the disease. In the same year, the Ministry of Health set up the AIDS Programme Secretariat (APS) to coordinate program activities, and in 1987, NAC and APS established the National AIDS and STDs Control Programme (NASCOP) within the Ministry of Health as the major implementing body of the state programs. NASCOP developed what was known as the first Medium Term Plan (MTP I for the period 1987-1991) which focused on public awareness campaigns, strengthening laboratory services and blood safety measures, surveillance of HIV/AIDS, and training new and in-servicing regular health workers on case management of HIV/AIDS. The overall goal was to build human and institutional capacity to cope with the new disease.

In 1992, the second Medium Term Plan (MTP II 1992-1996) was prepared, and although it was not fully implemented due to a number of constraints such as lack of coordination and funding (Government of Kenya, 1997; 1998; 1999), it represented an attempt to design a comprehensive intervention program for Kenya that went beyond the narrow approach (envisioned in MTP I) which assumed that the Ministry of Health should be the only relevant agency in activities related to HIV/AIDS. The plan was intended to involve other sectors, with the goal of mobilizing broader national response against the rapidly rising prevalence.

Despite these efforts, it was only in 1997 that the President of Kenya officially declared AIDS a national disaster. This declaration provided an official mandate that allowed the activities addressing the epidemic to be operated outside the sole umbrella of the public health sector of the Ministry of Health. The recognition led to an establishment of official policy guidelines, *the Sessional Paper No. 4 on AIDS in KENYA* (Government of Kenya, 1997), that charted out a framework for HIV prevention and control strategies. Since NASCOP, which had hitherto been coordinating HIV/AIDS activities, is affiliated with the Ministry of Health, the *Sessional Paper* underscored the importance of creating an autonomous body that can design an effective multisectoral approach to controlling the spread of the disease--one that would remedy the shortcomings of the failed MTP II by planning for and overseeing the coordination and involvement of other sectors of the government. The policy paper's recommendation led to the establishment of National AIDS Control Council (NACC, 2001) in 1999 (set-up activities are still ongoing however). The policy issues governing the Council are articulated in the *Sessional Paper*, the details

of which are outside the scope of this dissertation, but suffice it to mention that the Council has set as its main goal a reduction in the prevalence of HIV by 20-30 percent among people 15-24 years by 2005.

Since pubic health, under which HIV/AIDS activities were resident for some 15 years, was already overburdened and grossly under-funded, activities associated with AIDS were, for all practical purposes, left at the 'mercy' of foreign resources. Operating under the control (and mercy) of external funders somewhat hampered the ability of the state to pursue its own agenda, to take initiative in designing relevant programs and carrying them out, and especially in laying of strategies for future health promotion (Government of Kenya, 1999; see also case study of the Kisumu workshop reported on page 223).

The following discussion of foreign involvement in HIV/AIDS activities underscores the extent to which Kenya has been (and continues to be) heavily reliant on outside funding and in the process, her decision-making autonomy has been compromised. The major international agencies that have contributed significantly in addressing the epidemic in Kenya include what is collectively known as the United Nations System Theme Group, comprising of seven co-sponsoring agencies--UNDCP, UNDP, UNESCO, UNFPA, UNICEF, WHO and World Bank[38]. The seven UN agencies formed the Joint UN Programme on HIV/AIDS (UNAIDS). Except for UNDCP, the remaining six partners have been heavily involved in activities too many

[38] UNDCP--United Nations International Drug Control Programme, UNDP--United Nations Development Programme, UNESCO--United Nations Educational, Scientific and Cultural Organization, UNFPA--United Nations Population Fund, UNICEF--United Nations Children's Fund, WHO--World Health Organization, and the World Bank Group, comprising of: The International Bank for Reconstruction and Development, International Development Association, International Finance Corporation, Multilateral Investment Guarantee Agency, and International Center for Settlement of Investment Dispute.

to list here, including a recent 50-million dollar World Bank Pilot Project on establishing Voluntary Counseling and Testing (VCT) services whose implementation is currently underway.

Besides UNAIDS, other donors who have made significant contributions to the fight against HIV/AIDS in Kenya include the governments of the US, UK, Belgium, Denmark, the Netherlands, and Canada. For example, United States Agency for International Development (USAID) has been particularly instrumental in strengthening the nongovernmental organization (NGOs) network to combat HIV/AIDS, in providing sexually transmitted infections (STI) services at community clinics, and in social marketing of condoms and educational media campaigns (USAID, 1996). The United Kingdom Department for International Development (DfID) reached an agreement with the Kenya Government to assist NASCOP in institutional development, especially of non-governmental organizations (NGOs) and community-based organizations (CBOs) responding to AIDS. The HIV/AIDS Prevention and Care (HAPAC) pilot project phase one is currently being implemented in Nyanza Province with DfID's funding, and the Futures Group International (UK) as the implementing agency.

The Belgian Agency for Development Co-operation (BADC) has been supporting NASCOP (and now NACC) in the area of STD management, Information, Education and Communication (IEC), distant education of health workers, and funding studies on risk behavior in high prevalent areas such as Kisumu and its environs. Canadian International Development Agency (CIDA) support took the form of developing low cost means to treat STDs and community based health promotion,

while the European Union (EU) focused on strengthening of existing STD services and IEC in various parts of the country. Other donors include the Netherlands and Danish International Development Agency (DANIDA) which fund adolescent health, income generating activities for sex workers, and counseling services for different target populations. Ford Foundation has funded NGOs and several organizations supporting people living with HIV/AIDS, including the Association of People With AIDS in Kenya (TAPWAK) and the Kenya AIDS Society (KAS) to develop outreach and counseling services.

In addition to the international donor agencies, there are many foreign and local nongovernmental organizations directly involved in AIDS-related work. In Kisumu District alone (Figure 1), for example, the Ministry of Health estimates that at least 200 NGOs are involved in HIV/AIDS-related activities. However, there are problems with many of the programs and projects as illustrated in the workshop report appearing in the *Daily Nation* (February 4, 1999 and May 18, 2000), part of which I outline on the next page.

There are several drawbacks to such heavy dependence on international donor and bilateral development partners, two of which have emerged as key in prevention programs in Kenya, and particularly in Luo Nyanza. One, while this support has been welcome, and even essential, it is recognized that this dependency represents vulnerability in terms of program sustainability. For instance, in 1995 when the donors withheld funding because of a number of issues, including accusations of governmental interference with intervention activities, lack of accountability of funds, and what the funders felt was a deliberately slow process of embracing the Structural

Adjustment and Stabilization Programs (see Chapter One for further discussion), most AIDS projects almost came to a halt (Government of Kenya, 1998; 1999).

The second drawback is the loss of autonomy in influencing the type and direction of AIDS-related prevention activities in the region. I take the liberty to report some of the concerns raised in a workshop called to evaluate the performance of intervention programs in the country's current epicenter of AIDS--Luo Nyanza. The workshop, titled: "HIV/AIDS programs in Nyanza: their coordination, impact, and lessons learnt so far" was held in Kisumu in the week of May 18, 2000, and jointly sponsored by the Futures Group International of the United Kingdom, and the Health and Environmental Media Network. The newspaper report on the workshop, aptly referred to as: "Fight over donor money fuelling AIDS in Nyanza" (Otieno, 2000), provides insights into what is happening not just in this province, but also elsewhere in Kenya, and I have reason to suspect, in other parts of sub-Saharan Africa as well. A summary of the main concerns presented below are excerpted from the report:

- Nyanza continues to have both the highest number of organizations fighting against AIDS and paradoxically the highest rates of the pandemic. Reasons: rivalry and competition for donor funds. Cases of HIV infection have been on the increase in the province despite multi-faceted intervention measures undertaken by both the Ministry of Health and non-governmental organizations. The paradox of the increasing numbers of AIDS cases in Nyanza despite the province having the highest presence of NGOs working against the scourge relative to other provinces, is now being linked to lack of coordination of their

activities[39]. The government officer charged with coordinating health activities in the province--Dr. Ambrose Misore, the Provincial Medical Officer-- claimed that NGOs are 'untouchables' (i.e., no one dares question them or challenge their activities), asserting that even though his office holds jurisdiction over all health-related activities in the province, it is hardly in the know of what the high number of NGOs were doing in the province. He said coordination of anti-AIDS projects in Nyanza was being undermined by duplication and secrecy among NGOs, all who enjoyed aggressive protection from the Kenya AIDS NGOs Consortium (KANCO).

Membership to KANCO is open to NGOs, religious organizations or any other institution involved in HIV/AIDS/STI activities and who are willing to share their experiences with other members. It may be speculated that NGOs have minimal link with the state because they obtain funding entirely from outside sources (e.g., Family Health International/AIDSCAP, USAID, ActionAid, World Health Organization, UNICEF, UNDP, DfID, DANIDA, Danish Volunteer Service, and the Norwegian Church Aid - http://www.kanco.or.ke/about_us.html).

- In the word of the Provincial Medical Officer (PMO), NGOs view themselves as fully autonomous, that "You try to question their agenda and straight away get a letter from National NGO Consortium accusing you of interfering with activities of their members. It is so difficult. They would show up in the offices of the provincial administration and announce that they were proceeding to initiate

[39] It is interesting that official reports from the government, as well as the national and international agencies involved in interventions, hardly question the effectiveness of the programs they are delivering.

such and such a project in a particular division or location. After that you will never hear of them."

- Such secrecy posed a serious constraint in the coordination of activities in the province and gave way to a lot of duplication. The PMO added: "the duplication is so serious that you find that different agencies are undertaking the same activities in very different ways. At the end of the day we end up with a state of confusion in the community" (*Daily Nation,* May 18, 2000).

A case in point in the conflicting messages concerns condom use for HIV prevention. Besides the tug-of-war between condom-as-strategy for HIV-prevention advocated by non-religious-based organizations vis-à-vis condom-as-promoter-of-sexual-'excesses' campaign by religious leaders, there has also been a public debate about the efficacy of condoms in protecting against the virus. On the one hand, church-based NGOs are 'creating community awareness' about the ineffectiveness of condoms in protection against acquiring HIV, emphasizing, for example, that the pores on the condoms are larger than the size of the virus and can therefore not prevent infection, or that condoms often burst during intercourse or slide out and remain in the uterus causing untold illnesses for the woman. On the other hand, non-church-based NGOs are 'creating community awareness' at the same time by promoting condom use as the most effective prevention against HIV in the absence of abstinence or mutual sexual fidelity.

Drawbacks about over-reliance on outside funding notwithstanding, there have been achievements credited to these efforts. Of interest to my work are those touching on Information, Education, and Communication (IEC), because that is the format

taken by the interventions addressing behavior change towards widow inheritance (I deal with this later in the chapter). My interest is not just in the number of people who had received informational message about AIDS, but rather, on the impact the message had on their level of understanding about the disease, and subsequently, their attitude towards behavior change. For instance, it is reported that by 1993, the level of 'awareness'[40] about HIV/AIDS had reached about 90% in both rural and urban areas, increasing to 99% by 1998 (Government of Kenya, 1999), but during the same period (when the level of awareness increased to almost 100%), HIV prevalence in the country also increased from 8.7% in 1993 to 13.8% in 1998 (Government of Kenya, 1998).

Recently also, the Nyanza Provincial Commissioner (the highest political administrator in Nyanza province) decried that despite an awareness rate of 99% in the province (100% has also been reported in some sections of the province – for example, Siaya district [Onyango, 2000]), the HIV/AIDS scourge continues to rise. Perhaps, this should prompt us to question not only if we are reaching the right people with the right information but also, and even more importantly, how the information is received and interpreted. Results such as these call for a re-examination of the current interventions programs (which I do in the next sub-section) and raise the question whether it is more money we need (as the UN Secretary-General states) or if a bold overhaul of the entire

[40] I have put the term 'awareness' in quotation marks because, as our study of rural Luo men and women demonstrated, it is true that respondents had heard or knew about AIDS. However, in probing to assess their level of understanding, it became evident that they were conflating AIDS with *chira*, and so, even when they mentioned that AIDS was sexually transmitted (which would be recorded in an epidemiological survey as a measure of understanding the correct transmission channel), their interpretation of 'sexual transmission" was, in fact, in terms of breaching of cultural sexual taboos that result in *chira*, rather than the biological sexual transmission of HIV (Additional information in Chapter Four).

behavioral interventions framework is what is required, as Kalipeni (2000), Oppong (1997), Asthana (1998), and I would suggest.

Interventions for behavior change towards widow inheritance

The current situation of interventions is one where billboards, radios, workshops, meetings such as church services, Chiefs' *baraza* (weekly or monthly village meetings), funerals and political rallies are the main channels that have been used to relay information about health education in Kenya, such as awareness of the potential 'risk' associated with widow inheritance.

A typical billboard message in shown in Figure 6. This particular message aims at correcting the misconception between AIDS and *chira.* Two other messages that are commonly relayed on billboards are: "AIDS kills; AIDS has no cure", and "Anybody can get AIDS." The common themes of the three messages is that AIDS is real and it is different from *chira.* As I mentioned before, many Luos do not view AIDS as a new, fatal disease distinct from *chira* which has always been with them, and for which remedies were often available. Although the first message (shown on the billboard) was always written in the local language (the English translation is my addition), it was rather surprising that many times the other two messages were written only in English with no translation into the local language.

As our study demonstrated by the level of respondents' knowledge reported in Chapters Two and Four, this billboard message, although found in strategic locations along major roads and in most market places and health institutions, had not made appreciable impact on the participants in terms of boosting their knowledge about the

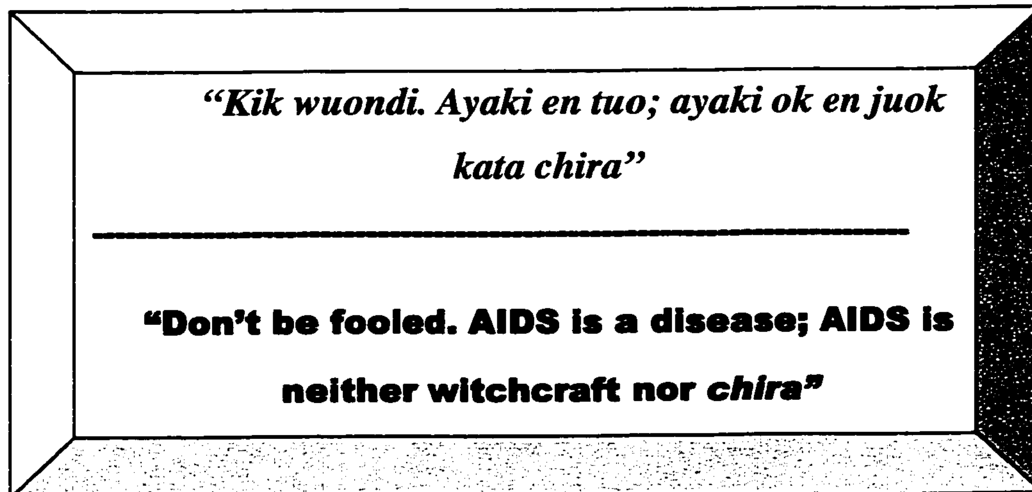

Figure 6: Typical billboard displaying a message on AIDS in Luo Nyanza

disease, and neither were those relayed through the other channels. Our results show that most respondents were still conflating AIDS with *chira* despite reporting having read these messages countless times, 'until the messages had blended with the natural habitat, and they no longer took notice.' Workshops appeared to be the only relatively effective channel. It was evident that the few respondents who were able to distinguish AIDS from *chira*, who were able to explain the transmission mechanism of HIV with relative accuracy, and who responded to most of the issues and questions raised by colleagues in the audience, reported receiving information through attending a number of organized workshops.

Because AIDS as a disease is difficult to comprehend, the most frequently cited reason for the ineffectiveness of the interventions was that short billboard messages need to be reinforced by more interactive workshop-type forum, which

comprise of conversation, discussion, and question and answer sessions.

Respondents cited the following as the main factors contributing to the ineffectiveness of the current interventions: single sentences on billboards (which were barely informative, much less educative); brief mention at funerals (which, given the somber atmosphere, could not provide opportunity for any meaningful discussion, or sometimes with clergy who are equally ignorant of the facts about HIV like the rest of the attendees); announcements of 'brief points of information' at Chiefs' weekly or monthly *baraza* (which were rarely attended by women or the youth); in special sessions in churches (with the underlying moral tone which many times inhibited open discussions); and on radio announcements and other programs (which mostly benefited those who owned radios, had time to listen to the programs, or understood the language of transmission when not in the local language). Overall, respondents were raising issues with both the approaches and contents of the interventions they were receiving, as the quotes below demonstrate:

Male respondent in his 20s:

> We have not seen anyone coming here to discuss AIDS with us. You [the research team] are the first ones. What we see are big vehicles [on] which are written "Save your family; Discuss AIDS" busy running on the road but they only discuss it in big hotels. You just see them in Imperial Hotel[41]. You hear about them in Sunset [in] Kisumu. And even if they come to Bondo, they only go to the best hotel in Bondo. They tell those who already know, but they don't have courage to come where we are. We have no Imperial [Hotel] food to give them.

A female respondent in her 30s (who had attended several workshops on AIDS)

> I have a radio at home and I see these wood [billboards] every time I go to the market. I have seen them for years [but] the time that information about AIDS

[41] Imperial and Sunset are four-star hotels in Kisumu, the main city in the area. Reference to them in the rural countryside was their way of saying that workshops are only held in the best venues that are out of reach for most of the rural folk.

> sank [in my head] was when I was invited to a workshop for community health workers. I am a traditional birth attendant and they wanted us to store condoms to make it easy for people to pick [up]. Even now I have gone for a number of workshops but I still have many things I don't understand well.

What I have briefly presented is a situation where health education takes the familiar top-down approach; where information that the recipients had no say in designing is "delivered to" them in ways over which they have no control. It is also individual-based and take no account of the social structure of the behaviors being addressed. Instead, with focus on the choices of the individual as its foundational assumption. Such practice of health education relies heavily on the giving of *information* about health and the encouragement of *behavior change* in the direction of health-promoting behaviors. This approach presupposes that information alone should lead to behavior change--a problematic and simplistic assumption, because simply knowing something does not mean one is able to act on it. As Wilton (1997) points out, if information alone were sufficient to translate into behavior change, nobody would smoke, drink too much alcohol, or practice unsafe sex, especially populations which have access to information on the dangers of these activities (See also Rakwar et al., 1999; Campbell & Williams, 1999; Frederick, 2000).

Research and empirical observation have demonstrated, again and again, that personal behavior is so profoundly influenced and conditioned by broader societal factors that focusing on change in personal behavior without influencing the relevant societal factors could never be sufficiently effective (Mann and Tarantola, 1996; Oppong, 1997). For example, low economic and social status limits the ability of many women to refuse unwanted or unprotected sexual intercourse, regardless of how

much they know about AIDS or wish to adopt recommended individual risk-reduction practices (Schoepf, 1991; Rakwar et al., 1999; Craddock, 2000; Preston-Whyte et al., 1991; Mallory & Stern, 2000). In the same way, societal responsibilities limit the ability of many widows to decline inheritance regardless of their knowledge of the potential risk.

Nevertheless, I am not discrediting the importance of health education. I totally agree with Wilton (1997) when she submits that whether or not health education alone is sufficient to prevent people becoming infected with HIV, it is undoubtedly true that disseminating straightforward factual information about the virus, its effects and routes of transmission, as well as the means of avoiding transmission, is a first requirement of public health response to AIDS. However, the type of health 'education' I am challenging is predicated upon assumptions of individual agency (the widow) divorced from social context, economic contingencies, inequitable gendered-power relations, and the cultural production of meanings of AIDS (See Chapters Two and Four). Hence, following Craddock (2000) and Schoepf (1991), I argue that ignoring the complex social context of which AIDS is a part and in which gender, economics, and cultural discourse play important roles, generates inappropriate and ineffectual prevention policies.

Slater (1999) expressed similar concern, arguing that the customary lack of attention to indigenous voices has resulted in policies that largely ignore the social and economic contexts wherein HIV is contracted (and, for our purpose, also wherein widow inheritance occurs). As Schoepf (1991) observed, with the help of an international donor community which channel funds primarily through health

ministries, it is not surprising that AIDS prevention is medicalized to the exclusion of other knowledges, and that sexuality is constructed as biologically driven individual behavior divorced from culturally significant meanings, as well as from social and power relations. The concept of vulnerability to HIV such as what I discussed in Chapter Three focuses upon social, cultural, and religious constraints and barriers to individual control over health across geographical scale. In other words, it is the barriers that give rise to vulnerability, which in turn, provide justification for interventions. Thus, it would be technically contradictory to design interventions around individuals independent of those factors that inhibit them from having control over their health, especially for a disease whose acquisition is as complex as that of HIV. Hence, I argue that there is need to widen our purview to acknowledge the fact that the HIV virus spreads not because of 'exotic' cultural practices (such as widow inheritance), but because of many situations of everyday life. It is these life situations we must identify--by asking those who are *living* the everyday lives, not those who are *writing* about them--and use to construct meaningful interventions that are sensitive to the local situations.

As the World Health Organization has recognized (Mann & Tarantola, 1996), in efforts to improve and refine informational and educational services, a major emphasis has to be placed on the participation of the intended audience (the targets) in the *design of the messages and in the choice of channels for their dissemination* (my emphasis; see also Craddock, 2000). With respect to widow inheritance, a process of consensus building with communities must be developed in order to replace the adverse practices with appropriate alternatives which meet the cultural requirements.

This is particularly pertinent because, as Wilton (1997:45) reminds us, information about health is not passively consumed but is actively processed in the context of pre-existing health beliefs. As such, any information which appears to diverge greatly from already held beliefs is likely to be rejected or profoundly modified by the individuals to conform to their 'lay' beliefs about HIV/AIDS--as demonstrated by conceptualizing AIDS within the framework of *chira*. Thus, while the practice of inheriting widows may be a potential conduit for the diffusion of HIV in the community, interventions following the biomedical paradigm should not expect to simply overwrite their text onto the existing cultural one. Rather, they must be willing and ready to renegotiate their epistemology around the existing knowledge base and be prepared not for a single victor--themselves--but for a compromise between the two worldviews.

It is therefore good news that the National AIDS Control Council, the executing arm of Kenya's Policy Paper on AIDS, has recognized the need for more efforts that promote local socio-cultural norms, values and beliefs that will help to reduce the risk of HIV transmission and to harmonize religious teachings on sexuality with those of the social and cultural practices (NACC, 2001). The Council has identified several channels through which to work towards this goal, namely, education, advocacy and persuasion, counseling, and the enforcement of both customary and written law.

In the next subsection, I provide an overview of the practice of female genital cutting (FGC) in sub-Saharan Africa, ultimately focusing on intervention programs that have been designed to change behavior. I will use three case studies to show

various strategies that have been applied to involve the communities in interventions to demonstrate how a bottom-up approach where members of the community are fully involved in the different stages of the intervention have better chances of succeeding in bringing about a desired outcome.

Campaign against Female Genital Cutting: examples from sub-Saharan Africa

Mkosa mila ni mtumwa (Swahili saying for: He [or she] who has no culture is a slave)

The saying cited above kept coming up during our discussion sessions, underscoring how important it was to the respondents to retain their cultural identity. Even when they acknowledged the potential risk associated with certain elements of the practice of widow inheritance, a majority still voted for its continuation regardless of whether or not their churches opposed the practice. However, they agreed that the elements that pose risk for HIV need to be modified, but in ways that remain culturally acceptable.

Before discussing the suggestions from the respondents on how this can be achieved (which I do in Chapter Six), it would suffice to demonstrate that what I am proposing, namely, that interventions need to find a middle ground between culture and biomedicine, has been tested under comparable circumstances elsewhere with relative success. I have chosen to focus on campaigns to address the practice of female genital cutting (FGC) because it is as deeply entrenched in the culture of the practitioners as widow inheritance. But since FGC is not the focus of this dissertation, I present only highlights of the practice, such as what it is, why it is performed, who

the custodians are, and the interventions that are currently being provided to address it. I use as examples programs that have been carried out in Mali, the Gambia, and Kenya to explore the potential for behavior change towards the practice. Extensive accounts of the practice across sub-Saharan Africa can be found in the excellent edited publication by Shell-Duncan and Hernlund (2000), and in two publications by the World Health Organization (1998; 1999).

The traditional practice of female genital cutting, (FGC), sometimes referred to as female 'circumcision' or female genital mutilation, has attracted increasing international attention in the past 20 years. For example, activists and nongovernmental organizations (NGOs) have used the opportunity provided by world conferences organized by the United Nations,[42] together with associated nongovernmental forums, to establish a strong global consensus against this practice and to consolidate the will and resources of national, regional and international institutions to stop it (WHO, 1998; 1999).

In a joint report by the WHO, UNICEF and UNFPA (WHO, 1999:7), female genital cutting is defined as a practice that comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons. The three agencies classified the different types of female genital mutilation as follows: i) Type I: excision of the prepuce, with or without excision of part or all of the clitoris; ii) Type II: excision of the clitoris with partial or total excision of the labia minora; iii) Type

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[42] World Conferences on Women, Copenhagen, 1980, Nairobi, 1985, Beijing, 1995; World Conference on Human Rights, Vienna, 1993; International Conference on Population and Development, Cairo, 1994; World Summit for Social Development, Copenhagen, 1995.

III: excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation); and iv) Type IV: unclassified, including pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice or cutting of the vagina; introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital 'mutilation' given above.

The practice is currently being performed in 28 countries in sub-Saharan Africa, with an estimated prevalence ranging from 5% of female population in Uganda, Niger, and the Democratic Republic of the Congo, to 98% in Djibouti, 99% in Guinea, and 96-100% in Somalia (WHO, 2001). In Kenya, it is estimated that some 38% of the women have currently gone through some form of genital 'mutilation'. It is mostly performed as a rite of passage from childhood to adulthood, for social identity and status, and for boosting marriage prospects. It is undertaken in most communities between a few months after birth and 14 years or older, depending on the community and the purpose for which it is being done (Shell-Duncan and Hernelund, 2000; Thomas 2000). For example, in southern Nigeria female genital cutting is performed on babies in the first few months of life, while in Uganda it is performed on young adult women. It is therefore difficult to summarize the cultural significance of the practice because the cultures in which it occurs are very diverse. Nevertheless, the reasons and meanings for observing the practice mostly revolve around social definitions of femininity and attitudes towards women's sexuality, with a common

feature being the social conditioning of women to accept the practice within social definitions of womanhood and identity (WHO, 1998; 1999; Thomas, 2000; Hernelund, 2000; Shell-Duncan, Obiero & Muruli, 2000; Gosselen, 2000; NCPD/CBS/MI, 1998).

With respect to the forces that keep the tradition alive, an increasing number of studies are challenging the blanket assumption by the international community in which girls and women are largely cast as victims of male patriarchy. Thomas (2000), for instance, found that among the Meru of Kenya, women are not just passive recipients; they are central actors. The author reported a period known as *Ngaitana*-- (Meru reference for: 'I'll circumcise myself') when adolescent girls circumcised each other in a show of defiance against a ban placed against the practice by the colonial government. More recently, a survey in Kenya covering about 95% of the population found that 58.5% of women who were 'circumcised' had made the decision by themselves (NCPD/CBS/MI, 1998). Other studies have also found that women play an important role in promoting and perpetuating the practice of excision (Shell-Duncan & Hernelund, 2000). Shell-Duncan and colleagues (2000:127), for example, remarked in their study of the Rendille of Northern Kenya, that it might surprise outsiders that genital cutting is not simply imposed on women by men, but that it is also perpetuated by women themselves, despite their awareness of the pain and serious health risks involved.

According to Thomas (2000), adherence to the practice is a show of women's efforts to preserve their bargaining tools so as to negotiate their subaltern status and to enforce their complementary role with men because through initiation, they (the

women) are transformed into figures of authority in the community. Reporting on a resurgence of FGC among educated Meru women who live in Tanzania, Nypan (1991) argues that because of lack of employment opportunities, education no longer accords women special status relative to the uneducated; it no longer provides the potential resources on the which the previous generation of women established a new cultural identity for themselves. According to the author, the revival of FGC may be regarded as a result of the weakening of education as a basis for establishing a cultural identity, hence the need of the girls to reclaim their self worth through 'circumcision'. This has become even more appealing given an increasing tighter marriage market due to, among other factors, a decline in polygyny (Nypan, 1991).

This last point shows that the interests of men are not irrelevant, and the issue of women's social status and its determination of 'marriageability' remains the critical force behind the continuation of the tradition. For instance, Shell-Duncan, Obiero, and Muruli (2000) document the following attitude from their study among the Rendille who perform the ritual as part of marriage ceremonies: "Circumcision is a brand. We get a brand to show that she is mine, and can only be with me, and will bear my children...Branding makes her mine". Increasing the potential for marriage is often measured not just by getting a partner, but even more so, by the bride-wealth she is likely to fetch for her family, which increases if she is 'circumcised'. Thus a strategic intervention must address the interest of the girls themselves, the parents, and the community from which prospective husbands would come.

Several strategies have been adopted to minimize the risk associated with FGC in ways that are also culturally acceptable. In Mali, for example, Gosselin (2000)

reports that traditional excisers have been incorporated into an intervention in which they hand over the knife in exchange for training in other income-generating activities. The underlying assumption here is that the main incentive for these women to practice excision is economic--which the author found to be important but not key. The need to conform to tradition was more central. Most of the excisers interviewed had not fully grasped why they were being told to abandon the practice even though a majority of them reported having been invited for a workshop where they were told (and shown pictures) of the "negative consequences" of excision, but the details were not explained to them. As Gosselin (2000) found out, a majority of them did not retain the information, and from those she interviewed, 23% said there were no negative health consequences to genital cutting, 20% believed that the consequences were positive, and 20% did not know. Only 9% linked the practice to possible unspecified "problems" or "illnesses".

I find it doubtful that, even though attempts were made to involve members of the community--the excisers--such a program would significantly contribute to ending the practice in Mali. There are several reasons to this: One, that most of the excisers had not labeled the practice as risky for reproductive health (63% of the respondents); two, that practitioners were being coerced with incentives to end the practice (Gosselin [2000] reports, for example, that incentives were withheld from villages that declined to support the program) and as such, change was not coming from the people themselves; three, that calling for total eradication was assuming that the cultural role played by the practice was insignificant and could be readily dispensed with; and four, that the sole reason why excisers were performing the ritual was economic, which, as I

have mentioned, was not the case. Even though the success of the program had not been evaluated by the time the research was being carried out, the author noted that medical personnel are increasingly replacing traditional excisers in performing the operation, especially in the cities, thus keeping the tradition alive despite the 'surrendered knives'.

An improvement over the approach in Mali is a campaign carried out in the Gambia. Historically, girls in many ethnic communities in Africa underwent genital cutting in the context of 'coming-of-age' pedagogy and celebration (Shell-Duncan & Hernlund, 2000; WHO, 1999). However, it has in recent decades become increasingly common for very young children to undergo a primarily physical procedure with little or no accompanying ritual or transmission of "traditional" knowledge (See also Gwako, 1995; NCPD/CBS/MI, 1998). In response to what Hernund (2000) observes as a growing pattern of *cutting without ritual*, some Gambian women activists have embarked on the reverse practice, namely, *ritual without cutting*, which entails the revitalization of the girls' adolescent initiation minus the element of genital cutting. The approach seeks to reach a compromise between the cultural meaning attached to the practice, and the health risk associated with certain components of it.

Instead of proposing *replacement* rituals as the end point, Hernlund (2000:235) suggests that in the particular context of the Gambia, seeking mutually agreed upon compromise between culture and health may not only contribute towards the elimination of the risky components of the practice but can also provide a powerful avenue for women's empowerment while allowing individuals and communities to avoid the accusation that to give up female genital cutting is to give up one's culture

(mkosa mila ni mtumwa). The author reports that the most important reason cited for practicing FGC is to maintain the traditions, or the pressure to conform. My goal in presenting this case study is to demonstrate that intervention providers oppose only the one harmful element of the practice--the cutting--and are not rejecting "the culture" as a whole. The aim hence is to modify, not eliminate.

In one such campaign, which Hernlund (2000:246) refers to as ritual negotiations and cultural compromise, teachings and other forms of training associated with actual cutting was provided for two weeks in a camp setting that mimicked what is often observed in the actual ceremony. The role of these rituals is to preserve the "culture" and add the much-needed discipline to the education of youth. At the end of the two-week camp, an alternative to the 'coming out' of the initiates was held in a way close to what is normally done at the close of the actual ceremony. The author reports that throughout the course of the youth camp there arose, *spontaneously*, remarkable instances of compromise, flexibility, and ritual creativity (my emphasis). The girls and their elders engaged in a constant process of negotiation on what to keep, what to change, and what to discard. This way, the girls were symbolically pronounced "circumcised", and the circumcisers allowed to retain their authority.

However, because the strategy is relatively new, it is premature to assess its success. As Hernlund (2000) concludes: only time will tell whether people participating in ritual without cutting will keep their collective promise and refrain from 'circumcising' their daughters in the future and whether the new rituals will continue being performed until they, too, are thought of as tradition. Uncertainty notwithstanding, this is an important improvement over the approach in Mali

(described earlier) especially because of the absence of coercion (withholding benefits) and the effort of involving different community members as participants, not just removing knives from the providers of the practice. In this approach, the ultimate hope is for the 'circumcisers' to voluntarily give up the knife. In the next few paragraphs, I present a case study among the Meru of Kenya where an approach similar to the one attempted in the Gambia has been designed, implemented, evaluated, and achieved what the providers have classified as "considerable success" (WHO, 1999).

Ten of Kenya's 43 ethnic communities have one-third or more of their women 'circumcised' (NCPD/CBS/MI, 1998). For example, Kisii community has the highest proportion of 97%, 88.8% among the Masaai, 62.2% among the Kalenjin, 59.2% in Taita/Taveta, 54.2% in Meru/Embu, 42% among the Kikuyu, and 33% among the Kamba (NCPD/CBS/MI, 1998; Gwako, 1995; WHO, 1998; 1999). The tradition is also popular in a number of other communities who were not included in the NCPD/CBS/MI survey but who have been listed elsewhere, such as the Rendille (Shell-Duncan et al., 2000) and the Samburu (WHO, 1998) of North Eastern province, the Sabaot of Mt Elgon District (Mwangi, 2001), as well as the Kuria of Nyanza province (Gwako, 1995). As typical of elsewhere in African where the tradition is still being observed, the types of cutting vary within ethnic communities, as do the reasons behind the practice. The current *Kenya Demographic and Health Survey* (NCPD/CBS/Mi, 1998) reports that being considered a good custom/tradition, preventing immorality, and better marriage prospects were the major reasons cited by those who continue to advocate for the practice.

Kenya is one of the four countries in Africa that the WHO (1999) has singled out as having launched a successful project to reduce the risk associated with FGC. Others are Uganda, Egypt, and Senegal. Starting in 1991, most of the campaigns have been directed to the Meru community who occupy Eastern Province of the country (See Figure 1). What I describe below is based on campaigns that have been directed specifically at this community. The Meru, as I pointed out previously in this subsection, still strongly holds onto the practice (reference is made to girls who circumcised each other in defiance of the colonial government's directive outlawing the practice--see Thomas, 2000).

The interventions in Meru provide an example of a strategy that brings the interests of the various stakeholders to a negotiating table. Known in the local language as *Ntanira na mugambo* (Excision by words), the aim has been to design and implement an alternative rite of passage (WHO, 1999). The program is a collaboration between a local national women's organization, *Maendeleo Ya Wanawake Organization* (*MYWO*) and an international organization, Program for Appropriate Technology in Health (PATH). Prior to starting the program, community outreach and mobilization activities were conducted to raise awareness about FGC and the proposed alternative approaches. Peer educators were used to recruit mothers and girls and teach them about the harmful effects of FGC. They had three specific objectives: i) to explore alternative rituals to current FGC practices with families of the girls at risk of undergoing the practice, ii) to reach consensus on the type of alternative ritual that is acceptable to all the stakeholders (i.e., the girls, their mothers, fathers, and the community at large) and to implement it in the community, and iii) to monitor the

alternative ritual processes--support or lack thereof--and determine whether it is a sustainable solution.

As reported in WHO (1999) and NCPD/CBS/MI (1998), the planning and implementation was done in four stages. In stage one, a conceptual framework was developed for planning and implementing such a program, including the steps to be taken. This stage involved holding initial discussions on alternative rites of passage, emphasizing that the project was not intended to install a foreign policy; rather, that what was being proposed was related to what was traditionally done. Stage two consisted of exploring the feasibility of the program with the four stakeholders (girls, mothers, fathers, community members). Each of the stakeholders suggested whether and how to implement such a program, what information was needed, what kind of gifts should be given, and who should participate. In the third stage, a program that was designed that excluded 'cutting' but otherwise mimicked the traditional 'coming-of-age' ceremony was carried out according to the consensus that had been reached. And in the final stage, the program was tested, initially with 30 girls from one division in 1996, increasing to 49 four months later, and to around 500 by 1999. The girls who participated in the alternative ritual significantly outnumbered (by several times) girls who were actually excised (WHO, 1999:114).

Although there was initial skepticism towards the program, with many believing it would fizzle out, it is reported to have increased and gained popularity both within and outside the Meru community, notably among the Kisii (WHO, 1999). The project planners attribute the success to the involvement of parents--especially fathers--and community members in planning, executing, and evaluating the activities.

The result of such involvement led to a sense of ownership of the project, as well as social support for the girls in their decisions. To improve its sustainability, since marriageability is one of the key reasons why the practice has persisted (See Thomas, 2000; NCPD/CGS/MI, 1998), seminars have also been held for boys who are reported to have "expressed their total support for the programs and declared that they will no longer make female excision a prerequisite when choosing a marriage partner" (WHO, 1999:115).

However, a recent newspaper report (*Daily Nation,* July 20, 2001) challenges these blanket claims of success. Mwangi (2001) found that despite the steps to eradicate FGC in many communities in Kenya, the practice appears to have been forced underground where it continues to flourish. In the report, the writer singles out the Tharaka and Igembe communities in Meru, and the Sabaot in Mt. Elgon District, as among those who have gone underground for fear of confrontation by those who are opposed to it, such as the churches, the government, and the pro-change groups like *Maendeleo ya Wanawake*. Among the Meru for example, Mwangi attributes some of this to an oath that binds men not to marry an uncircumcised girl. Such an oath acts in a similar way as that of sexual rite among the Luo which has played a significant role in sustaining the tradition of widow inheritance. As I suggest with respect to widow inheritance, there is need to work with relevant community members to address this oath so as to remove or 'loosen' its hold on the community.

Even if what is reported above is well founded, to me this is not necessarily a testament of failure; it in fact underscores my central argument throughout this dissertation, that bringing about behavior change in a culturally entrenched practice

such FGC or widow inheritance is a complex task. As such, reports such as these should actually be taken as a challenge to the often-simplistic linear approach to behavior change interventions that are being implemented in many parts of Africa. In the next chapter, I provide some suggestions on how compromises between biomedical and cultural conceptualizations of 'risk' and of 'vulnerability' can be negotiated in an intervention targeting a change in attitude and behavior towards widow inheritance.

Chapter Six:

Widow inheritance and HIV/AIDS interventions in sub-Saharan Africa: Bringing program designers and recipients into a dialogue

"Making the healthier choice the easier choice"

Chapter overview: I have demonstrated in the preceding chapters that the definitions of 'risk' and 'spaces of vulnerability' for HIV acquisition through the practice of widow inheritance differ between Kenya's Ministry of Health (who design and deliver the interventions), and the Luo ethnic community (who are the recipients targeted by the interventions). My goal in this chapter is to suggest ways to bring the two groups into a dialogue whereby the goal of the Ministry of Health in reducing the potential risk of HIV associated with the practice of widow inheritance can be accomplished in a way that is feasible and culturally appropriate to the Luo community. This way, 'the healthier choice would become the easier choice' for the widows.

I have addressed this goal in a four-stage process. Firstly, I highlight the key findings of the study, emphasizing especially how the community conceptualizes the association between HIV/AIDS and widow inheritance (derived from Chapters Two and Four). Secondly, I reiterate the major components and procedures of the current interventions that aim at reducing the prevalence of widow inheritance, including the main shortcomings with the programs (derived from Chapter Five). Thirdly, I use a tree and the relationship among its components (leaves, branches, trunk, and roots) as

a metaphor to illustrate why the current interventions have failed to achieve appreciable behavior change towards the practice of widow inheritance in particular, and in reducing the prevalence of HIV in general. The metaphor also serves as a framework for the suggestions that I provide at the end of the chapter. Finally, I discuss the recommendations provided by the participants, examine their effectiveness in reducing the risk and vulnerability for HIV, and assess the feasibility of implementing them. In reporting the recommendations, I include a number of excerpts from the discussion sessions to show how participants grappled with issues based on real life experiences and the processes through which most of them were able to reconceptualize the linkage between specific components of the practice of widow inheritance and the risk for acquiring or transmitting HIV. I also present examples of some of their deliberations concerning possible safe alternatives to inheritance, and what emerged as resolutions that policy makers can draw from in designing the interventions.

In presenting the suggestions from the respondents, I have included both those that are feasible as well as some that are not feasible, so as to prepare intervention policy makers and program implementers for the types and the range of issues that are likely to emerge in actual field situations. The issues at hand were complex since they concerned matters of sexuality, religion, cultural practices, and behavior change. As such, the sessions were characterized by long deliberations before a consensus could be reached. What I present however are excerpts from the sessions where resolutions were reached in a relatively shorter time.

I would like to mention at the outset that because the participants in our study were drawn from churches (see Methods Section in Chapter One), a number of solutions were provided within the contexts of a particular religious setting (even though the suggested solutions are sufficiently general to be adopted in other settings). Also as I mentioned previously, the potential role of the church in joining HIV prevention activities has been recognized by the state and by a number of international and local agencies and organizations, making such suggestions all the more timely.

The association between widow inheritance and HIV/AIDS: perspectives of the Luo

In this part, I present a summary of the main findings of our study (derived from Chapters Two and Four). The respondents cited five main reasons why widows are inherited: 1) to discourage widows from abandoning their marital homes and their children; 2) to restrain widows from seeking sexual liaisons outside the husbands' clan which, in cultural perceptions, could bring misfortunes to the widow and her immediate and extended family; 3) to give widows without children (especially sons) an opportunity to get children to continue the lineage of the deceased; 4) to entitle the widow to social and economic support from the inheritor; and 5) to enable her to participate in certain social events for which sexual rite is a component. From the discussions on the association between widow inheritance and HIV acquisition, two issues emerged as the most problematic to resolve, namely, inheritance for purposes of keeping traditions (*rito chik*) so as to 'put the home in order' (*rieyo dala*) and inheritance purposes of fulfilling biological need for sex (*rito del*) (See footnote 32 for

explanation of these concepts). The suggestions provided in this chapter apply to widows who wish (or are otherwise persuaded) to adhere to the traditions (*rito chik* so as to *rieyo dala*) and who must therefore grapple with competing cultural and biomedical conceptualizations of AIDS and associated 'risk', which I discussed in Chapter Four. They also apply to widows who are still sexually active but who may not want to infect others (or risk being infected) by being inherited (*rito del*).

The association between widow inheritance and HIV/AIDS: perspectives of the State

In this part, I highlight the key characteristics of the current interventions aimed at reducing the prevalence of the practice of widow inheritance (derived from Chapter Five). The first is that the ongoing interventions are program-based in approach and are targeting change in behavior (of widow inheritance) to the exclusion of social and cultural contexts within which the behavior is practiced. And two, interventions target individual widows outside the social structure of which they (the widows) are part, and in which HIV is acquired or transmitted. I argue that interventions that do not take into account the prevailing social and cultural contexts will continue to be ineffectual regardless of the amount of time and/or the resources expended to implement them. For instance, there is concern that despite an "awareness" level of AIDS of 99-100 per cent among the Luo community, the epidemic continues to rise as if no intervention has been going on (*Daily Nation,* March 24, 2001; Government of Kenya, 1999; NASOP, 2000; CDC/KEMRI, 2000).

By ignoring social and cultural contexts of widow inheritance and HIV/AIDS, the intervention planners and implementers have relied only on the plausibility of a biological mechanism to classify and target the behavior as a 'risk' for HIV. Even this is short-sighted without understanding HIV status within the sexual network both of the inheritor and the widow, as well as of the network each will enter if they do not partake of the inheritance relationship. However, most of those for whom the interventions are designed use cultural conceptions to frame the association between the practice of widow inheritance and risk for HIV. The result is that while the State is campaigning for the elimination of widow inheritance as a potential risk behavior for acquiring HIV, the community is campaigning for a revamping of the practice as a potential check against the rapid spread of the disease. Because the intervention planners are insensitive to the ways in which the community is constructing AIDS, their message continues to be at variance with the local knowledge of the people, leaving them ill prepared to tackle pertinent issues about the practice.

The epidemiological approach upon which public health interventions are designed assumes that society as a whole is equivalent to the sum of its individual parts, implying that dealing with the individual (widow) is sufficient to stamp out an undesirable societal behavior (inheritance). The approach also assumes that information about health is passively consumed rather than actively processed in the context of pre-existing health beliefs. However, throughout the dissertation, I have shown that the practice of inheritance is rarely dependent on the widow's personal choice alone because by partaking in it, she is linked to other members of the society, as well as to the historical past of the whole community. I have also shown that the

current interventions are proceeding on a terrain of contested meanings where cultural and biomedical knowledges struggle for control, and where the community is expected to alter sexual relations that have otherwise been widely considered normal, natural, and highly valued.

In these interventions, there is an underlying tendency for specialists to assume that people with whom they are working and whom they hope to 'help' are essentially 'rational.' Thus, if the medical expert has difficulty putting her/his program across, then the respondents are considered unusually conservative and cannot see the obvious (to the specialist) advantages of change. As I mentioned in the previous chapter, African culture is now being taken up wholesale to explain, justify and excuse nonexistent, inadequate, or failed intervention campaigns (Farmer et al., 1996). However, Foster (1973) posits that even when people understand the message perfectly, they have weighed the relative benefits of the alternative forms of behavior and have decided against the new program however logical and compelling the evidence may seem to the scientifically trained specialist, or to someone with a different point of view. This is because some of the secondary and tertiary consequences of the recommended change may be highly undesirable from the standpoint of the people affected, necessitating a careful consideration of its advantages and disadvantages within the prevailing cultural, economic, religious, and medical contexts.

Widow inheritance intervention must therefore be appraised in a broader perspective than just in terms of a single goal of its potential association with the spread of HIV. Trade-off alternatives must be considered and the possible results of

abandoning the practice deliberated on extensively. What follows is a metaphor to help in conceptualizing the level at which the present interventions are operating in their aim to bring about change in behavior towards the practice of widow inheritance among the Luo community.

Contextual analysis of widow inheritance and lessons for interventions: Tree as a metaphor

The actual practice of widow inheritance constitutes the observable byproduct of the interactions of a widow's background characteristics with unobservable social relations, religious affiliations, and historical contingencies. Although invisible, these social, religious, and historical trajectories are what nourish and sustain the practice. In this dissertation, I compare the relationship between the practice of widow inheritance and the underlying factors with the relationship between and among different parts of a tree. My goal is to use the comparison to analogue the approach used by the current interventions aiming at eliminating the practice. The tree here represents a single practice--widow inheritance. Other practices which are also embedded in specific cultural, economic, or other contexts (for instance, polygyny, sex work, male circumcision, female genital cutting, etc), would be represented by other trees. In the final analysis, just as every community would have several practices it identifies with, some of which may affect transmission of HIV, a complete 'landscape of risk' for the virus in any community can be conceived of as a coalescence of such trees--a forest, in other words. However, in the description that follows, I am isolating only one

practice--widow inheritance--as the target for intervention. I do recognize nevertheless that in a forest, all trees are somewhat interlinked, in the same way widow inheritance is also interlinked with other practices in the Luo community.

In a tree, the leaves are the most conspicuous component, yet they do not exist independent of other parts; they are kept alive by nourishment from the roots, the trunk, and the branches. To eliminate the entire tree, the most effective way would be to haul it out from its roots, while the least effective way would be to remove its leaves. Eliminating the branches and the trunk would have an impact of intermediate scale. Similarly, for intervention providers to effectively eliminate the practice of widow inheritance (especially for purposes of *tieko chik*--see footnote 32 for explanation), there is a need to get to the root or to the origin of the *chik* (taboos) and to address the practice from there. Targeting other parts of inheritance, such as the social relations, the religious doctrines, or social events--all of which oftentimes determine whether a widow is inherited or not--may have some impact on the entire practice, but not necessarily in the magnitude desired by the intervention providers (i.e., total eradication) or of the type I am advocating for in this dissertation (i.e., modifying the practice to optimize protection of the individual and the community from HIV transmission in ways that are also culturally acceptable).

I have demonstrated in the previous chapters, for example, that by and large, changes in the background characteristics of the widow, such as those brought about through education, Christianity, employment, and so on have only led to modification of the practice--some components are made more risky than before--rather than to

complete abandonment. This is because these characteristics, important though they are in potentially resisting the feeling of obligation to be inherited, are insufficient in and of themselves to translate into complete behavior change because they do not exhaustively address other crucial components of the practice, such as religious affiliation, social relations, or its historical origins. I use the metaphor to illustrate how the current interventions, which are aiming at eliminating widow inheritance, have superficial impact because they ignore the different components of the practice. In the discussion below, I show how the current interventions have left out the different components of inheritance, and how, as a result, they remain ineffective in bringing about change. Nevertheless, I do recognize that metaphors are always partial. In my illustration, I show this partiality by pointing out where the relationship between and among the different parts of a tree do not adequately illustrate the relationship between the practice of widow inheritance and the underlying factors.

Leaves: I posit that targeting widows independent of the cultural and social milieu in which they get inherited or contract HIV can be analogous to clipping off the leaves from a tree in the hope that it would eventually dry up. What happens instead is that once the weather conditions become suitable, the leaves will be nourished and will re-grow. Just as the leaves depend on the branches, the trunk, and the roots for continued nourishment, widow inheritance too depends on several enabling conditions. For instance, personal background characteristics of the widow (education

level, employment status, or urban residence) can either be conducive to, or inhibiting of the practice. However, if this was the only context in which widows made decisions on whether or not to be inherited, then interventions that targeted the widow alone would be fairly adequate to eliminate the practice. But their decisions also depend on their relationship with other members of the society--relationships conditioned by their roles as mothers, sisters, mothers-in-law, co-wives, or as members of given clans or of the community. In addition, the position of their churches towards inheritance, and how strongly they hold onto church teachings, may exercise some influence in their decisions. The underlying influence of these societal expectations and religious doctrines can be compared with the role of the braches to the leaves in terms of supplying the nourishment on which the leaves are sustained.

Branches: In Chapters Two and Four, I discussed how and why a widow's decision affects other members of the immediate and extended family. For instance, inheritance is required to follow a pecking order, such that a daughter cannot be inherited before her mother if both are widowed. Hence, because a widow's decision as to whether or not to disregard the tradition is largely dependent on these relationships, an intervention that targets the widows to the exclusion of other members of the family and the religious and secular society as a whole is analogous to clipping off the leaves and leaving the branches intact. However, this metaphor falls short of illustrating the relationship an individual widow (represented by a single leaf) has with her relatives: children, sisters, daughters-in-law, etc (represented by several branches). In inheritance, the different subject identities of the widow (as a mother, a sister, etc) put

direct demands on her concurrently in a way that is not comparable to the relationship between a single leaf and several braches at the same time. While a tree has more leaves joined to one branch, the relationship in inheritance is the reverse. An identical analogy would have been a situation where more branches (the different subject identities of a widow) are linked to one leaf (the widow herself).

This analogical shortfall notwithstanding, the metaphor still remains largely illustrative of the relationship between the practice of widow inheritance and the underlying societal and religious responsibilities. While the branches are critical to the survival of the leaves, they are themselves also dependent on nourishment from the trunk. Similarly, the responsibility a widow has for other members of the community is linked to certain events that provide circumstances within which the widow would then be obliged to get someone to inherit her (e.g., farming seasons, rites of passage, or establishment of homes). I discuss below the relationship between these events and the practice of inheritance as represented by the relationship between the trunk and the branches of a tree (See also Chapters Three and Four).

Trunk: The trunk represents activities in the normal life course of a widow that mandates her to be inherited because of the requirement that these activities should be sealed by sexual rites. Such activities basically include farming seasons, rites of passage of immediate family members, and establishment of homes. Because they are so central to the biological survival of the widow and her family (i.e., activities related to food production and shelter construction) as well as to the social and cultural identity of the community (i.e., rites of passage: birth, marriage, and death), these

events serve to ensure that the practice of widow inheritance stays alive and functioning through generations. In other words, outside these events, the widow would be under no obligation to be inherited for purposes of *tieko chik* and *loso dala* because there would be no *chik* (taboo) that she would need to be freed from (See footnote32). The events therefore provide the circumstances in which different social relations find meaning and are played out (what I refer to as 'spaces of vulnerability' in Chapter Three).

In essence, the otherwise inert taboos and cultural norms associated with inheritance are 'activated' every time these events occur. It is through the events that the historical meaning of inheritance are invoked and are channeled, through expected social behavior of a widow, towards the final decision about inheritance. In a way then, the events act as a trunk, linking the roots to the branches and eventually to the leaves. Interventions that fail to address the meanings attached to these events, especially the component of sexual rites, would be ignoring their contribution in sustaining the practice. This is analogous to ignoring the contribution of the trunk of a tree in serving as a conduit for continuing nourishment--from the root to the branches, and eventually to the leaves.

Roots: Everything about the survival of a tree begins from the roots, which supply the nutrients to the rest of the body components. As long as the tree receives nourishment and as long as it is still within the age to remain alive, it will continue to thrive. In terms of widow inheritance, the roots would be synonymous to the beliefs about the genesis of the practice (and the origin of sexual rite in social events), the

consequences associated with non-compliance (e.g., affliction with *chira* in self and others), and why the community still feels bound by the custom in this day and age. For instance, as long as sexual rites continues to form a central part in otherwise ordinary everyday activities such as farming, and as long as the fear of the disciplinary consequences for non-compliance continue to be held, the roots of the practice will continue to be well-supplied with nutrients to ensure its survival. If there was no belief in *chira,* for example, there would be no basis for inheritance for *rito* or *tieko chik* and *loso dala.* And even though passage of time in the course of the practice (and attendant changes such as in education, employment, etc) has brought about some natural 'aging' with respect to the original beliefs[43], nature alone has not eliminated the practice; it has only modified it. It is essential therefore that interventions delve into the roots of the practice and address it from its foundations.

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[43] We, the research team, resolved to point out examples of changes that have taken place in the past with respect to *rito chik, loso/rieyo dala*, and sexual rites. We found that demonstrating the inevitability of change was a powerful way to advocate for reconsideration of risky components of the practice. We pointed out that some of the customs being observed today are in fact modified variants of the original. Most of the cultural changes have been incorporated to accommodate changes in education, employment, cost of living, residency, and so on. For instance, the reason why there was need for the widow to move houses at the end of the mourning period was because traditionally, a man was buried right at the center of his house. Technically therefore, a widow could not continue to live in the same house, hence the need to build for her another house.

We used this example in particular because the practice (of moving into a new house--*loko ot*) emerged in the discussion as one of the major forces that push widows into inheritance. *Loko ot* required sexual rites, hence a widow is required to get an inheritor even if for just the purpose of *loko ot* alone. But while the sexual component has been retained, the original practice of *loko ot* has been modified due to, among other things, moving family cemetery away from the house, the increasing expenses involved in constructing another house, and the general impracticability of pulling down a permanent stone house (traditional houses were made from mud, wooden poles, and grass and therefore relatively easy and cheap to demolish and replace). Symbolic gestures are increasingly being used as substitutes for the original practice. For example, changing the position of the main door or removing and replacing a single roofing iron sheet, a roofing tile, or a little grass from a thatched roof, have, over time, been accepted as sufficient substitutes to fulfill the customary requirement. (A man was supposed to build at least four houses in the course of his life: a bachelor's hut followed by another hut when he married--both in his father's compound, and two more on his plot--one that he moves into and a more durable one to finally settle in.)

We also mentioned other changes that have come as a result of labor out-migration. For instance, traditionally, when a son/daughter was getting married, the parents were required to engage in sexual rites. However, parents can no longer monitor the marriages of their children because the latter are residing away from home, and as such, marriages are contracted when parents are unaware and thus no sexual rites are observed. Also, many husbands and wives do not live together and it is not feasible to observe sexual rites during farming seasons, yet women go ahead and participate in these activities without fulfilling the sexual requirement--with no reported adverse consequences.

What I want to get across by this metaphor is that the practice of widow inheritance is largely an end product of the interaction between the history of the community and the socio-religious relations of the widow with other members of her church and the society. This interaction is prompted by certain social events. A comprehensive intervention must address all the four levels: one, the practice itself (the leaves); two, the social relations and religious expectations that may make it mandatory for the widows to be inherited (the branches); three, the events that prompt these social relations to take place (the trunk); and four, the origin of the practice (the roots). But as I show in Figure 7 below, the current interventions are operating basically at the first level.

As I have used it, the tree metaphor represents a nature-based conceptualization of the relationship between the practice of widow inheritance and the underlying structures. It illustrates that the main reason the current interventions have failed to make appreciable impact is because they are interested in the proximal aspects of the practice of widow inheritance itself and have therefore focused on the individual widows to the exclusion of distal aspects such as how the practice is carried out or the social, cultural, and religious contexts in which widows become inherited. What is needed therefore is a process of consensus building with the community--not just the widows--that replaces the adverse components of the practice with appropriate alternatives which address underlying factors and meet the cultural requirements. This is my goal in the rest of the chapter.

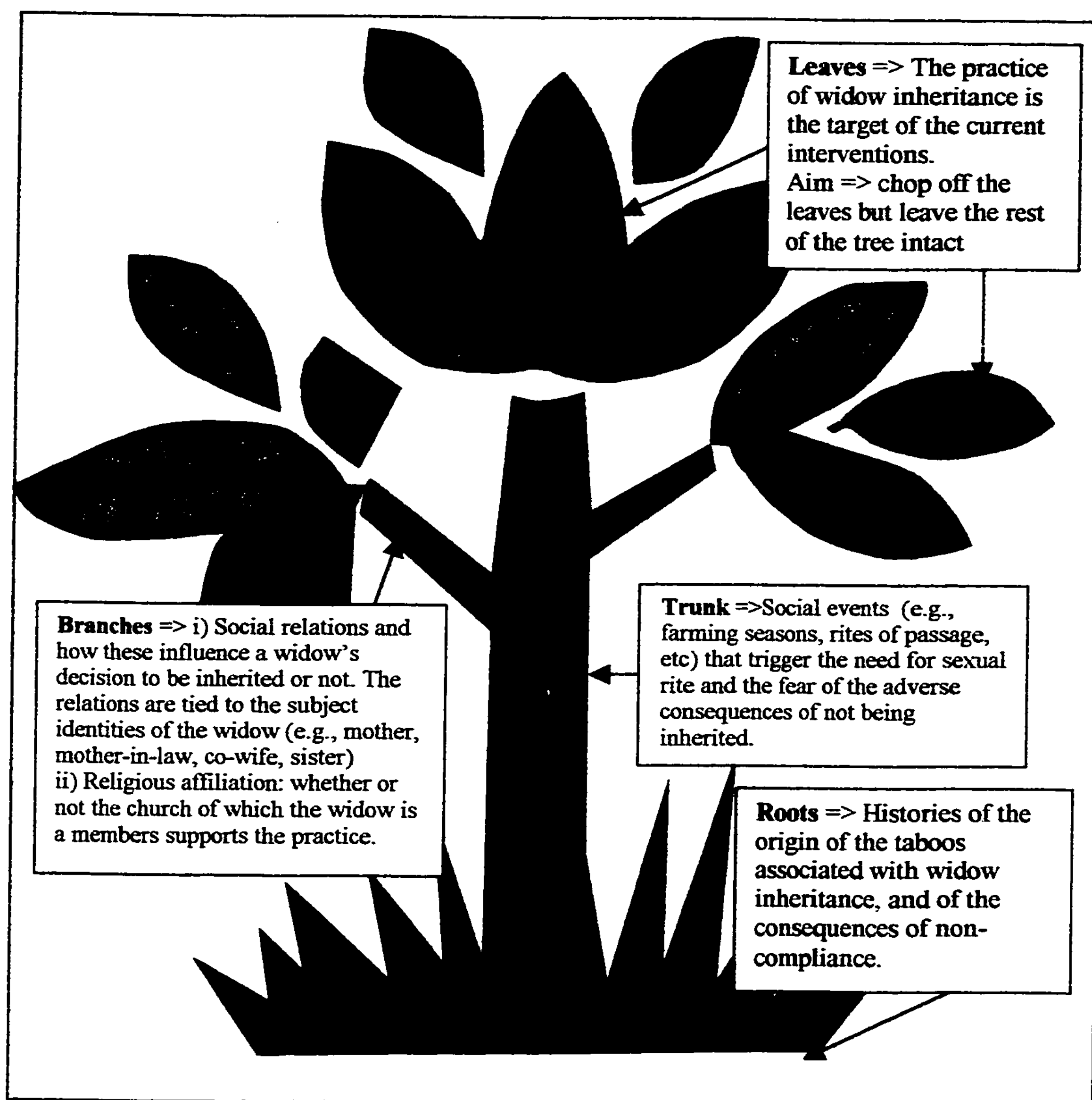

Figure7: Tree metaphor: widow inheritance and the impact of the current interventions

Reconciling biomedical and cultural perceptions of risk and vulnerability: lessons for policy makers

For the remaining part of the chapter, I report key suggestions given by the respondents on how to reach a compromise between the goal of the Ministry of Health to reduce the potential risk associated with widow inheritance, and the desire of the community to also preserve the functions of the practice. I start by presenting a selection of excerpts that demonstrate the opposing ends of participants' position on, and attitude towards widow inheritance to illustrate the type of disparate views that this chapter brings into a dialogue.

A female respondent in her 20s:

> My husband died six months ago and I am not talking about something I have heard or something I have been told. I am talking about what I have gone through. I am talking about my own life. How many mothers [polite reference for women, regardless of whether or not they have children] here in this meeting are discussing inheritance from personal experience? [She did not wait for response]. I just want you people to talk about the issue of inheritance with a lot of caution because those who are still young *must* be inherited.

At another venue, **a male respondent in his 40s,** said:

> You people who are coming with the new and foreign teachings want to interfere with our culture. Why are you and those who sent you [implying the government] targeting the Luo? Why not other communities as well? You want to tell me that we are the only community inheriting our widows? Is it just because we talk about it? What do you think happens to the widows in other communities? Do you think they leave their homes when their husbands die? No. They stay. They are inherited. But they don't talk about it, and nobody bothers them. They may call it another name but it is the same thing. And if inheritance can bring AIDS, which is a lie, then it is bringing AIDS to everyone who inherits [a widow], not just the Luo. It is you Luo people who are educated who are responsible for bringing to us strange and foreign traditions. Go and tell those who sent you that we will never condemn inheritance [and] it does not matter what! Even if it is announced over the radio how[ever] many times. Let them just say,

and continue to say until they get tired. What it [the problem] is, is sexual promiscuity by women [widows].

A male respondent, also in his 40s, in a different venue, with a different view:

> **Luo people never want to be taught. They are obstinate. I am a pure Luo [i.e., not from mixed marriage] and I say this not to discredit our people but because this thing is bothering me. We must find a way to get out, and the way is ourselves. If you ask [anyone] how these traditions all began, nobody gives you a clear answer. We are really in urgent need for a meeting to go back to [revisit] these issues. We need to sit down and talk about these customs [and to see] if they are useful to us now or not. Elders should sit together and release the whole community from the oath of the ancestors. Even if it means taking another oath to reverse the effects of the first oath. The bad ones that hurt us should be removed and the good ones kept. AIDS has shown us that we should have done this a long time ago. Why should we stick to traditions that lead us to the grave? What is killing us most nowadays is keeping traditions; because in the process, you bring death to yourself and then your people say you are bewitched. If you know that this person [referring to a widow] has AIDS, would you want to put yourself right inside a blazing fire knowingly?**

A male respondent, in his 40s:

> **I am talking as one whose father has died. I cannot imagine how my home can be considered cleansed when my mother must first have sex with someone! This does not feel right. [In fact], I do not think I would want to live in that home any more because to me, that is an abomination" (Respondent was, interestingly, a Bishop in a church that supports inheritance. He was also educated and relatively well off materially).**

These sentiments, and many more like them, were typical at the beginning of the discussion sessions when some of the participants were glad to get a forum to discuss what they felt were outmoded customs (See also Otieno, 1999; Tamba, 2000), whereas the majority were still suspicious of the motive of our visit and were jealously guarding their culture, possibly against assumed outside intrusion (See also Oywa, 1999). In the rest of this section, I offer a more general framework wherein similar conflicting opinions of respondents are reconciled in what I argue is a win-win

situation. I highlight key issues raised by the respondents, and where possible, report excerpts from the problem-solving approach which they adopted in working out alternative solutions to the controversial topics. Altogether, they identified five key alternatives from which widows can choose--alternatives that have both the advantage of reducing the risk for HIV without losing much of the cultural benefits associated with inheritance. Several other minor options were brought forth and debated upon, but to save space I have omitted them in the discussion. The main options emerging from our discussions include: 1) HIV testing prior to inheritance; 2) engaging in symbolic inheritance without the component of sex; 3) abstinence or mutual sexual faithfulness; 4) male condom use; and 5) calling upon the church to boost their support for widows in making decisions towards inheritance. For every alternative suggested, participants examined the feasibility of their adoption and together deliberated on possible solutions. In the discussion that follows, I report both the suggested alternatives and, where applicable, the potential difficulties in implementing them.

Taking HIV test: Respondents in every venue recommended that prior to being inherited, the widow, the inheritor, and if possible, his wife/wives should go for an HIV test. In fact, the recommendation was that HIV testing should be mandatory before any sexual relationship is contracted, not just for inheritance. It was also pointed out that an HIV test should not be seen as *the* final solution; that it is, in fact, the beginning, because continuing safety depends on whether or not all those involved remain faithful to the relationship afterwards. This is a crucial insight that can enrich the counseling component of the Voluntary Counseling and Testing services which are

currently being implemented in Kenya under the sponsorship of the World Bank. Several fears were expressed regarding the potential difficulty with testing, three of which are most pertinent to interventions, namely, fear of knowing one's HIV status, fear of divulging AIDS as the cause of death to the general public, and the risk of intentional spread of the disease for those who test positive. Some of the concerns raised regarding the first source of fear are presented below, while the remaining two causes of fear are discussed in the next sub-sections.

According to Ngwiri (2000), opening free AIDS testing centers in Kenya and offering counseling services in those centers may be more efficacious than anything tried before. However, he cautions that we should not be too optimistic with the programs because the main reason many people do not know their HIV status is not always because the test is too expensive or unavailable; it is the inhibiting fear of testing positive. People do not want to know. In our study, respondents were quick to suggest that testing services should be made available and affordable, but when we informed them that we were offering the same services right there and then, with a promise to bring back the results at the nearest health centers in two weeks, 12.8% (n=1217) felt they were not ready to be tested, and another 9% consented to giving blood specimens to support the study but said they did not want to know their results. Only 34% of those who were screened in our study came back for their results.

This may be attributable to different reasons, for example, that the participants did not initiate the request for the test and were therefore less motivated to know their serostatus. However, the general feelings that were expressed during the discussion sessions suggested that because no medical solutions or social support networks were

readily available for most those who might test positive, it was pointless to go for test, and especially to come back for results. Respondents felt that if it was difficult for one to agree to be tested; it certainly would be more difficult for the widows to suggest to the inheritors to take the test. The following excerpts show some of the dilemma in implementing this suggestion:

1st Female respondent in her 20s:

> What about if he [referring to an inheritor] refuses to go for the test? He will ask you, 'What have you seen in me?'" [A female voice at the back: "Why don't you leave him?"] Then she responded: "How can you leave him even if you want to? How can you leave him and yet you have an urgent 'problem' [taboo] that is pending and you need someone to *tieko chik* with? That is why you don't even want to suggest a test. Or if you are bold and hint and see that he is hesitating or beginning to change his attitude, you quickly drop it [the issue] before he refuses to help you *tieko chik.*

2nd Female respondent in her 30s:

> This AIDS thing is so difficult. If you can't know if someone has the disease in the body as you people are saying, and the way it is difficult to know the secrets of men's movements [affairs]. So, every time he leaves [home] and comes back, do we therefore go for test with him? Even if he goes for twenty minutes because you may be cooking your vegetables and he is with someone just outside the fence. You people suggest what can be feasible. This is your husband. You think an inheritor is the one who will agree? The test is difficult because of cost; but even more, it is the shock, and that the world will know. If I was planning to be inherited and suddenly everything goes quiet, people will suspect. And people talk. If it is I who has the virus, he will say so people know it is not him. So maybe we can use condom [thinks a bit and continues] but if we use condoms we cannot have a child and yet we want a child. This thing is difficult it has left me speechless. [sits down].

3rd Female respondent in her 40s:

> If my husband wants to take his sister-in-law, I have to make sure she is clean, if she refuses to be tested, or if she has AIDS, then I'll leave him. I cannot get into a grave with my eyes open ...." [another woman interjects at the back: "The problem is that by the time you as

a wife get to know, he has been sneaking there [to the widow's house] for a long time.[44]

Male respondent in his 40s:

You who say you will leave him, how about if you have children? Will you leave them also?

3rd Female respondent:

Then we will live in the same house but not share a bed. Or if there is a another house where I can move to so he does not bother me but where I can continue to look after my children so they don't suffer in the hands of another woman [a potential new wife].

4th Female respondent in her 30s:

No way, which man will agree? If you are the one having an affair, he will send you away. But if it is he, forget it. And you are still living in his home? He will still demand his [conjugal] rights. Men who have affair are so harsh you cannot even talk to them about anything related to AIDS; they will beat you. [Looks at me in earnest and adds] This teaching is good, but will you people manage?" (i.e., to come up with a solution?].

It was unfortunate that after deliberating on the issues associated with testing, we were unable to reach a consensus. However, a number of things were stressed: first, we acknowledged the difficulties associated with going for HIV test and coming back for results, and when challenged, we sometimes shared with them our own experiences. We also pointed out that for various reasons, there are those who may think they are already infected and do not see why they should bother going for a test. While it could be true that they are infected, what some may never get to know, unless

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[44] Almost four years ago, my brother inherited a widow whose husband had died of conditions that were suggestive of AIDS. When confronted by his wife about the dangers involved, that she did not want to risk being infected, he retorted that if the widow was infected then the wife had long since been infected because they began the affair secretly close to a year before the wife found out. And he adamantly declined to bring the widow so that the three of them could go for HIV test. He had no objection to being tested together with the wife minus the widow, but this would serve no purpose if their relationship was to continue--which it did.

they go for the test, is that it is the subsequent sexual encounters that may expose them to the virus.

The most effective approach happened to be in a few venues where we were able to show a video or a picture atlas of AIDS victims (Ansary et al., 1989). This was not done to scare the participants but to show them that AIDS was more than just becoming thin, vomiting, having diarrhea, coughing, or loss of hair quality as they commonly listed. We wanted to show the diverse impact of opportunistic infections. This strategy increased the willingness of a few who had initially declined to be tested to reconsider their position, most of whom came back for their results. In the next three sections, I describe some of the controversies that were raised concerning the suggestion for HIV testing.

<u>The government called upon to reveal diagnosis</u>: The secrecy behind HIV testing and results was decried. There was a strong concern that when doctors decline to divulge information to close family members about the diagnosis of their patients with HIV, they are, in essence, directly responsible for fuelling the epidemic. However, the issue of confidentiality in medical ethics runs contrary to the public outcry for openness. Fortunately, the public outcry is receiving attention from the Ministry of Health (Misore, 2001). For instance, it was reported recently in a workshop in Nyanza Province that doctors want the legal and ethical guidelines prohibiting them from revealing their patients' HIV status repealed to help in stemming the virus (*Daily Nation,* May 12, 2001). They felt that unless the confidentiality laws are changed, AIDS victims and their partners would continue to spread it.

But as we deliberated on the feasibility of this need during the study, several issues were raised. I describe two pertinent ones here. The first question was that even if the doctors divulged the diagnosis (which they sometimes do) to family members, this does not resolve the thorny question of who would announce the results to the public. A second concern was the potential impact of such public announcement on the surviving widow and her children. In most of the venues, it was initially suggested that the announcement can be done by the local Assistant Chief or the church clergy presiding over the burial ceremony. But this option was dismissed as unfeasible because often times, family members announce only the actual cause of death (i.e., meningitis, typhoid, tuberculosis, and so on) and conceal the underlying cause (AIDS). It would thus be inappropriate for an outsider such as a church or political leader to 'contradict' the family by announcing a 'different' cause of death.

They resolved that however difficult it is, the family must first come to terms with the disease, and they should be the ones to take the initiative to make the result public (or else give the Assistant Chief or pastor the mandate to make the announcement). Until families are ready to take a leading role, it was concluded in most of the venues that people were shifting blame to the government and the doctors, yet the responsibility largely laid in the hands of family members. This can be taken further to imply that inasmuch as any spread of HIV in the community is attributable to practice of widow inheritance, it was fueled more by the community itself in concealing cases of AIDS than by negligence of the government as originally alleged.

In a recent newspaper report (*Daily Nation*, July 18, 2001), titled: "Family defies stigma and admits man died of AIDS", Muganda reported a death and funeral

announcement that she referred to as "a funeral ceremony with a difference" because it was the first funeral notice in the *Daily Nation* in which the cause of death was clearly identified as AIDS. She adds that the family of the deceased broke the tradition in a country where death from AIDS is politely referred to as "a long illness bravely borne", by decorating his death announcement with two red ribbons--the universal AIDS symbol. Even though one could say this is 699 too few in a country where 700 people die daily from AIDS, it could be the first step to what may become a trend with correct political prompting, religious encouragement, and social support. Similar openness has been part of the many reasons why the epidemic in Uganda has been reversed (American Health Consultants, 1999).

Another concern expressed during the discussion sessions was the potential repercussions of such an announcement to the widow and her children. The excerpt below represents some of the dilemmas that were raised:

Female respondent, in her 30s:

> Sometimes it is true he [your husband] died of AIDS, but you don't have it. Maybe you were lucky; maybe you had stopped being together sexually long before he died, something people won't know. So when it [his HIV status] is announced, everyone will know you must also have AIDS. They will avoid you and gossip about you. Your children will also be treated as if they have AIDS. And you are still in pain about the death. Let me tell you, announcing [publicly] like that will kill some women even if they don't have AIDS.

Another concern about announcing at the funeral was that this would only benefit those who are in attendance--mostly those in the same clan. What this would do eventually is send the widow away from home where she can begin a new life. Ntozi (1997) reported similar trends in Uganda, that widows migrated to distant places

where their past was unknown and remarried unsuspecting men. However, both our study respondents and Ntozi conceded that the stigma against widows may be forcing them to migrate away from the public eye and avoid discrimination. This, however, would just shift the problem elsewhere rather than solve it.

Wanton spread of HIV (*dhiang' tho gi lum e dhoge*): An issue related to both HIV testing and disclosure of results that respondents felt merited attention, especially now that Voluntary Counseling and Testing (VCT) services are being set up countrywide, was the wanton spread of the virus after one tests positive. A popular coded phrase used to refer to this attitude is *dhiang' tho gi lum e dhoge* (which literally means 'a bull dies with grass in its mouth'). To continue eating to the point of death, as implied by the saying, is a sign of great courage. Similarly, knowing that one has HIV and faces imminent death is no reason to stop having sex, even if this was the last thing to do. In fact, continuing with sex is a show of defiance over the infection; a way of getting back at the disease, at the world, and at the 'lucky' people who are still free of the virus--some of whom may be known to engage in relatively more risky behavior.

In this spirit of *dhiang' tho gi lum e dhoge,* it was also reported that young men still have many (casual) sexual partners, or go after widows whose husbands died of conditions suggestive of AIDS, even much older ones, because of wealth and the prospect of having an easy life without having to work for it. The youth have developed a callous attitude towards AIDS and refer to it as an accident, claiming that "hearing, reading about, or even witnessing the frequent road carnage in Kenya has

never stopped people from traveling for fear of being involved in a motor accident". In the same way, knowing that there is AIDS out there is no reason to warrant sexual abstinence. Setel (1999:163) reported the same attitude in his study in Tanzania, that some respondents felt that AIDS is a matter of misfortune; 'an accident at work.'

We approached this issue by explaining the potential dangers associated with such attitude--especially to self--in terms of the risk to contract other sexually transmitted infections which may not only prove difficult to treat given the suppressed state of their immunity, but which also increase the chances of cross-infection with HIV, probably with another strain. We attempted to explain the concepts of viral load (using familiar diarrheal diseases), the difference between HIV and AIDS, and the incubation period. We then used this background to explain how infected partners would re-infect each other, increasing the viral load, and hastening the progression from HIV to AIDS and to death. Passing laws to criminalize such behavior was also deliberated upon, and participants acknowledged that this would be a difficult proposal to effect especially in Kenya where HIV is not a reportable disease and where testing is not easily accessible or accepted by a majority of the people. It was also pointed out either by the clinician or myself that it would not be possible to know for certain who has infected the other between two people.

Symbolic inheritance ***(ng'awo koti)*****:** One of the safer alternatives to widow inheritance is the symbolic version of the practice to replace the full-fledged version (discussion in Chapter Four). Traditionally, the practice of symbolic inheritance is

reserved for widows who are 60 years or older and who are no longer sexually active. When the mourning period is over, an elderly brother-in-law symbolically 'inherits' the widow by either hanging his coat in the widow's house, or giving her his traditional stool, staff, or smoking pipe (the phrase *ng'awo koti* [hanging a coat] is often used in reference to the practice in general, regardless of the type used). The idea behind the symbolic action is that whenever there is social or economic need, the person is consulted by the children as a father or by the widow as a husband. During the events when the widow would be required to observe a tradition involving sexual rite, he may spend the night in her house but they would not be sexually involved. Or he may just resolve the issue, eat, then leave.

The issue of symbolic inheritance of younger women arose in the discussion as a response to the concerns regarding the sexual component of inheritance in the era of AIDS. The issue was seen to be relevant to both HIV-positive widows who may not want to transmit the virus to others by being inherited and HIV-negative ones who would not want to risk contracting the disease from the inheritors. The discussion excerpted below represents a typical debate of whether or not *ng'awo koti* is an acceptable substitute for the complete version of the practice.

1st Male respondent in his 20s:

> Does the coat have 'strength' to work for *tieko chik*? [i.e., is symbolic inheritance an effective substitute for sexual rites in observing the custom of *tieko chik*?]

2nd Male respondent in his 30s:

> It is not possible. This woman will bring someone in her house at night. Young women these days can't take care of their bodies [i.e., can't abstain from sex].

Kawango:

That could be true, but let us first put aside the issue of inheritance contracted for purposes of fulfilling sexual need (*rito del*). We'll come back to it later. Let us for now see whether hanging a coat can replace the normal inheritance for purposes of *tieko chik*.

1st Female respondent in her 30s:

Yes, it does. If the woman herself, her family, and her clan agree that the symbolic gesture can be an effective substitute for inheritance and can *tieko chik* in a similar way as being inherited fully, it is right.

Kawango:

I was thinking that a taboo is a taboo, and it should not matter what the widow or her family says. Are you saying that if I decide that something is not taboo to me and we agree within my family, I can stop doing it? [Several objections. One male voice: "This 'mother' does not know what she is talking about"]

1st Male respondent

What I want to know is why inheritance must be flesh-to-flesh. Because if placing a coat is sufficient for old women, where is the 'flesh-to-flesh' in this? Yet it works for them, doesn't it?

2nd Female respondent, in her 40s:

But will her daughter or daughter-in-law be inherited in the proper way if hers was only done symbolically and yet she is under 60?

3rd Female respondent in her 20s responds:

But why else would it work for older women? As I am talking to you, my mother-in-law has been 'inherited' in the same way [a coat has been hung in her house] and if my husband dies, I still can be inherited the normal way because she has been inherited. It can be said that she is inherited. And if a younger woman is given a coat, isn't she too inherited? If we put aside the issue of sexual desires and abstinence.

1st Male respondent in his 20s:

Yes, she is inherited. A coat can be an effèctive substitute if the woman does not again engage in sex in secret. Or isn't it so?

3rd Female respondent in her 20s responds:

In that case, I am released from the traditions where sexual rites are required, isn't it? Which means that the concern that my daughter or daughter-in-law cannot be inherited because I am not inherited does not arise, right?

1st Male respondent n his 20s:

> The coat has laid restrictions which, if you bypass [ignore], you will suffer the consequences. But if you don't bypass, then nothing will happen to you. So let her be given a coat so that she does not disregard the Luo customs, and also so that she does not get or pass AIDS [to someone else].

Kawango [concluding]:

> It appears that what we are saying is that if I have AIDS, then I can be exempted from keeping the traditions. Which means that there are times when I can be excused from observing the sexual rites--if I am sick. If this is what we are saying, then the word "must" (*ochuno* or *nyaka*) which we started with [i.e., that all widows *must* be inherited irrespective of the HIV status] does not always apply?" [nods of consent by majority; skepticism on the faces of others].

It was important to deliberate on this issue until respondents themselves agreed that widows do have a choice--at least in as much as the choice depends on them--about inheritance. Almost at every venue, discussions started off with respondents feeling very strongly that widows *must* be inherited, and they made it clear that whatever solution we were to deliberate on had to be based on that premise. In this venue, as was typical of other venues, there was further discussion on the subject, after which respondents agreed that symbolic inheritance is sufficient to keep the traditions, but only ***if*** the widow remains sexually abstinent, otherwise it would be better if she were formally inherited (See also footnote 21). The significance of this resolution is that women who still want to keep the traditions without risking contracting or transmitting HIV would have a choice of a safe and effective alternative (provided they remain celibate for the rest of their lives, or practice protected sex only).

Sexual abstinence or mutual fidelity: Even though symbolic inheritance was being suggested for younger widows, an issue that kept coming up that would undermine this recommendation was how difficult it is for them to abstain from sex. This being the concern, there was a general consensus that the current form of inheritance is messy (*onyuandore*--adjective), not just for young widows, but also for older widows as well as for inheritors. In the cultural perspective, an example of messiness (*nyuandruok*--noun) was cited as "a widow who is still ritually unclean [has *kode,* see Chapter Four for explanation] and is pregnant at the same time." In the biomedical perspective, 'messiness' would refer to components that have been introduced into the practice which increase the likelihood of acquiring or transmitting HIV, such as professional and "interim" inheritors, as well as the high turnover of serial inheritors who are acquired by the widows in the course of their widowhood. At the end of the discussion sessions when majority of the respondents had conceptualized the potential biological link between HIV and specific components of inheritance, it was to the biomedical conception of 'messiness' that they attributed the problem, and not to the entire practice itself. The following quotes illustrate the attitude of the community towards today's practice of inheritance.

Female respondent in her 30s:

> **AIDS infects those who are promiscuous; not those who are inherited.**

Male respondent in his 40s:

> **It is not *ter* [inheritance]; it is *terruok* [promiscuity]. It is *chode* [prostitution].**

The two terms, *ter* and *terruok*, are derivative of each other. *Terruok* is a term used to designate sexual intercourse while *ter* (inheritance) refers specifically to the practice of widow inheritance. The term *ter* was probably derived from *terruok* (having sex) to designate the integral role of sexual rites in defining the essence of the practice. Nowadays, *terruok* is increasingly being used to refer to having indiscriminate sex, hence its association with *chode* (promiscuity or prostitution).

Male respondent, under 20 years old:

> Let the topic be that of sexual promiscuity, not inheritance. Inheritance does not bring [lead to infection with] AIDS; promiscuity does. Sexual immorality in relation to inheritance [*nyuandruok*] leads to *chira*; outright sexual promiscuity [*terruok* or *chode*] is the one that 'brings' AIDS. There is a big difference.

The first female respondent:

> The bottom line [in staying away from AIDS] is sexual abstinence or [mutual] faithfulness, and this is an individual decision. If one is faithful in her relationship, she cannot not get it; but if she is involved in some shady rendezvous [*goyo kona* or *gajruok*] then even if her husband is alive, she would still get it, because it is not always widows who have AIDS--which is what you people seem to say [imply].

The central message from these excerpts is that total eradication of AIDS is via abstinence or mutual sexual faithfulness, and not by stopping inheritance. But then, there was skepticism about young widows' ability to keep any pledge to abstain from sex. Several suggestions were offered, especially for young widows, such as using condoms (which I discuss later), testing for HIV (which I discussed previously), and arranging for an HIV-positive widow to be inherited by a HIV-positive man. We addressed the last concern in the same way we did with respect to "the wanton spread of HIV" discussed earlier in the chapter.

There was also a general feeling that sexual abstinence or faithfulness is an individual decision and that there is nothing much the government or any one else can do to enforce this. To underscore the importance of the personal decision in matters regarding sexual abstinence or faithfulness to one's sexual partner as the most sure way in which one could remain safe from sexual transmission of HIV, respondents used church teachings as their framework. Since all participants were members of a church (see methodology section in Chapter One), they related easily with this approach. The sessions comprised of deliberating on Biblical teachings, especially those about the creation of man, focusing specifically on man's intellectual endowment to think and reason before acting. This was then linked to man's decision-making regarding sexual issues.

With respect to the claim that young widows are not capable of keeping any pledge of sexual abstinence, the question that emerged in many venues was whether they (young widows or anyone else), ***can't*** (*ok ginyal*) or ***won't*** (*ok gidwar*) abstain from sex. Debating over the linguistic distinction between the two terms and their implications in decision-making brought out a new perspective towards individual responsibility in sexual behavior. One respondent aptly summarized the general consensus, that "to say we can't control our bodies as human beings is to admit that that our bodies lead [the way] and our brains follow" [i.e. the sexual desires of our bodies override our intellectual reasoning]. The take home message from all the venues was that "we ***can*** (abstain from sex) but we ***won't*** (do it)". Some participants argued that "the attitude about our inability to abstain from sex is all in the mind,

because most married women survive the long absences of their husbands without sex."

Granted that maintaining abstinence may not work for some people, one of the suggestions was the use of condoms. In the next section, I discuss the feasibility of implementing this recommendation, especially within the context of church teachings and the controversies that abound.

Male condom use: In terms of the role of condoms in reducing the risk of HIV through inheritance, three issues emerged. First, there was the issue of whether or not using a condom was deemed appropriate to fulfill the traditional requirement of 'true' inheritance. Second, respondents expressed skepticism around the efficacy of condoms in reducing the risk for acquiring HIV. Third and most topical, there was the 'church-versus-state' dichotomy of whether condoms are more beneficial (in controlling HIV) or harmful (by giving false protection, thus encouraging pre- and extra-marital sex). The excerpts below demonstrate the view expressed by some respondents concerning the appropriateness of using condoms during sexual rite:

Male respondent in his 50s observed that

> Condom during inheritance? No. Because it is not real. Sex with condom cannot *tieko chik.* The first meeting and other meetings to observe special events must be without condoms--flesh to flesh. Meaning this is like a new husband to you and you are beginning afresh.

However, others countered such a belief as having no basis and said that if hanging a coat is deemed effective in fulfilling the traditional requirement of sexual rites, then a condom would work even better.

On the issue of efficacy, respondents reported hearing or reading reports purporting that condoms have pores that are many times larger than the size of the HIV-virus, allowing the latter to pass through during intercourse; or that condoms have been reported to burst during intercourse; or that they can slip off and remain in the uterus and cause incurable diseases, including infertility; or that the lubricant inside condoms destined for Africa are specifically laced with HIV with intentions of wiping out Africans. Besides giving explanations to discount the theories around the pores and the lubricants, we addressed the other two issues by demonstrating and/or explaining the proper use of the condom. We explained five simple processes of condom use as follows: i) check the expiry date; ii) wait for the right moment to insert the condom (i.e., until the penis is fully erect then roll it on till full length while holding the nipple to expel the air, and ensure that there are no bubbles of air pockets between the skin and the rubber; iii) pull out before the penis becomes flaccid and remove the used condom; iv) tie the top in readiness for disposal; and v) dispose either by burning, burying, or throwing in a pit latrine.

However, the main issue about condom use was what has come to be seen as a tug-of-war between the State and the Church. As I mentioned in Chapter Two, the church has a large following in Kenya (See examples of such sentiments in Gathuru and Okiwi (2000; Getonga, 2001; Indakuli, 2001). Through this influence, they have in the past successfully blocked most attempts by the State to introduce Family Life Education in the schools or to provide contraceptives to the youth (NCPD/CBS/MI, 1998). The main concern has been the debate over whether or not condoms encourage sexual promiscuity. A recent newspaper report (*Daily Nation,* July 12, 2001) shows

how the President of Kenya is also grappling with the 'health-versus-morality' debate about condoms. In the newspaper, Omari reports that President [Daniel Toroitich arap] Moi has admitted he is embarrassed that Kenya is spending millions of shillings on importing 300 million condoms to fight AIDS. But the President acknowledged that condoms were essential to help beat a disease that was killing 700 Kenyans a day. He said: "As a president I am shy that I am spending millions of shillings importing those things . . .", he told a meeting of the Pharmaceutical Society of Kenya. His comment immediately provoked sympathetic laughter. Then the President went on to suggest that if Kenyans were to abstain from sex for two years, it would help save a generation.

In the study, our respondents strongly expressed that condoms were introduced in Africa too early, that the level of immorality in the West warranted condom use, but that Africa had not yet reached that level. Thus, they argued that marketing condoms in Africa was a way through which the West encouraged Africans to rise to the same 'standard.' They blamed what they called 'sexual excesses' in the youth on programs from the West, including condom distribution and the media. The discussion below shows the process of resolving the impasse in one of the venues and represents a shorter version of what transpired in other places as well:

Archbishop [of one of the denominations, directing the question to me]:

> Do you think it is right that the government is giving out condoms freely to everyone everywhere?

Kawango: Why do you ask? What are your thoughts [position] on this issue?

Archbishop:

> The government is giving out [condoms] to just anybody, including the youth, [so] it is the government that wants AIDS to continue among us. Because when you have a condom, you feel safe and must look for someone for sex. [Or] Why else would you have a condom in your pockets unless you are looking for illicit sex? If your protection comes from condoms, it is an indication that you are not in Christ. The two cannot go together.

Kawango [sidetracking the issue]:

> Tell me *jatelo* [leader], when you are up at the pulpit preaching on sexual abstinence, will everybody in the church change their behavior when they hear your message?

Archbishop: No

Kawango: Why is this, yet they are all listening to the message?

Archbishop:

> There are many possible reasons. Maybe they are not convinced or maybe there are reasons why they can't accept the message. People like things of the world more than things of God. [Anyway] There are many reasons.

Kawango:

> But you don't quit preaching because some refuse to obey, do you? [shakes his head]. You don't throw away your clergy-collar in protest, do you? You continue hoping that one day they will change, right? [nods] Yes, that is human nature. Not everyone does what they are required or asked to do.

[Then as I typically did in other venues, I used the Scripture familiar to the people (the Parable of the Sower in Matthew 13:1-9; 18-23) to frame my response to his question and to justify my position].

Kawango continued:

> All of you are familiar with the Parable of the Sower? [nods]. Just like in the Parable, some people will listen to your message, take in, and abstain totally from sex; others will abstain for a while and then relapse; and other will not abstain at all. It is those who do not abstain, those who relapse, and those who don't go to church that the

> government wants to capture by making condoms available to them. Which people do we use condoms with?

Several responded: Lover; Girlfriend; Casual encounter.

Kawango continued:

> We don't use condoms with our wives, right? [A chorus of "No"]. What we are saying is that whenever we use condoms, it is with somebody the church would not approve ["Yes"; nods]. If I am already outside the teachings of the church, then isn't it therefore contradictory to refuse to use condoms because my church is against condoms [less nods; more curiosity; some murmurs undertone]. Some of us have heard the current PC [Provincial Commissioner of Nyanza], who is also a Christian, supporting condom distribution. He says that until the church achieves their objective of total sexual abstinence by everyone, he will always have a box of condoms in his car trunk to pass on to those who may need them. What I am saying is that while we wait for the church to get everybody to abstain, it should allow the government to give condoms to those who want to use them.

After some further discussion it was resolved in this venue, as in most of the venues elsewhere, that the youth should still be kept away from condoms[45]; and also that the clergy cannot teach abstinence and at the same time show support for or give out condoms; but that the church can adopt an attitude that "if you must sin, sin with a condom" to protect those who would otherwise risk getting HIV "if only to keep them alive so that they may eventually respond to the preaching, change from within, and be totally abstinent." A number of respondents also challenged churches to come down from the moral tower and become more active in the fight against HIV from whichever front agreeable to them "because even the clergy are dying, faithful spouses

[45] This position was maintained even though I pointed out that by the end of teenage years, 97% of Kenyans have been sexually active at least once, but with only 5.5% of girls and 21% of boys reporting some condom use (NCPD/CBS/MI, 1998; Government of Kenya, 1998). My goal was to emphasize that the youth are sexually active with or without condoms, and thus it is not condoms that drive them into sexual activity.

are dying, and innocent children are dying." Below are some of the areas that churches were called upon to help the widows and to reduce the prevalence of inheritance.

The church as substitute for inheritance for *tieko chik*: Since we invited our participants through the churches and also because the church is the single institution that claims the highest membership of people in most parts of the country, including Luo Nyanza (further details in Chapter Two), the role of the church was recognized as critical in providing support for widows who may decide not to be inherited. Churches were especially called upon to take a leading role in addressing the plight of widows by setting up programs where women with longer experience as widows would help the new ones come to terms with the challenges of bereavement and widowhood. Women cited the vulnerability that comes with bereavement as one of the key reasons why some widows succumb to pressure from relatives and get inherited against their wish (See also Appendix 4).

Churches were also cited as places of refuge for widows, where those who decide not to be inherited in opposition to their children or their in-laws may find somewhere to fall back to for support. Many examples were cited where church leadership has stepped in to arbitrate in issues of actual or potential forced inheritance. In addition, widows who decide not to be inherited often turn to the church to 'bail them out' in events that would otherwise require that they engage in sexual rites. For instance, the church has come in to help women put up homes--something many clan members would be unwilling to perform for a widow who is not inherited for fear of

bringing misfortunes upon themselves and their families. However, it was noted that the effectiveness of the church in forestalling the effect of *chira* is conditional upon the widow remaining abstinent (in this context, abstinence is conceived in terms of breaking sexual taboos, not in the moral context of the church; see also footnote 21).

As the only place where husbands and wives often attend together, the church was also called upon to encourage spousal dialogue as another way to increase the likelihood of marital faithfulness. In addition, the church was asked to establish regular forums that promote parent-child dialogue on issues related to sex and sexuality. In the *Daily Nation* of March 24, 2001, the Provincial Commissioner of Nyanza, Mr. Peter Raburu is reported to have "created tense moments where many people hid their faces in shame while others reeled in laughter as he deplored sexual behavior in the province." It is often considered taboo to discuss matters of sexuality in public, or between spouses or parents and their children. One of the hurdles we had to overcome was to break this barrier in our discussion sessions to serve as an example of what we were calling for. We deliberately brought together the clergy and their congregants, men and women, young and old people, husbands and wives, parents and children, as well as literate and illiterate participants in joint discussion sessions. We explained that: "because the disease of our interest gains entry through the genitalia, it is there that we must look for it in order to flush it out." Respondents agreed that because sexual faithfulness is mostly a personal decision, and because sexual transmission of HIV is between two people, it is critical for sexual partners to have more dialogue to minimize situations similar to what is depicted in Figure 5.

Some reflections: The preceding recommendations are derived from the respondents' own suggestions and represent key issues, dilemmas, and controversies around the practice of widow inheritance and its association with HIV. They chronicle what the community members themselves consider important, what they feel needs to be changed, and how they think change should proceed. The process of collecting this information was for me a time of discovery and a time of learning--learning about things that, as a Luo, I thought I already knew. Although undeliberate at the start of my fieldwork (See Chapter One), I realized later that my approach was, in fact, a response to Spivak's call (1988, in Craddock, 2000:163) to give voice to and not to speak for members of the Luo ethnic community; to do research *with* rather than *about* them; and to allow them to express their own views on which conditions should be addressed instead of imposing pre-set research agenda and pre-designed interventions on them. To achieve this, I took the participants' own view of risk as my starting point and their suggestions for effective interventions as my closing point. In other words, I incorporated their perspectives, especially with respect to their position concerning the continuation of widow inheritance. Through a process of interactive discussion and learning, they came to acknowledge the potential risk inherent in some of the components of widow inheritance as practiced today. Eventually, the respondents themselves provided suggestions to safe and culturally acceptable alternatives, both within the institution of inheritance, as well as outside of it.

My experience in this process is summed up in Mann and Tarantola's observation (1996:426) that: "In the effort to prevent and control the pandemic of HIV/AIDS, we have all been learning. Who among us has not seen personal

preconceptions challenged? Who has not changed views? Who has also not been changed in the process?" It has been my aim in this dissertation to challenge, in some of the readers, the admitted and unadmitted, and the conscious and subconscious (mis)conceptions about HIV/AIDS in sub-Saharan Africa. If this dissertation has challenged you to rethink some old assumptions, then my objective is achieved. Yet I find it improper to talk of 'achieving an objective' when all along I have argued that in the sub-continent, the epidemic has undermined almost all the intervention efforts that have been implemented. For the reason that we in Africa are still so far from our goal of controlling HIV; for the reason that, in fact, we appear to be at the beginning two decades later; and for the reason that I am actually calling for a massive overhaul and a re-start of interventions addressing behavior change towards certain cultural practices, talking of 'achieving an objective' is a gross misnomer. Thus, I feel, as Treichler (1999:315) also did in closing her book, that given the continuing devastation of the HIV/AIDS pandemic in sub-Saharan Africa, I cannot bring myself to set aside space for a 'formal' *conclusion.* As Treichler observed, "Indeed, in the face of an epidemic that continues to continue, the word is arrogant and untrue." I feel the same way.

In lieu of conclusions: dissertation recap and recommendations

In summary, 36.1 million adults in the world are infected with HIV today, 70.1% of whom are found in sub-Saharan Africa, as are more than 80% of all AIDS-related deaths, all children orphaned by AIDS, and all infected women. According to UNAIDS (2000), the epidemic has outstripped the projections made by WHO in 1991 by 50%. As in many parts of sub-Saharan Africa (with notable exceptions of Uganda and Senegal), the prevalence in Kenya continues to grow despite the joint intervention effort sponsored by the government, international agencies, and non-governmental organizations.

Thus, and as I expressed at the close of the previous chapter, given the continuing devastation of HIV pandemic in sub-Saharan Africa and in the face of an epidemic that, to use Treichler's words (1999:335), "continues to continue", announcing a *conclusion* signals a false closure for a disease that is anything but under control. In lieu of conclusions, the word 'recap' describes the activity of this section more realistically, which is, to highlight the key issues raised in the dissertation regarding possible reasons behind the dismal performance of the current interventions aimed at eliminating the practice of widow inheritance. It also provides recommendations upon which policy makers can draw to design intervention programs that are more effective in reducing the risk of acquiring or transmitting HIV through widow inheritance--recommendations which are also responsive to the needs of the audience being targeted.

Recap: The study respondents identified five main reasons why the Luo community practice the tradition of inheritance, namely, to discourage widows from abandoning their marital homes and their children; to restrain widows from seeking sexual liaisons outside the husbands' clan; to give childless widows an opportunity to get children, especially sons, who would continue the lineage of the deceased; to entitle the widow to social and economic support from the inheritor; and to enable her to participate in specific social events for which sexual rite is a component, such as during farming seasons (cultivating, planting, weeding, and harvesting), during ceremonies associated with rites of passage of close family members (birth, marriage and death), and during establishment of homes. Because of the component of sex, sometimes performed by professional inheritors, and often times in circumstances that expose widows to a higher risk (such as when relatives force widows to be inherited--see Appendix 4), this last reason presents the most obvious *potential* risk for HIV. If inheritance truly poses risk for HIV (since there is still no evidence either way), then the widows who are in these circumstances and who may be faced with choosing between observing the sexual rite and risking contracting HIV, or breaching of traditional taboos and avoiding HIV transmission, are the most critical to focus interventions on. Thus, the current interventions need to revisit especially the three areas discussed below:

Firstly, it was evident right from the outset of the study that while the interventions were premised on the assumption that inheritance poses risk for widows and should therefore be eliminated, the respondents viewed the association in a broader context and identified circumstances where inheritance would pose risk as

well as where it would actually protect against the spread of the disease. As such, current interventions targeting complete eradication of inheritance cannot effectively engage any of these people. In order to avoid HIV risk behavior, an individual must first label his or her actions risky for contracting HIV before making a commitment to reduce the risk behavior and to increase safer behavior.

Secondly, with the changes in widowhood arising from education, employment, and labor outmigration, it is no longer feasible to fully partake of the customs detailed in the Chapter Four of the dissertation. As a result of these changing circumstances, many features have emerged about the practice that have the potential to increase widows' vulnerability to HIV. Respondents cited five major changes that have occurred, each of which could potentially pose risk for the acquisition or transmission of the AIDS-virus. These include the proliferation of professional inheritors; the increasing practice of soliciting the services of 'interim' inheritors (who inherits a briefly before a brother-in-law takes over); inheritance occasioned only by specific events when sexual rite is required; inheritance contracted in secrecy; and the increasing rate at which inheritors are divorced and new ones acquired. It therefore follows that blanket treatment of the practice as risk by the current intervention programs cannot speak equally to widows in different circumstances and could explain part of the inability of the current standard inventions to impact the community.

And thirdly, it is likely that the under-performance of the interventions can be attributable to the fact that only the widows are targeted with the message while other members of the community are left out. Yet it is evidently clear that the widows' participation in the practice is strongly influenced and sometimes dominated by the

community and societal context in which she lives (Appendix 4). Related to this is also the fact that current interventions focus on the practice as an independent and complete entity without addressing the underlying forces which nourish it (Figure 6). As long as these forces are left intact, the effect of the interventions will continue to remain dismal.

The overarching goal of this dissertation has been to demonstrate that many of the intervention programs designed to curb the spread of HIV/AIDS in sub-Saharan Africa have assumed behavioral and cultural homogeneity across the region and have collapsed the 1000-plus ethnic and sub-ethnic communities in the sub-continent under one label of 'risk group' or 'risk behavior.' Yet, as I show with respect to widow inheritance in Kenya, there are marked variations in how the practice is carried out among different ethnic communities and even among different sub-groups within the same community. These differences also translate into different levels of 'risk' and 'vulnerability', and thus challenge standard interventions.

Given this emphasis, I call for a re-construction of the concepts of 'spaces of vulnerability' and 'risk'--a reconstruction that is place-specific and group-specific--sometimes even individual-specific, but which does not, at the same time, perpetuate the stigma of labeling places as essentially 'risk-prone' or associating whole groups or an entire cultural practice with 'risk'. As I have demonstrated throughout this dissertation, the building blocks to be used in the construction of these concepts must be drawn both from the widow herself (her background characteristics) and the social and religious contexts that give rise to and sustain the practice of inheritance. Her HIV status and the likely status of individuals who may inherit her warrant consideration as

well. I argue that this can only be achieved by [re]placing the voices of the subjects at the core of interventions; by allowing them to re-define risk as they see it; by giving them an opportunity to challenge official discourses about the 'riskiness' of their behavior; by letting them question the appropriateness of the intervention programs targeting them; and by giving them a chance to chart out ways in which the programs should be made more relevant to them.

Recommendations: The first recommendation is the need to conduct a combined epidemiologic and ethnographic study to ascertain whether or not widows who are inherited are truly at a significantly increased risk for HIV compared to those who are not. This is particularly pertinent given that, as respondents pointed out, there are circumstances when inherited widows are at a potentially reduced risk for HIV. If this is the case, then current campaigns against practice may even be conceived of as detrimental to the community to some extent.

The rest of the recommendations have been exhaustively discussed in Chapter Six, and so I only reiterate those that I consider key. The overall goal of this sub-section is to suggest safe alternatives to widow inheritance without compromising the cultural functions of the practice. Because of the high prevalence of HIV in the population (we found a 25.5% prevalence among male church goers) and also because most of the widows being left behind are young, providing services and education about the importance of HIV testing prior to starting the relationship needs to be stepped up by the Ministry of Health joining hands with opinions leaders in the community, for example, traditional birth attendants and leaders of women groups.

Three other issues must however be taken into consideration when implementing this recommendation. One is that given the complex nature of HIV/AIDS, there is need for intervention messages to go beyond single phrases or sentences on billboards or radios. There should be a more interactive approach where people can raise issues and ask questions. Building the capacity of churches, as I discuss below, is one approach that can be taken advantage of. Two, there is the fear of taking the test due to social stigma attached to those who may test positive, and three, since currently there is no proper medication or established social support system in the rural areas for those who are infected, a lot of people see no benefit in being tested.

Participants recommended that since upwards of 80% of the population in Kenya belong to some organized religious group and also because the groups continue to enjoy high degree of credibility among communities in which they operate, this potential should be tapped more concertedly, especially in rural populations that have no access to formal workshops and other health education activities. In addition, religious organizations also have a unique infrastructure that has sustainable human resources and divergent target groups such as the youth, the women, the men, and the children in their formative years. Thus, they would provide excellent forums to reach out to these hard-to-reach populations. In countries where the epidemic has been markedly reduced, such as Uganda, or maintained at low levels, such as Senegal, involving religious organizations, or at least eliciting their support, has paid off in promoting mass acceptance of interventions programs (Spira, et al., 2000; Luba, 1998; Meda, et al., 1999; American Health Consultants, 1999).

In addition while negotiations about drugs are currently going on between Kenya's Ministry of Health (and in several other countries in sub-Saharan Africa) and relevant pharmaceutical companies, there is urgent need to set up local networks in rural areas to provide social and emotional support for the growing number of people living with HIV and AIDS in these places. In addition, it is important to bolster the counseling component of the ongoing testing services to prepare potential clients for the results and to forestall or reduce the likelihood of wanton spread of the disease. It is also useful for intervention providers to point out that taking an HIV test is important, but only as the initial step in starting a relationship. What is more important is remaining free of the virus subsequently, and this is dependent on whether each person in the relationship (the widow, the inheritor, and his wife/wives) remains faithful. For widows who test positive for HIV but who may still want to observe the custom of inheritance, and for widows who are HIV negative and may not want to risk being infected through inheritance, it was suggested that they can either use condoms or else opt for any of the various forms of symbolic inheritance which entails observing the customs without engaging in sexual relations.

The overall thrust behind these recommendations is that basing interventions on information derived from members of the Luo community is a more effective approach in inducing behavior change than when the cultural, social, economic, and religious contexts of the practice are ignored. This is because when widows are able to perceive that certain components of inheritance may pose increased for HIV, they would be more likely to change their behavior if three things happen: i) if they are provided with safe alternatives to inheritance to choose from; ii) if they believe in the

efficacy of the alternatives to perform cultural functions similar to those provided by inheritance; and iii) especially if they have support for their decisions and actions from their family, clan, and church members.

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Appendix 1:

Guidelines for Focus Group Discussions with denomination leaders

Serial # [ ]

Introduction: The Guide to introduce the Principal Investigator to church leaders.

The Principal Investigator:

Greetings. My name is Kawango Agot and I work at Moi University in Eldoret. We are here to conduct a study to find out whether male circumcision is associated with HIV infection. It is still not clear whether this is true or not. In this study we are approaching denominations in Luo Nyanza which are members of African Instituted Churches. The name of your church was given to us from your Headquarter Office in Nairobi (or by ..... the leader of ....church), as (name of guide....) has already mentioned. We hope to obtain information that will help us to answer part of this question by conducting this study in churches where male circumcision is practiced and also in those where the practice is not required.

I have a few questions to ask you concerning some teachings of your church. This is a group discussion and may take from one hour onwards but you are free to leave whenever you wish.

In addition, we would like you to introduce us to the leaders of your local churches so that we can explain to them the purpose of the study and ask the congregation under them to participate. We would like to assure you that this information is for research only and will not be used in any way to identify the denomination, church or the participants, or to obtain profit. Participation in all stages of this study is confidential

and voluntary. We will record the information using both video and audiotapes. I shall also write down notes as you talk.

Name of Denomination: __________ Year began: _____ Breakaway from: _______

Location: District: ______ Location: ________ Sub location: ______ Village: _____

To main leader: What is your position in the church: _____________

List of other attendees:

Name:	Position:	Since (year):
1. ____________________	________________	____________
2. ____________________	________________	____________
3. ____________________	________________	____________
4. ____________________	________________	____________
5. ____________________	________________	____________
6. ____________________	________________	____________
7. ____________________	________________	____________
8. ____________________	________________	____________
9. ____________________	________________	____________
10. ___________________	________________	____________
11. ___________________	________________	____________
12. ___________________	________________	____________
13. ___________________	________________	____________
14. ___________________	________________	____________
15. ___________________	________________	____________

Guidelines for discussion on widow inheritance (I have omitted questions on polygyny, male circumcision and condom use)

1. What is the position of the church on the practice of widow inheritance? (overall, for the clergy, for other church administrators, and for the church members--male and female)
2. Why does the church hold this position? (Scriptural, cultural, other explanations)
3. Is there a way in which inheritance can be associated with the spread of HIV? (Probe to find out how the association is conceived)

Either:

For those who support or are neutral to the practice:

1. What happens if a member of your church decides not to be inherited?
2. If a brother-in-law declines to inherit a widow, what should she do?
3. How about if she is inherited by someone who is not her brother in-law?
4. If she has HIV what do you advice? How about if she does not have HIV and does not want be inherited and risk getting HIV?
5. How about if she 'divorces' an inheritor? And if she wants to get another one after the 'divorce'?
6. Can you describe the role the church plays when a members is being inherited.

Or:

For those who oppose the practice:

1. What happens if a woman decides to be inherited even if the church teachings oppose this? How about if a man decides to inherit a widow while he is a

member of the church? What happens to the children if the widow gets married elsewhere?

2. How about a woman who joins the church after she is already inherited? And a man who has inherited a widow?
3. Considering that the position of your church is contrary to the cultural expectations of the community, what are some of the problems you experience? How do you resolve them? How successful are you in enforcing the teaching of the church? What does the church do to support widows who decline inheritance? How can this be improved?

Wrap up: Is there any other issues or questions you would like to ask or raise regarding widow inheritance, AIDS, or any other concerns?

Thank you so much for taking your time to respond to my questions and to give very valuable contributions towards our study. When we get results at the end of the study, we shall pass them on to you to share with your members. God bless you all.

Appendix 2:

Guidelines for Open Discussions with church congregations

Serial # [ ]

Introduction: The Guide to introduce the entire research team to the participants.

The Principal Investigator:

Greetings. My name is Kawango Agot and I work at Moi University in Eldoret. We are here to conduct a study to find out whether male circumcision is associated with HIV infection. It is still not clear whether this is true or not. In this study we are approaching denominations in Luo Nyanza which are members of African Instituted Churches. We have already obtained permission from your leaders (name key leaders of the denomination met during the Focus Group Discussions). We hope to obtain information that will help us to answer part of this question by conducting this study in churches where male circumcision is practiced and also in those where the practice is not required (then explain eligibility criteria).

While eligible men are taking part in the individual interviews, we shall have an open discussion about AIDS, male circumcision, and cultural practices of widow inheritance and polygyny. We shall follow this procedure:

i. While I am discussing with those who are proceeding for individual interviews, the clinician and the guide will divide the rest of you into small groups to discuss the following: a) What is HIV? b) What is AIDS? c) How is HIV transmitted? d) How can it be prevented? e) What is the role of widow inheritance? f) How it is linked to the spread of AIDS? g) Should the practice continue or not and why? Select one member to record the responses and give

a report once we reconvene (The questions were given to the elected group 'secretary' to jot down).

ii. We will reconvene and hear reports from every group. Then we shall have open discussion on the same issues and on other related or arising concerns.
iii. We will then break into the same small groups to make suggestions about what you feel should be done to reduce the risk for HIV following what we discuss in the open discussion.
iv. Finally, we shall summarize our group position on AIDS and widow inheritance.

The discussion will take from two hours onwards but anyone is free to leave any time before the end of the session. Please, feel free to ask any question or raise any concern you have in both small and open group discussions.

We would like to assure you that this information is for research only and will not be used in any way to identify you or your church, or to obtain profit. Participation in the discussions is confidential and voluntary. We will record the information using both video and audiotapes. I shall also write down notes as you talk.

Name of Denomination: ___________ Name of Church______________________

Location: District: ______ Location: _______ Sub location: _______ Village: ______

After listening to the reports from the small groups, I will facilitate open discussion covering further exposition, corrections, examples, and so on, on the following:

1. **Understanding of HIV as a disease –**
   a. What it is?
   b. How it is transmitted?
   c. How are HIV and AIDS related?

d. What are the common signs and symptoms?

e. How it is similar to, and different from, *chira*?

f. How it can be prevented?

2. **Understanding of widow inheritance**:

   a. What is widow inheritance?

   b. Why is it practiced?

   c. Can you describe how it was done in the past?

   d. Can you describe how it is done nowadays?

   e. What are the differences?

   f. Why is today's way of observing the practice different from the past?

3. **Association with HIV**:

   a. Given your understanding of what AIDS is and how it is transmitted following our discussion, how would inheritance as practiced in the past spread the disease? How about the way in which it is done now?

   b. Should we continue with the practice? In its entirety? Which components?

   c. How should it be carried out so as to reduce the way in which it can spread HIV? Will these ways be culturally appropriate?

   d. What should a widow who has AIDS do? And one who does not want to get the disease?

4. Any other issue you want to raise concerning widow inheritance, AIDS, or any other concern?

I want to thank each one of you for giving us your time and the very lively discussion. We will use the information obtained from here and in other places to make teaching materials to help the community. Once I complete the study, I will give the results to the leaders of your denomination to share with you. God bless you all.

Appendix 3:

Guidelines for Key Informant Interviews

Introduction: First, thank you for coming and taking part in our research when we visited your church. And secondly, thanks also for allowing us to visit you in your home to obtain additional information on widow inheritance from you. This interview will take about one hour, but you are free to end it before then; just let us know. We will record the information using both video and audiotapes. I shall also write down notes as you talk.

Name of informant: ____________ Church: __________ Church position: ______

1. Can you describe again how the practice of widow inheritance started?
2. Why was it started, by whom, and for what purpose?
3. Can you describe the procedure in the past?
4. What was done to ensure it was observed?
5. Why does the community feel they are still tied to this tradition today?
6. What happens if one does not observe it?
7. What has changed about the practice--between the past and now--and why have they changed?
8. In today's era of AIDS, what should widows who do not want to contract or transmit HIV do?
9. What happens when a brother-in-law declines to inherit the widow?
10. Are there comparable restrictions for a widower?
11. Can the practice be 'undone'? Which components? How?

Thank you again for the additional information. God bless you!

Appendix 4:

A newspaper report on forced inheritance

News (from the *Daily Nation*)

Saturday, March 24, 2001

Stop widow rituals, says PC

By JOHN OYWA

Those conducting widow-cleansing rituals in Nyanza Province will be arrested, the Provincial Commissioner has warned.

Mr. Peter Raburu condemned the practice and ordered a crackdown on culprits.

He said widows were being forced to undergo "traumatizing and barbaric sexual cleansing rites" at the hands of hired drug addicts or wife inheritors, known locally as *jokowiny*.

"Forced sexual cleansing rites are a conduit of Aids. They must stop forthwith because widows must remarry at their pleasure," he said.

Mr. Raburu said on Thursday that a notorious inheritor in Nyakach had been arrested in connection with an incident where two widows were forced into sex by in-laws.

The PC said the two widows, who had buried their husband a few days earlier, were locked up, tied with ropes and forced into sex with the hired man after refusing to be inherited.

An angry Mr. Raburu told a charged baraza at Thurdibuoro, Nyakach, that the man had been arrested on complaint by the widows. He is likely to be charged with rape and assault.

Mr. Raburu said wife inheritance should be made "a merely symbolic rite without involving sexual acts".

The meeting was convened to sensitize residents on Aids. Mr. Raburu advised against irresponsible sex and distributed Aids campaign literature.

Punctuating his lectures with biblical verses, Mr. Raburu asked why lodgings were doing roaring business from "illicit lovers" despite the increase in Aids awareness campaigns.

There were tense moments and many people hid their faces in shame, while others reeled in laughter as Mr. Raburu deplored sexual behaviour in the province.

At one stage, Mr. Raburu invited two nurses to demonstrate how to use a condom to guard against Aids.

Using a piece of wood, the two nurses took the crowd through the process as Mr. Raburu cheered them on.

"Love or hate it, I must tell you the truth. Lack of openness has contributed to the fast spread of the disease in Nyanza because many people speak about Aids and sex only behind closed doors and windows," he said.

The PC, who spoke for three hours, said he was disappointed that, despite an

awareness rate of 99 per cent, many people were still contracting Aids in the province.

He dismissed as untrue claims that poverty was to blame for Nyanza's high HIV infection.

"If it is poverty, how come poor areas like North Eastern are not as badly hit as Nyanza?" he asked.

The meeting was also addressed by Nyakach MP Peter Odoyo and an HIV/Aids educator from Ace Communications, Ms Maureen Ongombe.

Mr. Odoyo said Aids infections may worsen in the constituency following the influx of foreigners working at the Sondu-Miriu Hydro Power project.

The MP called on the project managers to start an intensive HIV/Aids at Work place campaign to help stop further spread of the disease.

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Educational background:

1996-2001:	Ph.D. in Medical Geography, University of Washington
1997-2001:	MPH in Epidemiology (International Health), University of Washington
1994:	Postgraduate Diploma in Human Nutrition, Uppsala University, Sweden
1989-1991:	Master of Philosophy in Medical Geography, Moi University, Kenya
1980-1984:	Bachelor of Education (Geography), University of Nairobi, Kenya
1977-1979:	East African Advanced Certificate of Education, Nyakach Girls' High School, Kenya
1973-1977:	East African Certificate of Education, Rang'ala Girls' H. Sch., Kenya

Professional experience:

Summer 2001:	Instructor for the Geography of Health and Health Care course, University of Washington
Winter 2001:	Teaching Assistant of Population and Health, Univ. of Washington
1998-99; 2000:	Teaching Assistant of Human Geography, University of Washington
1998:	Program Evaluator, 1997-98 Americorps Program of Greater Seattle.

1992-Present: Lecturer of Geography (Medical Geography), Moi University, Kenya (Currently on official study leave)

1989: Lecturer, Kisii Teachers' College (Trainer of High School Diploma Teachers)

1984-1988: Lecturer and Head of Social Science Department, Shanzu Teachers' College, Kenya (Trainer of Primary School Teachers)

Research awards, fellowships, honors, invited talks:

2001: Arch Gerlach Dissertation Fellowship Award, University of Washington.

April 2001: Invited Panelist: "Globalization and Health - Challenges for African Youth", Yale University, Connecticut. Presented two papers:

a. Youth and HIV/AIDS intervention programs in sub-Saharan Africa: *From* missing the link *to* the missing link.

b. Women in sub-Saharan Africa and 'risk' for HIV/AIDS: Excuse me! Whose 'risk' are we talking about here?

1999-01: International AIDS Research and Training Fellowship (Fogarty International/National Institutes of Health)

1999-00: The Population Council Fellowship

1998-01: Philanthropic & Educ. Organization, International Peace Scholarship

1996-98: The Fulbright Junior Staff Development Fellowship, U.S.I.A.

1995-96: The Robert S. McNamara Fellowship Program of the World Bank for research on AIDS education (later withdrawn due to degree in progress).

1995-96: The 7th Research Competition on Gender Issues from the Organization for Social Science Research in Eastern and Southern Africa (OSSREA) for research on AIDS and selected cultural practices of the Luo community

1995-96: Association for African Women in Research and Development (AAWORD) award for research on the association between

childbearing and childrearing responsibilities by parents in Siaya District Nyanza province.

1994: The Swedish Institute Fellowship for a Diploma course in Nutrition in Developing Countries at Uppsala University, Sweden.

Research experience: (General topics of inquiry)

1999-00: Cultural risk factors for HIV among the Luo ethnic community in rural Kenya (for my PhD dissertation and MPH thesis) – funded by the Population Council and Fogarty International, National Institutes of Health.

1995-96: The perceptions around polygyny and widow inheritance as risk behaviors for HIV - funded by the Organization of Social Science Research in Eastern and Southern Africa

1995-96: Inhibitors to family planning adoption in rural Kenya – funded by The Association of African Women for Research and Development.

1992: Impediments to Achieving Health for All by the year 2000: Indicators from Nyanza Province, Kenya – funded by self.

1990-91: Physical and Socioeconomic Factors affecting Household Food Security: The case study of Siaya District, Kenya. Funded by the Government of Kenya (for my M.Phil. thesis, Moi University)

Publications:

Submitted: "HIV-1 in rural Kenya: a comparison of circumcised and uncircumcised Luo men from African instituted churches" *AIDS*

In preparation: "HIV/AIDS in sub-Saharan Africa: re-constructing 'spaces of vulnerability' within the framework of widow inheritance"

1998 Vanishing borders within sub-Saharan Africa: achievements, counterforces, and prospects. In *Vanishing Borders: The New International Order of the 21st Century,* edited by Lee Boon-Thong and Tengku S. Bahrin. Ashgate International Publishers, Aldershot.

1997 Book Review. *The African Inheritance* by Ieuan LL Grifith. In *The Professional Geographer* 49(3): 380-381, August, 1997

1995 Ethnomedical remedies and therapies in maternal and child health among the Luo of Rural Kenya. In *Traditional Medicine in Africa*, edited by Isaac Sindiga, Chacha Nyaigoti-Chacha, with M.P. Kanunah. East African Educational Publishers, Nairobi.

1994 Impediments to achieving health for all in rural Kenya by the year 2000: Indicators from Nyanza Province. *African J of Health Sciences*, 1(4):51-7

Participation in international conferences:

June 2001: HIV-1 in rural Kenya: A Comparison of Circumcised and Uncircumcised Men from African Independent Churches. Presented at the International Congress of Sexually Transmitted Infections, June 24-27, 2001, Berlin.

Feb/Mar '01: HIV/AIDS in sub-Saharan Africa: re-constructing 'spaces of vulnerability' within the framework of widow inheritance. Presented at the Association of American Geographers, Annual National Conference, February 27 – March 3, 2001, New York.

Oct. 1996: African culture and reproductive health: are women empowered to negotiate safe sex? Presented at the Association of Third World Studies Conference the University of Montgomery, Alabama.

Aug. 1996: The impact of polygyny, widow inheritance, and migration on AIDS transmission in rural Kenya. Presented at the Association of Anthropologists of Southern Africa Conference, the University of South Africa, Pretoria.

Aug. 1996: Vanishing borders in sub-Saharan Africa: Achievements, counterforces, and prospects. Presented at the Commonwealth Geographical Bureau Conference, the University of Malaya, Malaysia.

April 1995: Gender and the use of environment in teaching Geography. Presented at the Commonwealth Geographical Bureau Conference on Geography and Gender, the University of Amsterdam, The Netherlands.

Feb. 1995: Widow inheritance and AIDS transmission in Kenya: preliminary considerations. Presented at the African Health Sciences Congress, Kenya Medical Research Institute, Nairobi.

Membership to professional organizations:

Since 1994: The Association for African Women in Research and Development (AAWORD)

Since 1995: The Organization for Social Science Research in Eastern and Southern Africa (OSSREA).

Since 1998: Association of Third World Studies (ATWS)

Volunteer work:

Since 1996: Founder and Director, Ushindi Children's Support Services – providing basic needs to AIDS orphans in their foster homes.

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