SEXUAL AND REPRODUCTIVE ISSUES IN THE CONTEMPORARY AKAMBA OF MACHAKOS DISTRICT, KENYA: IMPLICATIONS FOR THE MANAGEMENT OF CHILDBEARING AND STD AND HIV/AIDS

Thesis Submitted for the Degree of Doctor of Philosophy

By

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Abstract

This thesis examines some sexual and reproductive aspects and their implication for the management of childbearing and STD/HIV. I explore these issues using anthropological data collected over a period of 10 months among the rural Akamba. The study suggests that the destabilisation of traditional institutions that provided support and maintained a balance between individuals, family and community has impacted negatively on women’s reproductive health, and has also exposed individuals to dangers associated with sex, including HIV/AIDS.

I explore the local perceptions and explanations of reproductive successes or failures and drawing on specific case studies, show that they are embedded in the Kamba notions of disease causation, health and wellbeing. In presenting an intricate complex of sexuality, reproduction and health, the study recognises the influence of historical processes in these domains. These changes, it is argued, have considerably diminished the social support traditionally available to women of childbearing age. The changes, it is further argued, have resulted in the expansion of the role of men in childbearing events.

The problem of STD and AIDS is real in rural Kenya. Using material in part three of this thesis I show that the meaning of STD to women is different from that of men; men and women experience STD differently and this calls for different management strategies. In examining the AIDS epidemic I contend that it cannot be explained only by cultural practices, including sexuality perceived as lacking in morality. In rural Kenya, the spread of AIDS is rooted in part in what may be termed as migratory sexuality whose main cause is poverty. The current programmes have made positive impacts in the creation of awareness, prevention, and management of AIDS. But I suggest that emphasis on AIDS much to the exclusion of STD may hamper the success
of AIDS programmes. The thesis concludes with a discussion of how intervention programmes aimed at enhancing sexual and reproductive health and wellbeing can be improved.
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### List of Abbreviation

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>CBD</td>
<td>Community-based Distributor.</td>
</tr>
<tr>
<td>CBS</td>
<td>Central Bureau of Statistics</td>
</tr>
<tr>
<td>DARE</td>
<td>Decentralization of HIV/AIDS and Reproductive Health</td>
</tr>
<tr>
<td>DASCO</td>
<td>District AIDS and STD Co-ordinator</td>
</tr>
<tr>
<td>GOK</td>
<td>Government of Kenya</td>
</tr>
<tr>
<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NACC</td>
<td>National AIDS Control Council</td>
</tr>
<tr>
<td>NASCOP</td>
<td>National AIDS and STDs Control Programme</td>
</tr>
<tr>
<td>PSI</td>
<td>Population Services International</td>
</tr>
<tr>
<td>ROK</td>
<td>Republic of Kenya</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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Fig. 1: Location of Machakos District in Kenya.
MWALA AS STUDY AREA

Figure 2: Mwala Division in Mchakos District as Study Area.
Thesis Organisation

This thesis is structured into three parts. Part one covers chapters one to three and deals with the setting by providing background information to the issues under examination. Chapter one summarises the research problem and provides some recent figures on the health situation in Kenya, especially HIV/AIDS and STD, and maternal and child health. Section 1.2 focuses on the research area in terms of its geographic location, population size and the research site itself. I discuss the fieldwork process, including the problems encountered and how they were resolved in section 1.3.

In chapter two I situate my research problem within the broader literature on sexuality, reproduction and STD/AIDS. Section 2.1 focuses on childbearing and 2.2 attempts to locate the so-called ‘African sexuality thesis’ in its historical and sociocultural context. The focus changes to STD/HIV/AIDS in section 2.4. The chapter closes with an exploration of issues around illness management. Chapter three introduces the Kamba people. I focus on those aspects that are pertinent to aspects of sexuality, childbearing and illnesses/health. The aim of the chapter is to provide some historical and cultural context within which to read and interpret part of my data.

Part II and III presents my research material. Chapter four explores the contemporary Akamba notions about health and wellbeing, particularly sexual and reproductive health. Chapters five and six deal with issues around reproduction, especially the meaning of childbearing processes. Part III shifts the focus to STD/HIV/AIDS. The question of the meaning of STD to both men and women is addressed in chapter seven. Chapter eight focuses on the management of these sexually transmitted diseases. The thesis concludes with a discussion on some possible HIV/AIDS prevention strategies in the Akamba context and by implication the wider Kenyan context.
PART I
Chapter One

Introduction

1.0 Summary of the Research Problem

One of the major public health problems in Africa today is illness caused by sexual contact and conduct. This recognition has resulted in a large number of epidemiological, biomedical and social studies to understand sexual behaviour. These studies have provided useful information on the dynamics of sexual and reproductive behaviour with regard to HIV/AIDS. Because vaccine for AIDS still remains elusive two decades after its emergence, understanding and changing heterosexual sexual behaviour, the primary mode of transmission of AIDS in Africa remains important.

Sexual behaviour does not occur and cannot be understood in isolation. The meaning of sexual behaviour can only be understood in the social, political-economic and cultural context within which it occurs. These contexts have not received due attention in research until recently, where there has been a shift away from simply describing and documenting sexual behaviour (see e.g. Caldwell et al., 1989) to an examination of these complex dynamics with regard to sexually transmitted diseases, including HIV/AIDS. However, most of the anthropological and other social science research that has produced our knowledge on sexual and reproductive behaviour with regard to HIV/AIDS and STD has been based on migratory labour, that is, on urban contexts often focusing on women and/or certain socio-economic groups. Anthropological studies that specifically focus on both men and women in rural contexts are, with a few exceptions (e.g. Muange, 1999; Moss et al, 1999; Bujra, 1999) largely lacking. Consequently, rural people’s perceptions and beliefs about sexual behaviour in relation to STD/HIV remain poorly understood. More disturbing is the fact that because much of the research on STD/HIV/AIDS prevention and reproductive health has focused in Africa on women, our grasp
of where men situate themselves (or are situated) in sexual and reproductive health remains weak.

There is a close link between STD and HIV (Grosskurth et al., 1995; Moses et al., 1991). STD especially those that cause genital ulcers make one more vulnerable to HIV infection (Green, 1992; Konde Lule et al., 1997). STD is also associated with infertility or poor reproductive outcomes. Yet in spite of this knowledge there exists few studies focusing on the meaning of STD infection to both men and women and the strategies they employ to manage it.

Some of the early accounts on the Akamba are found in the works of Lindblom (1920), Penwill (1951), Middleton (1959) Dundas (1913), and Middleton and Kershaw (1965). With the exception of Lindblom there is no substantial ethnographic work on Akamba until Ndeti (1972). Penwill (1951) focuses on the legal aspects of the Akamba life, particularly witchcraft while Ueda (1981), Akong’a (1982), Mbiti (1966), and Kimilu (1962) are short descriptions and deal with specific rituals or other aspects of the Kamba. Mbiti (1975) is theologically inclined and does not specifically focus on the Akamba while Mbula (1977), Kabwegyere and Mbula (1979), and Mutunga (1994) are more concerned with belief systems particularly religious issues, without explicitly connecting them to local theories of disease causation and health. Johnson (1999) and Good (1987) do not deal directly with sexuality and reproduction, but have provided invaluable accounts of the Akamba health care knowledge, especially knowledge on illness management. A recent study by AMREF is limited because it focuses on sexual and reproductive health of adolescents and is intervention oriented rather than ethnographic (Amuyunzu-Nyamongo, 1999; Nyamwaya, 1996). Elsewhere in eastern Uganda, there has been rural-based research to understand the explanation of illness and misfortunes, including those associated with sexuality and reproduction (Whyte, 1997).
1.1 Health Situation in Kenya

1.1.1 HIV/AIDS and STD in Kenya

AIDS is not just a serious threat to our social and economic development, it is a real threat to our very existence...AIDS has reduced many families to the status of beggars...no family in Kenya remains untouched by the suffering and death caused by AIDS... the real solution to the spread of AIDS lies with each and everyone of us (president Moi, 25 November 1999 cf. MOH/NACC 2001: Vii)

So as to understand the sexual and reproductive problems associated with STD/AIDS we need to have some knowledge about their epidemiological status in Kenya. These figures need to be read with an understanding in mind of the limitation imposed by the method used to collect the information on STD and HIV/AIDS. Data for the rates of HIV are taken using the sentinel surveillance system. This system obtains data mainly from antenatal and STD clinics. Thus data on sero-prevalence are obtained from a certain section of the population. Prevalence at antenatal clinics is calculated, manipulated and assumed to represent prevalence among adult population. It is, therefore, possible that the data over-estimate or under-estimate the prevalence of HIV.

The first HIV case was described in the country in 1984. Since then, AIDS has become an epidemic. By March 1989 reported AIDS cases were 5949 (Ministry of Health, 1989 cf. Nzioka, 1994:161). Ten years later, June 1999 over 87,000 AIDS cases were reported to the Ministry of Health but the actual AIDS cases were estimated to be 760,000 (NASCOP, 1999:3). 11,000 more cases were reported to the Ministry of Health by 2000 bringing the figure to 98,000 AIDS cases. Since the epidemic started, it is estimated that over 1.5 million people have died from AIDS related illnesses with some 180,000 dying in the year 2000 alone (Ministry of Health, 2001:2). Deaths associated with AIDS will continue to rise because of the number of people who already have
HIV and will develop AIDS each year, even if new cases of HIV infection were prevented now. By the end of 2000, some 2 million Kenyans were estimated to be infected with HIV but were asymptomatic (ibid). It is estimated that about 500 people in Kenya die each day from AIDS (NACC, 2000:2) and by 2000, AIDS was estimated to have produced over 800,000 orphans (NASCOP, 1999:24).

The main mode of transmission is said to be unprotected heterosexual sex. Other transmission mechanisms are from mother to child during pregnancy; and transfusion with infected blood (Ministry of Health, 2001:7). There may also be homosexual transmission, but information is unavailable (Nzioka, 1994). Thus HIV/AIDS is principally a sexual disease. The majority (80%-90%) of those infected is between the ages of 15 and 49 (NACC, 2000:2) and the rate of infection in males and females is about equal. The spread of AIDS tragedy has been felt across the Kenya’s social landscape with 72 per cent of people personally knowing someone with AIDS or who died from AIDS (KDHS, 1998:142).

The national HIV prevalence is estimated at 13.5%. HIV prevalence is higher in urban areas (between 17 and 18%) than in rural ones (between 12 and 13%) (MOH, 2001:6). This perhaps explains the paucity of rural-based studies focusing on sexuality. There are regional variations between and within rural areas just as there are variations between urban areas. However, HIV has been increasing rapidly in the rural areas. Although prevalence is higher in urban areas, the total number of the infected is larger in the rural areas because 80 per cent of Kenya’s population lives in the rural areas (ibid). This is also because of the strong urban-rural kinship ties, which offer paths of transmission (Nzioka, 1994:161), and because many cases go unreported or are misreported.
The Central Bureau of Statistics estimates that without HIV/AIDS, life expectancy at birth would currently be 65 years. However, with AIDS on the scene, life expectancy is actually 50 years, which is predicted to decline to 42 years by 2010. There has also been an increase in infections associated with HIV/AIDS. Tuberculosis has become more pronounced in the 15-44 age group corresponding to similar pattern reported in HIV/AIDS cases standing at 34,980 in 1996 up from 28,142 TB cases in 1995 (Ministry of Health, 1999). Figures will rise to about 120,000 cases of TB due to HIV by 2005 (NASCOP, 1999). Thus people suffering from illnesses associated with HIV/AIDS are said to occupy over 50 per cent of medical beds in public hospitals (ibid:7). One study had estimated that by the year 2000, the cost of AIDS management would equal the entire 1993/94 recurrent budget of the Ministry of Health (Nalo and Aoko, 1994 cf. Ministry of Health, 2001:18).

Information on STD is rather sketchy suggesting that STD has taken a back stage with the emergence of HIV/AIDS. STD is ranked among the top 10 causes of illnesses and contributes to about 15% of all out-patient consultations (Ministry of Health, 1999:42). Considering that many STD cases are managed outside modern health care facilities, it is likely that the actual STD cases are higher. Prevalence of primary infertility is about 5 per cent and secondary infertility is about 10-30 per cent (ibid:57). Over all, STD contributes to about 80% of the total female infertility (ibid:42).

HIV/AIDS and STD are more than medical or even health problems. HIV/AIDS kills people at their reproductive and productive ages. The epidemiological statistics may not be accurate but they point to the fact that HIV/AIDS and STD are a major public health problem given their social, economic, emotional, psychological, cultural, and sexual and reproductive meanings and implications. These factors alone justify this study, which aims
to understand the meaning of sexual and reproductive aspects and their implication for the management of HIV/AIDS and STD and childbearing.

1.1.2. The Prevention of HIV/AIDS

Once HIV/AIDS was recognised as a major health concern, a number of programmes were put in place to deal with the epidemic and help prevent further infections. The government established in 1985 the National AIDS Committee (NAC) in the ministry of Health to advise the government on matters related to the prevention and control of AIDS (Ministry of Health, 1997). Nzioka (1994:162) writes that the committee did not start its work until 1987. In 1987 Kenya National AIDS control programme was established followed by the development of a five-year strategic plan, Medium Term Plan (1987-91). The object was to create awareness about AIDS, blood screening, clinical management of HIV related infections and capacity building. Thus the main strategies pursued in this plan were the prevention of sexual transmission, prevention of transmission through blood, prevention through mother to child transmission and disease surveillance (Ministry of Health, 1997:3).

The HIV sentinel surveillance system became operational in 1990 and has been conducted annually (NASCOP, 1999:4). The Second Medium Term Plan (1992-1996) pursued the same strategies as the first one and in addition emphasised the need to provide care and social support to people infected with HIV, their families and community. This has remained a mirage due to lack of resources to implement it.

Recognising this limitation and the seriousness of the AIDS epidemic, the Kenya government came up with a policy framework paper ‘Sessional Paper No. 4 of 1997 on AIDS in Kenya’, which recommended the establishment of
National AIDS Council to provide leadership at the highest level and mobilise resources locally and externally (Ministry of Health, 1997). The National AIDS Control Council was not established until 23rd November 1999 (Kenya Gazette Supplement No. 65 Legal Notice No. 170). President Moi addressed Members of Parliament in a conference held in Mombasa on HIV/AIDS on 25 November and declared it a national disaster. Since then, discourse of HIV/AIDS has preoccupied leaders in every public space. Curiously STD is rarely mentioned. Thus AIDS/HIV has become the most widely talked about disease and by extension sex and sexuality.

Heterosexual behaviour change remains a major intervention strategy focusing on promoting celibacy before marriage and faithfulness to one partner; promoting the use and availability of condoms. Some successes have been made: the Ministry of Health reports that more than 50,000 STD cases are being treated each month (NASCOP, 1999:45) and knowledge about the presence of HIV/AIDS and that it is a sexual disease appears universal – at 99 per cent (KDHS, 1998:136). Sexual behaviour change is also said to be high with between 80-90 per cent saying they have altered their sexual behaviour: 18% of men saying that they have reduced the number of sexual partners and 16% of women asking their spouses to remain faithful (NASCOP, 1999:37). This massive behaviour change does not seem to be supported by the increasing HIV/AIDS epidemic; hard economic realities may be playing a role.

KDHS (1998) reports that over 40 percent of men report using condoms the last time they had sex with a woman other than their spouse. Perhaps it is on the basis of this that recently the government came up with a ‘National Condom Policy and Strategy’ 2001-2005 document. One of the objectives is to promote and create demand for condoms as a prevention strategy for HIV/AIDS/STD. Like any other aspect of health-care the government will introduce user-fees for people to meet part of the cost and ensure ‘rational’ use.
of the condoms (Ministry of Health/NACC, 2001). Indeed, the government has committed some USD 10 million in World Bank DARE loan funds to purchase some 300 million condoms during the period 2001-2004 (ibid:7). Meanwhile, the government continues with the social marketing of *Trust* condoms.

The assumption here is that those who need to use the condoms are able to negotiate their use and will make rational decisions to do so. 'Condomisation' as one of the safer sex strategies has its own limitations, some of which I discuss in chapter 8 of my thesis.

The Kenya National HIV/AIDS Strategic Plan 2000-2005 has several priority areas. ‘Priority Area # 3’ aims to reduce the negative social and economic impacts of the HIV/AIDS epidemic. Interestingly, none of the small strategies under this priority area deals with providing a socio-economic enabling environment or resources as a strategy of sexual behaviour change. Instead, support will be provided to the ‘infected and to enable the affected to cope with their loss’. In other words, the strategy is about coping, not prevention.

### 1.1.3 Maternal and child health

One of the important indicators of the health status of women is maternal mortality which is defined as ‘deaths of women from pregnancy-related complication’ (UNICEF/GOK, 1998:107). Like statistics on STD and HIV/AIDS, statistics on maternal deaths are notoriously unreliable. Maternal mortality is currently estimated at 365 maternal deaths per 100,000 live births (Ministry of Health, 1999:51) but the deaths could be higher. These data show that the major causes of maternal mortality are post-partum haemorrhage (PPH), hypertensive disorders (eclampsia) and complications resulting from
maternal infection such as anaemia, TB, HIV/AIDS, and malaria, postpartum and post-abortal infection (ibid). There are regional variations with Nyanza Province having the highest rates, accounting for 24 percent of all recorded maternal deaths and Eastern Province occupying the third position with 21 percent. Malaria alone accounts for between 25-30 per cent of all cases seen at the out-patient clinics while perinatal and maternal health complications account for 27 per cent of total disease burden in the country.

Malnutrition is a serious health threat afflicting a large number of children and women. Poverty incidences are high and nearly 50 percent of the rural population lives on less than Ksh.980 (about £8) per capita a month and in the towns it is about Ksh.1490 (about £13 a month).

Ten percent of the country’s poor reside in Machakos and Kakamega districts (Republic of Kenya, 1999). Poverty has a bearing on sexual and reproductive health and general well being. The poor have no good shelter, clothing, food, transport and other essential non-food items. The poor also migrate in search of employment. O’Connell (1996) writes that generally, the consequences of poverty are more severe on women than on men. Lack of material wellbeing affects maternal and child health but social poverty also has far-reaching effects on maternal health even with little material resources.

Antenatal care services appear universal with 92 percent of pregnant mothers claimed to be receiving antenatal care from a doctor or trained nurse or midwife. TBAs are reported to provide antenatal care for only 2 percent with 6 percent of all births receiving no care at all (KDHS, 1998:97). These statistics say nothing about the quality or type of care. While antenatal services appear universal, only 42 percent of births are delivered in a health care facility and the majority of women who do not receive antenatal care do not deliver in a health facility (ibi:100). This shows a declining trend of non-home (or
hospital) birthing because in 1993, 44 percent of births were in a health care facility. Thus women are delivered at home assisted by a traditional birth attendant and/or relatives. The majority of these births occur in the rural areas. Older women are said to be more likely than younger women to have a home birth. Inadequate and inaccessible health care facilities are major causes (Olenja and Kimani, 1995) but there are other reasons (which I discuss in chapter 6). Less than half of the antenatal attendance at Machakos District hospital delivered there.

About 7 percent of babies born in Kenya are delivered through caesarean section and it is uncommon amongst rural women, older women, women with a large number of children, and those with little or no education. And out of about 3300 deliveries at the Machakos District hospital in 1999, 399 births were by caesarean section. And up to August 2000, of the 1448 births, 2772 were through caesarean section. Family Care International (1998 c.f. KDHS, 1998:103) writes that C-section rate of less than 5 percent reflects a limited access to maternal health services. Birth weight figures are largely inadequate but 8 percent of the babies born are low birth weight (that is less than 2.5 kilograms) although according to KDHS (1998:104) 16 percent of mothers report that their children are either small or too small. Of the more than 3, 300 delivered at the Machakos District Hospital in 1999, over 690 babies were recorded as below the normal weight of 2.5kg.3 Although there have been gains in reducing childhood deaths in the last 30 years, these gains are being reversed by HIV/AIDS (UNICEF/GOK,1998). Nationally, childhood deaths especially under fives4 is 112 deaths per 1,000 births meaning that 1 in 9 Kenyan children does not live to see the fifth birthday (KDHS, 1998). This is

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1 Current exchange rate £1 = Ksh. 112
2 Figures obtained from Machakos District hospital medical records
3 Statistics obtained from Machakos District hospital medical records
4 Under five mortality is the number of children who die between birth and the 5th birthday per 1000 live births.
an increase from the previous estimate of about 99 per 1000 live births. Without AIDS it was expected to decline to about 70 by 2005. The major causes of infant and child deaths are malaria, pneumonia, diarrhoea and birth trauma (UNICEF/GOK, 1998).

Childbearing begins early and by the age of 19 about 45 percent of girls have begun childbearing (KDHS, 1998). Early childbearing suggests that sexual life begin at an early age. There are social, economic and health implications for starting childbearing early (Zabin and Kiragu, 1998). On average at the current rate, a Kenyan woman will have about 5 children in her lifetime. For a variety of reasons the majority of married women do not or are reported not to use modern contraceptives. The figures quoted in this discussion may not be accurate and conceal variations that exist within urban or rural areas and between women themselves. These figures also tell us nothing about individual experiences and meanings attached to childbearing. One of the aims of my research is to disaggregate these statistics on childbearing experiences in order to understand the cultural explanations, interpretations and the meaning of childbearing processes and their management.

My research is situated within the general health area and examines two aspects of sexual and reproductive health: Childbearing, HIV/AIDS and STD. I focus on the following:

- The cultural processes and meaning of childbearing
- The meaning and management of STD/HIV/AIDS
- The place of men in the control of STD/HIV/AIDS
1.2 Research Site

1.2.1 Kenya

Kenya (map 1) occupies a total area of 582,646 square km and lies between 3 degrees north and 5 degrees south of the equator, and between 33 degrees and 42 degrees east longitude. It borders the Somali Republic to the east and north east, Tanzania to the south, Ethiopia to the north, Sudan to the north-west, Uganda to the west and Indian Ocean to the south east (UNICEF/GOK, 1998:11). The country is divided into eight provinces with Eastern as one of the provinces. The country has two rainy seasons. March to May is the long rain season and short rains occur in the months of October to December. Agriculture is the backbone of the country’s economy. According to the 1999 population census, Kenya has an estimated population of 28.7 million people (Republic of Kenya, 2000:214).

This study was carried out in Machakos district, Kenya. Machakos (map 1&2) is one of the twelve districts that comprise Eastern Province. It lies south east of Nairobi, the capital of Kenya. It borders Kitui and Mwingi Districts to the east, Nairobi City and Thika District to the north west, Kajiado to the West, Murang’a and Kirinyaga Districts to the north, Mbeere District to the north east and Makueni District to the south. Machakos District covers an area of 6,051 sq.km (Republic of Kenya, 1996). The landscape is largely a plateau rising from 700m to 1,700m above sea level. In the central part of the district, there are a number of hill masses that stretch in a roughly north-south axis, which include Kangundo, Kiima Kimwe and Iveti (ibid).

Machakos District is generally hot and dry. There are two rainy seasons, the long one starting at the end of March and continues up to May. The short rains

\[^5\text{Figures on 1999 population and housing census are still provisional}\]
season starts at the end of October and lasts up to December. The annual average rainfall ranges from between 500mm to 1,300mm with significant variations. Machakos District as a whole experiences perennial droughts and crop failures are not infrequent. The mean monthly temperature ranges from between 18 degrees centigrade to 25 degrees centigrade. According to the 1999 population census the current population of Machakos District is estimated at 915,000 (Republic of Kenya, 2000).

The research site was in Mwala (map 2). Mwala is one of the eleven divisions of Machakos District. It is about 40 kilometres south of Machakos town. Mwala division has 4 Locations one of which is Mwala. Mwala Location has 4 Sub-locations, among them Kibau sub-location. A sub-location is the smallest administrative unit and is headed by an Assistant chief. The fieldwork was conducted in Kibau sub-location.

Mwala Division has a population of about 89,000 (ibid). Mwala Location within which Kibau Sub-Location is situated has a population of about 9,531⁶. The population of Mwala market centre was 791 during the 1989 population census and was projected to be 892 by 2001 (Republic of Kenya, 1996) and is probably about 1000 currently. Kibau Sub-Location has 6 villages with a population of about 3000 and 500 households. There are no permanent rivers and people dig shallow wells on the river beds to supply water for domestic use.

The majority of the people are engaged in small-scale agriculture on land parcels that are less than 10 acres. The main food crops grown in the area include maize, beans, cowpeas, pigeon peas, peas and a variety of fruits, mangoes, lemons and oranges. Cotton used to be grown as a cash crop in the

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⁶ Data obtained from Mwala Location Chief's office. These figures are the raw data collected during the 1999 population and housing census.
past, but it is no longer grown since the collapse of cotton industry in the country well over a decade ago. There is a large livestock market every week, which attracts many businessmen and other people from within and outside Mwala Location. There are two market days in a week, during which the centre experiences an influx of people and increased social activity. Even on non-market days, the centre is fairly active. Mwala is ethnically homogeneous, inhabited by the Kamba people.

Public transport between Mwala and Machakos town is reliable. There are regular mini-buses that serve the area and it takes less than two hours to reach Machakos town. Thus the area is well linked to the neighbouring urban centres. Within the villages, non-motorised modes of transport are commonly used, mainly bicycles and walking. Oxen-drawn carts and donkeys are used to transport goods, and water. The area is not served with electricity, but has telephone service and a small post office at the market centre. There are two secondary schools and several primary schools within the Location.

There is one public health centre at Mwala market centre, which services the Location and beyond (Republic of Kenya, 1996:47). Malaria, respiratory infections, skin diseases, STD/UTI, diarrhoea, and typhoid are some of the major diseases in Mwala. The context of birth in Mwala mirrors the pluralistic nature of health care in Kenya as a whole. Home deliveries coexist with deliveries in modern health care facilities. Traditional birth attendants (TBAs) are the ones who are largely responsible for home birth, most of them for a fee. In Machakos District as elsewhere in the country, health care facilities vary in terms of their quality and training of staff, their equipment, and generally the adequacy of their care. Mwala health centre has a small maternity facility, with six birthing beds and no other equipment. The health centre staff include one mid-level trained clinical officer who is in-charge of the centre, and a few nurses some of whom have trained in midwifery.
1.3 Fieldwork process

I had planned to start my fieldwork in the month of August, 1999 but encountered some problems that were mainly administrative. The national census was to be conducted in the same month and the administration at the local and national levels were very busy preparing for the census exercise. Although at the national level I acquired a research permit unbelievably sooner than anticipated, the local administration (that is the chief and assistant chief) who were to facilitate my fieldwork by allowing me entry into their territories were busy with the census exercise; they were helping the census personnel by conducting education and publicity campaigns about the census. I did not begin my entry to the field until the end of September and settled in early October, 1999.

However, during the months my fieldwork was in the control of other people’s hands, I visited local libraries and research institutions to review and collect relevant local literature. I also used the time to make contacts and engage in discussions with other local researchers with research interests similar to mine.

Once granted permission to enter the field, I had difficulty choosing the specific research site. Given my research interest, I needed a site that was rural, yet with a reasonable health care facility where I could make observations and hold discussions on the management of local health problems with the health personnel. I also needed a site that was rural but with good communication and transport links with the ‘outside’ world to observe how people interact.

Mwala Location fitted this description because of its distance from Machakos town, and links with other urban centres. Mwala has a health centre and Machakos District general and Kangundo sub-district hospitals are within 40
and 30 kilometers in case of cases with serious reproductive problems or STD needed to be referred there. Mwala health centre, therefore, offered an ideal facility to make observations on the issues around antenatal, birthing and postnatal care. Mwala has historically one of the biggest and famous livestock markets in the district and this provides easy money and thus an excellent opportunity to observe social behaviour in a rural setting, especially on the market days (Wednesdays and Saturdays). Machakos District as a whole has a long history of labour migrations as it is a semi-arid area and its surplus labour has to seek wage employment outside the district. Given the proximity of Mwala to Machakos town and other urban centres, familial ties between urban and rural migrants and families provide possible conduits for STD/HIV. The Nairobi-Mwala-Machakos-Kitui road borders Mwala and Machakos-Mwala-Kithimani-Matuu road cuts right across the Location. Thus there is easy movement of people in and out of the villages.

One of the problems I had initially was to negotiate my identity. I had assumed that given my cultural background and being a speaker of the local language, that would make my field entry easy and unproblematic. As it turned out, that was not to be; my assumptions were most misplaced. When I started ‘hanging out’ in the village without letting people know what my intentions were, I ran into trouble with some people since they did not know who I was and what were my interests in the village. Some people suspected that I was a devil worshipper. The problem of ‘devil worship’ is a thorny issue in Kenya and is associated with disappearance and subsequent death of children. I quickly sought the intervention of the local gatekeepers (the Assistant Chief and the village headmen) who organised public meetings in which I was introduced. People took the opportunity to ask me about my project and I clearly explained to them what my research was all about.
But still there was a dilemma of who I was as the local people do not understand what anthropologists do, and the few who have ideas about anthropology know that it is white foreigners who are interested in learning about other people’s cultures. So ‘what would I be doing studying a culture that I should know?’ I skillfully dealt with the issue of my identity and research interest by saying I was studying health problems in the area. From this point onwards some people identified me with the medical profession. In one of the public meetings, I was told of how children in a neighbouring primary school were treated for skin infections and other schools were left out. They sought my indulgence. I gave the information to the health centre. People opened up and talked about the health problems they were experiencing including typhoid, malaria and skin infections. Indeed, my first meeting with the local chief included a catalogue of the health problems the people of his area were experiencing. He did not talk about social problems that could be a threat to health and wellbeing. In all the cases it was good for me because it gave me an opportunity to capture the health concerns of the people. I dealt with the issue of health problems by saying that the research findings would be made available to the relevant authorities so that they can act on the issues the people had raised. The context of my affiliation also played a role. My affiliation with Moi University and UCL made me a ‘foreigner’. This is in the context of the value people attach to education. Universities are associated with knowledge and people in these institutions are perceived to know a lot to the extent that they forget their own culture; they become somewhat ‘foreign’ to their own culture and they can thus be re-enculturated. Thus it was understandable that I should be interested in learning about my own culture to which I had become ‘foreign’; the ‘insider’ became ‘outsider’. Finally, I became accepted and my fieldwork gained momentum.

Initially I had planned to do my research in a village but the limitations of getting informants with STD and poor childbearing outcomes or experiences
meant that I abandon this initial plan and include the whole sub-location as the focus of my study. Given the homogeneity of the area in terms of culture, economic activities, political, and the physical environment etc, it meant that there was not going to be any difference in terms of variations in my findings. A smaller area would have limited my chances of capturing people with the sexual and reproductive experiences that were of interest to my research.

Given the intimate nature of my research, no single anthropological method could adequately produce material for this thesis. I therefore, triangulated my data collection strategies. Triangulation allows a researcher to employ a variety of methods to gather data (Bhattacharyya, 1997). Thus the methods I used were not only complementary, they also checked each other. I collected my data using various strategies, some of which were formal and others informal. Where and when I could not use my 'mouth', I used my 'eyes'. In the early stages of my fieldwork and on the basis of the concerns raised in my first public meeting with the people, I decided to make use of an unstructured questionnaire guide to familiarise myself with and collect data on the local health concerns. The value of this material became clear later on when I realised that many of the concerns and problems people talked about can be categorised as threats to health and wellbeing, yet they can easily be left out in a narrowly focussed research inquiry. Besides the health problems, including those I have already mentioned, people talked of lack of income/money, poor crop yields, lack of food, lack of rains, lack of school fees, and poor health services (attributed to mismanagement and corruption). One woman said she was worried that her son who was old enough to marry had not married. These are not just threats to wellbeing, they are directly linked to health. On prompting, people appeared to be aware of and talked more about AIDS than STD suggesting that AIDS has become a 'public' disease while STD still remains private.
I held in-depth discussions with individuals on health in general and issues relating to childbearing and sexuality. I held focus group discussions with men and women. This offered me an opportunity to obtain data on issues that people of the same socio-economic background agree on and those that they do not. In one such discussion, it became clear to me that men have several cultural limitations in the reproductive domain but some made efforts to appear 'in step with the times'. This approach provided me with useful information regarding what men say they do and think they should do to help their wives in childbearing processes.

Key informants who included elders provided information on what they used to do in the past and what their feelings were of the present time. Contrary to my own fears women past childbearing age did not have any problem discussing sexuality matters perhaps because I am an 'outsider' and thus needed information on such issues so that I do not remain ignorant. In fact some seemed enthusiastic about it because 'young people these days are not interested in things about the past.' As one of the male informants put it, he was educating me on the Akamba culture. In one of my discussions with a woman in her 40s, I was surprised by the extent of her openness about her 'past' sexual behaviour. She discussed about how she used to 'go outside' because her husband was also 'going outside' – perhaps as a way of getting at him. Many women had difficulty discussing sexual matters while many others were to the extent possible open, including matters about contraceptives. There was much shame at the initial stages of my fieldwork as many women could not talk facing me. As I gained field experience, I learned to introduce discussions about sexuality and reproduction later in my interviews. I sometimes made sexuality and reproduction less of the focus of my discussion.

Interviews with men on sexual matters generally and STD in particular were less problematic. Men did not talk about STD in the first instance; it is after a
long chat that they would open up and tell me about their experiences. The 15 men who had STD experiences became my case materials. Five of the male STD cases were current but the rest ranged from a few months to 3 years since they had the infection. Those that narrated past STD experience did so in such graphic detail that I doubted the past was that distant. Some people allowed me to tape record the discussions, others did not. I interviewed three women who at the time were suffering from STD. Women were not open about this and so I had to devise a strategy to get some women STD cases. On many occasions I 'camped' at Mwala health centre and this is where I interviewed 3 of the women cases. After introducing my research, I was provided with an 'office' from where I interviewed informants and to which the clinical officer directed those women who had STD. Where tape-recording of the discussion acted as a barrier to obtaining quality data, I did not do it. For example, I never taped any discussions with the women who had STD. I instead made use of my personal notebook once I finished interviews with them. I have used STD case materials in chapter seven and eight. At the health centre, I also interviewed women who had come to the antenatal or postnatal clinic. They raised many issues, including the use of contraceptives and medicines suggesting inadequacy in the health care provided.

At Mwala health centre, I made observations about the health care provided. In one such occasion, I found myself in an awkward situation. I had introduced myself to the officer in charge as an anthropologist but since I was interested in and doing research on health, she allowed herself to think that I was a medical doctor. As we were discussing health problems in the area, a very ill man was brought in. I suspect he was suffering from malaria. Then she asked me: 'How do you deal with cases like this one?' I reminded her that I am an anthropologist and not a medical doctor and told her that she is the one qualified to deal with medical cases. She did not insist but this did not change her perception about me.
I took the opportunity while at Mwala health centre to compare what men in
the villages were telling me they do such as accompanying their wives to
antenatal and postnatal clinics, and what they actually did. This produced
information on what people say they do and what they actually do, perhaps to
appear 'modern'; few men actually accompanied their wives to the clinics.

I visited and held discussions with TBAs and traditional healers. Initially, I
had fears that since TBAs are women, they would not be open to me about the
way they conduct their work. However, as one TBA put it 'my son you know
these things because this is what you always do so, I will not hide anything
from you' (she assumed that I was a medical doctor and, therefore, we shared
some knowledge). I made observations when I visited TBAs and traditional
healers. One of the traditional healers was so busy that every time I visited
him, I had to wait for pressure of work to ease.

I collected my data from people as they went about their daily businesses and
sometimes I would walk, sit and participate in a variety of activities with them
as we discussed matters of interest to my study. For example, I participated in
helping to fetch water from the river using oxen-drawn carts. I looked after
cattle and did farm work – harvesting, weeding or ploughing. I sat with people
in social places (bars, hotels) and at their homes. I observed behaviour in
these social places to compare what people say about changed sexual
behaviour and what people were actually doing. I played draughts with men in
social places as I engaged them in discussions about their personal lives,
including the use of condoms in an extremely informal way. In one group
discussion men raised questions about condoms and sought my opinion about
their safety, including their effectiveness. I occasionally visited a family with
an AIDS case and held discussions with the sufferer and relatives. I observed
the conditions under which the patient was in and other experiences.
There were occasions that I could not make notes while doing the interview. I made brief notes after the interview and comprehensive notes later in the evening. I used my notebook to record comments that did not make sense to me at the time of the fieldwork. These have turned out to be very useful in the analysis and contextualisation of my material. I held discussions with health personnel both local and at Machakos district hospital. At Machakos district hospital, I held interviews with the District AIDS and sexually transmitted disease coordinator (DASCO) on the AIDS and STD situation in the District and Mwala in particular. There were relatively good records for HIV/AIDS but not for STD, although all STD cases recorded in health centres are supposed to be forwarded to the DASCO office. I also examined the disease entry records at Mwala health centre and Machakos district hospital to get ideas about the prevalence of disease and other health problems. Overall the methods I employed were quite flexible and unstructured. I collected both verbalised and non-verbalised data.

However, my fieldwork was not without drawbacks. In addition to the initial entry problems, there were days I did not have any interviews because people were not available due to domestic and other engagements or were just not willing to discuss anything on that particular day. To such people, I left the interview for a day that was convenient for them. Then there is the human exhaustion. Reaching informants entailed a lot of walking, traversing the villages and this was exhausting especially during the hot season.

Although I did not have to cover the whole of Kibau Sub-Location, which is about 23 square kilometers the area was expansive enough to cause exhaustion. Thus there were days I did not interview people but sat at my ‘base’ and organised my field notes while I rested. The traditional healer who treated the AIDS case in chapter eight was rather problematic to interview especially at
the initial stages. He insisted, as did one TBA, that I should pay him since the
information he was going to give me would be used by the government for its
own use. He also felt that I was going to benefit from it financially and so I
should pay. Thus he made no distinction between government and research.
This reflects a long-standing suspicion of government and research institutions
by traditional healers. He argued that in the past the government has taken
medicinal herbs to test their therapeutic value and the traditional healers are
never told about the results. This is an extension of the mistrust between
traditional medicine and modern medicine. This particular traditional healer
kept referring to another traditional healer called Onyango (should be from
western Kenya - many kilometers away) and what happened to him in the year
before my fieldwork. He never explained to me what happened and I never got
to know. After several visits to him he relaxed and became open. He said ‘I
do not want you to go saying that I denied you information, I may need you in
the future’. I later learned that the TBAs who refused to cooperate unless I
paid her was not popular in the area.

At the initial stages of the fieldwork I nearly got into trouble with one man, a
police officer, who found me at his home having an interview with his wife.
He asked ‘who gave you permission to talk to my wife?’ He demanded to see
my research permit. I produced the three research permits I had: one from
office of the president, another from Machakos District Commissioner and the
other from the Assistant chief of Kibau Sub-Location. After a long chat, he
calmed down and from then he became cooperative. I suspected what was in
question here, was my sexuality not my identity. I actually feared that this
particular incident and the devil worshipping one were going to cause disaster
to my fieldwork but those were just two isolated cases.

I never observed any birthing and there was none at Mwala health centre at the
time of my fieldwork. Only one birth occurred at home and I was not available
and I doubt I would have been allowed to be present. I however, observed the activities that went on three days after the delivery.

And finally, there were times that I felt 'guilty' because of 'squeezing' too much information about people’s private lives. My consolation: what has been private (sexuality) is increasingly becoming public through AIDS discourse. What is private must be made public if efforts to prevent further spread of AIDS are to produce meaningful results.

Thus my fieldwork experiences were similar to those experienced by any anthropologist attempting to enter the field and create a rapport with informants in a ‘foreign’ culture. I am partly to blame for the initial hitches I experienced in the field because I assumed my cultural background would offer me immunity to problems of field entry typical to anthropologists. But that was a lesson learnt.

My cultural background allowed me insights into the research issues that, maybe, an ‘insider’ turned ‘outsider’ could fathom with less difficulty, particularly where everyday language and notions carried deeper meanings in the context of sexuality and reproduction. On the whole, my fieldwork was exciting and rewarding. Given financial and time constraints, I spent ten months in the field and collected data adequate for this thesis.

In presenting my material, I have used pseudonyms to protect my informants. I have also not given the actual date of the cleansing ritual that I have presented in chapter six. However, I have not attempted to disguise the study area. The names of the local administrators and others I spoke to, including the local medical personnel are the real ones.
Chapter two

Sexuality, reproduction and STD/AIDS

This chapter reviews the literature around childbearing, sexuality, and STD/AIDS. In section 2.1 I examine the question of the meaning of childbearing and its relation to health. The section pays special attention to the role men play in these processes. It will become evident that childbearing events are not just biological, they are also cultural. Section 2.2 briefly reviews critically the notion of African sexuality. In addition to recent work, I use selectively early ethnographic material which, though not focusing directly on understanding sexuality and reproduction, contextualises data that are used to construct the morally loaded ‘African sexuality thesis’. By situating this material within the proper historical and cultural context the chapter aims to demonstrate that sexual and reproductive behaviours are culturally constructed and there cannot be a universally distinct and internally coherent African sexual system encompassing, among other things, marriage and family. The point to be made is that any argument that places the blame for AIDS epidemic entirely on sociocultural factors as suggested by some authors (e.g. Caldwell, et al., 1989) is not only questionable and most inadequate, it is also ethnocentric. It will be clear that the rapid spread of AIDS is a function of a multiplicity of forces, among them sociocultural, behavioural, political-economic factors, and gender relations. The last section of the chapter focuses on illness management making the point that notions of disease causation and the meaning attached to illnesses or misfortunes have a bearing on their management.

2.1. Childbearing and health

Childbearing has increasingly received considerable attention in anthropological literature (e.g. Graham and Oakley, 1991; Lindenbaum and
The majority of these studies have focused on the social construction of pregnancy and the factors that influence birthing locations. Others have focused on authoritative knowledge regarding birth and control of childbirth (e.g. Browner and Press, 1996; Sargent and Bascope, 1996). In Africa and in particular in Kenya, few studies have focused on the meaning attached by men and women to reproductive processes and their outcomes and how these are linked to notions of illness, health and wellbeing. Some studies in Kenya have examined pregnancy and birthing practices particularly the utilisation of health services but mainly from the perspective of women (see e.g. Raikes, 1989). More recently, some studies have examined the role of men in birthing again drawing much of the information about men’s role from women (see e.g. Olenja and Kimani, 1998). The place of men in reproductive processes is still not well understood and few studies have specifically focused on men to understand perceptions of their role, particularly in the management of childbearing processes such as pregnancy, birth and postpartum care. Little is also known about what women’s attitudes and perceptions are of the extent to which men should be involved in roles traditionally assigned by society to the former, including attendance at birth, prenatal and postpartum care and general household support. Literature on childbirth in Kenya and elsewhere in Africa suggests that husbands are excluded from the birthing scene (see e.g. Olenja and Kimani, 1998; Raikes, 1989; Chalmers, 1990), but it is not clear whether it is women who exclude men or men exclude themselves. Yet despite poor knowledge, greater male involvement in reproductive matters is considered desirable in order to improve reproductive wellbeing of women and by extension men (Mundigo, 1998; Mbizvo and Bassett, 1996).

Childbearing is both a biological and a cultural affair (Browner and Sargent, 1996; Romalis, 1981). As a biological event, reproduction has health implications for the mother and the baby. Biomedical and demographic
dangers associated with childbirth have been extensively documented. They include, among others, maternal age, marital status, and birth intervals (Bledsoe et al., 1998; Boerma and Mati, 1989; Kuate-Defo, 1997; Ginneken and Kok, 1984; Pison and Bledsoe, 1994). Young motherhood, for example, is associated with birth complications and poor reproductive outcome. While these aspects have been extensively documented, there is still no adequate information on how individuals themselves perceive and interpret these and other related aspects of reproduction with regard to health and wellbeing. Bledsoe et al. (1998) argue that in Africa the cultural construction of reproduction, such as the depletion of bodily resources in the course of life’s wearing events such as childbearing, may inform women’s reproductive behaviour. Thus the cultural meanings and individual interpretations of behaviours and events associated with childbearing offer more insights into the meaning of reproduction and wellbeing.

2.1.1 Preparation for pregnancy and birth

Each cultures practices what it considers to be the correct birthing practices (Jordan, 1983 cf. Chalmers, 1990:71). Each cultural group has prescriptions on the circumstances under which pregnancy may take place, who may legitimately engage in childbearing and who may be excluded from where birth is taking place (Browner and Sargent, 1996; Helman, 2001). In most cultures marriage in one form or another often paves the way for childbearing and rearing to the extent that it is often regarded as the universal legitimate setting for this event (Olenja and Kimani, 1998). But motivation for marriage and childbearing differ substantially from one individual to another. However, these aspects of human life remain culturally determined (Helman, 1994). For example, many societies still frown upon motherhood outside marriage. But with so many cases of premarital pregnancies, this may be the ideal rather than
the real situation even in those societies which traditionally stigmatised pregnancy premaritally.

Preparations for pregnancy, childbirth and other life events may be formal or informal. Chalmers (1990:72) notes that the African systems of preparation for pregnancy, birth and parenthood have tended to be informal while the Western culture emphasises formal systems of instructions. In practice, however, this dichotomy is far less than clear-cut. Preparation for pregnancy and parenthood was traditionally institutionalised through initiation rites; these included instructions regarding sexual and reproductive roles including what to do during pregnancy (Chalmers, 1990; Kabwegyere and Mbula, 1979). The training adopted a holistic approach taking into account physiological, cultural, spiritual, and psychological development as well as notions of disease causation as opposed to the modern biomedical approach that focuses largely on the bio-physiological processes of pregnancy and birth.

Pregnancy is considered a time of vulnerability for the woman and unborn baby (Browner and Sargent, 1996). The woman is vulnerable to both physical and social environments. In some cultures a woman's change of behaviour and those around her, particularly the husband, is considered necessary to ensure her wellbeing. Yet in others a woman may be reluctant to disclose early pregnancy to others for fear that others may use this knowledge to cause harm to her pregnancy. Among the Sotho, Xhosa, and Zulu of South Africa women in early pregnancy are advised not to use certain paths, which are considered to pose a danger to them (Chalmers, 1990:16). And Jok (1999:207) reports that in Western Sudan the Dinka women in their early pregnancy are advised not to walk on the main road, which is full of dangers. If it is suspected that a woman has stepped on the footprints of a woman who had an abortion, she is given a special substance to drink to prevent termination of the pregnancy. Indeed, women may wear charms to protect themselves from social dangers such as
bewitching that may result in pregnancy termination (Chalmers, 1990: 16). For example, the Luo of Western Kenya may not only wear a protective charm, they may also rub it into small incisions on the skin to ward off harmful intentions from men or evil spirits (Kawango, 1995).

Food prohibitions are traditionally part of pregnancy preparation and birth. Pregnant women may be discouraged from eating certain foods to avoid making delivery problematic (Chalmers, 1990). Foods rich in proteins such as eggs or fatty meat are prohibited in some cultures for fear that they would make the foetus too big making birth difficult. In some cultures eating of non-food substances such as earth is associated with pregnant women. Among the Bondo Luo, for example, it is not uncommon to see school children and women of childbearing age eating earth (Geissler, 2000). In spite of the dangers of infection that earth eating entails, the practice becomes ‘acceptable during the fertile period of women’s life’ (ibid: 668).

Sexual conduct is an integral part of managing pregnancy. Changes in sexual activity and behaviour are required during pregnancy. Except for a few studies (e.g. Chalmers, 1990; Taylor, 1990), research has not examined people’s explanations and interpretations of how sexual behaviour relates to pregnancy management and wellbeing. Some studies show that in some cultures, sex during pregnancy is associated with ill health while for others, sex during pregnancy contributes to a woman’s health. Among the Zulu of South Africa and some communities in Central Africa, sexual intercourse during early stages of the pregnancy is considered good and encouraged as semen is believed to strengthen a woman and her baby (Brindley, 1985 cf. Chalmers, 1990: 17; Taylor, 1990). And to Rwandese, according to Taylor, semen, which is thought to be blood in a purified form, fortifies the woman by adding to her blood. A woman who has frequent intercourse with her husband during pregnancy is less likely to miscarry. semen is also considered to aid in healing
after delivery. Thus to Rwandese, semen is a ‘productive fluid, which either
directly contributes to the fetus’s growth within the womb or contributes to the
woman’s health before and after giving birth’ (Taylor, 1992:68). Sexual
relations between the two partners are not only expected to continue after
pregnancy, but to be more frequent until later stages of pregnancy as this is
part of the process of building the child (Taylor, 1990:1027). This does not
appear to be the case among the Zulu according to Chalmers (1990:17), who
writes that while coitus early in pregnancy is ‘beneficial psychologically as it
would impart a reassurance of affection between the couple,’ it is discouraged
in late pregnancy so as to ensure some protection for the mother and the baby.
Also according to Chalmers sex in the last stages of pregnancy is frowned
upon because it is believed that it will result in semen coated baby at birth.
When this happens, it is the woman who is reprimanded at the time of delivery.
Chalmers seems to suggest it is women who are expected to show sexual
discipline during pregnancy. This implies that men are not blamed for their
sexual conduct during their wives’ pregnancy. Kawango (1995:84) makes the
same point when she writes that a pregnant Luo woman must avoid sex outside
wedlock because this is likely to lead to miscarriage. Thus male sexual
behaviour when their wives are pregnant and how this is perceived to affect
pregnancy outcome has not received due attention in the literature.

2.1.2 Birthing

Women regard childbearing as a normal biological process in which medical
intervention is unnecessary. Graham and Oakley (1991:110) observe: ‘a
woman views reproduction not as an isolated episode of medical treatment but
as an event which is integrated with other aspects of her life.’ By contrast,
biomedicine views pregnancy as a medical event, thereby separating it from
the rest of the woman’s life experience (Graham and Oakley, 1981 cf. Helman,
This conflict reflects the wider differences between lay persons and biomedical explanatory models about illness and health (Helman, 2001). Although most research on birthing in Africa (see eg. Chalmers, 1990; Raikes, 1989; Olenja and Kimani, 1998) has treated women as though they were a homogenous group with similar notions and perceptions about these events, the meaning and experience of pregnancy and birth differs culturally, sometimes within a culture, and between women themselves.

The shift of birthing location from home to hospital has been associated with the reduction of pain and death associated with childbirth. It has also altered the meaning of birth and motherhood (Davis-Floyd and Sargent, 1997 cf. Obermeyer, 2000:174; Lindenbaum and Lock, 1993), and it is considered to have disempowered women in terms of the use of their experiential knowledge about and control of birthing process. In other words, authoritative knowledge about birth shifts from women to hierarchically socially structured institutions whose birth managers have specialised knowledge (Jordan, 1993 cf. Browner and Press, 1996:142). For example, knowledge about births in a high-technology birthing system like that in the USA rests with the biomedical personnel (Sargent and Bascope, 1996). While pregnancy and birth are highly medicalised in the West, this is only partially true in other birthing systems where the management of these events has not completely shifted from home to hospital. In a low-technology birthing system such as Yucatan, older women share general knowledge about birthing procedures; experiential knowledge is what counts (Sargent and Bascope, 1996: 231) and there is less medicalisation of birthing. Gabe and Calnan (1989:223) define medicalisation as 'the way in which the jurisdiction of modern medicine has expanded in recent years and now encompasses many problems that formerly were not defined as medical entities.' A wide range of events including many normal phases of the female life cycle such as menstruation, pregnancy, childbirth, menopause, and old age have been medicalised (Helman, 2001:114).
Questions that cause disquiet among the critics of medicalisation in the West are different from those that concern people, especially women in non-Western cultures. In the West the medicalisation of birth has been framed by discourse about power and social control; it has been criticised as yet another example of women's loss of control of their bodies to a male dominated profession (Obermeyer, 2000; Graham and Oakley, 1991; Miles, 1993; Correa, 1994; Gabe and Calnan, 1989). At issue is the extent to which a woman can claim to 'own' a birth (Jordan, 1993 cf. Sargent and Bascope, 1996:215). But this 'ownership' or control of birth has to be assessed in the context of the status of the birthing woman who may be perceived as a patient by managers of the birth. Moreover, women are not a homogenous group sharing similar experiences regarding pregnancy. Even in the West, there is no agreement that medicalisation of birth disempowers women; some women value it. Indeed, many women consider that medicalisation is safer for them and their babies; others feel it offers them more control over the birthing process (Browner and Press, 1996:152). In Japan where birth is constructed as primarily a healthy physiological event though potentially dangerous, biomedical technological intervention is valued more as a potential intervention than as an actual application (Fielder, 1996:196).

Pain management during labour and birth is one of the aspects for which women in the West seek medical intervention. Chalmers (1990:78) writes: 'Western women use many available techniques to escape from pain such as the physiologically based approaches of relaxation and breathing...and the pharmacological use of analgesics and anaesthetics.' In African cultures pain is part of the childbirth experience and women are socialised to expect and want it (ibid). But there are cultural variations in the way women express pain during birth or labour. Pendi women of South Africa are expected to be stoical during birth. Women are encouraged to try not to make any noise; outward
expression of pain is frowned upon and brings shame on the family who may scold the woman (Chalmers, 1990:50). Sargent (1982) reports similar expectations of Bariba women of Benin. By contrast, a Moroccan woman in labour is exempted from rules that normally constrain discourse and the woman may shout and speak her mind (Obermeyer, 2000:183). In a sense, birthing pain in the former is experienced and expressed as private while in the latter private pain becomes public as it is expressed socially (see Helman, 2001:129). It is thus hypothesised that modern health institutions do not offer the social space women require to express and manage labour pain.

Issues that concern women and men with regard to medicalisation of childbirth in Africa generally, and Kenya in particular, are thus radically different from those of the West; they are not about power and control. As Obermeyer (2000:174) observes, 'the strongest critiques of medicalization have been based on analysis carried out in societies of the North, where the risks of mortality are very low and virtually all births take place with the assistance of trained personnel.' However, in Africa the social and cultural meaning of the medicalisation of birth has received less attention in research on childbearing.

Home births coexist with modern health facility births, which vary greatly in terms of personnel and equipment. But the boundaries between home births and health care facility births are fluid because many births combine elements of both. In this sense treating traditional and modern birth practices as exclusive categories in terms of their use is less than a reality in Kenya and in Africa as a whole (Raikes, 1989; Obermeyer, 2000). Rather than the shift from home to hospital birth being a linear progression, birth practices are varied and are constantly evolving in response to both changes in the political economy and individual circumstances and practical considerations (Obermeyer, 2000:178). In any case, birthing practices harmful to health and wellbeing of women and children are found in both home and hospital settings. Home birth
remains primarily a woman’s affair (Sargent, 1989; Olenja and Kimani, 1998; Steinberg, 1996). But to conceive of home birthers as a homogenous category is also to miss the point. Like other traditional healers (see Kramer and Thomas, 1982; Good, 1987), there is considerable internal heterogeneity among traditional birth attendants (TBAs) and the care they give to women.

2.1.3 Men, pregnancy, birthing, and postpartum care

Even though pregnancy and childbirth are female events, men are psychologically, physically and socially involved (Helman, 2001:126). There are variations in the extent to which males are involved in the childbearing events but generally the majority of cultures exclude men from the scene of delivery (Helman, 1994:176; Chalmers, 1990). But the extent and type of male involvement particularly in Africa is still not well understood or systematically documented. Much of the male involvement has been assessed in terms of physical presence or material support for their wives. The less overtly ritualised male participation has received only scant attention in anthropological literature.

In the West, men tend to be involved during their partner’s pregnancy, and are often present at the actual birth (Helman, 2001:126); the husband is regarded as his wife’s important source of support and comfort during pregnancy and birth (Grossman, et al., 1980 cf. Chalmers, 1990). In other cultures men’s involvement may be through rituals that they must perform during their wives’ pregnancy, birth and postpartum period. This is considered to be an integral part of the actual management of these events. In others, however, this involvement may be less ritualised but still serve to promote pregnancy and birth management as when a man has to change his sexual behaviour to avoid endangering his wife’s pregnancy.
Not all non-Western cultures exclude men from birthing; in some, the husband or even his father may participate in the actual birthing. For example, Sargent and Bascope (1996:220) describe a delivering Maya woman in rural Mexico being assisted by her husband, her mother and mother-in-law. But in a culture where it is considered inappropriate or embarrassing for a man to be present at the actual birth, the presence of other female relatives is a main reason to keep away the husband. However, to what extent can this hold in a fast-changing social environment? Elsewhere, such as in India, men’s role is largely functional: they are available when required to run errands such as fetching the dai (TBA) from beyond the village (Jeffery and Jeffery, 1993). In other cultures it is the husband’s responsibility to ensure that the birthing site is conducive to child delivery, that is, it is safe for the mother and child.

In Kenya, the few studies that have attempted to examine the place of men’s participation in birthing have focused largely on the physical presence and material aspects of men in this process (Olenja and Kimani, 1998). The male role is considered peripheral during delivery but becomes central after birth and during postpartum, as a man is required to provide materially to ensure convalescence for his wife. However, the extent of a man’s social, emotional and even economic involvement in the whole process beginning with pregnancy through delivery to postpartum care, may be in ways that are less than obvious, including anxiety or even taking to drinking when a wife goes into labour. The extent of male involvement in events associated with childbearing is affected by a multiplicity of factors including socio-cultural, political-economic and individual characteristics as well as role expectations. Given the foregoing scenario it is hypothesised that the changing socio-cultural environment has resulted in less social support for women, especially in the postpartum period, from extended family, relatives, and neighbours and this is likely to increase male participation in childbearing events.
2.2 The Caldwells' African sexuality thesis

In attempting to explain the reproductive values and behaviour and the spread of HIV/AIDS in Africa, Caldwell and colleagues have posited the existence of an African model of sexuality lacking in morality and socio-cultural institutions to regulate sexuality (Caldwell and Caldwell, 1987, 1988; Caldwell, et al., 1989, 1991). They argue that 'there is a distinct and internally coherent African system embracing sexuality, marriage, and much else...' (Caldwell, et al., 1989:187). According to them, unfettered sexuality is an integral aspect of the African cultures in contrast to the Eurasian system, which has controled sexuality (ibid: 195-197; Caldwell et al., 1991:242). The Caldwells claim that it is this sexual freedom that makes this system vulnerable to attacks by all coital related disorders such as STD/AIDS (Caldwell et al., 1989). This aspect of African culture (sexuality) can only change by adopting Western values and those espoused by external religions such as Christianity. The Caldwells see morality as something that arrives or is being brought from outside the African cultures.

Secondly, Caldwell et al. argue that the traditional institution of marriage in the African social system is emotionally bankrupt because of the weak bond between husband and wife. This is so because of the strong attachment that couples have with their natal lineages (Caldwell, et al., 1989:201/2; Caldwell and Caldwell, 1987:419). They link emotional impoverishment to extramarital sexual liaisons or (in the extreme case) divorce (Caldwell, et al., 1991:236) thus exposing men and women to dangers of STD/AIDS. Finally, the Caldwells assert that it is the African sexual system that accounts for the reproductive values that result in persistently high fertility (Caldwell and Caldwell, 1987); they link African reproductive behaviour and values to the role of ancestors and traditional religion in fertility.
Caldwell's distinct African sexuality thesis, as it has come to be known, has been called into question for, among other things, its apparent moralistic overtone and ethnocentric approach to sexuality and disease of sexual contact in the African context (Le Blanc, et al., 1991; Ahlberg, 1994; Heald, 1995; Gausset, 2001; Ocholla-Ayayo, 1997). This has made it problematic and inadequate for explaining contemporary sexual patterns and reproductive values, and the AIDS epidemic in Africa. African societies and cultures are very heterogeneous and to talk of one single sexual model is not just to undermine the diversity of African cultures, but the very notion of culture. Indeed, the enormous variations in sexual practices and reproductive value in the studies that Caldwell et al. (1989) report render their African sexuality thesis untenable.

The quality of the early ethnographic work regarding customs and practices in Africa on which the Caldwells drew for their 'African sexuality thesis' has been questioned (see e.g. Gausset, 2000; Ahlberg, 1994; Le Blanc et al., 1991). The missionaries, colonial administrators and many early twentieth century ethnographers described behaviours, practices, customs, beliefs, and taboos regarding sex and reproduction such as marriage patterns, initiation rites, and pre-marital sexual practices either as irrational, that is, lacking any cultural or social explanation, or as simply immoral (Gausset, 2000:510; Schoepf, 1991). But Waite (1988 cf. Ocholla-Ayayo, 1997:110) writes that 'most of the stereotypes were based on myths' adding there 'was nothing inherent in African practices to support the notion that sexual excesses were widespread.' And Gausset (2000:510) finds early studies of patterns of sexual behaviour in Africa fundamentally flawed because the data are historically decontextualised, thereby assuming different meanings. In sum, many of the early studies of sexuality and reproductive behaviour in Africa were imbalanced and loaded with cultural biases and little effort was made at the time to understand the
broader as well as the specific socio-political and cultural context in which the behaviours and practices they described were rooted.

In the pre-AIDS era, few studies by social scientists, particularly anthropologists, focused directly on the issue of sexuality (Standing, 1992; Schoepf, 1991), in part due to the legacy of the moral and political climate in which modern anthropology developed, particularly in Britain (Ahlberg, 1994; Schoepf, 1991). In the 1960s through early 1980s research focusing on sexualities in Africa was heavily dominated by a feminist or demographic paradigm, especially in family planning studies (Gausset, 2001). The emergence of HIV/AIDS in the early 1980s made it necessary to focus on sexuality (Lindenbaum, 1991; Schoepf, 1991; Vance, 1999; Gausset, 2001; Larson, 1989).

Analysis of sexual and reproductive behaviour must be geared toward understanding the meanings attached to behaviour patterns and placing social practices in the context of the wider social, cultural, economic and political environment (Standing 1992:477). Failure to do so, as in the Caldwells’ case, is to decontextualise behaviour and the meanings attached to it, thus revealing little continuity and discontinuity, and sometimes contradictions in cultural meanings and practices. As Packard and Epstein (1991:794) have argued, those who essentialise culture in the study of sexuality and AIDS treat it as a ‘conservative force, which determines behaviour patterns, rather than the means by which people mediate experience.’ Sexual behaviour, attitudes, and institutions which encourage or restrict behaviour as well as give it meaning vary culturally, even within the boundaries of a single culture, as between men and women; and in different contexts, for example, between urban and rural. In this thesis I hold the notion that sexuality and reproductive behaviour, values and practices, and their meanings can only be understood when
examined within the political-economic, sociocultural, and historical context in which they occur.

2.3 Putting sexuality and reproductive behaviour in Africa in context

Sexuality, according to Standing (1992:475), is socially constructed, so there can be no ‘natural sexualities’. The rates and forms of sexual expression vary culturally and across time and space. Sexual behaviour includes three main elements: 1) specific sexual practices in terms of the forms within which contact occurs; 2) the range and number of sexual partners, which entails consideration of the social, economic and political factors which influence the changing patterns; and 3) the social meanings of sex in any given context, which includes ideologies of masculinity and femininity, culturally sanctioned modes of sexuality and sexual expression, and associated forms of control and coercion (ibid: 475-476). Thus as an aspect of human experience sexuality is not just personal and subjective or what happens at the interpersonal level between sexual partners; it is embedded in a culture and a given context (Wallman, 1998; Setel, 1999).

Pre-colonial and post-colonial African societies exhibit diverse practices regarding sexuality and reproduction. In some cultures multiple sexual relationships were culturally permissible, sometimes encouraged in various social contexts (Schoepf, 1991; Pellow, 1990 cf. Muange, 1999). Among the Nyakyusa of Tanzania, Wilson (1950:123) reports that married men and women had sexual liaisons outside marriage and that divorce was, at the time she was doing her research, frequent but had been relatively infrequent in earlier times. Social control mechanisms in the form of punishment strongly discouraged both the man and the woman from breaking the society’s sexual norms (ibid:122). The man could be ostracised by his relatives and villagers for fear of attack by the injured village. The extreme sanction against sexual
relations with a married woman was spearing. It would appear that among the Nyakyusa, men had to control their own sexuality and that of the women because no punishment was meted out to the woman; the husband just sought her and brought her back. Among the Yoruba of Nigeria marital instability including divorce is more frequent today than in the past and is closely associated with adultery (Feyisetan and Pebley, 1989 cf. Le Blanc, et al., 1991:502).

Kenya is culturally diverse; so are sexual practices and ideologies. In a countrywide study covering 29 ethnic groups on Sexual practices, STDs and HIV/AIDS in Kenya, Ocholla-Ayayo et al (1992) found that traditional sexuality among these ethnic groups has dramatically changed. They concluded that the sexual practices we are witnessing in Kenya today are ‘largely artifacts of modernisation and not elements of traditional Kenyan society’ (ibid:110). Carttell has shown that among the Samia of Western Kenya, the current sexuality among the young people, particularly premarital sex and pregnancy, is a recent development since in the early part of the twentieth century female virginity at marriage was expected, tested and rewarded (cf. Kilbride and Kilbride, 1997:213). However, at times a different sexual conduct was desirable because fertility was equally important, sometimes more desirable than virginity. A young woman could increase her chances of marriage by becoming pregnant (Wagner, 1941 cf. Kilbride and Kilbride, 1997:212). But if the girl became pregnant, she had to quickly find a husband. This implies that such a girl could also be married to a man who had not made her pregnant.

In many cultures sexual expression and pleasure were important aspects of young people’s sexual life (Ahlberg, 1994; Ocholla-Ayayo, 1997; Kabwegyere and Mbula, 1979). The Kikuyu and the Luo permitted young people to have lovers and engage in non-penetrative sex for various reasons, among them to
procure pleasure, experience, and mate selection. However, premarital virginity was regarded as important and there were cultural institutions to ensure this. A virgin woman at marriage earned herself respect and honour from her parents and husband (Parkin, 1973 cf. Ocholla-Ayayo, 1997:116; Ocholla-Ayayo, 1976) and loss of it resulted in the woman being ridiculed. Through the institution of *ngwiko*, young circumcised Kikuyu boys and girls learned about sexual matters and experienced the pleasure of sex without penetration. It also facilitated mate selection (Worthman and Whiting, 1987; Ahlberg, 1991; Kinoti, 1983). As Kinoti (1983:310) puts it, the young initiates were only after each other's breasts and warmth to enable them to enjoy their youthfulness. Sexual intercourse proper belonged to the state of marriage, where it was performed for pleasure, procreation and many other rituals in the home (ibid). However, the ideals of *ngwiko* were not always realised as a young man could persuade a girl to have sex secretly (Kinoti, 1983:313).

In other cultures premarital virginity is not desirable much less required. Among the Rendille of Northern Kenya, it is acceptable for circumcised boys and girls to be sexually active as long as the girls do not become pregnant before marriage (Shell-Duncan, et. al., 2001:117). In Sierra Leone, Ahmadu (2001:285) argues that the Kono are not culturally obsessed with virginity, feminine chastity, or women's sexual fidelity. Traditionally, the Baganda of Uganda, the Tutsi and Hutu of Rwanda (Feldman, et al., 1987 cf. Muange, 1999; McGrath, et al., 1993) granted some premarital sexual freedom. The same is reported of some communities in Zaire (Schoepf, 1991). The traditional Akamba expected the initiated boys and girls to have practical penetrative sex as part of their sexual training and preparation for future reproductive roles (Ndeti, 1972; Mbula, 1977; Kabwegyere, 1979; Mutunga, 1994). I discuss the traditional Akamba sexual model in chapter 3 but the point I wish to make here is that to them reproduction was more important than
virginity. In this sense sexuality cannot be treated as separate from reproduction; they are intertwined.

There are social and cultural contexts in which men and women could have sex with somebody other than their spouse. In Zaire, Schoepf (1991:755) reports that in some socially accepted situations, 'husbands could deploy their wives' sexuality' to strengthen patron-client relationships. In Rwanda and Zambia, the practice of symbolic ritual cleansing between relatives and the wife of a deceased man is not unknown (Webb, 1997). However, Taylor (1992:104) observes that certain sexual relations accepted in the past in Rwanda are now inconsistent with today's Christian-influenced morality. Elsewhere in East Africa, a man may have sexual relations with the wife of a close relative for various reasons, some of which are culturally sanctioned, for example, to produce if the husband is impotent. Other sexual relations may be condoned though not socially sanctioned (Schoepf, 1991). Among the Iteso of Kenya, having sex with a brother's wife may be considered 'simple theft' (Karp and Karp, 1973 cf. Heald, 1995:493).

2.4 Sexuality, reproduction and health

Sexual behaviour, reproduction and health are in many ways interconnected. Improper sexual conduct including breach of sexual rules can result in ill health and other misfortunes (Heald, 1995; Ahlberg, 1991; McGrath, et al., 1993; Orubuloye, et al., 1993). Among the Luo, for example, *chira* are illnesses and misfortunes associated with sexual misconduct, including infertility and death of children (Ocholla-Ayayo, 1976, 1997). Among the Nyakyusa of Tanzania, irresponsible sexuality is likely to arouse the wrath of ancestral spirits and could result in lingering death, sterility and illnesses (Wilson, 1950:137). For the Akamba, *thaavu*, which are maladies and misfortunes associated with improper sexual and reproductive relationships
have similar consequences. Thus the consequences of breaking sexual prohibitions go beyond the individual wrongdoer, to affect others (Mutunga, 1994; Ahlberg, 1991). Health and wellbeing is safeguarded through a moral discourse that emphasises responsible sexual conduct. Sometimes coitus may be symbolically performed to correct things that have gone wrong as a result of the irresponsible sexual conduct (Webb, 1997). This is embedded in the notions of disease causation which lead infected men to have sex with other women not just to pass the STD sickness out of themselves, but to be completely cured (Moss, et al., 1999; Brown, et al., 1996). In such situations the symbolism surrounding sex is more crucial than the act of coitus itself; the sexual act is intended to promote health of not only the individual, but also the wellbeing of the wider social group or community (cf. Heald, 1995). Thus sex is fraught with many dangers; it entails threats to health and wellbeing of not just the individual partakers, but a larger group.

The principle of *chinsoni* underwrites everyday practice within the Abagusii family (Hakansson and Le Vine, 1997). It carries sexuality messages and involves rules of avoidance and respect between generations and sexes, particularly between the father and daughter-in-law and other defined relations. Avoidance and respect between generations and sexes within the family to avoid breaking sexual taboos is also reported among the Nyakyusa (Wilson, 1950:127). Wilson asserts that Christianity brought changes and new values resulting in a different sexuality; sons built near their fathers and so daughters-in-law could be near their fathers in-law, which was tabooed before (ibid: 128). For the Swahili of the Kenyan Coast, except for a man and his wife, members of the opposite sex are not allowed to pass time together in the same room for fear of breaking norms and rules regarding sexual conduct (Akong’a, 1997:11) which may interfere with the social balance.
2.4.1 Men, Women, Sex and STD/AIDS

Studies on sexuality that are informed by Western models and which treat sexuality, gender and reproduction (see e.g. Vance, 1999) as though they were inherently separate domains of human experience do not necessarily fit African contexts (Setel, 1999). In African cultures sexuality is interwoven with aspects of paternity, maternity and sexual identity (Schoepf, 1990). This has a bearing on STD/AIDS infection. As Farmer (1997:414) notes, a study of the dynamics of diseases of coital contact brings to fore the complex relationships between power, gender, and sexuality.

Heterosexual contact is the main source of HIV/AIDS spread in Africa (Standing, 1992:477; Bond et al., 1997:6; Brown, et al., 1996). Sexual behaviour is, therefore, vitally important in the infection, prevention, and management of STD, including AIDS. Much of the research on sexual behaviour with regard to STD/AIDS in Kenya (see e.g. Nzioka, 1994; Pickering, et al., 1997; Moses, et al., 1994) and elsewhere in Africa (see eg. MacPhail and Campbell, 2001; McGrath, et al., 1993) has been carried out in urban social contexts. Other studies have focused primarily on women (see e.g. Kielmann, 1997; Wallman, 1996; Ogden, 1996; Schoepf, 1988, 1992b) or youth (eg. Wood, et al., 1998; Setel, 1999; Amuyunzu-Nyamongo, 1999) in order to understand sexual behaviour in the context of STD/AIDS.

Many other studies informed by a biomedical paradigm have been facility-based, focusing on STD/AIDS clinic clients and/or epidemiological ‘high risk’ categories such as ‘prostitutes’ (e.g. Moses, et al., 1994; Ngugi, et al, 1988; Garland, et al., 1993; Simonsen, et al., 1990; D'Costa, et al., 1985). These studies provide good insights into and rich material on dynamics of sexual behaviour. However, few studies have focused on rural men and women to understand the social meanings of sexual behaviour and to systematically
document the implication of migratory labour on sexual conduct in relation to STD/AIDS (see eg. Muange, 1999; Bujra, 1999; Gausset, 2001; Orubuloye, et al., 1997). Consequently, rural people’s perceptions regarding sexual behaviour in relation to STD/AIDS, the meaning and implication of STD remain poorly understood. Indeed, intervention studies about prevention and management of STD/AIDS and also birth control through information supply and use of contraceptives, including condoms have largely assumed that women should take responsibility for their own sexual and reproductive health and that of their male partners (Mbizvo and Basset, 1996; Campbell, 1995). There remains, therefore, a major silence in the literature on where men situate themselves in sexual and reproductive health, including the control of STD/AIDS.

Social norms and values regarding sexuality and reproduction offer, at least in theory, more freedom to men than to women (Frayser, 1989). Male sexuality in Africa generally, and Kenya in particular, is constituted in a discourse which depicts men as somewhat homogenous in their natural inclination to promiscuity and less concerned about the consequences of their behaviour, whether such behaviour results in STD infection or pregnancy. It has been argued that the economic burden is unlikely to produce decision-making in favour of a small family because men do not carry the full burden of their sexual and reproductive acts. Women on the other hand are portrayed as submissive and reserved in some contexts, and as active and needy in others (Standing, et al. 1989 cf. Nzioka, 1994:37). This view echoes the social construction of male and female sexuality in Victorian Britain, which depicted men as full of unfettered sexual desires on the one hand, and a belief in female sexual ‘anaesthesia’ on the other (Doyal and Pennell, 1994:153; Caplan, 1974 cf. Nzioka, 1994:37).
Among the Baganda of Uganda and Tutsi and Hutu of Rwanda, it is assumed that men will have more than one sexual partner (McGrath, et al., 1993). Larson (1989:723) goes further to say that ‘cultural factors provide Ugandan men with higher-than-average opportunity to find lovers’ and so they need not visit prostitutes. But the urban Baganda women are also reported to have relatively more control over their lives, including sexuality (Obbo, 1980). Nzioka (1994:38) observes that in Kenya, men are culturally constructed as having unquenchable sexual appetites, which seems to encourage multiple sexual relationships with the attendant problems. For example, the Luo of Kisumu have a strong ideology that men must have constant access to sex (Buzzard in Nzioka, 1994:38). A recent study by Muange (1999) among the Luo shows that while married women are expected to maintain one sexual partner, men are not expected to confine their sexual relations to one woman. And in her study of the Kikuyu migrant women in a Nairobi slum, Nelson (1987:219) found that men were considered to require a lot of sex and with a number of women. In some societies of central Africa, lack of sex is considered detrimental to health because it causes bodily emaciation, sometimes madness, making the point that engaging in sexual activity is a healthy exercise (Poewe, 1981 cf. Nzioka, 1994:37).

In Zimbabwe, dry sex is believed to make sex more pleasurable, especially for men. Dry sex involves women using substances to make the vagina less moist and tighter (Civic and Wilson, 1996). The practice of dry sex is partly based on the notion that a woman is not supposed to be sexually excited before meeting her partner because if she has a moist vagina before intercourse, ‘this could be interpreted as the sign that she has just had sexual intercourse with another man’ (Gausset, 2000:513). A wet vagina is thus associated with ‘loose behaviour’. Among the Tonga of Zambia, dry sex is practised mainly by women who have given birth, and who want to have a ‘normal’ and tighter vagina (ibid). Dry sex practice may result in vaginal abrasion during
intercourse making it easier for HIV transmission (Brown, et al., 1993; Civic and Wilson, 1996). However, Gausset (2000:514) notes that the practice of dry sex is nothing more than practising basic personal hygiene before having intercourse; warm water is the most commonly used drying agent. In contrast, the Rwandese men and women prefer wet vaginal intercourse and the man has to ‘externally stimulate the woman’s clitoris by tapping his penis against it’; only after the woman produces copious vaginal secretions does the man penetrate her (Taylor, 1990:1026).

It is not just men who are considered to need sex, and women do not have sex just to satisfy men. Among the Dinka of Western Sudan, most men think that women have a limitless appetite for sex; a man’s insistence increases a woman’s sexual desire and their ‘no’ to sexual advances is not taken to mean ‘no’ (Jok, 1999:209). Among the Baganda a woman’s sexual satisfaction is essential for a stable marriage (Kisseka, 1973 cf. Ogden, 1996:112). In a study of three East African societies, Swartz (1969 cf. Kabwegyere and Mbula, 1979:5) found that cultural prescription of sexual enjoyment was very important in understanding reproductive issues. In one of the societies he studied, sexual satisfaction for a woman depended on the extent to which she was filled with semen. Elsewhere in parts of Europe, it is women who are thought to require and have the strength to engage in a lot of sex. For example, in a rural town community in Spain, men fear female sexuality because it threatens to rob men of their masculinity and perhaps convert them symbolically into females. Women are considered to have superior sexual ‘strength and drive to that of men’ (Brandes, 1996:224).

In a great deal of African societies a married woman cannot refuse her husband sex even when she has reason to suspect there is danger of infection. The issue of power in gendered relations is not just relevant in HIV/AIDS infection but also in its management (Nzioka, 1994; Setel, 1999). In Lushoto, Tanzania
women are not in a strong negotiating position for safer sex such as condom use partly because of patrilocal marriage residence, which requires them to leave the support of their natal homes, but also because of their limited resources (Bujra, 1999:69). Far from male domination, marriage among the Shona of Zimbabwe implies that the husband or the wife cannot refuse his or her spouse sex (Mutambirwa, 1990 cf. Nzioka, 1994:37). A Dinka woman cannot refuse her husband sex as it may result in a beating (Jok, 1999:209).

The Yoruba women of Nigeria are reported to have no control over their husband’s sexuality (Caldwell, et al., 1991). Caldwell et al. also contend that a great deal of married women in the rural areas have extramarital relationships for various reasons, among them need to ensure help for themselves and their children, money, and gifts. The Digo women of Kenyan coast are reported to engage in adultery to obtain cash independently from their husbands (Gomini 1972 cf. Ocholla-Ayayo, 1997:114). In urban Nigeria, Karanja (1987:253-257) describes the phenomenon of public and private polygyny; the latter has led to the emergence of ‘outside wives’ whereby young educated professional women are involved in sexual relations with men of means for financial and material gain. The class of women who become outside wives in Uganda for similar reasons is different; they are poorer (Obbo, 1980). In urban Kenya, Ocholla-Ayayo (1997:114) claims that few women would meet expenses for an evening out with a man in spite of their good economic status. Poverty on the part of women is a major factor in such sexual liaisons, while for men it is largely a function of the ability to command resources and purchase relationships. But also some relationships and behaviours have little to do with poverty; they result from the cultural construction of the social roles of men (as givers/providers) and women (as receivers/takers) in social, sexual and/or reproductive relations (McGrath, et al., 1993; Obbo, 1980; Larson, 1989). For men it may also be sexual adventure or the ‘need for an educated and well-turned out companion at business functions’ (Standing, 1992:479).
There is considerable diversity in the extent to which women have control over their sexuality (Schoepf, 1992; Orubuloye et al., 1993). Some of the occasions are socially and culturally sanctioned as when a child is sick, a woman is pregnant, after delivery, or when death has occurred in the home (McGrath, et al., 1993:433; Orubuloye, 1993:864; Kimani and Olenja, 1998). For example, the Pongoro of Southern Tanzania consider it both unclean and dangerous for a man to sleep with a woman during her menses as the blood entering his body may make his genitals swell (Green, 1999:57) and possibly cause infertility. In Kenya, Muange (1999) found that widow inheritance is prevalent among the Kisumu Luo. Some widows refuse inheritance for fear of contracting AIDS or passing it on to the inheritor. Many are unable to decline inheritance for, among others, cultural, economic and moral reasons. The Maragoli women base their decisions about whether or not to be sexually inherited on compelling practical considerations. Some women may consent to sexual inheritance for economic, cultural and personal reasons. Others may refuse to be inherited because they have economic security, health concerns such as fear of STD and HIV/AIDS infections, or simply the desire for autonomy (Gwako, 1998:186). For some men, however, the immediate sexual benefit and material gains far outweigh any possibility of contracting a ‘far fetched’ disease like AIDS (ibid).

2.5 Explaining social change and its implication for sexual and reproductive health

In Africa many of the traditional cultural and social institutions, customs, practices, and behaviours relating to sexuality and reproduction have considerably eroded. This change has emanated from internal mechanisms and external forces such as colonialism, Christianity, labour migrations, or diseases and illness, and adaptations that have taken place in the past century (Schoepf, 1991; Setel, 1999; Gausset, 2000; Ahlberg, 1994). Many other institutions
have not changed and some have changed in ways that are not health promoting.

The institution of the extended family has been considerably weakened although not completely transformed. Change in family values resulting in tendencies toward nuclear families has in many ways become problematic for both men and women. The tendency toward nucleation has made marital and domestic arrangements highly fluid and variable (Le Blanc, 1991:503). Parkin and Nyamwaya (1987:14) observe that matrifocality is increasingly becoming common in towns in Africa and even among the poor rural people, for example, the Swahili of Lamu, Kenya. Family nucleation has to some extent given men and women greater control over their sexuality, biological and social reproduction. But diminishing extended family network has in many ways impacted negatively on the health and general wellbeing of poor women, especially after delivery, because fewer family resources, including social support, are available to the new mother.

The emergence of the nuclear family has only partially diminished the influence and the role of the kin in the affairs of young husbands and wives. Young married men and women consult their close relatives on matters of illness and health that are beyond their comprehension. In this sense the negative effects of the traditional African extended family on the conjugal family as suggested by some authors (eg. Caldwell, Caldwell, and Quiggin, 1989; Caldwell and Caldwell, 1987; Caldwell, Orubuloye, and Caldwell, 1991) may be less than the reality.

Historical processes have had a serious influence on many aspects of life in both urban and rural Africa today. Colonialism resulted in male labour migrations and conscription, which drastically altered social relations; the slave trade, though to a lesser extent, had similar effects (Schoepf, 1991:755).
Missionisation changed the sexual landscape in Africa by bringing in new values and morality. Mission societies sought to eradicate practices they considered incompatible with Christian morality and here ritual practices such as initiation rites including circumcision were major targets (Mbula, 1977; Hastings, 1994; Comaroff and Comaroff, 1991; Ahlberg, 1991). This campaign had a major role in undermining traditional sexual systems and cultural strategies, which women and men not only employed to regulate sexuality and reproduction, but aided in maturation and training young people about these matters (Ahlberg, 1991; Kabwegyere and Mbula, 1979; Akong’a, 1997). Caldwell et al. (1992:1179) make the same point; they argue that in much of Africa, there is a gap between sex as it is practised and sex as it is discussed. They add, ‘Islam and Christianity have compounded that problem and deepened the silence’ (ibid).

The whole process has resulted in what Kilbride and Kilbride have called economic and ethical and moral delocalisation. According to them, moral delocalisation means ‘erosion of traditional localized moral codes and ethical practices in favor of modern derived legal, religious, and educational norms and values’ (Kilbride and Kilbride, 1997:213). In this sense, they argue, sexual knowledge, practice, and moral responsibility have been delocalised. In traditional Africa, sexuality had been localised in that it was embedded in a system of moral obligations, which maximised sexual pleasure as well as social responsibility for both men and women. The erosion of traditional institutions including systems of avoidance has resulted in behaviours that are destructive at a time when menarche age and that of first intercourse has declined, and extramarital and sexual relations have become common even among relatives (Akonga, 1997:16). Caldwell et al (1991) have described how these processes have destabilised the traditional Yoruba sexual system. The foregoing notwithstanding, the process of eliminating traditional institutions including those concerned with sexuality, childbearing, treatment, and health
has only been partially successful. Mbiti (1989:268) aptly captures this scenario that most Africans are not in a hurry to abandon many of their traditional aspects of life including beliefs about magic, spirits and the living dead. As a result people’s behaviour is guided by more than one social order depending on the context, subjective experience and meaning they attach to any particular life situation and behaviour. Thus many people see modern life as largely responsible for a host of social ills such as prostitution, alcoholism, premarital pregnancies, and recently HIV/AIDS (Gausset, 2000; Orubuloye, 1981; Ocholla-Ayayo, 1997; Bujra, 1999).

Premarital sexuality is high in Kenya (KDHS, 1994:36; Maggwa, 1985; Gage and Meekers, 1994; Amuyunzu-Nyamongo, et al., 1999; Nyamwaya, 1996) and stigma traditionally attached by some communities to lack of virginity has become irrelevant (Ocholla-Ayayo, et al., 1993b, 1997). The Nandi, whose circumcision of their daughters remains important, have adopted the strategy of circumcising girls earlier than before to avoid pregnancy before initiation (Ocholla-Ayayo, 1997:115). However, in a recent adolescent sexual and reproductive health study among the Akamba, Amuyunzu (1997:16) claims that sexual behaviour and experiences of young people are not considered to be significantly different from those of past generations.

2.5.1 Political economy of migratory labour: its relevance in understanding contemporary sexual behaviour, reproduction and STD/AIDS

The current epidemic of HIV/AIDS in the context of contemporary sexualities cannot be fully grasped without looking at their history, power relations and the transformations that have taken place over time. Recent studies on illnesses associated with sexual contact and conduct in non-Western societies have emphasised the need to take into account historical and political
economic processes in understanding these aspects of human experience and in contextualising the evolution of the contemporary sexual behaviour patterns (Brown, et al., 1983; Schoepf, 1991; Kielmann, 1997; Farmer, 1997; Packard and Epstein, 1991). Political and economic structures introduced by and inherited from the colonial regime, particularly the migratory labour system affected and continue to affect men and women in ways that have been deleterious to their health (Larson, 1989; Dawson, 1988; Inhorn and Buss, 1997; Hunt, 1989; Schoepf, 1991).

Migratory labour brings a host of social ills and health problems including STDs that cause infertility and death (Inhorn and Brown, 1990). Farmer (1997) has demonstrated how political, economic and social processes have structured HIV/AIDS infection among the poor Haitians. Elsewhere in Africa Inhorn and Buss (1997) have shown that both labour migration and sociocultural factors are a major contribution to female infertility in Egypt.

Doyal and Pennell (1994: 111,131) argue that the migrant labour system brought many rural Africans into direct contact with Europeans and this resulted in the spread of many new diseases (such as measles and tuberculosis) hitherto unknown in Africa. In Central Africa, Schoepf (1991:751) describes how contact with colonial armies and male labour migration resulted in the spread of new STDs in Zaire and much of Central Africa with the attendant problem of female sterility which spread to rural areas. Doyal and Pennell (1994:119) capture how STD spread to rural areas: ‘...most destructive of all, was the way in which workers, travelling from labour areas back to their villages, opened up much of the countryside to new diseases such as tuberculosis and VD.’ Indeed, migrant labour and movements between urban and rural areas in East Africa have had a substantial influence on the growth of paid sex and the spread of STD including AIDS into the rural areas (Hunt, 1989; Shoepf, 1991).
The disruption of traditional patterns of life and extraction of men and women from family life resulted in the erosion of traditional marital and sexual patterns as well as creating new ones not congruent with traditional practices (Doyal and Pennell, 1994), for example, sexual relationships with strangers in urban settings. In Kenya the separation of men from their families resulted in split households, that is, men having one (or more) home in the village and another in the urban area (Nelson, 1987). Consequently, men oscillated between the town and the rural area (Thadani, 1979 cf. Kielmann, 1997:382).

This colonial legacy is still evident today, and, coupled with contemporary economic realities, the majority of urban wage-earning married men do not live with their wives in towns. But rural-urban ties remain very strong and there is a constant interaction between the urban and rural. Husbands visit wives in their rural homes and unmarried men working in towns return to court and seduce girls in the rural areas (Parkin, 1978; Bujra, 1999; Le Vine, 1979). If their income is too low men may not visit rural family regularly; they may visit their rural homes once a year, often during Christmas holidays - something quite common in rural Kenya today (see also Ferguson, 1987). This has certain implications in terms of sexuality, disease and wellbeing. As Nelson (1992:130) puts it, ‘men are lonely in town and start casual relationships with women in town’. This may result in a divided or lack of emotional, marital or sexual commitment on the part of the men.

A man may find a girlfriend, drink too much in frustration, or just forget to send money home (Larson, 1989:725). And Gusii women concerned about their husbands’ sexuality fearing that they will start relationships with other women while in town (Levine,1979 cf. Nelson, 1992:130). This they feared would cause their husbands to neglect the family including failure to fulfill their male postpartum roles. Levine cites a young wife who had given birth
complaining that her husband had married another 'wife' and 'failed to send
the money for the customary clothes to mark the occasion' (ibid). Most
importantly, however, it is instructive to note that such temporary relationships
carry the possibility of STD/HIV infection. If the man does not visit his rural
wife frequently, and is unable to support her, she has minimal opportunities to
make up for the shortfall (Larson, 1989:725). As a consequence, she may start
liaisons with another man in the village. Such a relationship has its own
dangers including unwanted pregnancy, which threatens the stability of a
marriage. This sexual and reproductive aspect of men and women in the
villages has received little attention in the literature. Indeed, in the villages
men exert considerable pressure on women of migrant husbands or boyfriends
who take a long time to visit. If it happens that a man comes home to his wife
or village girlfriend with an infection, or the wife visits him in his place of
work and there is infection, the same is likely to be passed on to the spouse
(see e.g. Moss et al., 1999). Young women also migrate in search of work or
to visit relatives. They may find work as house helps or bar work. If none of
these is forthcoming, some of these women find themselves in sexual
relationships, which border on prostitution (Bujra, 1999:67). Indeed, many
combine such work and sexual exchange with gifts and cash to supplement
their meagre incomes.

A political economy approach takes cognisance of the historical developments
that have shaped and contributed to contemporary sexual patterns, their bearing
on STD/AIDS, and to some extent reproductive outcomes. Like Farmer
(1997), Kielmann (1997), Setel (1999), Schoepf (1991b) and others who have
employed political economy and historical approaches to the study of sexuality
and STD/AIDS in non-Western cultures, I find this perspective relevant for
understanding, analysing and contextualising sexual behaviour and STD/AIDS
infection in rural Kenya. The political economy approach to health makes the
point that sociopolitical and economic factors such as migratory labour are key
to the production and spread of disease (see eg. Doyal and Pennell, 1994; Farmer, 1997; Kielmann, 1997). Here there is a shift in emphasis from individual to structures that interfere with social relations, influence behaviour or impinge on the health of the individual (Morsy, 1996; Webb, 1997). Regarding childbearing, political economy brings into focus the reproductive and productive roles of men and women, which are shaped by gender relations in the domain of sexuality and reproduction.

This approach, however, does not adequately deal with individual and cultural factors, which are also important in the causation of sexual illnesses. It locates the blame or cause of illness outside the individual in the wider structure, yet some illnesses find explanations in terms of the individual’s sexual conduct as when he/she breaks sexual prohibitions, resulting in miscarriage. The political-economic approach does not explain the continuity of cultural aspects and practices that have a bearing on sexual and reproductive health.

Furthermore, a political economic approach in the context of disease, illness, suffering and health depersonalises individuals’ experiences and knowledge (Schepere-Hughes and Lock, 1986; Morgan, 1987); it ignores the existential experience and meaning of illness and suffering. In sexuality and reproduction, it fails to adequately explain the meaning people attach to various reproductive outcomes, much less the strategies employed to manage the various aspects of childbearing. Understanding the social and cultural context in which action and behaviour related to reproduction and sexuality occur helps us to see the internal logic of the ways in which they manage sexual problems such as STD/AIDS and poor childbearing outcomes such as miscarriage.

Understanding in less generalistic terms how men and women experience STD and/or why they experience it differently helps in making sense of the
meanings attached to infections and misfortunes associated with coitus. One of the limitations of a political economy perspective is the tendency to homogenise people and their lived experiences. Not all migrant labourers, men or women were and are infected with STD or exposed to dangers of infection with AIDS. It is true that both men and women are infected largely as they carry out activities on which their livelihood is dependent, after which they spread the disease through both desire and in their attempt to reproduce (Bujra, 1999:61). The poor and the socially weak are vulnerable to STD/HIV/AIDS infections (Farmer, 1997:428). In a sense, however, AIDS does not discriminate, neither does it recognise material distinction if those with material wealth do not recognise its presence (see AIDS case study 6 in chapter 8). The wealthy are exposed to dangers of infection through their capacity to purchase sex. Thus wealth is not by itself a preventive measure.

The meaning and explanations of reproductive outcomes such as stillbirth and miscarriage differ even within a culture. Similarly, the meaning of childbearing to both men and women but also between women themselves is different. In this thesis I adopt a meaning-centred approach to explore the meanings men and women attach to sexual behaviour, reproductive events and STD/AIDS infections and contradictions that entail the management of misfortunes and dangers associated with coitus.

2.6 Dangers, metaphors, stigma, and spoiled identity: Locating explanations

Douglas (1966) argues that culture is a means of ordering experience. Order has something to do with boundaries; it implies restriction. In other words, order entails creation of symbolic demarcation (Wuthnow, 1987:69). In practice, however, these boundaries are fluid. They could contain a whole culture or a group of people within a culture such as family or clan, men, women, youth and adults. Inevitably, anomalies, ambiguities and 'disorders'
arise within a culture or an ordering system; the system must be prepared to restore order and control the violators when they cross some forbidden line (Nations and Monte, 1997:468). Once an act is considered anomalous and/or the person violating the social norm is labeled as 'polluting', 'impure' or a source of 'danger', then a whole society or a group of people must get rid of the destructive effects of the act. One way of doing so is through ritual. Rituals are performed to cleanse the offenders and offended of the danger that they acquire through breaking sex or other taboos.

Even though sex produces a number of benefits including children, health, and pleasure, it can also be destructive at times (Douglas, 1966:151-2). The dangers associated with improper sex include miscarriage, contamination/pollution, infertility, STD/AIDS, misfortunes, and death. Some sexual acts are thus dangerous and threaten the wellbeing of an individual, family, clan or community. Such is the case as when a man or woman transgresses sexual norms. For example, when a man has sex with a woman who has had a miscarriage, a state considered impure, and is also sleeping with his pregnant wife; or when a man has sexual intercourse with his son's wife. This brings pollution and the individual is himself/herself in danger and can transmit the danger to others such as the wife or husband through sex, sometimes to the unborn child or a larger group (clan or lineage). Such a danger is removed by ritual, which separates and cleanses the individual from the polluted status to afford him a return to his old unpolluted status. The enactment of the ritual may be public or private, depending on the social consequences of the act. Its performance brings order not only by banishing the effect of the polluting or dangerous act (and ridding people off contamination), but also by punishing the violator directly and/or symbolically within certain social boundaries such as clan or family, rather than the whole society. Failure to do so can be physically and/or socially lethal. It may result in poor reproductive outcomes, such as loss of children at birth, miscarriage or
unexplained maladies and misfortunes. It can also cause social disharmony between kin. In this sense, it is not the ritual *per se*, as Douglas (1966:94) suggests, that recognises the power of disorder, but the people who recognise the power of disorder or pollution, and the power of ritual performance to bring physical, psychological and social healing.

Order means control, while disorder implies that there are no restrictions, according to Douglas (1966:94). Uncontrolled sexuality thus crosses moral boundaries and so it embodies disorder. Sexually transmitted diseases symbolise moral disorder because they result from dangerous or excessive sexuality (Weeks, 1989). In fact, any disease/illness brings physical and/or social disorder. So physical and social disorders too can produce disease or illness. Because STD including AIDS are associated with culturally and socially, even physically disordered environments (eg. urban settings, lodgings) and people, those who contract these diseases are considered morally deficient, and are blamed for the infection.

Because moral sentiments support the rules of purity (Douglas, 1966), there is a sense in which morality enters the discourse of danger as those who bring danger to others are considered not morally upright (Caplan, 1999:23). In a sense, they become polluted. To avoid being contaminated, moral boundaries may be erected between "us" and "them", the safe and the dangerous, members and outsiders’ (Wallman, 1998:176), as between the urban and the rural or men and women, at least in the case of STD/AIDS. This is particularly so when not just an epidemic disease, but a lethal one like AIDS transmitted through sex, occurs, which is ‘seen as a threat to the purity and the survival of “us as moral beings’ (ibid). Inevitably, the infected become stigmatised. According to Goffman stigma is:
An attribute that makes him (person) different from others...of a less desirable kind...a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive. (Goffman 1963:2-3 quoted in Nations and Monte, 1997:468).

Stigma spoils normal identity, sometimes permanently, as Goffman writes:

Stigma is so closely connected with identity that even after the cause of the imputation of stigma has been removed and the societal reaction has been ostensibly redirected, identity is formed by the fact of having been in a stigmatised role...one’s identity is permanently spoiled (Goffman, 1963:74 quoted in Nations and Monte, 1997:469).

In a village where most people know each other, the knowledge that one has STD can damage their image. However, when a disease is treated as a collective social and political concern rather than a problem of individual bodies (Schepere-Hughes, 1988 cf. Good, 2001:58), much of the stigma or moral gaze associated with it may disappear and the moral boundaries become less rigid. When an illness is interpreted as a problem of not just individuals but society, the focus of attention is shifted (Good, 2001:67). AIDS is considered a sexual disease, even sinful, but it is no longer surrounded with silence as has been the case in the past (Nzioka, 1994; Caldwell et al., 1992). Indeed, unlike in the West where modern forms of contraception and feminism opened up sexuality to public negotiation and discussion (Giddens, 1992), in Africa it is AIDS more than anything else that has brought sex and sexuality into the arena of public discourse (Bujra, 1999:77). AIDS has increasingly moved from the private to the public domain, partly because of the public discourse on it, partly because of its prevalence, and because its consequences refuse to be contained within the boundaries of the infected and the kin, but affect the wider community (Barnett and Blaikie, 1992). Once a ‘public’ health problem, the blame and shame associated with AIDS shifts from the infected and affected, at least in part (Wallman, 1998:176). By the same token,
the stigma placed on those infected and affected is likely to become less
pronounced.

The ordinary STD remains invisibly private not public both in its very nature
as an illness and consequences. But at the same time it is a highly moralised
and socially stigmatising illness. However, men and women do not experience
the stigma of STD in the same way. For women, to be labeled as having or
having had an STD is stigmatising; their identities as wives, girlfriends or girls
are spoiled, often permanently even when they are cured, because a woman’s
infection with STD threatens the moral fabric of the entire family as it
symbolises uncontrolled sexuality. It is even more problematic when STD
interferes with childbearing.

The situation for men is different. The stigma associated with STD may
disappear, and their identity as husbands, boyfriends, or simply men is not
debased, at least, not permanently. This has to do in part with perceptions of
male sexuality. The metaphors used, especially by young men to discuss
ordinary STD, destigmatise it. Regarding metaphor, Lakoff and Johnson (1980
in Nations, 1997:462) write that “the essence of metaphor is understanding
and experiencing one kind of thing in terms of another.” So metaphors are
employed to define and give different meaning to a phenomenon, event or
illness while at the same time masking real meanings and experiences
(Nations, 1997:462), such as stigma associated with it, as when people call
STD ‘common cold’; or refer to it as ‘woman’s disease’ (to paint men as the
moral community while heaping blame on women who contract STD); or
when an informant says ‘AIDS is not rain so that it rains on everyone even
when you do not want it; if you shelter, you will not be rained on;’ or when
young unemployed people say ‘AIDS is like an accident’ to mean it is
unpredictable and one has no control over life events. In this context then, as
Farmer (1997:414) shows in rural Haiti how poverty and powerlessness,
including gender inequality structure the risk of STD/AIDS infection, so it is necessary to understand the complex relationships between power, gender, and sexuality in rural Kenya. As in Haiti, these aspects remain closely intertwined in rural Kenya. The question of the meaning of a disease and who it is that is sick then becomes important, at least in its management.

2.7 Managing illness: what illness?

In attempting to understand and explain how reproductive misfortunes and illnesses associated with sex are managed, I draw upon theoretical arguments grounded in medical anthropology. As Lock and Scheper-Hughes (1996:64) observe, illness and suffering are experienced by ‘real’ people as they live out their lives in specific social and cultural contexts. Regarding illness and health, Frake (1998:42) says: ‘Every culture provides a set of significant questions, potential answers, and procedures for arriving at answers.’ Questions such as ‘Am I sick?’, ‘What kind of disease do I have?’, ‘What caused this disease?’, ‘Why did it happen to me (of all people)?’ (ibid.; see also Wallman, 1998:176) are evoked by illness in all cultures. Notions of disease and illness causation provide cultural answers to these questions. And people use the meaning they attach to an illness or misfortune to arrive at or look for a specific answer to an illness. Definition of signs and symptoms as constituting illness or misfortunes is influenced by cultural knowledge, lived experience, social norms and the meaning people attach to these events.

Foster (1998:145) has classed disease aetiologies in non-western societies into personalistic and naturalistic categories. In the personalistic system illness causation is attributed to active agents that cause misfortunes and religion and magic are intimately tied to illness occurrence. In the naturalistic system illness is attributed to equilibrium loss, is unrelated to other misfortunes and religion and magic have no connection with illness. Further, Foster categorises concepts of disease causation /illness and misfortunes into different levels: the
immediate causes which deal with who or what has happened to be ill; and the ultimate explanations of illness causation, which attempt to answer the why question in addition to dealing with immediate aetiologies. In reality, however, when people are confronted with illness the dichotomy becomes very fluid and overlaps occur during therapy search.

Illness is first recognised and defined and management activities are initiated in what Kleinman calls the popular sector of health care (Kleinman, 1980:50). The popular or lay sector is a matrix consisting of several levels and players: individuals, family, friends, and community beliefs, and activities. Self-treatment by individuals or family is the first therapeutic step taken in many cultures the world over. The individual and his/her family draw upon not just beliefs and values about illness or misfortune that are a part of the cognitive structure of the popular culture (Ibid: 52), but also on knowledge and lived experience, and depending on the meaning given to the illness or misfortune. The individual and/or the family may disregard the signs and symptoms for various reasons: they may consider them inconsequential, not life threatening, or begin therapy themselves or consult with friends, neighbours, and relatives about what to do. These constitute a ‘therapy managing group’ (Janzen, 1978:4) or what Good (1987) calls ‘significant others’. According to Janzen a therapy managing group is constituted whenever an individual or group of individuals becomes ill or is faced with overwhelming problems. The therapy managing group sifts information about the illness and helps making decisions and arranging for therapeutic consultations; it provides material and/or moral support. Janzen demonstrates the importance of the therapy managing group in the pluralistic health care environment among the Kongo of Lower Zaire who combine biomedical treatment with traditional and religious healers.

The phenomenon of groups managing illnesses hinges on the assumption that there is necessary consensus and cohesiveness among the group and the
strategies to employ in managing an illness, which is not always the case (Boeck, 1991; Last, 1999:75), especially with the continued erosion of traditional institutions of social support. Also, it is scarcely the case that family, neighbours, relatives, and friends are always eager and ready to help, as Janzen contends, particularly if the cost stretches to the limit as is the case with a debilitating fatal illness like AIDS. Rather than creating social harmony in a group, an illness may actually create social conflict even among family, who are likely to experience economic hardship because a fatal illness like AIDS depletes emotional, social and material resources. And the greatest poverty may not even be the lack of material wealth, but the absence of social support (Last, 1999:78). In other words social poverty - whether it is the lack of family, friends, neighbours and relatives to provide support to a sick person or a newly delivered woman who needs help with household chores to facilitate quick convalescence.

Also of particular relevance to my thesis is that the notion of group management of illness does not take into account who is sick and what type of disease/illness they are suffering from. It assumes that the experience and meaning of any illness is the same for men and women. Diseases/illnesses that are suffered privately because they are shaming and stigmatising may hinder the sufferer from disclosing their illness status. As Frake (1998:42) points out, disease concepts are verbally labeled and readily communicable if they are talked about, not just suffered and treated. Later in this thesis I will show that the experience and meaning of STD to women is different from that of men. For women in Mwala and certainly elsewhere in Kenya, STD is suffered, sometimes treated but not talked about because it is socially stigmatising. Revealing their STD status has the potential of spoiling their identity permanently; consequently, for them a therapy managing group is both unwelcome and non-existent. However, I find Janzen's notion of a therapy managing group useful in the management of childbearing problems,
especially where the young generation consults with the older one about how to deal with reproductive problems, the cause of which are rooted in the socio-cultural realm.

If people seek therapy beyond the family, their choices are not only anchored in the cognitive and value orientation of the culture (Kleinman, 1980:50), but are also informed by lived experience. In many cultures people may be more concerned with why a particular misfortune occurred to them (Good, 1987; Wallman, 1998; Last, 1999; Whyte, 1997) in addition to what the misfortune is and how it happened. The purpose of diagnosis at this level is not just to identify and label the illness, 'but to uncover its cause, and its connection to other illnesses and misfortunes' (Last, 1999:77). Here people are interested in finding and dealing with the underlying or the ultimate cause, be it social conflict or a particular behaviour. For example, if a woman has miscarried or is infertile, people will want to find out why the miscarriage occurred, which may be a result of sexual misconduct that angered ancestral spirits. Illness can also result in others as a consequence of one's own actions. In such a case healing may be directed not at the ailing individual alone, but also towards others (Chalmers, 1990). This, as Last (1999:77) argues, 'is not simply being mystical or personalistic, involving metaphors or magic, but rather pinning responsibility for the victim's manifest vulnerability on social or political factors.' This level of illness can only be successfully managed by healers who adopt a holistic approach to suffering but not healers guided by a reductionist biomedical model, which looks at disease and illness experience in a limited, narrow and mechanistic view. The biomedical model based on Western scientific rationality assumes that all phenomena are testable and verifiable under objective, empirical, and controlled conditions. 'Phenomena relating to health and sickness only become 'real' when they can be objectively observed and measured under certain conditions' (Helman, 2001:79).
Because the biomedical model emphasises physical dimensions of illness and suffering, it considers sociocultural aetiologies or explanatory models of suffering and healing as simply extraneous to the 'real' illness and disease management (Good, 2001; Helman, 2001; Lock and Scheper-Hughes, 1996; Good, 1987). By contrast, the approach taken by traditional healers encompasses social aspects in diagnosis and management of illness and suffering (Last, 1996; Good, 1980, Fabrega, 1982; Nyamwaya, 1992). About traditional healing Last (1996:389) writes, 'traditional healers are considered specialist in one of the two main aspects of healing: divining or diagnosing the ultimate causes of an illness, and identifying the nature of the illness and treating it.' Their approach takes cognizance of social, cultural, and psychological dimensions of illness and misfortune, and the context in which it occurs, 'which determine the meaning of the disease for the individual patient and those around them' (Helman, 2001:81). For example, in Mozambique traditional healers are considered experts in treating STD (Green, 1999, 1994) while among the Luhyia of western Kenya, traditional healers are favoured because, among other things, they cure the root cause of STD (Moss, et al., 1999).

However, the dichotomy in the use of tradition and biomedical services is not clear-cut. Janzen (1978) has, for example, shown how the Kongo of lower Zaire combine the use of biomedical therapies in the form of clinics and divination, herbalism, and religious healing. Thus in a pluralistic health care environment, healer 'shopping' and illness management are often complex; people seek the services of biomedical and/or traditional healers alternately, serially and/or simultaneously (see also Good, 1987; Sidinga, 1995). So people with reproductive problems or STD/AIDS adopt various strategies of managing the problem, including utilisation of different sources of therapy in search of cure of a single or different STD episodes (Moss, et al., 1999; Wallman, 1996).
2.7.1 Health promoting strategies

But people are not just preoccupied with illness and cure; they are concerned with health and health maintenance (Kleinman, 1980:53; Chalmers, 1990:10). This is about illness prevention. Prevention may be provided for not just the individual, but the family, community and property (Chalmers, 1990). About prevention in non-Western health care systems, Foster (1998:148) writes: ‘preventive medicine insofar as it refers to individual health-oriented behaviour, can be thought of as a series of ‘dos’ and ‘don’ts’ or ‘shoulds’ and ‘shouldn’ts’. But the ‘shoulds’ and shouldn’ts are not limited to non-Western societies; they are also found in the West. For example, a personal health strategy that emphasises ‘shoulds’ may require an individual in the West to do physical exercises regularly while in non-western societies, a health strategy may emphasise ‘dos’, which may require individuals to make sure their social relations with others or with ancestors are maintained in good working order. It also involves ‘don’ts’ which require an individual to avoid those acts known to provoke resentment from ancestral spirits, including sexual relations that are a danger to the individual and/or others. The ‘dos’ and ‘don’ts’ are thus regulations, norms, taboos, prohibitions, and prescriptions that cultures create to help individuals maintain their own health, which in turn contributes to a group’s or community’s wellbeing.

But individuals have a responsibility to avoid health-threatening behaviours. Trust becomes a major factor here, especially in domestic relationships (Bujra, 1999). Women trust or hope that whatever their husbands/partners do out there, they will do it safely and carefully not to bring home misfortunes, including STD/AIDS. And men trust that their wives cannot give them STD/AIDS, perhaps because they are not expected to engage in sexual liaisons.
outside marriage. In the same way a cultural group trusts and expects individual members to live according to the expected norms. For as Last (1999:83) argues, ‘in the final analysis it is not health itself but only the means to health’ that can come from organisations or from governments and, in this case I would add, from the community. In the same vein, if the means by which individuals can achieve health is unavailable or inadequate as when individuals live in poverty and engage in sexual behaviours that expose them to dangers of STD/HIV; or as when material resources are unavailable to a pregnant woman or newly delivered mother or the social support traditionally available to her is no longer adequate resulting in poor health; or as when norms that controlled sexual behaviour have eroded and individuals engage in sexual conduct that brings illness, misfortunes, or disaster, the responsibility for health lies not with the individual but elsewhere, with the larger collectivity - government or group of people.
Chapter 3

The Akamba

This chapter introduces the Kamba people. The examination and analysis of life of the Akamba in general and sexual and reproductive aspects in particular in this chapter are largely based on the written material about the Akamba and my discussions with the older Kamba men and women in the field. I also draw from my own personal experience. The Kamba ethnic group is mainly found in Eastern Province and occupies four districts, namely Machakos, Makueni, Kitui, and Mwingi. This is the region known as Ukambani. The Akamba are Bantu speakers and their language is Kikamba and a person of Akamba is known as Mukamba. The 1989 population census put their population at 2,448,302 (CBS, 1998) but according to the unpublished 1999 population census, the total population of the Akamba is close to three million. They are the fifth largest ethnic group in Kenya.

Although the existing early Akamba ethnography does not deal directly with the issues of sexuality, reproduction and health (see e.g. Lindblom, 1920; Hobley, 1967; Penwill, 1951; Middleton, 1959; Middleton and Kershaw, 1965; Dundas, 1913) there are instances in more recent works (see eg. Mbula, 1977, 1982; Kabwegyere and Mbula, 1979; Mutunga, 1994; Ndeti, 1972; Johnson, 1999) that some aspects of sexuality and reproduction, especially beliefs and practices concerning sex and reproductive behaviour and their bearing on health have been addressed. I draw selectively from these studies on issues that are pertinent to my study in understanding the contemporary notions of illnesses and misfortunes associated with sexual and reproductive conduct and the management of these problems among the Kamba. In doing so I go beyond mere reporting of the available ethnography about the Kamba to offer some critical assessment of the material, especially the colonial literature.
Like other aspects of culture, sexuality, biological reproduction and the means of social reproduction to which they have been connected have undergone constant transformation, but have not entirely lost continuity with the past. Consequently, some contemporary sexual and reproductive illnesses and childbearing misfortunes have continued to be explained in ways similar to those in the past hence the need to provide a cultural context within which to read, analyse and interpret some of the materials in the latter chapters.

3.1 The Akamba social system

3.1.1 Family, marriage and reproduction

Family [*musyi*] is a basic social unit which refers to both the physical home and the social relations between a man and his wife (wives) and their kin (Ndeti, 1972; Mbula, 1977). *Musyi* may have more than one household. Typically, household members include the head, his wife (wives) married sons and unmarried children (Akong' a, 1982:2). A mature man or woman is expected to marry and have a home. Having a home demonstrates that one is not only physically able to produce children, but he/she is socially capable of bringing them up, that is, playing the role of a parent. Even a sexually impotent man traditionally married and a close relative produced children for him (Ndeti, 1972:67; Kabwegyere and Mbula, 1979:11).

If a woman was barren or had no male issue and the man could afford to pay bridewealth [*ngasia/mali*], he married another wife; often the first wife sanctioned the taking of a second one. Similarly, a barren woman could marry another woman [*iweto*] and a male relative of the husband of the marrying woman was selected either by the ‘social husband’ or the ‘social wife’ [*iweto*] herself to have children with her (Mbula, 1982). The children identified with
the social husband who had the responsibility of bringing them up. She became the social father and the biological father could not lay any claim on the children. Traditionally, the practice of woman to woman marriage is also found among the Kikuyu, Luyia, Kipsigis and Gusii communities in Kenya (Akong’a, 1997:12). But unlike among the Luyia where the husband of the marrying woman was given the bride to have children with her, the husband of the marrying woman among the Akamba could not have sexual relations with iweto. Thus the society allowed women in a patrilineal and patrilocal society, where the normal order of things is for men to marry and have children, to marry other women to satisfy their quest for children for social and psychological satisfaction (ibid). Missionaries condemned and sought to eradicate polygyny and maweto marriages because these did not fit with their Christian faith. Both institutions represented values repugnant to Christian morality; indeed like the missionaries, some authors (see e.g. Caldwell; et al., 1989) perceive maweto marriages as nothing but prostitution. This, as we shall see, created hitherto unknown stresses for infertile men and women.

Traditionally livestock and farm produce form the bulk of bridewealth. Cash has been added to this and the amount of bridewealth paid is not uniform; it varies from clan to clan and ranges from a few cows and goats to tens of cows and goats. What has remained constant is that three goats are always given to the bride’s family. Caldwell et al. (1991:252) argue that as the nuclear family replaces the extended one, and since Christianity has taken firm root in Africa, the traditional marriage ceremonies have been eroded. Among the Akamba, whether one plans to have a civil marriage or a wedding in church, they must first perform the traditional rituals, which include payment of the first three goats [mbui sya ntheo]. If a woman dies and the husband had not paid the three goats to his in-laws, he will not be allowed to bury her until this is fulfilled. This is done regardless of one’s social status in society: educated or not, rich or poor, Christian or not. Discussions with my informants, young and
old, revealed that this aspect of Akamba life remains universal and every Mukamba man strives to fulfil it. Bridewealth legitimises marriage and reproduction while children give a marriage meaning. However, it is true that in some cases many elaborate rituals and celebrations have changed, some postponed or skipped. But this cannot be explained by the tendency toward nucleated family or by Christian values. It is largely an economic problem (see also Heller, 1971).

3.1.2 Social reproduction and health

As indicated above, the traditional family is not simply the nuclear but the extended family. It is within this traditional family structure that children were socially reproduced to fit in the Akamba culture. The Akamba are patrilineal and the principle of patrilocality made this unproblematic. Grandparents spent time with grandchildren socialising them into the Akamba culture through songs, proverbs and riddles, stories, and gossips. Matters about sexuality and reproduction were introduced gradually (Ndeti, 1972:78). Thome, a fireplace by the entrance of the homestead where grandfathers sat with boys in the evening, played a key role in these matters. Grandmothers did the same with girls inside their living place.

Young people did not just learn about body changes as they moved from childhood to adulthood, they also learned about the Akamba moral codes, beliefs and taboos to be observed in order to avoid bringing social disaster and afflictions to the individual, the family and society. Thus the responsibility of teaching growing children matters about sexuality and reproduction did not lie entirely with the parents; it was also the responsibility of grandparents, extended family, older siblings and other society members. But the modern western-oriented society and education calls on parents to deal directly with
sexuality of their children, putting them in a socially difficult situation. As we shall see later, it is partly the erosion of the role of the extended family institution that has created a situation in which young people grow up with little knowledge about sexual and childbearing matters resulting in many social, sexual and reproductive problems. As Akong’a (1997:15-16) observes, the breakdown of traditional family and kinship systems, conflicts engendered in modern religious teachings, and contradictions between African and Western cultures have adversely affected the process of social reproduction, leaving the youth unprepared to face the challenges of life.

The extended family took care of the newly delivered mother by performing the role of *kuvyuvisya*, which includes cooking, washing, and helping her with household chores as she recuperated. Thus the extended family rather than being a hindrance to health, as the Caldwells (1989:225) suggest, promotes health by affording the new mother enough time to rest after delivery. Lindblom (1920:31) claims that a Kamba woman returned to her work the same day while Hobley (1967) and Middleton and Kershaw (1965:82) say the mother stayed in the hut with the child for 20 days. This discrepancy is an important part of my argument in this thesis. This early ethnography perhaps reflects the authors’ own point of view rather than the people and aspects he set out to represent. I will comment later in my thesis on the impact the weakening of extended family has on the pregnant and newly delivered mothers. For now the point I wish to make here is that, given the social support traditionally available to a new mother and the rituals that had to be performed including child naming, it is inconceivable that a woman returned to her duties soon after delivery.

Traditionally, *musyi* also functions as a centre for economic life. The family’s economic survival is largely based on ties and access to land. Girls and boys grow up knowing their role in terms of economic production for the survival of
the family (Kabwegyere and Mbula, 1979:42). The household head allocates land for production to his sons and between his wives. When the head becomes too old, he passes on the leadership and ritual responsibility to the first born son in a blessing ritual \([\text{kuathima}]\), and the son carries out his responsibilities in consultation with his mother. Thus the kinship principle plays an important role in resource allocation in that inheritance is through the male line. Nowadays although uncommon, however, there are women who may inherit land from their fathers. Often, these are unmarried or divorced women with children or women who are beyond marriageable age and there is little hope for them being married.

Much of the early literature on the Akamba follows the ethnographic writing of the time that depicted African societies as culturally homogenous stable units (e.g. Lindblom, 1920; Penwill, 1951). O'Leary's (1979) work is a notable departure from this tradition; he shows how the Akamba of Kitui differ from those of Machakos in certain aspects (see also Johnson, 1999). True, the Akamba are, as are other ethnic groups in Kenya (see e.g. Parkin, 1990:194), a distinctive cultural group in terms of language customs and traditions. However, there are, albeit minimal (but sometimes significant), internal heterogeneity. Some of these are based on clan practices. The clan \([\text{mbai}]\), which is made up of several lineages, is an important institution for social reproduction. The Akamba trace their descent through and children identify with their father's clan. However, they recognise both biological and social fatherhood and a child may identify with his social father's clan. If a man marries a woman who already has children with another man, the children become members of his clan. In a sense, therefore, clan identity may be produced through practice; that is, clan identity may be more a matter of kinship than descent. This is partly what makes payment of bridewealth vitally important as it legitimises claim and responsibility over children. There are over twenty clans whose members are bound by a code of conduct and
existence (Ndeti, 1972:70). Clans are not limited to a territorial boundary and a village has several different clans who may have migrated separately from different areas of Ukambani (Akong’ a, 1982). Migration may be occasioned by famine, land shortage, or witchcraft related problems in the original or subsequent villages.

Each clan has its own prohibitions and taboos which members are expected to observe (Ndeti, 1972). Some clans, who in the past were strictly exogamous, have in the recent past become less strict in enforcing the rule of exogamy. For example, Atangwa clan may allow marriage among its members while Asii clan remains exogamous, although in some cases it has condoned marriage among its members. If that happens, however, the couple must be ritually cleansed before they have children. These changes notwithstanding, generally most of the clans are exogamous with regard to sex and marriage. Breaching rules governing sexual and reproductive conduct results in thaavu (see section 3.2.3) affecting the wellbeing of the individual, family, lineage or clan.

The clan provides codes and means of social control among its members; it disciplines any wayward member. Each clan maintains certain social boundaries to the extent that disputes between its members are resolved internally. The disputes may be of economic, social, family or even marital nature. Clan remains an invisible power always ready to help in whatever way possible in the interest of its members. Traditionally, for example, clan has helped to pay bridewealth and damages [maambo] for those who genuinely cannot afford to (Kabwegyere and Mbula, 1979). The clan also helps to finance education of its members (Ndeti, 1972). Its decisions are binding on its members because it carries a sense of common justice for all members. Thus clan members regularly interact in various categories including those involving rituals. Although the colonial policies and legal system considerably eroded clan powers, it still evokes an overwhelming respect, sometimes fear,
among its members and the last thing a person would want is to antagonise themselves with his clan even with the present modern legal government structures.

3.1.3 Initiation: cultural creation of sexual and reproductive bodies

The Akamba had elaborate initiation rites, which formed an important cultural framework for the social, physical, and psychological preparation of boys and girls for adulthood. The first circumcision [*nzaiko*] known as minor circumcision of both boys [*ivisi* pl. of *kivisi*] and girls [*eitu* pl. of *mwiiitu*] involved the actual removal of the whole foreskin of a boys’ penis and the girls’ small part of the tip of the clitoris (Lindblom, 1920; Penwill, 1951; Ndeti, 1972). This was performed by man or woman specialist [*mwaiki*] well versed in these matters. Circumcision was the first step in the initiation process. Circumcision was an important marker of physical and social movement from childhood into adulthood. But although the first circumcision endowed the novices with status, they were not considered adults yet and were not entitled to participate in all social activities (Mbula, 1977: 185). The second circumcision followed soon after and involved making incisions on the novices’ private parts, which for boys signified potency and for girls, fertility (Kabwegyere and Mbula, 1979). Circumcision for boys was to become the most enduring aspect of the Kamba initiation rite and has remained universal.

Circumcision for boys was performed somewhere about the age of 13, and girls before menarche. Soon after neophytes were secluded to live in separate huts under the care of a tutor, *muvwikii* (literally means one who covers); boys had their own and girls theirs. *Muvwikii* had vast knowledge and experience of the Akamba culture. His role was to nurse the initiates’ wounds and tutor [*kutaa*] them on various aspects of life, revealing to them the secrets of society.
During this time they continued to learn about community values, beliefs, respect for others, taboos, prohibitions, and generally the expected rules of conduct. The neophytes learned about what goes on in the secret world of adult men and women, and acts that could bring misfortunes to themselves, family and the community. According to my informants aged over sixty years old, these initiations took several weeks. The youth, the parents and the community knew what initiation meant; it formed the basis for acquiring knowledge and social status. Thus the traditional Kamba education was both family and community centred. The initiates were prepared for their future roles as mothers and wives or fathers and husbands (Mbiti, 1969:135). Discussing about the initiation Mbiti writes:

Initiation rites have [had] a great educational purpose. The occasions often marked the beginning of acquiring knowledge, which is otherwise not accessible to those who have not been initiated. It is a period of awakening to many things, a period of dawn for the young. They learn to endure hardships, they learn to live with one another, they learn to obey, they learn the secrets and mysteries of man-woman relationship. (Mbiti, 1969:122)

After this initiation the senior ivisi moved to the next age grade of social and cultural development and became anake and the girl became eiitu ma wathi (literally girls of the dance). Young men and women formed separate groups but there were many social occasions, family and community activities that brought them together. They joined and participated in social and cultural activities, including dances [wathi].

Wathi was mainly a source of leisure and pleasure for young adults. It was a cultural dance held during the dry season but it also involved participation in community activities (Ndeti, 1972:86). Wathi emphasised discipline, responsibility and teamwork. Members of the same wathi group belonged to the same age-group [yiika] and provided social support and helped each other
with work (ibid: 169). It is during dances and associated activities that sexuality was properly addressed. This cultural dance provided a well defined social space for initiated youth to meet and demonstrate their social worth; show dancing skills, self discipline and respect for others, and to choose a partner who may well have been a future marriage partner. It provided social space for young people to have full sexual experience. Ndeti writes that during wathi dances, young men had little control because it was young women who had the sexual power (ibid: 171). The girls had the freedom to choose dancing mates. According to Ndeti, to win the girls young men had to prove their wooing skills and demonstrate a high sense of patience and kindness. Ahlberg (1991:66) describes a similar ritual ceremony of songs and dance performed by the newly initiated Kikuyu youth and which addressed the sexual and reproductive roles of men and women. Similar rituals of songs and dance have also been reported among the South African Zulu (Krige, 1987 cf. Ahlberg, 1991:66).

The young people had now lived their life of youth to the full, participating in all social activities characterised by wildness, less family commitment, but more community responsibility. The wathi group disbanded when the members now in their late twenties married and settled down to family life. Many of the girls, however, married not long after the initiation.

The married men nthele in their twenties through thirties assumed serious responsibilities, which included providing for their households and the extended family. They had other roles including leadership in the community in various capacities. Nthele worked in close consultation with elders [atumia singular mutumia]. A nthele was not expected to consume alcohol [uki] until he had raised children old enough to be circumcised (Akong’a, 1982:4) and not before his father blessed and gave it to him to taste and drink in a ritual ceremony (Ndeti, 1972). He did this by taking a calabash of beer to his father
and slaughtered a goat for the ritual occasion. He now joined a higher social status, that of an elder, which was and still is a respected one. Mutumia who is the household or family head has a wealth of experience and is knowledgeable. He is consulted on matters about morality, marriage transactions, taboos, prohibitions, misfortunes, and rituals. Taking beer without the father’s blessings meant disrespect to tradition and custom, which could bring curse and destruction to the individual. It was (and still is) believed that the man would unnecessarily cause trouble to his drinking mates. Thus traditionally, the consumption of alcohol was regulated by custom. Today, few young people have their fathers bless the beer before they start drinking; old informants were unequivocal that this partly explains why young people abuse alcohol – over drinking and causing trouble. Doyal and Pennell (1994:114-115) trace the problem of beer drinking in African societies to the colonial period when the social character of drinking began to change.

3.1.4 Young adult sexuality

The traditional Kamba social system of production of sexual and reproductive members of the society differs radically from that of many other Kenyan societies. The Kikuyu (Ahlberg, 1991; Kinoti, 1983; Worthman and Whiting, 1987), the Luo (Ocholla-Ayayo, 1976; 1997; Parkin, 1973 cf. Ochola-Ayayo, 1997:116; Muange, 1999), the Luyia (Cartell, 1989 and Wagner, 1949, cf. Kilbride and Kilbride, 1997:212/213), and the Nandi (Ocholla-Ayayo, et al., 1993b) discouraged full premarital sexual intercourse and bridal virginity was valued and rewarded. By contrast the traditional Akamba were culturally not obsessed with bridal virginity and the sexuality of young people was not denied or treated with shame (see Middleton and Kershaw, 1965:82; Kabwegyere and Mbula, 1979:10; Ndeti, 1972).
The traditional Akamba expected the initiated young adults to have full sexual experience for pleasure and in preparation for marriage and childbearing. During *wathi* dances the young people were expected by both parents and the community to put into practice what they had theoretically learned about sexual matters during initiation (Ndeti, 1972:87; Mbula, 1977). My elderly informants confirmed this, adding that there was nothing to be gained by being a virgin and being ignorant of sexual and other youth matters. Young men and women were allowed to enjoy their youthfulness to the full before settling down into married life. This sort of sexuality must be understood in the context of the value the Kamba people attached to childbearing.

The Akamba put a high premium on family life and young adults had to be adequately prepared physically and socially for their future roles as mothers and wives and husbands and fathers. A girl’s virginity at marriage impacted negatively on her and her family; it was shaming for the bride and her family for it meant she had not been adequately prepared for wifehood and motherhood (Kabwegyere and Mbula, 1979:70). It indicated a failure on the part of the parents as it implied that the girl was not allowed to participate fully in social, cultural and leisure activities. Consequently, the girl was sent back to her parents for preparation for marriage. A ritual was performed in which the girl’s father looked for a man to deflower her before she was returned to her husband to undertake her mature task of being a wife and mother (Mbula, 1977:109). In other words a sexually uninitiated girl was not marriageable. Practical experience in sexual matters was, therefore, an important part in the development process of a Mukamba youth.

The traditional Kamba sexual training contrasted sharply with Christian teaching, values and morality, which emphasised virginity and chastity. To the Missionaries sex before marriage was a sin, while to the Akamba sex was not confined to reproduction or restricted to marriage; it was part of the whole
process of preparing young people for adult life. The traditional Akamba emphasised openness in sexuality matters, while Christianity muted them. Inevitably, the two moralities were on a collision course.

In spite of the open sexuality in the traditional Akamba, premarital pregnancy was rare and frowned upon (Middleton and Kershaw, 1965:82; Kabwegyere and Mbula, 1979:10). How then was order maintained in this seemingly free and open sexual terrain, particularly when there is no evidence to suggest there were more premarital pregnancies among the traditional Akamba than in any other community? It is to a more detailed consideration of this question that I now turn.

3.1.5 Maintaining sexual order: dangers associated with sex

The many dangers that littered the sexuality and reproductive landscapes made sex partakers whether or not they were married, be extremely careful. Mbula (1977:139) offers an insightful observation.

Although sex as such was sacred, the traditional Akamba society did not claim every coition as ritually unclean. Therefore, except for tabooed persons, sex was allowed freely, and yet it did not lose its sacredness because of the number of people who were made partakers in it.

I have already shown the importance of initiation rites. Among the Akamba circumcision came rather late, perhaps because their sexuality was more open. An uninitiated person was not only considered not mature physically but also socially, as he/she had not learned how to handle life situations such as matters to do with sex and reproduction. Ideally, therefore, any uncircumcised youth was not expected to engage in sexual intercourse. Ndeti (1972:87) writes that 'in the traditional Akamba, circumcision came rather late because theoretically
nobody would participate in sexual intercourse with an uncircumcised person.' Mbula makes the importance of circumcision more explicit. Again to quote her,

Before this instrument [penis] could be utilised by the society, for purposes of procreation, it had to be purified. This purification took the form of shedding of blood [circumcision]. Through this, the youth joined himself to the ancestors, and forged forward to work on the third time dimension, the yet-to-be-born. From then on the youth could look for a mate. (1977:92)

Sex was fraught with dangers, and taboos limited the frequency of sexual intercourse. For example, sex was prohibited if death occurred in the home (Mutunga, 1994; Mbula, 1982). A girl was expected not to have many lovers at a time. This was so in the event she married a different man other than the one she had been sleeping with and reproductive problems such as miscarriage occurred in the future, it would be easy to trace the source of the problem. This resonates with Parkin’s (1978:77) notion of a relative chastity among the Luo, that is, a girl is not expected to be a virgin at marriage but at the same time she is not expected to have had many lovers. With the erosion of social control institutions and less community pressure, new sexual patterns emerged. Today men and women have sexual relations with people they do not know their social background and when reproductive and other related problems occur, it may be difficult to locate the source. More critical is the danger of contracting STD/AIDS when one has sexual liaisons with strangers, as is often the case in urban settings. Case materials I present later in chapter six and seven provide compelling evidence for these problems.

The energetic and bustling biological and psychological changes and problems associated with and occasioned by teenage stage of development were contained and accommodated through culturally defined age grades and wathi dances. Ndeti (1972: 91) captures this properly by noting that wathi, which
involved fertility and sexually suggestive dances, helped to channel young adults’ energy into a useful personality expression.

Initiation rites inculcated in young men respect for girls. *Wathi* participants were expected to adhere to the socially accepted behaviour. During and after cultural activities any young man forcing a girl into unpleasant experiences risked being avoided by girls during dances. To control young men who may have been tempted to force girls into sex, the older initiated young men in the villages were put in charge to ensure proper conduct of other members in their group; there was peer control. A badly behaving man minimised his chances of finding a wife in the village because it would soon become known to the girls’ parents and others that the man was not likely to make a good husband. Husband’s cruelty was enough reason for a woman to divorce him (Penwill, 1951:17). Given the importance attached to marriage and considering that men looked for wives in the villages, they had to be careful. The punishment was sometimes severe and a young man could be ostracised from the group (Ndeti, 1972) thereby loosing all the benefits associated with membership to the group, including company and friends. If a woman became pregnant and the man accepted ‘ownership’ of the pregnancy, with blessings of the parents the parties involved married.

This ideal was not always realised as some girls could have more than one lover at a time. Kabwegyere and Mbula (1979:10) write that ‘if the girl claimed that one particular man had made her pregnant and he denied it, he had to swear in front of elders, and expect repercussions if he swore falsely.’ Unclaimed pregnancy could also result in a girl being married off to an old man. Therefore, young men and women had to behave in ways that were acceptable in the eyes of the community.
3.1.6 Regulating and managing sexuality and childbearing events

The Akamba placed a high value on children. Children provided parents with social and psychological security and status; they provided labour, perpetuated the name of the individual and entire family. Mbiti (1969, 133-4) observes that in African cultures, marriage and procreation are inseparable. Procreation makes a marriage complete; it is the focus of existence. Among the Akamba, marriage was (and is) the institution that provided cultural legitimacy to childbearing and rearing. Children stabilised and gave marriage a meaning. Therefore, marriage was not fully recognised, in a symbolic sense, until a woman had given birth (Mbula, 1977). Although children were valued, they were born and spaced at intervals in a social environment that permitted proper child development and good health of the child and the mother. The social and cultural environment was full of beliefs and practices that promoted health by regulating sexuality and reproduction because sexual conduct was closely linked to individual, family and community health and wellbeing.

Men and women used a number of strategies to control their sexuality and childbearing. Sexual intercourse continued in early pregnancy but was forbidden in advanced pregnancy (Hobley, 1967), that is, from the time the man noticed his wife’s ‘belly’ (which could be about the fifth month) through the period the baby was ‘wet’; that is, until the umbilical cord stump fell off and the scar healed. Some informants said sex was prohibited before the return of a woman’s monthly period, which could take several months. And yet others said intercourse was prohibited until the woman weaned the baby, which could take a couple of months. After the return of her menstrual cycle, a man had to wait for another three to five days before intercourse with his wife. The foregoing questions Lindblom’s (1920) assertion that the traditional Akamba couple had sexual intercourse during menstruation because they believed that was the period during which a woman could conceive.
Unlike in some communities, where a woman could not have sexual intercourse during lactation because that was believed to spoil the breast milk, as was the case among the Kikuyu (Ahlberg, 1991:69), the Akamba did not consider sex and semen as bad for the child's health; it was not thought to spoil the breast milk. However, pregnancy during lactation diluted and spoiled the breast milk. Thus the length of birth interval was important. It also suggests that contrary to the commonly held demographic view that the period of postpartum sexual abstinence among the African societies was universally long, often given as two or more years (see eg. Lesthaeghe, 1989; Page and Lesthaege, 1981), the period as given by my elderly informants was varied, ranging from over a month to more than a year.

The man had several options during the period that his wife was not available for sex. According to my elderly informants the first option was that the man was normally expected to show restraint and self-discipline during this period. The second option for a man who could not show restraint was to marry another wife. But the cost of polygyny in terms of bridewealth and building another home for and taking care of another woman meant that this option was available to a few who could afford it. Among the Akamba, polygyny was not the main organising principle of their marriage; it was not universal as implied by some authors (see eg. Caldwell, et al., 1989) because it was only the wealthy who could afford it (Ndeti, 1972:67; Kabwegyere and Mbula, 1979). But I need to point out here that polygyny, had other functions among them management of barrenness. As I pointed out earlier, a man had the option of marrying another wife if the first one was barren.

A man could engage in 'partial sex' for the purpose of relieving himself but he had to ensure no semen was deposited in his wife. A man could freely but secretly have sex with a close relative's wife, usually from the paternal side.
This ensured that a man did not have sex with strangers who could bring misfortunes and diseases to the home. As a way of managing infertility it was also acceptable for a close relative to father children on behalf of an impotent man. During the period that a woman was not sexually available, a man could also have a secret lover in the village provided the woman belonged to the same yiika as his wife. The lovers were not supposed to be strangers to avoid putting reproduction in jeopardy. The man and the woman could have belonged to the same wathi group and participated in cultural and social activities together. Some of these relationships ended up being formalised, that is, the man married the woman a second wife (Ndeti, 1972). Thus under certain circumstances it was culturally acceptable for men and women to have sexual relations outside their marriage. It is reasonable to argue here that although the love affair was supposedly secret, more often than not it was a public knowledge and it carried no negative connotations. There is, therefore, no denial that sex among the Akamba, as in some other African cultures (see eg. Ahlberg, 1991; Schoepf, 1991), was not always confined to marriage. In a sense then the Kamba sexual model was open. As Ahlberg observes, this open sexuality ‘differs from the Victorian sexual model, where extra-marital sex is [was] socially prohibited, but nonetheless widely practised secretly’ (Alberg, 1991: 222). Weeks (1989:19) puts it more candidly: ‘It [Victorian] is the age when sex was publicly, indeed ostentatiously denied, only to return, repressed, to flourish in the fertile undergrowth.’

Contrary to popular belief and unlike the modern family planning that focuses largely on women (Frank and McNicoll, 1987; Bongaarts and Bruce, 1995; Raikes, 1989; Kamau, 1997; Ekani-Bessala, et al., 1998), the foregoing discussion suggests men were fully involved in the regulation of childbearing. It suggests the existence of a strong co-operation between a man and his wife to avoid pregnancy at the wrong time (Kabwegyere and Mbula, 1979:70) contrary to the commonly held view about African male sexuality as insatiable.
It also questions the notion that men are less concerned about the health of their wives and children (see e.g. Caldwell, et al., 1989; Caldwell and Caldwell, 1987). The length of sexual abstinence in postpartum seems to have been exaggerated perhaps because it was assumed that men had no control or were not required to show restraint when their wives were either pregnant or unavailable due to other cultural reasons. In fact the traditional Akamba men were so sexually disciplined that a newly married couple slept together but without intercourse on the first two or three nights of marriage (Middleton and Kershaw, 1965:82). Separation of couples, due in part to migratory labour system, destabilised the lived experience and knowledge of men and women, thus undermining sexual control and reproductive health. It resulted in close birth intervals and its attendant problems as evidenced by women who say childbearing is strength consuming and weakens a woman’s body (see chapter five).

Mbiti (1969:110) argues that infertility is very humiliating because there is no source of comfort in traditional African life and that even when the fault lies with the husband, the wife remains accused in the eyes of the public. However, this is only partially true among the traditional Akamba. A number of social institutions were used to deal with both male and female infertility. As already pointed out, a man could marry another woman to have children if the first one was barren. An impotent man had a close relative such as younger brother or step brother have children with his wife and the children belonged to the impotent man. I have also pointed out that a barren woman could marry iweto to bear children for her. Thus traditionally, the institution of iweto provided a mechanism by which a barren woman could fulfill her role as a parent. I would, therefore, argue that among the traditional Akamba, barrenness did not cause as much pain to the woman or the couple as it does today because there were cultural institutions that provided remedy. But barrenness was not the only cause for marrying another woman. A man could
marry another woman if he had only girls (although this did not help if the man was the cause of the problem). And an old wealthy couple could also marry another woman to take care of them or help the first wife with domestic and wifely roles (Ndeti, 1972).

3.2 Some Akamba notions about illness and misfortunes

Ancestral spirits [ngai sya musyi literally gods of the home] have considerable influence on the behaviour and life of the Akamba (Mutunga, 1994:110) to the extent that Mbiti (1969) refers to them as the ‘living dead’. They influence the life and health of the living positively or negatively depending on how they are treated (Ndeti, 1972:174). Misfortunes and afflictions such as mystical sickness, and reproductive problems, such as infertility, miscarriage, and infant loss, could be visited upon the living family members by the ancestral spirits if they are displeased by their conduct, for example, breaking of sexual taboos (Mbula, 1977:146; Mutunga, 1994:115). If barrenness is the punishment, a ritual to appease and placate the ancestral spirits had to be performed so as to return fertility to the woman. If a new born child should be given a particular name as per the wishes of ancestral spirits and this is ignored, the child may develop unexplained health problems until the proper name is given to him/her. A diviner may be consulted over the cause of the problem. The parents or grandparents may also try giving the child the name of a family member, living or dead, he/she takes after in terms of appearance [kututya]. Thus naming not only marks family continuity, it also contributes to general wellbeing because the departed ancestors have interest in the health of the living family members.

If an ancestor wants a family member to become a traditional healer and she/he is not initiated into the healing ‘profession’, the spirits of that particular ancestor may cause affliction until such demands are met. There were and still
are regulations to help people live in a harmonious relationship with ancestors and avoid misfortunes. Thus illnesses, misfortunes, and other afflictions may be a pointer to social imbalance or a breach of rules of conduct.

The Akamba know that not all people are ‘good’. Some people are known to be agents of affliction; they are bent on disrupting the harmony that exists not just between people, but also between people and the physical environment. Anti-social practices such as witchcraft \( [\text{uoï} \] \) are prevalent (Mutunga, 1994; Johnson, 1999; Ndeti, 1972). Besides physical and/or environmental causes, misfortunes and afflictions such as mysterious diseases, poverty, barrenness, inability to find a spouse, death of livestock, draught and unproductive soils, may sometimes be explained in terms of human agency; could be seen as manifestations of witchcraft. Sometimes lack of progress or development at both the individual and community level may also be partly attributed to these antisocial forces (Johnson, 1999). Just as there are people who engage in antisocial practices, so are there traditional healer specialists in countering and neutralising the effects of such acts; they provide treatment and protection to individuals, their homes, and property.

3.2.1 *Kithitu*, reproduction and health

Breach of rules of conduct could result in the suffering of individual or group of individuals other than the one who breached the rules of conduct. This means that traditionally the responsibility for the wellbeing of the individual and others rests on the individual, the family or a larger group such as lineage \( [\text{mbaa} \] \) or clan \( [\text{mbai} \] \). Sometimes the suffering could be experienced by the second or third generation. Traditionally, the misfortunes may be experienced through non-human beings such as death of livestock or poor farm yields. This is true of *kithitu* [oath]. Traditionally, *kithitu* has been used as a social control
mechanism to resolve social problems that go beyond the finite human knowledge, such as when a person denies causing death of another (Ndeti, 1972).

*Kithitu* bridges the dichotomy of faith and knowledge (Ndeti, 1972:126, 128). The Akamba believe in *kithitu* because it affects and kills individuals who take it falsely (Good, 1987:91) as well as their immediate family and blood relatives such as the lineage members. According to my elderly informants, the belief in the power of *kithitu* to annihilate a family was so strong that traditionally, it was acceptable for a woman who suspected there was *kithitu* running through the family to secretly conceive a child with a man not related by blood to her husband, so that the child could survive to perpetuate the family’s name (*kithitu* affects only those related by blood and excludes married sisters for whom the three goats of bridewealth have been paid). Johnson (1999) seems to imply that *kithitu* affects the entire clan. While it is true that those affected by *kithitu* also belong to the same clan, its effects are limited to lineage and never go beyond the fourth generation; it would mean that *kithitu* effects are experienced by a generation that has no knowledge about it, thereby serving no purpose. She also seems to suggest that the effect of *kithitu* is purely psychological and works on the basis of blackmail. She writes: ‘The strength of *kithitu* as an agent of affliction relies on the belief that swearing a falsehood or breaking a sworn oath will bring dire consequences to the individual and his/her clan relatives… It works because if the accused is guilty he will confess rather than risk bringing death and disaster to his family and clan relatives’ (ibid: 151-152).

The workings of *kithitu* are mystical, known only to *kithitu* specialist traditional healer. But its destructive effects are demonstrably physical; its effects are not purely psychological because *kithitu* causes death of both people and domestic animals. When its effects are observed and sometimes
confirmed by a diviner, the affected party seeks the services of a traditional healer, a ritual specialist known as *mundu wa ng’ondu*, to cleanse [*kuusya*] them and put to an end its disastrous effects. I describe a *ng’ondu* ritual in chapter six. The point I want to argue here is that *kithitu*, in the sense I have discussed it, is associated with reproduction and wellbeing, which can only be understood in the context of the whole gamut of Akamba notions of disease causation.

### 3.2.2 *Kiumo*, reproduction and health

Another notion related to reproduction and health is the power of curse or renunciation [*kiumo*] (Ndeti, 1972). Hobley (1967:27) provides no details about the effects of curse but he writes that it was (and is) feared. Parents use curse only in extreme cases when a child repeatedly and deliberately mistreats them. The parents do so by uttering words to the effect that they wish him/her a miserable life in the same way that he/she mistreats them. The curse evokes supernatural powers and the person and his/her children are most likely to suffer misfortunes. In the extreme they may become infertile or have children who have poor health. Rarely does curse result directly in death, but death may result from disasters associated with curse. A curse that is directed at one child also affects other siblings. That is why it is evoked as a last resort. In a way therefore, *kiumo* can be connected to health and reproduction. A purification ritual is performed to remedy the situation, which involves retracting the bad words/wishes uttered by the parent.

### 3.2.3 *Thaavu*, sexuality, reproduction and health

The notion of *thaavu* lies at the core of the Akamba code of sexual conduct. *Thaavu* can be described as a contamination brought about by breaking mainly
taboos concerning sexuality and reproduction (Mutunga, 1994; Lindblom, 1920). *Thaavu* is mainly transmitted through sexual intercourse but it is not an STD or illness *per se*; it is a pollution that manifests itself in a single or combination of unexplained long illnesses, and reproductive misfortunes among them stillbirths and miscarriage.

Sexual relations with or marrying a blood relative are taboo and bring *thaavu*. This displeases ancestral spirits who may punish the offenders, their children or other relatives. Pregnancy as a result of such a relationship or union is not carried to term and if it is, the children develop poor health; they may eventually die. The ancestors refuse to be associated with such a union through blessing it. Miscarriage or stillbirth makes a woman impure and if a man has intercourse with her, he contracts *thaavu*. A man who had sex with a widow before she was ritually cleansed became ritually contaminated and sexually passed the same contamination on to his wife (Mbiti, 1969:225; Mbula, 1977:161; Mutunga, 1994:131). This affected them in two ways. Their health became poor; they would slowly but steadily become thin and weaklings as a result of illnesses and if not cleansed they would eventually die (Mbiti, 1969). The woman would either miscarry or give birth to babies who are dead or who die soon after. This is also what makes sexual relations with strangers dangerous. The physical manifestations of people affected by *thaavu* are in many aspects thus strikingly similar to those of AIDS. In fact, when AIDS first struck in the 80s, it fitted well in this aetiologic notion of disease that it was considered *thaavu* by some people. Thus AIDS added to the many dangers coitus is awash with. I will comment on the perceived connection or lack of it between *thaavu* and AIDS later in chapter 8. The point I wish to make here is that *thaavu* threatens the health of individuals, reproduction and survival of family and marriage. Although *thaavu* is mainly a sexual and reproductive problem, some other behaviours that fail to respect traditions and customs [*kikamba/kithio*] may bring about *thaavu* (Johnson, 1999:149).
Notions of *kithitu* (oath), *kiumo* (curse), *uoi* (witchcraft), and *thaavu* (contamination) as causes of illnesses, misfortunes, and afflictions traditionally made it important for a man or woman to have knowledge about the social background of a marriage partner. As some of my elderly informants put it: ‘some of the problems (sicknesses) we are witnessing today are a result of people’s failure to do things according to Akamba traditions.’

3.3 Production, reproduction and health: explaining changes in aspects of sexual and reproductive health

The evolution of contemporary Akamba sexual and reproductive behaviour and experiences can be traced to the forces of modernisation namely western education, colonialism and christianisation processes. The role of Christianity in transforming many aspects of African cultures has been extensively documented by various scholars of different persuasions (Mbiti, 1971; Oliver, 1969; Mbula, 1974, 1977; Kabwegyere and Mbula, 1979; Hutchinson, 1957; Hastings, 1994; Horton, 1971 cf. Johnson, 1999; Ahlberg, 1994, 1991; Johnson, 1999; Mutunga, 1994). These authors are in agreement that Christian missions aimed at the eradication of African customs, practices and institutions, which to them were incompatible with their teachings. Early missionaries in East Africa and presumably elsewhere were united in their aim: to evangelise, educate, and ‘civilise’ (Hastings, 1994:209 cf. Johnson, 1999:297). My focus here is on those aspects that are pertinent to the emergence of the contemporary sexual and reproductive practices among the Akamba and their relevance to understanding of sexual and reproductive health.

Christianity gained a foothold in Machakos District in 1895 when African Inland Mission, the African protestant missionising agency of the Church Missionary Society, established the first mission at Kalamba in Nzaui Location.
Mwala had one of the earliest influences from Catholic faith in Ukambani. The Holy Ghost Fathers came to Ukambani in 1912 and established the first mission station at Kabaa that same year (Mbula, 1977:81).

The missionaries sought to change the traditional Akamba institutions, practices, customs, and values all of which they considered repugnant to Christian morality. In sum, they required them to abandon, albeit with little success, their way of life. But it is in the area of sexuality and reproduction that the approach of Christian missionaries was most unsettling as for the Akamba what they considered a normal open sexual system was considered immoral. Central to the traditional Akamba training was knowledge about physiological and biological body changes and what that meant for a growing young person in terms of sexuality and reproduction. Equally important was education on behaviours that are a danger to the individual, family and society. As I have already shown, initiation rites were part of the social training process; training for adult sex and reproductive life began with these initiations.

Evangelism and Western education went hand in hand (Kabwegyere and Mbula, 1979:59). Missionaries introduced schools as part of the wider strategy to win individual souls to Christianity (Mutunga, 1994:162). School education led to the breakdown of the traditional education and along with it near collapse of institutions that were largely responsible for training young people in matters of sexuality and reproduction. Unlike the traditional education, Western education is individual based rather than being family and community focused, because Christianity was (and is) interested primarily in the individual convert. Indeed, missionaries worked in consort with colonial administrators to destabilise African moral systems (Comaroff and Comaroff, 1991). The consequence was that little attention was given to young adults’ sexual and
reproductive needs; these were left to them to handle through trial and error. The silence that has surrounded sexuality among the Akamba, indeed the Kenyan communities (see also Ahlberg, 1991) has had social and physical implication in terms of sexuality and childbearing, for example, teenage pregnancy. The emergence of HIV/AIDS has returned discourse on sexuality and by extension and reproduction into public domain but without the cultural context within which it was previously addressed.

The assault by missionaries on the initiation ceremonies, songs and dances which provided social space to openly address young people’s sexuality was one of the major contributory factors to the changed sexual order. I have already pointed out that virginity among the Akamba was not a virtue to be proud of as there was no cultural basis for it. Rather than absolute virginity, the Kamba were concerned more with a relative chastity. Missionaries held that the girl had to be a virgin because sex before and outside marriage was a sin. Without understanding its cultural basis, the missionaries condemned this aspect of life of the Akamba as lacking in morality. This moral panic is well captured even in the language of early writers such as Dundas who cast aspersions on their morality: ‘morality is altogether at a low stage among the Akamba’ (Dundas, 1913:488 cf. Johnson, 1999:100). As Johnson (ibid) notes such material probably speaks volumes of the writers than the Akamba whose lives they claimed to depict. Nevertheless this moral gaze seems to have been favoured by some authors up to the present as an explanation for the rapid spread of HIV/AIDS in Africa (see e.g. Caldwell, et al., 1989).

Extramarital sexual relations were acceptable in certain circumstances including ritual cleansing. The internal logic of this sexual order was threefold: one, to avoid diseases and misfortunes associated with coitus; two, to prevent an impending health consequence; three, to promote general health not only of the individual but also family and the larger collectivity.
Christianity advocated monogamy as to them this embodied love and a strong conjugal bond. Polygynous marriage allowed a man to have children with another wife if the first one was barren. *Iweto* marriage permitted a barren woman to have children. Missionaries and the early Akamba writers regarded this a form of institutionalised prostitution (Kabweyere and Mbula, 1979) just as have more recent writers on sexuality in Africa (see eg. Caldwell et al.1989). When a man died, his brother, half brother or a close relative inherited his wife, and if they had no children, the children born from the new relationship belonged to the deceased husband. Dying without children meant that one was forever dead since there was no one to continue his physical line (see also Mutunga, 1994:170; Mbula, 1977:54-56; Mbiti, 1975). It was through children a Mukamba was able to recapture at least in part the lost immortality (Mbula, 1977:82).

Missionaries considered these institutions and practices associated with marriage and childbearing irreconcilable with the message they sought to propagate and tried to eradicate them (Hastings, 1994:330 cf. Johnson, 1999:298). Quoting colonial Annual reports from Ukambani, Good observes that the missionaries were adamant that the Akamba abandon their most dear social and cultural institutions, including giving up practices that supported their social life (see eg. Central Province Annual Report, 1916-1917; Kitui District Annual Report, 1912-1913; Machakos District Annual Report, 1910-1911 and 1912 cf. Good, 1987:82). Specifically, the missions required the Akamba to end their rituals that they performed at the sacred places, *mathembo*. Further, they pressurised them to end consultation with *andu awe* (traditional healers), and the use of the *kithitu*. They also assailed initiation rites, wathi dances, female circumcision, and bridewealth. The missionaries, particularly the Protestant Africa Inland Mission (AIM), adopted a shaming strategy by having a “fornication chair” in their churches, in an attempt to
force the Africans into conformity with missionary values and sexuality (Tignor, 1976 cf. Good, 1987:82);

However, the Catholic missions, especially the Holy Ghost Fathers, were more tolerant and less rigid than the Protestants with regard to African traditional practices such as bridewealth, dancing, and drinking (Good, 1987). That notwithstanding, both the Catholic and Protestant missionaries shared similar cultural background and mission so that they treated in the same way those Kamba practices and institutions that did not conform to Christian morality (Munro, 1975:106). The same is reported for Uganda (Welbourne, 1971:337 cf. Kabwegyere and Mbula, 1979:26) and Tanzania, where Church Missionary Society considered polygyny unacceptable and men who practised it could not be admitted into church until they divorced all the other wives safe the first one (Beidelman, 1982 cf. ibid). For the Akamba and presumably for other Africans, these institutions and practices served as their cultural aspiration of the moment.

Although missionaries condemned sexual practices in Africa as immoral, they themselves and other Europeans in Africa did not live a life that was blameless in terms of sexual morality (Ahlberg, 1994:231; Dodge, 1964 cf. Ahlberg, 1994:232; Doyal and Pennell, 1994). Indeed, the recent Catholic church sex scandal among its priests in Britain and the USA and which has rocked and threatened to tear the church apart provide persuasive evidence that many priests have not lived up to the moral standards that they have always preached. Dodge reports that in the early part of the twentieth century, European men were visiting women prostitutes in Nairobi (cf. Ahlberg, 1994:232). Dodge argues that their being separated from their families, the institution that imposed social control, probably occasioned this moral laxity on the part of the Europeans. Thus morality, be it European or African, 'makes sense only when its maintenance mechanisms operate effectively' (ibid).
Suffice it to say that the disruption of the personal life and traditional family institutions led to the disintegration of marital and sexual patterns hence the changed sexuality.

The foregoing is half the story. The destabilisation of traditional economic institutions adversely affected health of women, especially of childbearing age. Traditionally, besides maize, beans, and peas, the Akamba grew other food crops such as sorghum, millet, and finger millet. These traditional food crops are suitable in a drought-prone and historically famine-stricken area like Ukambani (see Munro, 1975; Tiffen et al., 1994) and, therefore, are valuable in preventing famine. These crops are also good for pregnant women and recuperating mothers after delivery because of their high nutritional value. However, the crops are labour intensive and were abandoned because they required labour, which was earlier provided by children who had now joined the Western school education. The undermining of traditional labour organisation as a result of migratory labour system and school participation by children resulted in labour shortage, which had negative effect on household food production.

Another point is that the introduction of new crops such as coffee and cotton that were grown specifically for the market undermined both existing methods of food production and the indigenous foods themselves (Doyal and Pennell, 1994:109; Kabwegyere and Mbula, 1979:31). As early as in late 1890s large scale farming and monetary economy had taken a firm root in Ukambani and by 1898 Indian traders in Machakos had employed Kamba men as shop assistants. Earlier in 1893, a white settler established a fruit farm in Machakos hills and in the early part of the twentieth century, there were over forty large-scale farming concerns in Machakos drawing labour from the Kamba and other African men (Kabwegyere and Mbula, 1979:43). Thus the monetary economy
drew men from the villages to the urban and European farms, resulting in the disorganisation of traditional modes of production.

Doyal and Pennell (1994: 33) argue that the current dietary habits in Africa can be traced to the colonial promotion of Western patterns of consumption, which have now permeated rural areas. 'Modernity' in a sense negatively influenced attitudes towards many of the traditional foods. For example, many people now prefer tea to porridge. The combined result of this has been the erosion of nutritional status of women and children. And for many women in rural Kenya, poor nutritional intake has contributed to poor physiological development making childbirth problematic (Ginneken and Muller, 1984; Voorhoeve, et al., 1984). This coupled with the spread of STD in the rural areas increased the danger of infertility and poor pregnancy outcome.

Migratory labour as part of the wider colonial economy also brought in new diseases. The Akamba men conscripted as Kings African Rifles carriers during World War I returned to the villages with new infections, which spread to the rural population. For example, Spanish influenza was introduced into Machakos Township in 1918 by policemen who had just returned from an official visit to Nairobi (Good, 1987:84). The disease quickly spread to the surrounding rural areas causing several deaths. Although fragmentary, early colonial reports suggest that STD may have been introduced in Ukambani around the turn of the twentieth century by spreading around the government administrative stations, which were along the new railway line (Ukamba Province Annual Report, 1908-1909/1917-1918 cf. Good, 1987:83). The new illnesses resulted in demand for a new type of medical care. But Africans had little or no access to modern medical care to deal with the new diseases (Good, 1987:84-90; Doyal and Pennell, 1994:241-246). For example, although there were a few scattered Christian mission medical services available to Africans between 1895 and World War I, these could hardly cope with the large
numbers of the population (ibid: 83). The colonial system did not introduce western biomedical services in Machakos District until 1921 when the first Medical Officer of Health arrived and subsequently opened dispensaries in various parts of the district (Machakos District Annual and Quarterly Report, 1922 cf. Good, 1987:85).

In many circumstances Westernisation and Christianisation processes went hand in hand, and in many cases the people could not distinguish between colonial administrators from missionaries. Missionaries, colonial administrators, and the settlers all worked in concert to eradicate traditional medicine, including notions about disease and illness causation and management. Although unsuccessful, missionaries and colonial administrators unambiguously opposed indigenous knowledge and beliefs about illness diagnosis, treatment and management as part of the wider scheme to replace the so-called nonscientific approaches to human healing with Western biomedical system and its theories of disease causation. To the Church, the fight against traditional therapies was a fight against evil (Feierman and Janzen, 1992:15). Thus it became part of the wider campaign to wipe out traditional belief systems (Maclean, 1979:9 cf. Doyal and Pennell, 1994:119; Turshen, 1984:145 cf. Morgan, 1987:144). Indeed, as Sindiga (1995:25) observes, Christianiy has always discouraged the use of traditional medicine, particularly those aspects based on principles that biomedicine finds difficult to fathom, hence equating traditional theoretical aspects of disease, illness, and misfortune causation with magic, ritual and witchcraft (which are only a small part).

But as Morgan (1987:145) puts it, missionisation and colonialism did not automatically destroy non-Western medicine. Biomedicine did not find a vacuum upon its arrival in Ukambani. The Kamba traditional medical system was ‘part of a unified whole, interconnected with virtually every other aspect
of social life and with ideas and practices that reflect a system of cosmological and earthly order’ (Good, 1987:91). This pragmatic and holistic approach to health and illness suggests that traditional management of certain illnesses among the Akamba will continue to flourish as my research and a number of other authors demonstrate (see e.g. Good, 1987; Ndeti, 1976; Johnson, 1999; Kramer and Thomas, 1982).

It would, however, be incorrect to assume that change among the Akamba started with colonialism and missionisation. Changes were already taking place even before contacts with European settlers, administrators, and missionaries (Shorter, 1974). Commenting on changes already taking place among the Akamba before the last two decades of the nineteenth century, as a result of the processes of monetary economy, Christianity, and Western education, Kabwegyere and Mbula (1979:12) note that the Akamba were not an isolated people. They were a mobile people and in the process of migration, they met with other people from whom they acquired new traits, though the extent of this influence in not known. The Akamba interacted intensely with the Maasai, Kikuyu, and Embu through trade and raiding for cattle and women, among other things. Natural catastrophes such as famines and droughts were, and still are, a perennial feature in Ukambani (Munro, 1975; Dundas, 1913). During periods of famine, the Akamba traded and intermarried with the Kikuyu as they moved to Kikuyuland to seek food and water (Munro, 1975:20). In their survival efforts, they also came into direct contact with the towns and communities of the coastal area. These towns were experiencing economic revival resulting from the general expansion of the world economy and Arab interests in East Africa (Kabwegyere and Mbula, 1979:13). As a result, there developed commercial links between the coast and the eastern highlands controlled and initiated by the Akamba (Munro, 1975:23), which obviously could have introduced some diseases in Ukambani.
However, although the Swahili and Arab traders are said to have been doing business in Ukambani by mid-1840s, their impact on the Akamba culture seems to have been comparatively less, partly because of the length of the contact period (see also Ahlberg, 1994). The colonial administrators and missionaries brought in change that was qualitatively different due to the nature of interaction; they had intense and prolonged contact with the Akamba.

3.4 Have I presented a disease free culture?

Is it possible or even conceivable that the Akamba of the pre-colonial contact were without diseases and social problems? The answer is a simple no. What I have presented in this chapter is largely based on the historical materials and information from elders. The very fact that there were and still are famines is a pointer to the fact that malnutrition was not unknown. Child and maternal mortality must have been high; a reason, among others, to want to have many children. Some of the food prohibitions and taboos that were there had to do with the avoidance of overlarge babies. In the absence of modern birthing technology, it is not difficult to visualize problems occurring, including maternal death.

Social control mechanisms among the Akamba may have weakened as they did elsewhere in Africa, and the world over in the twentieth century (Ochola-Ayayo, 1997). Even in the pre-colonial contact, the very presence of taboos, prohibitions and prescriptions is evidence to suggest that all was not controlled. Given some of the social practices, it is not unlikely that some diseases, including STD (of whatever sort) were attributed to the wrong cause, including breakage of taboos associated with sexual and social contact and conduct. ‘Good old days’ are unlikely to change to be what they should not be. What is unwritten about the past is probably unknowable. As Schoepf has warned about Africa:
If historical reconstruction of social relations is a difficult intellectual enterprise, an archaeology of sexuality is virtually impossible to establish for the period without written records and beyond the reach of memory (Schoepf, 1992:357 cf. Setel, 1999: 27).

What appears clear is that many of the changes that have occurred have had positive impact on the health and wellbeing of the Akamba, including the management of disease and illness. But it is also apparent that some changes have not produced positive results. The point to make is that the change has never been entirely embraced, as evidenced by the contemporary explanations of some of the health and illness problems in sexual and reproductive arena, which mirror those in the past. The past is also present.
PART II
WHO (1975) defines sexual health as:

The integration of physical, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love (Hardon, 1995:121).

To this definition, the 1994 Cairo Conference on Population and Development added enhancement of life and personal relations, and not merely counseling and treatment of reproductive health problems and sexually transmitted diseases. The meaning of sexual health is, however, much broader. Indeed, sexual health can be said to encompass reproductive health because reproductive health is seen in terms of sexual health.

In this chapter, I explore some of the elements that the people of Mwala use to describe sexual health and wellbeing. I seek to understand how sexual health is conceptualised. Using sexual health in the broader sense of wellbeing a range of issues are included and discussed in this chapter, among them, trust, age of partners, perceptions of social and physical maturity, sex actions and social and sexual relationships, and personal cleanliness. The chapter also seeks to explicate the subtle gender and generational differences that exist with regard to perceptions of the parameters that are used to define sexual wellbeing. But to understand these issues, I need first to explore the Kamba notion of health and wellbeing.

4.1 Defining health

There is no single Kamba term that adequately captures the meaning of the term ‘health’. But there are a number of Kikamba words whose meanings imply that a person is well. The use of these words is context dependent and
can take on different meanings in every day life and practice. The closest term but which is very broad is *useo*, which can loosely be described to mean 'wellbeing'. In social interaction, the term *useo* is used, for example, in the exchange of greetings: How are you? [*wi museo* or *ni waseuva*], ‘I am alright’ [*nimuseo* or *nikuseo*]. *Nimuseo* is used in this context to refer to the physical body coping well. People say this even when they may be experiencing some bodily discomfort.

In other contexts the use of *useo* carries moral connotations. In the context of social relationships *useo* refers not to the body-self, but to the social relationship or behaviour of an individual. *Mudu museo* means a ‘good person’, one whose character and behaviour are not questionable. It means the person can be trusted; it carries an element of honesty and faithfulness; a straight person [*mulungalu*]. This then means that one knows the person well, not a ‘stranger’ to call them *mundu museo*.

Another term is *nesa*. *Niendee nesa* can mean that one is not ‘experiencing illnesses’, ‘recovering from an illness’ or simply ‘things are okay’. In other contexts the meaning is different. For example, *kuendeea nesa* may connote material possession and the happiness brought about by material wellbeing. *Kwaniwa* or *nimwianie* is in some way linked to the term *niendee nesa*. It means to be contented (with what you have) or satisfied and happiness is implied in the notion. In one context it suggests material possession. But one can say *nimwianie* not to mean they are really well-off but that they are happy with the situation they are in or are able to meet their (and family’s) basic requirements. In this sense then *nimwianie* carries a wellbeing message not necessarily an absence of illness (See also Johnson, 1999).

*Utheu* in some contexts carries health meanings. *Kuthea* means to be clean. *Utheu* mainly refers to physical cleanliness. *Mwii mutheu* means a ‘clean
body', *ngua ntheu* 'clean clothes', and *musyi/nyumba ntheu* 'a clean home/house'. In a sense, therefore, the term *utheu* connotes hygiene. But *utheu* has a deeper meaning in moral and social contexts. For example, to say so and so has *ngoo ntheu* 'clean heart' is to say that a person is warm and welcoming. *Uima/kuima/muima* is another term, which means to behave and do things in a responsible and mature way, not like a child. Some times physically less mature people may display *uima* in their behaviour. *Kuima* connotes physical and social maturity, that is, one is an adult. It means that one is reliable and can be entrusted with responsibility. *Mundu muima* means a person is physically and socially mature to marry and bear children. It implies that a person should be able to bear children, meaning they have nothing including disease/illness that may prevent them from achieving this goal. In the context health, *muima* can mean one is well. Closely linked to this is the notion of *vinya*, which implies strength. In a sense, it carries the notion of health and wellbeing.

The usage of these terms in a wide range and sometimes related social situations and contexts demonstrates that we cannot understand the notion of health by limiting it to its biomedical conceptualisation. Its meaning is much broader and can only be understood in its broader context, wellbeing. The meaning of sexual health can, therefore, be understood by situating it within this broader definition of wellbeing. I begin my discussion by focussing on some aspects of social and sexual training of young people. The relevance of this in understanding sexual health and wellbeing will become clear later in the chapter and the entire thesis.

**4.2. Social training: the context of social and sexual maturity**

In chapter 3, I have discussed the traditional Akamba social system, which facilitated the training of children into adulthood. The training included matters about sexuality and reproduction. The way men and women deal with
sexual and reproductive issues has to do in part with the way they were socialised into adulthood. The traditional social system has collapsed in part because much of it is irrelevant to the contemporary Kamba society. Yet teaching children about social responsibilities and sexual matters has also become one of the most difficult things to do.

In the absence of a systematic system of socialisation, social responsibilities among the Akamba are undoubtedly today learned progressively as children gain experience through participation in everyday activities. Small children are an important source of support for their parents at home. From an early age children are involved in light household activities such as fetching firewood, taking care of their younger siblings while parents, especially the mother, do other household chores. They follow their parents and bigger siblings in the farms and try to imitate them in whatever they do. They take care of small livestock such as goats and calves. As they grow bigger, they are given roles that require more energy such as fetching water or roles that require greater care and intelligence: keeping the fire burning, taking care and contributing to the discipline of younger siblings when parents are away in the market or working on the farm. Later, at the age of 6 and above, they start doing chores that require more skills like serving meals or beverages to people including visitors. Thus children gradually become responsible and gender, as Munroe and Munroe (1997:311) show elsewhere, is less relevant for household roles and training. Children as Last (2000:369) observes ‘are thus drawn gradually through work into the adult world.’ It is, therefore, not uncommon to hear people marvel with regard to a child who conducts himself or herself like a grown-up [mundu muima]. This has got little to do with age, but ability to act and behave socially appropriately. Thus becoming an adult is a process defined by what a child can do; it is not just a stage, or a matter of years or going through a single well-defined ritual or a biological change (cf. Last,
In other words it is no longer culturally created through formal rituals.

However, childhood and adolescence are marked by considerable social ambiguity. On the one hand and depending on circumstances or situations, a little boy or girl may be considered ‘big’ and socially mature because of his or her behaviour. On the other hand, such a child or even an older one may be considered too young to be given information on sexual and reproductive matters. Thus provision of information on sexual matters does not necessarily go with social training. This is complicated by the migratory patterns where, as in Mwala, large numbers of men have moved away to towns or other places in search of employment. Even the men who have remained in the rural areas have little time with their children. Therefore, in many cases it is women who carry the responsibility of training the children, both boys and girls. However, the ambiguity of adolescence means that mothers and fathers do not always execute their responsibility for training their children. Indeed, while the traditional Akamba social system recognised the nature of youth and tapped their resource by preparing and training them for adult life (see chapter 3), today, young people lack guidance on issues about social relations and responsibility, about their bodies and how they work.

Even though men and women say that it is their responsibility to train, guide and prepare their children for adult life, there are limitations to this in terms of time spent with them due to the school education. A middle-aged woman wondered:

Where are they? In school throughout! The school has taken our children so when does a parent sit down with her child and discuss some of those things? Teachers can help our children understand the way things are, particularly matters that concern men and women.
Discussing sex related issues with daughters and sons is difficult especially when fathers have to talk to their daughters or when mothers have to talk to their sons about sexual matters. Mothers find it easy to talk to teenage daughters about dressing, sitting manners, but they do not find it as easy to discuss sex with them. What may be of much concern, therefore, is not whether parents or adults discuss with their children about their sexuality, but rather the quality and content of the discussion. Some women commented that ‘matters concerning sex are not easy to talk about; you do not know how much your daughter knows and you may in fact spoil her by giving too much information about certain things’ ['maundu amwe, meaning sexual matters]. Others said that mothers have to talk to their daughters, even if indirectly, particularly about their body changes; many women do so after the changes have already occurred, for example, when they have started to menstruate. They talk to the girls about cleanliness [utheu] but most importantly, to avoid boys:

Parents are the teachers of their own children and mothers should show the way, advise their daughters because they [girls] are the ones who begin sex early. A mother should talk to her daughter lest she brings another child home. Fathers should also talk to their sons and tell them what will happen if they ‘play’ with girls. If the son impregnates somebody’s daughter, and things go wrong, then everything will come to you. You will be told ‘your son impregnated my daughter and if death [of the girl] is the result, then you will have to pay.’ Parents have to take responsibility [40 year-old woman].

Muange (1999) found similar concerns among Luo married women about their daughters’ sexuality: that they feared they would be blamed if daughters became pregnant. Consequently, the only sexual discussion with their daughters is to tell them not to play with boys in case they got pregnant.

Mothers discuss sexuality issues with their daughters more than fathers do with their sons perhaps because sons are not perceived to be in danger of pregnancy.
This could also be explained by the fact that the Akamba do not compel boys and indeed men in general to take full responsibility for pregnancies occurring outside of marriage and this perhaps influences parents' thinking that boys are not equally in danger of pregnancy. Sexual training for boys is compounded by the absence of a role model in the family. Many men work away from home, in urban areas. Those around are not always available and/or do not give much thought to matters concerning the sexuality of their sons. A middle-aged father of two teenage boys said: 'I do not discuss such matters with them; they have friends; I hope they discuss such things with their grandfather. But I warn them about AIDS.' Quite often, therefore, boys learn from their mothers.

Young people learn about sexuality and reproductive matters from many sources, formal and informal, among them older siblings and friends, books, magazines and newspapers, school and in social places including weddings and parties. But they also learn them through experience as one young man put it: 'You learn some of those things by trial and error.' Young people spend much of their time in school and teachers may help them understand developmental changes in their bodies. Until recently, however, there has been no comprehensive curriculum on sex education in primary schools (Amuyunzu, 1997). In fact the idea to introduce sex education in schools in Kenya has over the years been met with stiff opposition from religious leaders and only recently (2001) has primary school curriculum on AIDS been developed. It is worth noting that school education has its own limitations just as many aspects of the traditional Kamba social education would be inappropriate in the modern world. The traditional Akamba social training was based on family and community with the object of transmitting the Akamba culture, including

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1 See the Daily Nation August 29, 2001 in which Education Permanent Secretary Japheth Kiptoon says the Ministry had established a unit to coordinate training and teaching of AIDS in schools and colleges. He adds that some 40 national trainers and 86 provincial and district coordinators have been trained to implement AIDS programme in schools.
dangers of inappropriate sex, while modern education transmits a culture couched in universalistic terms.

The church plays an important role in moulding the young. They organise seminars for the young people during holidays. These seminars deal with issues that help young adults be better Christians—teaching them good morals, which basically revolves around avoidance of sex before marriage. A pastor of Africa Inland Church (AIC) said:

As young people grow up, they need a good Christian foundation to remain morally upright. We occasionally organise seminars and we have speakers who deal with a wide range of issues that affect and concern young people. We offer them opportunities to discuss matters that parents find hard to deal with such as sexuality. We now also deal with AIDS; it is causing concern to the church because it is not just affecting the young people, but also adults.

Giddens (1992) argues that in the west contraceptives and feminism opened sexuality and sex to public domain and discussion. Bujra (1999) however, argues that in Africa, unlike in the west, it is AIDS that has placed sexuality discourse in public domain: ‘...we can see that in Africa similar effects [sexuality discussion] have flowed from a more sombre cause. AIDS has drawn sex and sexuality into the realm of public discourse in Africa’ (ibid:77). To some extent, however, modern society seems to ‘demonise’ (see Amuyunzu, 1997:16), indeed ‘criminalise’ the sexuality of young people, blaming them for all the problems that they experience in the sexual and reproductive arena including pre-marital pregnancies, abortions, infections with STDs and the resultant, social, economic and health problems.

The church in Kenya, indeed as elsewhere, takes a moralist approach in dealing with the sexuality of young people rather than equipping them with adequate knowledge to understand and deal with their own sexuality and wellbeing. Their message: sex before marriage is a sin. HIV/AIDS has now
offered the best opportunity for leaders to use public space to control young people’s sexuality, indeed every body’s sexuality by propagating sexuality messages similar to those given by the church. Parents seem to discuss sexuality with children when ‘danger’ is apparent; much of the discussion entails a catalogue of warnings and directions to sons and daughters. Mothers warn their daughters about dangers of pregnancy when they start to menstruate, how to maintain personal cleanliness and, recently to warn them, albeit indirectly, about AIDS. Similarly, some fathers find themselves having to talk with their sons about AIDS. Thus ‘danger’ seems to be creating a situation where parents must discuss matters tabooed in the past. However, the majority of the parents do not even warn their children about AIDS principally because to discuss AIDS is to discuss the very sexuality of their children that they have all along denied. This has implications for behaviour that expose young people to dangers of STD/HIV.

4.2.1 Perceptions about physical and social maturity

How then is maturity constructed in the absence of formal initiation rites? A young adult may be socially mature but not so physically and the reverse is also true. Physical maturity may correspond with social maturity but not necessarily with age. For a girl, physical appearance, that is, body size rather than years may suggest that she is mature and can begin her reproductive life. Menarche alone, as Last (2000:369) also argues, is not seen as a good marker of development as it only suggests that a girl can get pregnant. The body size determines whether she can bear children safely and/or get married.

However, physical changes for both boys and girls to some extent signal biological and by extension sexual and reproductive maturity. For girls menstruation is associated with maturity and fertility. But the development of
breasts and broadened hips are seen as good markers. For boys it is the broadened chest and broken/deepened voice. Age is also considered with some people considering a girl to be mature at about age 12 while the boy would be mature at 14 years.

There are social behaviours that point to sexual and even physical maturity. For girls consciousness of her physical appearance including dressing and cleanliness are associated with physical maturity. A girl may behave boastfully towards boys, sometimes shy, partly due to biological changes. But she may also be happy in the company of boys. Boys may change their behaviour and start coming home late or flirting with girls, sometimes inviting them home. Quite often, boys as they mature construct their own small houses and move out of their parents' house. There are thus social constructions of maturity - that is, behaviours perceived to point to physical maturity in the same way perceived physical maturity occasions certain social-sexual behaviour. There is no circumcision for girls as part of their initiation to womanhood (see below) while circumcision for boys is not only an initiation, but also one with some sexual and reproductive implications.

4.2.1.1. The meaning of circumcision
Circumcision [nzaiko] remains a very important cultural aspect of a Mukamba male child. There are several reasons for circumcising boys, but perceptions of the importance of circumcision vary with age. The older generation, both men and women, stressed that circumcision of boys is an important Akamba tradition that must be adhered to. Further, they emphasised that it is inconceivable that a boy would grow into a full adult without being circumcised. Besides being a Kamba cultural identity [kithio], circumcision prepares a boy for a life to come-for marriage in due course. Symbolically, therefore, circumcision becomes an important initiation rite into adult
life/manhood. It is not directly associated with boys starting to engage in sexual play, but in a sense circumcision is recognised for its reproductive potential.

The circumcision rite has another meaning. It is said to make a young man 'feel good and strong.' The concept of 'strength', as we shall see later, implies wellbeing. Thus the meaning of the notions of good and strong with regard to circumcision is deeper; it encompasses aspects of health and more specifically, cleanliness [utrau] and sexual relations. This findings, therefore, questions Lindblom's (1920:42) assertion that hygiene was never a factor in Akamba circumcision. The younger generation emphasised the importance of utrea even more strongly: it makes it easy for boys to 'keep clean'. In this context, 'dirt' means the presence of the foreskin; it also implies stigma that would be attached to an uncircumcised man. Many young people observed that when a man is circumcised the chances of getting sexually transmitted disease are minimised. Furthermore, the young informants contended that both the man and the woman cannot enjoy sex if a man is not circumcised. An uncircumcised boy will shy away from girls, for fear of being embarrassed or ridiculed. Indeed, men and women were unequivocal that an uncircumcised Kamba man cannot find a wife. Thus before the penis starts its reproductive (and sexual) work, it has to be purified through circumcision (Mbula, 1977; Ndeti, 1972). Thus as in the traditional setting (see section 3.1.3), nzaiko can be and is seen as part of cultural creation of a sexual and reproductive man. But is circumcision rite the same as in the traditional setting? It is to a brief examination of this question that I now turn.

4.2.1.2. Circumcision: cutting without ritual

Today's circumcision is different in many ways from the traditional one. The physical procedure, that is, the removal of the whole foreskin of a boy's penis
remains primarily the same. However, unlike in the past (see for example, Penwill, 1951; Mbula, 1977), it is now carried out without any traditional ceremony. *Nzaiko* is today not a community/group thing; it is conducted individually and there is no social education *[motao]*, including transmission of knowledge about sexual and reproduction matters that traditionally accompanied it. This is because boys are now circumcised at a very young age, between six and seven, sometimes younger, especially in urban settings. At such a young age the boys do not understand the meaning of circumcision until they are big enough. This is what Hernlund (2001:235) call cutting without ritual. Cutting without ritual refers to very young children undergoing the physical procedure of circumcision with little or no accompanying ritual or transmission of ‘traditional’ knowledge.

The site of circumcision has also shifted from home where it was conducted by a traditional circumciser *[mwaiki]*, an elderly (man or woman) versed in such matters, to hospital where it is performed by doctors, clinical officers, and nurses. Thus what has been a cultural practice has now been medicalised. Individual parents or grandparents, therefore, decide when to take their sons to hospital for circumcision and they may also invite the modern ‘circumcisers’ to perform the procedure at the initiate’s home mainly in the month of August\(^2\). In other words a ‘public’ cultural practice in the sense that every Kamba boy undergoes it has become ‘private’ in the sense that it is not communally done and no ritual. There are, however, perceived health benefits with regard to the shift of the site of circumcision from the home to the hospital. Informants observed that it is much safer to have boys now circumcised in hospital as there is less chance of getting infections including AIDS. In health care facilities it is performed under anaesthetic which reduces pain. Health care facility is considered hygienic and is well placed to deal with emergencies,

\(^2\) In Ukambani, circumcision takes place during the month of August when children are on holiday. It is also dry and hot – good for quick recovery.
suggesting that traditional circumcisers are no longer considered competent or are no longer there. In spite of the changes that have occurred in *nzaiko*, the underlying principle remains much the same and strong. It is not uncommon to hear men congratulate a boy after circumcision and remind him that he has become a ‘man’.

### 4.2.1.3. Clitoridectomy: what people say

Although the practice of clitoridectomy was common in the past among the Akamba including those of Mwala, the present Akamba of Mwala do not initiate girls into sexual and reproductive matters through clitoridectomy. Njeru & PATH (1996 in Shell-Duncan, 2001) report that clitoridectomy is practised, though to a small extent, in parts of Ukambani. The majority of cases are circumcised very early, at about age three to five before they start school so that they are not found out since the practice is outlawed. However, I found no traces of it among the young girls in Mwala and never came across any single case of a circumcised girl, although I did for boys. Female circumcision is widely practised by a number of Kenyan communities mainly the Kisii, Maasai, Kalenjin, Meru and Embu (Watson, 2000; KDHS, 1998). Its disappearance notwithstanding, it emerged in my discussions with people about sexuality and childbirth. Perceptions and social meanings were varied.

The young and educated especially women perceive clitoridectomy in terms of gender, sexuality and power; they associate it with reduced women’s sexual desire and pleasure. Their perceptions seem to be informed by the Western feminist notions of female sexuality that link clitoridectomy to female sexual control by men (and older women) and decrease in sexual pleasure³ (Watson, 2000:256, Ahmadu, 2001). Some saw clitoridectomy as promoting

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³ For a debate on female genital cutting in Africa, see an edited volume by Shell-Duncan, B. and Y. Hernlund, ‘Female “circumcision” in Africa: Culture, Controversy, and Change.’
reproductive health: 'I hear women who are circumcised do not experience problems during delivery' or 'I hear that it reduces a woman's sexual desire,' were some of the responses from young women.

While some of the young people perceive female circumcision in terms of female sexuality and gender power relations, the older generations see it in terms of preparation of the young woman for womanhood and motherhood responsibilities. I have already shown that circumcision was not simply the removal of the tip of the clitoris but the whole initiation process. By implication, therefore, traditionally circumcision has a bearing on marriageability and uncircumcised woman risked failing to get a husband (see section 3.1.3.)

The increase in cases of teenage pregnancies witnessed in the villages is explained in part by the discontinuation of this practice; it has meant that young girls are not properly prepared for womanhood and motherhood as there is no social preparation for the same. Some, therefore, said clitoridectomy was a good practice. Traditionally, it is not about control but about enabling and empowering women to be good daughters, mothers and wives. Clitoridectomy is also seen in moral terms; failure to circumcise is perceived by some to make women 'too sexual.' Generally young people are perceived as having 'hot blood' [nthakame mbyu] and this makes it difficult for them, indeed for adults including parents to control their sexuality. The consequence of this is that it puts young people at a higher risk of contracting sexually transmitted diseases including HIV/AIDS, of unwanted pregnancies that almost always lead to school drop out, or of poor reproductive outcomes such as miscarriage, stillbirth, and abortions.

However, there exist tacit tensions between the old and the young generation with regard to sexuality perceptions. Young people do not see themselves as
'abnormally' sexual. Young men in a group discussion argued that the older generation depicts youth as more sexually active but, according to them, the older men and women were no less sexually active during their time. They cited the presence of AIDS to buttress their argument noting that there may be more teenage pregnancies today, but AIDS is killing both young and old alike in Mwala and elsewhere in Kenya. These findings partly concur with those of an earlier study in Mwala which showed that people did not consider the young people's sexual behaviour and experiences as different from those of past generations (Amuyunzu, 1997:18). In the remainder of this chapter, I examine the local meanings of sexual health and wellbeing.

4.3. Toward a definition of sexual health

If the definition of health is varied then defining/explaining sexual health is more problematic. Like health itself, sexual health entails a number of concepts, which may have little purchase in biomedical explanations.

4.3.1. Sexual relationship: trust or faithfulness?

Trust and/or faithfulness [kuikiia] in the context of sexual relationship is expressed through the 'inside' and 'outside' metaphors. The notion 'to go outside' [kuthi nza] takes on a variety of meanings in different contexts but within sexuality and reproduction, means having sex with a person other than one's partner. Danger of misfortunes or infection with STD/AIDS is always lurking, particularly if people go with 'strangers'. Men are particularly in danger because they are considered or consider themselves to be relatively free of cultural limitations in their sexual conduct. The reverse, that is 'inside' which means staying at home or not having sex 'outside' is now considered the best way to prevent infection with especially AIDS and by implication fostering/strengthening sexual relationships. Married women remain 'inside',
that is, they do not move with other men, or so it is the expectation. Women hope that their husbands will not ‘go outside’ and if they do, then they trust that they will ‘walk’ carefully. As people put it: ‘Things are bad these days people [men] have stopped going ‘outside’, meaning not having extra marital sex. Bujra (1999) has found similar notions used in rural Lushoto, Tanzania in relation to dangers associated with sex. Married women consider themselves not at risk of infection because they do not have extramarital affairs. Men who ‘stay at home’, that is in the village, consider themselves not in danger. This is considered prophylactic with regard to AIDS infection. However, as Bujra shows and as we shall see in chapter seven, this may provide a false security for the married.

Trust and faithfulness are considered prophylactic because they help avoid infections with STDs, which in turn interfere with relations between partners by causing conflicts, anxieties and mental anguish. Besides the emotional and mental pain, there is the physical pain and the financial cost, and the stigma and shame occasioned by STDs are enormous (Wallman, 1996; Moss, et al. 1999). Equally important, remaining ‘inside’ helps to cement a relationship whether within marriage or otherwise and this creates an environment which is emotionally and sexually fulfilling. One grandmother told me: ‘married couples ought to ‘stay well’ because where there is no peace, problems arise and the body can sometimes direct somebody to, ‘go outside’’. Going outside is potentially hazardous because it implies multiple sexual relationships that may result in infections further straining the relationship between partners. But also going outside leads directly to tensions, quarrels, and conflicts that may result in separation, divorce or violence, particularly against the woman, sometimes resulting in loss of life.4

4 Some people told me that in urban areas some women beat up their husbands. This was said to be very rare in the rural areas, however. Also see East African Standard newspaper 27 October, 2000 in which a man beheaded his newly born baby girl and slashed his wife severally because he believed he did not father the child. He suspected his wife ‘went outside’
4.3.2. Cultural construction of sexual pleasure

Closely related to trust and faithfulness is the notion of sexual pleasure. Sexual pleasure for both men and women is an integral part of a stable and successful marriage. Men and women of all ages emphasised the importance of sexual pleasure for both partners; sexual satisfaction for both partners is crucial for a stable marital relationship, and to avoid either the man or the woman ‘going outside.’ Other studies have had similar findings (see eg. Naibatu et al. 1994 c.f. Ogden, 1996:112; Obbo, 1980; Taylor, 1991, 1992). In Northern Rwanda sexual intercourse is not only a productive act, but also an activity to procure pleasure (Taylor, 1992:68). In my own study, men and women discussed and explained sexual pleasure in less direct terms mainly because of two reasons. Firstly, because there is no single word to describe or capture the notion of sexual pleasure and, secondly, the mention of the word sex elicits a great deal of shame [nthoni] and thus people have to use terms that are socially acceptable. Therefore, in the context of sex, terms such as ‘need’, ‘to know somebody’, ‘sleep with’ are commonly used. Sexual pleasure is described as ‘taking care of’ or ‘looking after’ ones partner and satisfying his or her needs. The latter two terms have a wider usage and meanings outside of sexuality including material provisioning hence wellbeing.

4.3.3. Bodily fluids and substances

The notions of bodily fluids and substances play an important role in understanding health and wellbeing in general, and sexual and reproductive health in particular (Taylor, 1990, 1992; Thomas, 1999; Green, 1999). Such substances include menstrual blood and semen. Green (1999:57) reports that the Pogoro of Southern Tanzania say it is both unclean and dangerous for a
man to sleep with a woman during her menses as the blood entering the body may make his genitals swell affecting his ‘blood’. This affects a man’s potency making it difficult to have children. Traditionally, among the Akamba, a menstruating girl has to handle the blood with care because carelessness can jeopardise her capacity as a woman and future mother; it can result in barrenness (Mbula 1982:31; Mutunga, 1994:132).

Men and women in contemporary Kamba consider it improper to sleep with a woman during her monthly period. It is said to be not good; it demonstrates lack of self-control, and women themselves say they have no interest in sex during menstruation. A woman should be able to control her own sexual desire and by extension that of her husband. Self-control is important for it also helps one not to ‘go outside’.

There are no rituals associated with menstruation and there is no sense to which menstrual fluid is associated with male potency. It does not affect the male ‘blood’ or a man’s virility. However, people associate menstrual blood with both fertility and infertility. Not only can poor ‘handling’ of the menstrual blood by a young woman result in her barrenness, it can also result in a woman (or a couple) having children of one sex. In other words it can negatively affect her reproductive potential. A twenty-eight year-old woman vividly captured this belief, thus: ‘If a woman is not careful a malicious person can collect her urine or, menstrual blood and put it in an anthill hole directing misfortunes to her. She will never become pregnant.’ The advice that a girl is given to take extreme care during her first menstruation has to do more with cleanliness [utheu] or personal hygiene. As a girl grows up she needs to know how to take care of herself as a woman and a future mother. The avoidance of sex during menstruation emphasises cleanliness, which also implies Akamba

son and daughter because she suspected her husband had an illicit love affair with another woman.
personal hygiene. Lindblom (1920:40) claims that among the traditional Kamba, married people always have sex when the wife is menstruating since they believe that a woman can be impregnated only during the period of menstruation. My findings are at variance with this view (see also Chapter 3). This view seems to be rooted in the widespread belief about the polluting power of menstrual blood, and also its ability to cause weakness in males (see e.g. Ngubane, 1977; Green, 1999; Olenja and Kimani, 1998). The traditional Kamba do not consider menstrual blood polluting. About the Akamba Lindblom writes that they do not consider a menstruating woman ritually unclean and the menstrual blood does not interfere with a man’s virility. If a menstruating woman is not unclean and the menstrual blood does not interfere with a man’s potency, then to Lindblom nothing would stop a Kamba couple from having sex. Lindblom’s view also assumes a lack of knowledge among the Akamba on when a woman could become pregnant. Admittedly, knowledge about many issues regarding reproduction was limited in the traditional society. However, it is unlikely that it was lacking as implied by Lindblom.

4.3.4. Location of sexual intercourse: Health relevance?

Sexual health is also described in moral terms. Personal and environmental cleanliness is associated with sexual health. Clothes that are not clean may be a source of infection, which would interfere with sexual enjoyment. On the other hand, personal cleanliness and clean environment can enhance a sexual relationship. This partly explains why the location of the sexual intercourse is relevant. Lodgings as sites of sexual intercourse embody moral decay, unfaithfulness, prostitution, and uncleanliness of the partakers and the bedding. The objective of casual sex as in the context of lodgings is not pleasure, procreation, or partnership (Wallman, 1998:174) but survival. Sex in lodgings
is, therefore, bad sex because it symbolises ‘improper’ sex and creates disorder in the sexual landscape - indeed, social and ill health. It is sex ‘outside’ or places people say are the sources of STD/AIDS. People, especially men contract STD here and bring it ‘inside’, that is, at home (see chapt. 7). On the other hand, sex at home is perceived to be ‘good’ sex, ‘proper’ sex played by ‘proper’ women and men. Sex in the context of home is not necessarily for profit or survival but for pleasure, procreation and partnership. Implied here is that sex is for married people only. But perhaps one of the interesting points to note here is the notion that lodgings have brought sexuality into the public domain when it should be treated as private. Many of these lodgings are in urban centres behind bars, in markets and other public places.

4.3.5. Gender, Sex and Strength

In a few sexuality and reproductive discourses, the notion of ‘strength’ is predominant (See e.g. Thiessen, 1999; Taylor, 1992). Sexual desire is considered a form of strength (Thiessen, 1999:197). Although engaging in sex is considered healthy, a lot of sex is thought to be not good; it can even lead to impotence. Playing sex consumes strength [vinya], especially of the man. It is said that whenever a man has sex with a woman, he loses strength while the woman gains; the semen gives strength to a woman. A man must, therefore, eat well to restore his strength. Lindblom (1920) had similar findings nearly ten decades ago. He says sexual intercourse is believed to make a man grow lean while the woman thrives on it. In Tanzania among the Haya, Weiss (1996:190) found that the notions of male sexuality, food and strength are closely related. The food eaten by men (grasshoppers) gives them sexual strength. In my study, a man without strength cannot fulfill his sexual obligation. The notion of vinya is also connected with reproduction for it is also said that a man without it cannot ‘give birth’ or gives birth to girls only.
A man who has strength is said to have libido, which is a sign of good sexual health and wellbeing. A herbalist put it: ‘A real man is one who has strength, his body and veins [mikiva] are working well, ‘standing well’ (meaning able to sustain erection) and must have interest in women.’ Any man who is not able to ‘stand well’ must have a problem, he is without strength; he is impotent or a ‘castrated bull’ [ndewa], he added. Ndewa has both sexual and reproductive health problems for he cannot ‘give birth.’ Indeed, men and women, especially the young say that in any one sexual play with a woman, a ‘real’ man, one who is virile, should sustain erection for a long time. In a sense gender identity is partly constructed in terms of sexual strength; that is, male gender identity is framed in terms of sexual strength. These findings are consonant with other studies in Africa. Among the Baganda of Uganda, for example, an ideal man should maintain an erection for a reasonable period of time so as to be able to satisfy his wife/partner (Naibatu, et al. 1994 c.f. Ogden, 1996:112). This also suggests that contrary to the popular perception that it is men who need a lot of sex because they have more sexual strength (eg. Nelson; 1987; Buzzard cf. Nzioka, 1994), women are not inferior in sexual strength and desire. In some cultures it is women who are considered to have more superior sexual strength (Brandes, 1996).

In many cultures a woman’s sexuality is fraught with ambivalence (Ogden, 1996: 107) and any woman who shows her sexuality openly is seen as socially dangerous; not a proper woman, but one with questionable morals, for she cannot exercise self-control. As Wallman notes, sex is not only a biological activity, it is also a cultural one with social meanings (Wallman, 1990 cf. Ogden, 1996:106). In fact, the concept of vinya in the context of sexuality does not apply to women; it applies to them in the context of reproduction, that is, childbearing. The foregoing notwithstanding, many male informants said that in private, women express their sexual desires without hindrance. Too
much alcohol interferes with 'proper' functioning of a man sometimes resulting in loss of *vinya*, which is not good for a healthy sexual relationship. People, especially women said that if a man wants to remain strong, then he should avoid consuming a lot of alcohol. What this confirms is that women do not see sex as only being played for reproduction and the pleasure of the man; it is also for the pleasure of the woman. These are less than obvious meanings or expression of female sexuality that can easily be missed out in research that does not locate meanings that are in every day language but coded with deeper meanings, especially when applied in the context of sexuality. Another point to note here is that when a man takes time in drinking places and away from his wife it may create 'friction' between them.

4.4. The cost of starting sex at an early age

Problems associated with early sex debut revolve around closely interrelated social and health aspects, both of which have a bearing on the future status of the individual’s sexual and reproductive health.

4.4.1. Early sex debut: A threat to health

Engaging in sexual intercourse at an early age is considered potentially damaging to the health of the young people. A girl who starts to sleep with men at an early age is likely to have reproductive problems in the future. These problems are brought about by a number of factors.

Sleeping with 'big men' can damage the girl’s reproductive tubes and/or the womb. This would make it difficult for her to conceive, much less give birth in the future. The notion of 'big man’ has two meanings. ‘Big man’ is used with reference to the size of the male sexual organ (penis) in relation to the not fully developed sexual and reproductive organs of the girl. People say that a
big man can also damage the internal organs such as kidneys. ‘Big man’ also refers to an older man perhaps old enough to be the girl’s father. Mixing the girl’s ‘blood’ with that of an old man weakens her blood while at the same time making the blood of the old man ‘strong’. The mixing up inside the girl’s body of the blood of not just one man but all the men she sleeps with ‘spoils’ her blood - makes it bad. Consequently, the girl may in the future not conceive. If she conceives she is likely to miscarry. Green (1999:57) found similar notions in Tanzania: that a young woman’s blood can be spoiled through sexual intercourse. It is believed that a girl who habitually sleeps with old men would look older than her actual age while the men themselves would look younger, that is, they would be rejuvenated, a finding consonant with Karanja’s (1994:204). This probably explains why old men like having sexual relations with young women/girls, besides the belief that they are less likely to be infected with HIV/AIDS (see also Nzioka, 1994). But girls who ‘move’ with old men are also despised, shunned by young men and thought to be after money, not ‘genuine love.’ Early sex with the same generation is not perceived to be as damaging as sex between very young and very old people. Thus male ‘blood’ can be dangerous when used at the wrong time; as when sex is between too young girls and old men.

On the other hand, young men who have sexual relations with older women are said to have lost direction. The blood of a young man who sleeps with older women is thought to become weak while the blood of the women he sleeps with becomes stronger. Furthermore, if the young boy habitually sleeps with old women, he would ‘grow old’ while the women he sleeps with look ‘younger’ than their actual age. A male group discussion captures the foregoing. (F: myself, P: participants),

F: What is the problem with a girl who ‘knows’ men early?
P1: If a girl knows men early, she cannot be right/okay later.
P2: It depends on the ‘blood’ she is ‘going’ with...going with an old person [man] and she is a little girl...
P1: The blood of the man can damage her...
F: How does the blood damage...?
P1: The blood of the old man cannot be compatible with hers, such blood causes problems, and it can destroy or weaken her blood, never to give birth later.
P3: It is worse if she sleeps with many/different men. Her blood will become spoiled.
P4: A young girl ‘running’ with old men, the old men will become young in the process, and the girl grows old, looks older than her...her age.
F: What about a young boy?.
P2: Even a young man who sleeps with an old woman... she may look ‘clean’, well dressed, but the young man starts to become weak; he will look older while the woman starts to look like a teenager.\(^5\)
P1: But such a man has completely lost direction...there is something wrong somewhere.
P3: The man will still ‘give birth’, yes, but he may lose interest in sex.

The notions of ‘strong’, ‘weak’ and ‘blood’ are used metaphorically and can be interpreted and understood in terms of bodily substances and how these are related to sexuality and procreation. For conception to occur the ‘blood’ (euphemism for semen) of the man must be compatible with that of the woman. The lack of ‘similarity’ between the man and the girl (or the boy and the woman) in terms of huge age differences makes compatibility impossible hence the girl cannot conceive. Furthermore, such a relationship is founded on sexual exploitation and is devoid of the emotional, intellectual, mutual, and social respect, which are important components of sexual health and wellbeing (Correa, 1994:69; Hardon, 1995:121). But there are those who do not perceive any danger of starting sexual activities early. Indeed, young boys and girls are known to engage in various sexual acts such as petting.

\(^5\) See Carole Agunda-Amandi’s on ‘why a woman strays’ in the Daily Nation Saturday Magazine, November 11-17, 2000. One of the reasons Agunda-Mandi says is emotional
Some people use more concrete terms to explain the health risks of early sex debut. The womb may be unable to support a pregnancy and she may have delivery problems due to the not fully developed reproductive system or due to inability of pelvic girdle \[\text{manyunyu}\] to expand to accommodate the passage of a baby. This may lead to caesarian section which is perceived as a poor pregnancy outcome since it reduces a woman’s capacity to give birth and to perform her normal productive duties (see sub-section 5.6).

Starting penetrative sex early widens the possibilities of a young person to have many sexual partners in the course of her/his sexual life. It makes sense to think that as young persons grow up, they may be tempted to enter into various relationships, serially or concurrently as they try to experiment with life. Some may engage in multiple relationships in search for a marriage partner. But also others may get involved in multiple sexual relationships for economic survival. Taken together, these factors enhance [though not always] the risk of infection with STD including HIV and other undesirable outcomes like unwanted pregnancies with concomitant psychosocial, economic, and health problems.

4.4.2 Starting sex early: social creation of biological/reproductive maturity?

Sex before menarche is said to hasten the girl’s biological maturity, something that does not happen to the boy. The girl may start menstruating earlier than she would have if she ‘kept off’ men (or if men kept off her). This may also contribute to prolonged menstruation. A young woman is said to develop breasts earlier than she would have if she did not engage in sexual intercourse deprivation. She then reports a woman who had an illicit affair and the woman says that it made her feel alive and like a teenager again.
especially with old men at an early age. A woman's reproductive maturity is thus socially created through sexual relations. This opens the way for reproduction. Llewelyn-Davies (1996) found similar explanations among the Maasai of Kenya - that males opened the female path for reproduction. According to Llewelyn-Davies, sexual relations between the already circumcised men and young girls enabled the girls to grow breasts a sign that they were mature and could undergo clitoridectomy after which they would be ready for marriage and childbirth. A study done among the Abagusii of Kenya had similar findings (Amuyunzu, 1997). In this case an alternative explanation was some of the foods girls eat. These notions (of maturity creation) are consistent with my informants' views that, young people, especially girls mature earlier these days than in the past. The current high rate of teenage pregnancy in Kenya (See KDHS, 1998) is considered a clear testimony that girls attain biological maturity at an early age. But as discussed earlier (see sub-section 4.2.1), biological maturity does not necessarily go together with physical maturity.

4.4.3 Social cost of early sex

The social costs associated with early sex debut include unplanned pregnancies. Teenage pregnancy often results in school dropout by the girl (voluntarily or otherwise), although, if it is a boy responsible, he continues with his schooling (Amuyunzu, 1997:16). In fact in Kenya until very recently, regulations required that schoolgirls who became pregnant must leave school; and for many rejoining is difficult on practical grounds.6

6 See the Daily Nation newspaper March 9, 2001. Rosalind Mutua says even though since 1996 it has been the policy of the Government to allow girls to go back to school after giving birth, this policy may fail due to parents’ ignorance. And even if the parents knew about the policy, there would still be a problem because teenage pregnancy is almost always seen as resulting from immoral behaviour of the girl and teachers and other pupils may not be positive about the girl.
Not only does teenage pregnancy result in school dropout, which limits the girl’s chances of pursuing a meaningful career, it also occasions untold socio-psychological and emotional suffering. Many of the young girls who drop out of school either because of pregnancy or other reasons such as lack of school fees end up working as barmaids in local bars or in cities and towns, or they work as house helps locally or in towns. Some end up in selling sex full time or part-time to supplement their low income (see also Bujra, 1999). Dangers entailed in sex for survival, including AIDS have been well documented (see eg. Keilmann, 1997; Wojcicki and Malala, 2001). Also teenage mothers are likely to suffer low self esteem not only because of their low social standing, but also because the roles they are expected to play as mothers are inherently incompatible with their physical and emotional immaturity (Zabin and Kiragu 1998). This is particularly true if there is little support from the parent(s), siblings and/or other relatives.

A young girl’s pregnancy is considered shameful perhaps because it symbolises uncontrolled sexuality, which is perceived to embody disorder. Teenage sexuality and pregnancy are loaded with moral overtones. Quite often, teenage pregnancy is not only considered as resulting from irresponsibility and bad morals on the part of the girl, it also is blamed on the girl’s mother who did not bring up her daughter ‘properly’. At its extreme, teenage pregnancy may cause marital problems where the man feels that his wife did not instill good morals in the daughter. Although a boy who impregnates a girl can easily escape blame and responsibility, many perceive such an act to bring shame to the boy and his family as well.

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7 See a report in Daily Nation Newspaper May 1&2, 2001. B. Amadala and K. Tamui report about a 43-year-old man from Kakamega District of Western Kenya who with a machete hacked to death eight family members including his wife and four children and left seven other family members critically injured. Among the alleged reasons for his macabre behaviour is that the man had complained about his daughter being involved in a love affair with a village boy.
Shame occasioned by teenage pregnancy is only one side of the story. People know and say that young people are having sex. When a girl becomes pregnant, few are surprised. Indeed, the general feeling was that teenage pregnancy was so common that if it were to be stigmatised, then nearly every home in the village would probably be stigmatised. Ocholla-Ayayo (1997) and Amuyunzu (1997) make similar observations about youth sexuality and pre-marital pregnancy in Kenya. Few of my informants thought a girl could be virgin at marriage, in spite of the widespread Christianity.

There could be tacit benefits for some teenage mothers. Consider this from a 20 year old married mother of one: When I asked why she discontinued her schooling when she had just a year to finish secondary education (Form 4), she happily responded: ‘I had had enough of education and was big enough to get married!’ Although this was the only case I encountered, and an exception rather than usual, it made me look at the issue of education, school dropout and young adults sexuality and reproduction from another perspective. The case resonates with Wilkinson’s (1996:211) point that there is life outside the marketplace, life not dominated purely by economics. Ndeti’s point three decades ago about the dilemmas that young people in Kenya and perhaps elsewhere face is still valid:

Today, man’s pluralistic culture can promise all the comforts of the material world if a modern youth will go out and seek them. He is constantly reminded of the importance of material success, since he is told that this gives meaning and security to human life. He tries his luck and sometimes succeeds, at other times he does not. He becomes skeptical and questions the rationale and the purpose of the entire system (1972:92).

Modern Western education, which is part of the pluralistic modern culture, stresses success in education as it is considered the only gateway to prosperity.
Some may find it difficult to cope with its demands, or get disillusioned by the acquired education that does not deliver the much-publicised material success. Some young people (also adults) may opt out and seek other alternatives. For girls it is not too bold to argue that they may opt to get pregnant and marry and continue to have children as the above case suggests (also Last, personal communication). It has been argued that education is one of the major, if not the leading, modernisation variable as it affects attitudes and value systems (Stambach, 2000). But this is only true to the extent that people see and experience its immediate benefits. Education remains important to individuals, community and the society as a whole, but childbearing is equally important. In uncertain circumstances, it is better to marry and have children, both which are desirable culturally and acceptable in the eyes of the society, than to fail in education which is almost always perceived as signaling failure in life, something unacceptable in the eyes of the contemporary society.

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8 There are many young people in Kenya both in rural and urban areas who are well educated, some even university graduates, but without formal employment.
Chapter Five

Sociocultural Meanings of Childbearing and Wellbeing

This chapter considers the meanings and perceptions of childbearing processes. It examines the perspectives of men and women with regard to meanings attached to reproductive outcomes and how these are linked to Kamba notions about illness, health and wellbeing. More specifically, the chapter explores the meanings of reproductive failures and successes. The importance of childbearing for individuals, the family and the wider kin/community is discussed. The chapter draws on specific cases to show the ways in which men and women perceive and explain social, sexual and reproductive/pregnancy misfortunes.

5.1. Marriage and parenthood

Among the Akamba, it is inconceivable that an adult man of marriageable age will remain without a wife. Failure to marry when one is old enough elicits intense gossip and speculations among family, relatives, friends and the neighbours; it may imply that there is something not right with the man. Indeed, it is considered a pointer to sexual ill health, while failure to get children may imply poor reproductive health that may also have roots in sexual ill health. If a man is ‘functioning’ well and has ‘strength’ (see 4.3.5), he is not expected to remain without a wife.

Failure to marry is attributed mainly to two, sometimes related factors; physical and social. The physical explanation may also be linked to cultural notions of disease and illness aetiology and management. Besides being perceived as not sexually functioning properly, the man’s failure to marry may be attributed to human agents, that is, anti-social practices such as witchcraft.
For example, a person with evil intentions may collect soil from his footprints and use this to destroy his physical, social and even psychological well-being.

Education confers a high status, so that young educated people may command respect traditionally available to elders. That is, status is constructed not in terms of age, but in terms of modern achievements. However, an unmarried man commands less respect in the community and in social places. He does not attain full adulthood and manhood; he is always treated as a youth.

These anti-social forces also apply to a woman. Sometimes, however, she is blamed for her own misfortune of failing to get married. Here people focus on her behaviour, especially if she lives in town, which often is associated with corrupting young people’s morals. Many people perceive a highly educated woman as having a higher chance of remaining unmarried. She is perceived as too domineering, knows too much, and is socially uncontrollable, something some men are uncomfortable with. In other words a well-educated woman is largely perceived as unmarriageable. This perception can be understood in the context of expectations, obligations and rights of family members, which are still based on gender as well as perceptions of the production and reproductive roles of a ‘good wife’. These roles include bearing children, taking care of them, looking after her husband’s parents and kin, and generally taking care of the home.

Hakansson and Le Vine (1997:258) remark that a married Gusii man considers to work and clean for himself would reduce him to a state of unmarried, which is like reducing him to a boy. These services are performed by a man’s wife and do not befit the status of a married man. And Whyte (1997:56) observes that men recognise that controlling women depends on maintaining control over crucial resources, which include education, bridewealth, land and wealth, and also children. She claims that in Uganda, a man would always want to
marry a woman who is less educated than himself, lest she may rule over him. Bockie (1993:7) makes the same point about the Kongo people of Congo who believe a well-educated woman will have a difficult time getting married and being a good mother. I suggest that this has to do more with the concern for social order than the control of women’s resources. This argument is in consonant with Stambach’s observation about the Chagga of Tanzania. She notes that among the Chagga education, an agent of modernity, is perceived to have negative effects on women and their marriage (Stambach, 2000:6/7). It is particularly damaging to women and to a normative patrilineal social order; educated girls are considered rebels, fathers have no authority over their daughters and similarly husbands will have no control over their wives-so men would not want to marry them. In other words, education is perceived to contribute to girls’ moral decline more than boys’.

People recognise men and women can and many do begin their reproductive life before they get married. They also say that it is possible for a woman to continue with childbearing without marrying. But this is not possible for a man. However, a good woman is framed in terms of respect for her husband and kin, marriageability, and having children within the marriage institution. This resonates with Ogden’s (1996) notion of ‘proper woman’.

The foregoing does not in any way suggest that the Kamba do not value education. Far from it, education is perceived to make positive contributions to sexual and reproductive wellbeing. More education is perceived to offer greater economic opportunities that should enable one to afford a better lifestyle and health services; greater economic opportunities also offer greater power hence greater independence to both men and women. The point to make here is that education is good for both men and women and is highly valued. For men, however, it is not perceived to be limiting in terms of the dominant sociocultural models of adaptation. For women it does. They may
have difficulty balancing the demands of the new roles conferred by education on the one hand, and traditional family roles on the other, which remain largely unchanged in both urban and rural settings. It is in this sense that education is perceived to negatively affect women more in terms of traditions and the normative order.

5.1.1. Children are ‘gifts from God’: motherhood and barrenness

Children provide a sense of security for the future by providing social and economic support, especially in old age. They stabilise a marriage by giving it meaning. Children also provide continuity. To die without a child means that one is forever dead as there will be no heir or child to perpetuate his or her name or as it is called ‘to make one’s name stand’ [kuungamya isyitwa]. As is elsewhere in African cultures (Last, 2000; Watson, 2000), children help their mother with household chores such as cooking, collecting firewood and water, and taking care of the young siblings. Children confer certain status to the mother and the father within the home, community, and in the society. To be addressed as mother of so and so [inyia wa ngany’a] or, father of so and so [ithe wa ngany’a] is a social status men and women and their kin look forward to. Therefore, in a symbolic sense a marriage is not complete without children. Below I present a case of a barren woman to demonstrate how marriage and motherhood are connected.
This is a case of a 35 years old barren woman. Maria was first married in 1981 at about the age of 15. Her first marriage lasted 8 years – ended in 1989. She was married a second time in 1995 and since then she has lived with her current husband. Maria’s current husband, a trader in second hand clothes lost his first wife in 1993 [about 7 years ago] and he had 2 daughters with her. Both she and her husband are staunch Christians [Salvation Army].

Maria was never happy in her first marriage because her husband used to harass and beat her saying that she is barren [ngungu]. ‘Yet I know that children are gifts from God [syana ni mithinzio kuma kwa Ngai]. I sat down, thought to myself and realised that although I am married, I am alone and my husband is alone.’ Maria decided to leave her husband. Brothers to her first husband were good to her, very understanding but his sisters were hostile to her. She says that her former husband had not paid bridewealth; not even the first 3 goats [mbui sya ntheo]. She explained that barrenness is not something ‘new’. ‘I am not the first woman to be barren, neither will I be the last.’ Maria says that some of her relatives started bearing children when they were very old; one of them at close to 40 years. Maria gets her monthly periods regularly and says it is a normal flow; it lasts two days, sometimes three days: ‘it is not too heavy or irregular like that of somebody who is sick-with bad disease [STD-gonorrhoea]. Even women with bad diseases like AIDS can bear children.’ Her first husband took her to hospital but the doctors said there was nothing wrong with her body. Maria has, however, not consulted any traditional healer to find out what is her problem, although she says that it is possible there could be some traditional reasons as to why she cannot give birth. She sees no reason for following up the issue because ‘I have seen people use a lot of money to treat infertility and some are never successful; Children come from God and may be my time has not come yet’ [twana tuetawe ni Ngai]. However, she would not refuse her current husband of 5 years to marry a second wife if he wanted to. Maria’s first husband married another wife and has had four children with her.

It has variously been argued that infertility is the greatest misfortune, especially in African cultures, that a woman can experience (Mbiti, 1969; Kawango, 1995; Whyte, 1997; Ochola-Ayayo, 1988; Watson, 2000). Childbearing enables a woman to attain womanhood. Childlessness affects a woman more because she controls fewer resources than a man, both productive and reproductive. The fact that on marriage, a woman in a patrilinial society moves away from her natal kin to live with those of her husband is reason to make her feel insecure if she has no children. Mbiti (1969 cf. Kawango, 1995:84) remarks that barrenness is a painful and humiliating state for which there is no source of comfort in traditional life. However, I found that a barren woman is also treated with compassion. Many people said they sympathise with a barren woman and do not like reminding her that she is barren. Maria’s
experience is partly a result of the erosion of cultural institutions of managing infertility. Traditionally a barren woman would marry iweto to bear children for her. I found this less acceptable to the majority of my informants. Given this scenario, it is likely that barrenness causes more pain today than it did in the past.

It is not childbearing alone which, among the Akamba, gives a woman a higher status, cultural value and security. Bridewealth functions as a seal (certification) and, therefore, a major stabiliser of a marriage. In this sense, bridewealth is related to reproduction and well being. In the absence of both children and bridewealth investments, it is unlikely that a marriage will last. But most importantly, is how motherhood articulates with marital status that makes the difference. In other words, it is motherhood at the right time and the right place that earns a woman respect (see also Ogden, 1996:246-7). Marriage brings honour to both men and women and for this reason it is a desirable social status.

**Case study 2: the state of unmarried - Leah.**

Leah is a 42 year old unmarried medical nurse who has two children. Her father has two wives. She blames her failure to find a husband on her stepmother who ‘blocked her path’ (wamukelanile) so that she would never get married. Her first serious relationship did not end in marriage. Leah, however, got a daughter with this man who, soon after, deserted her.

After sometime, Leah found another man whom she introduced to her parents and who, by local standards could be considered wealthy. According to her, the stepmother was never happy about it as evidenced by her comments that she was lucky to have found a wealthy suitor. Sometime after introducing the man, she moved to stay with him. They stayed together ‘as man and wife’ for less than two years. Leah got a son with this man. Soon afterwards, they separated.

The traditional marriage rites were never performed to cement and ‘legalise’ the relationship. Leah has never found another man and she does not think she ever will. She told me that ‘single mothers really have it rough because, unlike married women, they have to do everything by themselves.’ She blames all the failure on her stepmother who, she says was envious about her relationship with the wealthy man and bewitched it.
In Bunyole, in every day discourse about marriage and children, misfortunes and adversity may arise and here people look for explanations that may be found in social relations. Whyte (1997:59) writes about marriage in Bunyole ‘...not sticking in a marriage is considered a misfortune that may be caused by an agent.’ And among the Sukuma and Nyamwezi of Tanzania many abnormalities in the lives of individuals are attributed to witchcraft (Abrahams, 1994; Bukurura, 1994:65). Indeed, anti-social practices such as witchcraft are used to explain many social and health problems and especially those that seem difficult to understand. Kawango (1995: 82) makes similar observations about the Luo who may attribute many misfortunes such as failure to pass exams, secure jobs, and barrenness to anti-social practices by human agents. As in these cultures, so is it among the Akamba (Ndeti, 1972; Johnson, 1999). Witchcraft discourse provides reasonable explanations for misfortunes, afflictions, and undesirable situations that seem to have no other apparent cause.

Motherhood outside the culturally accepted social institution, marriage, is undesirable even though it is tolerated in the community. To be addressed as mother of so and so [inya wa ngany’a-usually first born] alone does not provide cultural worthiness. A woman feels more fulfilled when also addressed as grand daughter of so and so - usually her paternal grandfather [ng’a ngany’a]. This happens only within marriage as husband’s parents address her as such as a show of respect. Thus through marriage many women achieve respectability (see also Ogden, 1996:60). But when marriage and motherhood are combined a woman commands more respect in the community because for many, these are statuses that not only construct a morally upright and respectable woman, they also ensure security for a child’s future.

It is thus not a woman’s reproductive potential alone that counts, but also the social arrangements within which the reproductive events and goals are
realised (Olenja and Kimani, 1998). It is within social relationships that a young woman can find social and reproductive support, protection and gratification. Many informants said to me that a married woman has, besides her own kin to whom she can turn, her husband's who, in practice, are the people she turns to for support and sometimes protection. For example, older members of the family versed in traditions [kithio] best handle reproductive problems associated with sociocultural models of illness and misfortune causation. In this sense, I would argue that the extended family plays an important role in the health of a nuclear family and its erosion also erodes an important aspect of health care.

5.2. 'I now look different': perceptions of childbearing and health

Uncontrolled childbearing is said to results in the depletion of women's physical strength [vinya]; some reduce in body size and weight and others become prone to illnesses. The following comment from a middle-aged woman clearly captures perceptions of the effects of childbearing: ‘This is not how I was before I gave birth. I now look different; I used to be very big but have slimmed and lost strength. If I continue giving birth, I will definitely become weaker.’ People observed that some women become big in body size while others become smaller after delivery but that does not mean their health is poor. At issue here is not the body size but the bodily resource that a woman expends in childbearing (see Bledsoe, et al., 1998; 1994). Childbearing is perceived to make women grow old quickly, especially if the children are many and born in quick succession. It is not the chronological age per se that is considered here but the social age, which is rooted in the physical appearance and the notion of strength. Childbearing is not, in itself, seen as a threat to a woman’s physical reproductive health. Rather, it is 'uncontrolled' reproduction; the number of children a woman bears and the time a woman takes to have another child. Giving birth every year makes a woman’s ‘blood
become lighter'. A woman thus requires a rest between births to regain her strength.

Besides the depletion of the physical strength, childbearing also results in the loss of social strength. Social strength is depleted when children tie a woman down so that she cannot find time to participate in social activities such as women group meetings, *myethya*. Children require constant attention when small and if births are closely spaced, then no time is left for the mother for these activities. The general feeling was that today women receive less social support after delivery. Many young women said that they receive support from relatives, friends, and neighbours after they have given birth. The support includes help with household chores, including collecting firewood and water. But they say it is for a short time and, therefore, not enough. In the traditional setting social support was readily available to a newly delivered woman; the social support system was working better. This support has become less available with the weakening extended family structure as a result of the changing sociocultural and economic environment. This is akin to social poverty (Last, 1999). Thus the resources available to a woman both physical and social will influence her reproductive wellbeing.

Perceptions about the effects of childbearing on a woman’s health need also to be understood in the context of notions about sexuality. The cultural institutions and taboos that regulated sexuality and reproduction have weakened. The long post-partum sexual abstinence that ensured proper child spacing has become less effective. The traditional sexual model permitted men to have sexual relations with other women when their wives were not sexually available. Polygyny, although a preserve of the rich helped in spacing births and controlling fertility. Also the dangers that littered the sexual landscape required a fair amount of sexual discipline on the part of men and women (see Mbula, 1977). While the old generation are happy to say they, on certain
occasions, allowed husbands to ‘go outside’, this is not an option to young women and men; they do not approve of it. Suffice it to say that the traditional institutions of sexuality and fertility regulation have become less and less relevant in the contemporary social situation, and in light of other realities such as AIDS.

It should be added here that African men are often presented in the reproductive discourse as not caring about their wives’ health (Ratcliffe, et al., 2000). This view is very extreme and is not supported by my data. Men are concerned about their wives’ health and physical appearance. They are concerned about the health of their wives because men would not like their wives to look weak and perhaps be unable to bear more children. But also a ‘healthy’ looking woman bolsters a man’s social image – that he has looked after his wife well. Thus people say a man and his wife should cooperate in sexual and reproductive matters so as to avoid unnecessary pregnancies; so that the wife can regain her physical and social strength. This is why young men and women support women’s use of contraceptives.

Rising costs of child rearing (see 5.3) may explain why women, including the Catholics are using and are willing to use modern contraceptives, in spite of the official church policy opposing the use of artificial birth control methods. It may also explain the willingness of men to allow their wives to use contraceptives. As some Catholic women put it: ‘In public I agree with what the church says about contraceptives but at home I do what I think is good for me. Will the priest help me when I will be struggling to feed my children?’ This suggests that discrepancy exist between what people practice and church policy with regard to family planning.
5.3 Changing perceptions about children?

5.3.1. The perceived cost of children

I have already shown that any marriage remains incomplete until the ‘fruits’ of the union which give meaning to it are seen. Children fulfil social, cultural, economic, psychological, and emotional needs. They also have a ‘health’ value. Bringing up children these days is considered difficult; it is also costly, which has a wider than economic meaning.\(^1\) It includes social cost, time and other resources used to bring up the child (see also Kyomuhendo, 1997). As already indicated, reproduction involves gestation, caring for the children, and feeding them, all of which is time consuming. In the early stages, the cost of a child may be felt more by the mother than the father in terms of time taken to care for the child, including hospital/clinics visits.

I have shown in the preceding section that childbearing especially at close intervals is considered strength consuming, which is perceived to impact negatively on the health and wellbeing of both the mother and child. Many people felt that 5 children or less are good for the health and wellbeing of the mother and child. Even the older generation that had finished bearing children said that if they were to go back to childbearing now, they would prefer fewer children. A few of my informants, however, felt that more than 5 children is a good number.

Men are physically invisible in the early stages of bringing up children. Men and women consider it a mother’s responsibility to take small children and babies to clinics. I saw few men at Mwala children’s clinic in spite of the

\(^1\) Even when people talk of economic hardships and benefits, children are not given an economic label \textit{per se}. Furthermore, people in the village do not quantify what they spend on a child and do not keep records about their expenditure on children partly because of the low literacy levels. It is also because doing so would be like refusing gifts from God since children are a gift from God. This ties with the belief that each child is born with his or her own
claim by many men that they accompany their wives when they visit the clinic or take children for treatment. However, they buy medicines, provide transport for their wives, clothing, and paying for other costs such as hiring a house-help. Thus they play the enabling role. Men’s physical absence could also be explained in economic and sociocultural terms. Many men were away in places of work or engaged in farm activities within or outside Mwala. As children grow up, fathers become more involved through payment of school fees and other requirements. Many of my informants said it was the father’s responsibility to meet these requirements. This questions Caldwell’s assertion that economic burden is unlikely to make men to favour small family because they do not bear the full burden of their reproductive acts. The present economic hardships and the cost of rearing children are a disincentive for people, especially the young generation, to desire many children. Indeed, men themselves expressed greater anxiety about childrearing costs. This is the situation in many other parts of Kenya (Bradley, 1997). Babatunde (1991) reports similar findings in Ghana and Nigeria. The perceptions about children is also influenced by a somewhat improved health services that have brought about higher child survival now than in the past (see KDHS, 1998; GOK/UNICEF, 1998). In reality, however, child mortality has been rising since the mid 1980s now standing at 41 per 1000 from the previous estimate of 33.5 per 1000 live births (KDHS, 1998:90). This rise is attributable to AIDS epidemic (NASCOP, 1999:28). Land as a source of inheritance and livelihood has also diminished; and community leaders and politicians keep extolling parents to educate their children, as today education is seen as the best inheritance available.

One of the important arguments in the value of children in the literature is that parents benefit from large families once the children are working and can send

wealth. See also Ratcliffe et al., (2000) on the perceived supernatural role in reproductive process.
money and gifts home (Caldwell, 1982 cf Bradley, 1997:229/230). Evidence from my study to support this hypothesis is, however, mixed and in some instances, non-existent. Parents’ experience tells them that it is not always the case that their children will support them. Many young people, among them university graduates,² have finished school/college but returned home to continue with the village life just as those who are less educated. And those who migrate to towns have not found work to support themselves much less others; if they are lucky to find work, it is less rewarding. Indeed, today payoffs from investment in children come in late in life and perhaps too little. In Kakamega, for example, Bradley (1997:242) found that many parents have children who work in less paying jobs such as maids and security guards. Therefore, the good life supposed to come with education has become a mirage for the majority. In other words the cultural hypothesis that many children are always a source of joy is only partially true. Consequently, perceptions about children have changed. Other studies have come to similar conclusion (e.g. Hakansson and Le Vine, 1997; Kilbride and Kilbride, 1997). It is not just children but also the number and types of children a couple or a parent can support.

5.3.2. Ideal family

The desire is not just the absolute number of children, but an ideal family with boys and girls. But the conflict between the desired number of children and the ideal family makes some couples to get more children in search of a boy.

A man who ‘gives birth’ to girls is perceived as having a blood weaker than that of his wife; in this context his wife has more strength. A man may, therefore, consider himself (or be considered) a reproductive failure if he

² At least there were 3 University graduates in the area I was doing research who were
'gives birth' to girls only. This partly explains why a couple may have more children than they initially planned. It also explains why a man to some extent, may marry another woman in the hope that if her blood is weaker than his, he would get a boy. But some people also wondered what would happen if a couple looking for a boy got only girls. Young people feel that a woman couldn't continue giving birth as though 'she has an order to supply the children!' It is on the basis of this that the notion of children as 'gifts' from God holds even when the perception of an ideal family is one with both sexes. Therefore, some people say that 'a child is a child', whether a boy or a girl and 'couples should accept what God has given them.'

The notion of an ideal family is well captured by a story I was told of a local primary school teacher who divorced his first wife because of giving birth to girls only (4 girls). He married another woman who also bore him girls only. He divorced his second wife and married another who was his house help. She gave birth to 3 girls. Meanwhile, he had a fifth baby girl with his first wife (while still divorced). Thus the man, as many others, thought the mother determines the sex of a child. And a young woman said 'both boys and girls are good but my prayer was that my first born would be a boy.' While such comments, which I heard frequently, reflect genuine wishes of and preference for boys by women, it may also reflect the wishes of men and family as well as the community's cultural expectations. Indeed, they underlie not just the preferred order of children, but also the social value of male children even with the changing sociocultural and economic environment.

Although sons are preferred and as I have already indicated, the present socioeconomic reality puts serious limitations on the extent to which they can provide economic support to their parents. And daughters are today less seen in terms of bridewealth. Many have not been married and those who have, not
much has been gained from them due to lack of resources; the case of Maria (see 5.1.1. case study 1) is one among many examples. Some people especially women consider girls who have been to school more helpful to the family than boys. ‘If she is working, she will always help not only her mother, but also her siblings,’ or ‘these days things have changed, men just disappear into big cities after school and they never come back to see their parents; they only come back around Christmas holiday,’ I was variously told. As a result, some women felt that they would rather have girls. Davison (1989, cf. Nelson, 1992:131/132) had similar findings among the Gikuyu. Educated girls who had found good jobs helped with among other things, payment of school fees for their brothers and sisters while most boys moved to the city and did not send help to their family. In my study, however, I never heard any man say they would rather have girls only. Among the Luhyia of Western Kenya, Bradley (1997:232) found that both male and female children are valued and wanted.

It has been argued that the sociocultural milieu within which women operate exerts pressure on them and this may influence their reproductive behaviour and desires (Browner and Sargent, 1996; Ratcliffe, et. al., 2000; Handwerker, 1986). While this may be true, my findings suggest that the present reality has occasioned changes in the perceptions about children. Men and women want sons to perpetuate the family’s name but girls are also wanted because they provide both social and economic support. Thus both boys and girls are desired and this explains why people say an ideal family should have both sons and daughters.

5.4. Infertility and pregnancy outcome: meaning, explanation and blame

Infertility and poor pregnancy outcome may be caused by human agency. Strained social relationships between close relatives or neighbours can result in
anti-social acts that are harmful to the person to whom they are directed. A woman’s womb can be ‘tied’ or ‘turned upside down’ so that she cannot become pregnant or sustain pregnancy. A witch may do this. This infertility is temporary because it is treatable. A malicious person can also collect menstrual blood of a careless woman and put it in an anthill hole; menstrual blood is associated with fertility. It is believed the woman whose menstrual blood has been put into an anthill hole will never conceive. This then becomes a structural defect on the part of the woman because the problem is located within the woman. This may explain why it is the woman who carries much of the blame for infertility. Some sterility is, however, caused by forces that the woman or the man has no control over. People attribute such to the will of God about which no human intervention can help. In this case, no one is blamed for being infertile as children are not given as a present by men to women, but are given as gifts by God (see also Thiesen, 1999:197).

The belief in ancestral spirits [the living dead] taking active part in the life of the living ‘relatives’ is still prevalent in Mwala. Unhappy ancestral spirits [Ngai sya musyi] can cause misfortunes. Neglecting the wishes of spirits of the departed ancestors may bring misfortunes to a family. For instance, if a woman was born to be a traditional healer, say to take after a departed relative and the family does not take the necessary steps to initiate her into the ‘profession’ of healing, the ancestral spirits become unhappy and express their anger by causing problems among them sterility.

Inappropriate sexual conduct can cause not only infertility but also many social and physical misfortunes. Violating sexual and reproductive taboos by one or both partners, for example, having sex with a blood relative can cause infertility. The ancestral spirits may get offended and strike by denying one a child. If this ‘sin’, is not ritually cleansed, and a couple has a child, then the child is likely to die. The couple becomes contaminated [thaavu]. Misfortunes may manifest
themselves in the second or later generations so that children suffer because of ‘hidden sins’ committed by their parents or grandparents (see section 6.8). If barrenness is the result, then infertility becomes inherited. This means that infertility is genetically perpetuated. Sex with a woman who has had a miscarriage or abortion is bad sex as it can result in other miscarriages. The only way to manage such a problem is by use of traditional medicine; to conduct a cleansing ritual [ng’ ondu- chapter 3 & 6].

Infertility can be a result of structural defect in the functioning of the woman’s body. People say it is an in-born handicap [musyawa] about which nothing can be done. A woman can be born without a ‘womb’ making it impossible for her to become pregnant. She may also be born with an organism in her womb so that a woman sometimes appears pregnant but the pregnancy gets ‘lost’ in the womb.

Starting penetrative sex before menarche may contribute to a girl’s infertility in the future (see section 4.4). Early sex, especially with older men spoils and weakens a young woman’s blood there by making it difficult to conceive. It also widens the possibility of young people sleeping with more than one sexual partner in the course of their sexual life. A lot of sex is not good, indeed it is said to be unhealthy. Mixing up inside her body, her blood and that of the men she sleeps with spoils a young girl’s blood. This partly explains why in the Kamba traditional sexual model, young girls were discouraged from having many lovers. Besides, starting sexual intercourse early exposes young people to dangers of infection with STD. People particularly the young and more educated know that sexually transmitted diseases such as gonorrhoea and syphilis are major causes of infertility. STD makes a woman have light or heavy menstrual flow making it hard for her to conceive. In a woman STD also causes the blockage of reproductive tubes or destroys the womb while in men it destroys the ‘blood’ [nthakame] or seeds [mbeu/vinya wa munduume]. Starting sex early
widens the risk of unwanted pregnancy. Girls may abort unwanted pregnancies. Several abortions can cause infertility.

A couple may not be infertile, but if their bloods are incompatible, then sterility may result. Thomas (1999:27) observes that among the Tamanambondro of Madagascar similarity and compatibility between a man and a woman is thought to be necessary for any procreation to take place. In my study, several factors among them early sex debut, the use of modern contraceptives, and too much drinking may occasion incompatibility of blood. Using contraceptives when one is too young or for a long time particularly before delivery of the first child can make a woman miscarry or become barren. Contraceptives not only destroy a young woman's womb, they make her blood incompatible with the man's blood so that conception is impossible. Excessive beer drinking for a long time not only weakens a man, it also can spoil his blood making it difficult to mix with that of the woman. But there are men who naturally have 'bad blood' so that any woman who sleeps with them will always miscarry.

Many writers argue that in many cultures, the blame for childlessness is placed on women (Whyte, 1997; Steinberg, 1996; Frayser, 1989). Whyte (1997), for example, says that in Eastern Uganda, people do not think that men can be infertile. And Mbiti observes that a childless woman suffers because even if it is the husband who is the source of the problem, the wife is not exempt from blame by the family and society (cf. Kawango, 1995:84). My findings show that this view is common as captured by a middle-aged woman who explained: 'it is hard to find a man who is infertile. Men are not created like that. Women who are barren are said to have been bewitched. Men are never mentioned.'

However, while women may carry the biggest blame for childlessness, I found that the blame is not always placed on women alone; infertility can also be
blamed on the family, community, supernatural forces, the man or both the man and the woman. A young woman aptly captured this: ‘A lot of times women are blamed but we know men can also be infertile.’ She cited a case of her stepbrother who ‘chased away’ his first wife after she failed to become pregnant. He married another who did not get a child. He also divorced her. The first wife married another man and soon she was pregnant. The second wife was also married and got children. The man died without any children. According to some people, men’s infertility is rarely confirmed because they seldom go for any medical test. And even when men are found to be the problem, no one knows about it as they may deny they are infertile or keep it a family affair.

Below I present some cases to elucidate the meaning of poor pregnancy outcome as well as strategies people employ to deal with them.
In this example, a 31 year-old John discusses a reproductive misfortune that occurred to his wife. They have been married for 4 years and have one child. John and his wife are Catholics. He says that two of his wife's pregnancies 'did not end well'.

His wife has had two miscarriages each when she was about three months pregnant. In both miscarriages, the wife would complain of severe stomach pains (kutemwa ni ivu) for about three days. The first miscarriage occurred in February 1999 at night. After the incident, John asked his wife whether they could walk to Mwala health centre but she refused. His wife said it was the same place that she attended antenatal clinic a week before and was not told she had any problem with her pregnancy. She, therefore, said they would not get any help and should wait until morning to go to Machakos General Hospital.

In the morning of the following day his wife said she was feeling weak but she did not think it was necessary to go to hospital. John called a neighbour Traditional Birth Attendant (TBA). The TBA massaged his wife’s stomach but did not give her any ‘medicine’. She felt better later in the evening of that day and was able to warm water for her bath. On the third day after the incident, his wife was still not feeling well so he took her to Kangundo sub-district hospital where she was treated. She was given pain-killers and two other types of tablet medicines.

The second miscarriage occurred four months after the first one. John talked to his father about it. His father inquired from the parents of his wife whether they knew what was the problem with their daughter but the parents did not know. John’s father traveled to Kitui [about 100km. away] to consult a female diviner to find out the cause of the problem. According to John that particular diviner is famous. The diviner divined that a jealous woman neighbour did bad things to John’s wife long before John married her. This was meant to specifically prevent her from carrying any pregnancy to term. The diviner asked for KSh.1000 (£10.00) to solve the problem. Together with his father, they took his wife to the traditional healer. ‘My wife was treated and bore that child you can see...[pointing at his five month-old son].’

The diviner said there was also another problem. John’s father and a neighbour keep quarreling about the exact position of their land boundary. The diviner said this also contributed to his wife’s problem. John says that after visiting the diviner, he now thinks the boundary dispute could be part of the problem because his brother’s wife had had two miscarriages also and gave birth to a baby who died two weeks later.
Case study 4: Premature birth- Annah’s case

Annah is aged 26, and mother of a 4 year-old boy whom she got before she was married. Annah has been married for 3 years and her husband works as a bus conductor of a local public transport firm. She is over eight months pregnant and has two weeks to go before delivery.

She delivered her first born through caesarean section delivery because ‘the baby was not coming in the right way’. Her second born, the first child with her husband, was born 3 months before term at Machakos general hospital. The baby died 5 days later. This happened in 1999. Annah started bleeding when she was 5 months pregnant and she thinks doing heavy work caused both the bleeding and the subsequent pre-mature birth. It started with severe stomach pains. Annah's husband took her to Machakos general hospital where she was x-rayed but was not told of any problem. She thinks the bleeding had a connection with the death of her child. But Annah also has another explanation: it could have been 'God's plan to lose the baby since he is the one who brings children.' Annah's husband shared her view as he told her not to worry because God would give them another child. The cause is located not in the social world, but in the supernatural world and nothing can be done to change divine plan.

Infertility and poor pregnancy outcomes are explained in ways that reflect not only people’s concepts of disease causation, but also the lived experience. Among the Luo, Sindiga (1995:66-68) has identified 5 aetiologic categories of disease and illness: disease of air, water and food; diseases caused by humans; diseases of the “living dead”; disease of inheritance; and disease resulting from breaching taboos or customs. The Abaluyia’s aetiologic concepts are similar to those of the Luo (Wandibba, 1995; Maithya, 1992). And Nyamwaya (1992) writes that traditional explanations of health and illness are common in Kenya. Focusing specifically on infertility among the Luo, Kawango (1995) identifies causes that fall within the above general aetiologic notions among them witchcraft, ancestral spirits or breach of taboos such as those regarding sexual conduct. In all the cases, the Luo seek not just to establish the root cause of a pregnancy or infertility problem, but to maximise chances of regaining health in the face of conflicting symptoms and causes.

As in the above studies, and as my data show, it is clear that among the Kamba, causes of infertility are multiple. These can be classed as social, biological, supernatural, ancestral spirits, behavioural, and organic. These aetiologies are
not mutually exclusive; they can and do overlap. The point here is that there is no single explanatory model for all the misfortunes associated with childbearing. Just as the aetiologic concepts are multiple, so are the management strategies.

Another point is that if explanations of misfortunes are rooted in the sociocultural explanatory models, the gatekeepers of the Kamba traditions have to be involved (see case 3). In a sense, the extended family constitute a therapy managing group.

5.6. Caesarean section delivery: safe delivery or a threat to reproduction and production?

Caeserean section delivery threatens a woman’s reproduction as well as her social and economic roles. It threatens fertility because there is a limit to the number of children a woman can have through caesarean section; a woman or couple may not have the number of children expected by themselves and the family. But also and perhaps most importantly, they may not have the desired sex composition. Having one sex (particularly girls) makes both men and women feel insecure (see 5.3.2.).

Caesarean section threatens production because a woman is not able to perform her usual household duties thereafter as it is perceived to weaken a woman. Perceptions about caesarean section delivery should be seen in light of a community whose small-scale farming is the main economic and subsistence activity and, also, where women are involved in many of these activities such as planting, tending and harvesting of the crops in addition to household chores. These roles require a strong ‘healthy’ woman. A caesarean section wound takes some time to heal and few women in the village have the luxury of free time to allow complete healing in the context of declining social support.
In another perspective, caesarean section, particularly if performed before the labour process begins \textit{kwaunya} denies a woman one of the important aspects of childbirth experience - labour, which adds value both to her womanhood and motherhood. Many women said doctors do not give them time to labour and deliver in the normal way. Some people, especially women felt that caesarean section delivery is a matter of choice. Women asked: 'How can a woman fear labour pains? Chalmers (1990) has argued that African women are socialised to expect and want labour pain. I further discuss the perception about C-section in chapter 6. The point I wish to make here is that women consider it important to be given the opportunity and time to experience their womanhood/motherhood; labour pain is part of the reproductive life of a woman. In this context, therefore, caesarean section not only denies a woman the experience of this necessary and 'normal' pain, but it is considered a poor pregnancy outcome as well as a threat to fertility and production.

5.7. ‘It is shameful to continue giving birth’: when women should end childbearing

Women are expected to stop bearing children if their children are also having children. Both men and women consider it inappropriate, indeed ‘shameful’ for a woman to become pregnant and give birth when her adult daughters or sons’ wives are also giving birth; it is childbearing at the wrong time. By the time a woman has grandchildren, she should have already finished performing her reproductive role and start guiding and advising her sons’ wives and/or her daughters. In other words, a woman should stop her parenting tasks and start the grandparenting role, which commands a higher social status, as old women are moral gatekeepers.

Many people were not specific about the age at which a woman reaches menopause. Most people tied this to a woman’s status as a grandmother. Some
people, however, considered a woman approaching fifty years to have reached menopause or just too old to be still giving birth. Besides, men and women recognise that reproduction is associated with health and exhaustion. There are physiological costs of childbearing on women (see 5.2). If by age nineteen a large number of teenagers are on the family formation pathway (KDHS, 1998:36) then it means that women are exposed to reproduction for longer periods. If a woman started bearing children at this early age, not only will she have no strength left to give birth by the time she is over forty, it is possible that she will have a daughter or daughter in-law bearing children. Also and as Bockie (1993) has shown in Congo, for the majority of women and men in the rural areas the physical appearance and chronological age are two variables that do not always match. Due to poverty and hard work, many women look older than their actual age and the reverse is also true. This is also true for many men in the villages.

The ‘shame’ associated with women who produce children at the wrong time does not seem to apply to men who, it was said remain sexually active until very late in their age. This articulates well with polygynous models of marriage, in which older men marry younger women as second or third wives. A young woman captured this: ‘A man does not grow old; he may weaken a little between ages fifty and sixty but at the age of eighty years and above, he becomes more sexually active; he feels like a young man.’ Thus age construction for a man in the context of reproduction and sexuality is different from that of a woman.

The above social construction of age may play a more powerful role in determining fertility. It questions the dominant medical and demographic theories of childbearing that construct the body (women and men) as a universal tool of reproduction that can be manipulated to fit within the chronological age data. These perceptions in the context of childbearing may play a more powerful role in determining when a woman should end her
reproductive life. Thus a woman who starts bearing children at an early age may stop childbearing long before menopause because her daughters or son’s wives are having children.

Men control productive and reproductive resources, including land, livestock, cash, and children. If the husband does not support his wife materially or otherwise, she should stop having children. A wife expects that her husband will provide for most of her requirements, including household basics, clothing for her and the children, taking care of education, and the family’s health such as buying medicines and payment of bills. Money may be hard to get but a man is not excused from these responsibilities. People say that a man who cannot provide for his wife and family is not worth calling himself a man. I was severally told, ‘it is the surest way to give your wife away - to other men.’ The meaning here is that failure to provide for his wife may also result in a man’s failure to control her sexual behaviour. Failure by men to maintain control over crucial resources may result in the disruption of the patrilineal social order (Stambach, 2000; Whyte, 1997:56).

However, as I pointed out earlier (see 5.3) the present economic realities are making it increasingly difficult for many men and women to meet their obligations. The prevailing poverty levels in Machakos district in particular and Ukambani in general are a reflection of the national economic performance where 50 per cent of the Kenyan population is estimated to be very poor (ROK, 1999). Many children in local primary schools are sent home nearly every week due to their parents’ inability to pay, for example, money to complete the construction of a classroom. The problem of childrearing is considered more serious for single mothers who are not working. People express surprise if an unmarried woman continues to give birth as though she was married. Despite the difficulties, a married couple is expected to stop
childbearing when they have the right number of children of both sexes (see sub-section 5.3.2).

Ending childbearing does not, however, suggest or even mean that a woman stops having sex. People recognise there is a distinction between a woman’s reproductive life and her sex life. In other words, men and women do not only have sex when they want to reproduce; they have it also for pleasure. Even though people said the frequency of sexual activity reduces with age, women are expected to continue to have sexual relations even long after cessation of menstruation.
Chapter Six

Management of Childbearing and other Reproductive Events

In this chapter, I discuss the various aspects of childbearing with the object of explicating the ways in which these reproductive events are managed. I explore the differences that exist between the young and the old and between men and women, and within women in terms of meanings, perceptions and management of events associated with childbearing. From the perspectives of both men and women I explore tensions that exist between them in the reproductive arena. I also examine home and hospital births with a view to showing why men and women may prefer one option to the other. The chapter makes the point that in a pluralistic health care environment, the boundaries between one option and the other are fluid. I conclude the chapter with a presentation and analysis of a case study to show the place of rituals in physical and psychosocial health and wellbeing.

6.1 Perceptions and management of pregnancy

Men and women in Mwala say pregnancy is a ‘kind of illness’. A pregnant woman may sometimes be unable to perform her roles as expected. It is an illness also because misfortunes associated with pregnancy can occur. It is, however, through pregnancy and childbirth experience that a woman proudly talks of her children and family. In a sense, therefore, pregnancy at the right time is also a time of increased joy and happiness because a woman will soon be a mother and a man a father.

A pregnant woman is perceived as vulnerable and should not be exposed to dangers like doing hard work because that can cause changes in the positioning of the baby. The state of pregnancy is a time of increased anxiety and vulnerability (Sargent and Browner, 1996; Obermeyer, 2000). Women whose
husbands work and live away from home captured the feeling of vulnerability and anxiety; they said they would like them to come home more frequently when the delivery date draws near. This anxiety is also based on the lived experience; pregnancy outcomes are unpredictable particularly in an area without adequate health facilities. The physical presence of husbands during this period is important as this provides a feeling of invulnerability and offers emotional and psychological security thereby lessening a woman’s anxiety.

The state of pregnancy especially at its advanced stage can mean that other people including the spouse, relatives, neighbours and friends perform roles that were hitherto performed by the woman. Taking on board roles that under normal circumstances are performed by somebody else is by its very nature disruptive. For example, when the pregnancy is at an advanced stage, a woman participate less in social events and self help groups not because of uncleanliness (Lindblom, 1920:30), but because of impaired movement occasioned by the pregnancy itself.

Less explicit but eloquent in expressing the perception of pregnancy as an illness is the tension that it creates between men and women. Some women admire those men who accompany their wives to the antenatal clinic or those who help with household work when their wives are ‘tired’.

However, the meaning of and tensions occasioned by pregnancy are perhaps more marked between women themselves, especially between the young and the older women. For many young women pregnancy is disruptive, and needs special attention and care especially at the advanced stage. The older generation of women said treating the state of pregnancy as not a ‘normal’ state is a recent phenomenon. Obermeyer (2000:189) reports that older Moroccan women complain about younger women’s inability to endure pain when the old women themselves ‘used to work until the last minute.’
Graham and Oakley (1991: 101) observe that women do not view reproductive events as isolated episodes but rather as integrated with other aspects of their life. In my study the older women see pregnancy as something to be experienced by a woman in her life course and, therefore, a woman should take it as normal without complaining and continue with her normal duties of a woman. While young women share this view, they also see pregnancy as an illness that requires proper attention and care. They therefore, see resting or reducing the amount and type of work they do during this period as necessary. There are, however, contradictions even among young women, as they do not always perceive pregnancy as disruptive; some perceive it as normal. These findings suggest that the state of pregnancy is an ambiguous one and this points to the fluidity of the notion of illness (Last, 1993:652) as it applies to pregnancy; pregnancy is not seen as a medical condition that requires specialised medical intervention.

Massaging the stomach of a pregnant woman is an important component of managing pregnancy outside the formal health institutions. Many pregnant women visit traditional birth attendants (TBAs) [aisikya pl. of mwisikya] for massage. It is said to reduce discomforts associated with pregnancy and helps to position the baby well in the womb making delivery easy. Massaging also helps to restore appetite (Kramer and Anthony, 1982:174).

Many pregnant women go for antenatal services at Mwala health centre but few deliver there. They attend firstly, because the health personnel advise them to regularly attend the clinic when they are pregnant. Secondly, they attend the clinic because they want to be sure everything about the pregnancy is going well - to know whether they will or will not have complications during delivery. Thirdly, women attend the antenatal clinic because if they go to deliver at a health facility and it happens they have not been attending the clinic, the health personnel may be less cooperative. They ask, as some
women put it, 'have you been attending clinic? Where is your clinic attendance card?' Pregnancy as we have already seen is said to be a kind of illness and so is not without some risks. The high attendance at the antenatal clinic is, therefore, partly a result of women’s (and/or spouses’) concern about pregnancy outcome and partly an attempt to fulfill the wishes of the health personnel; clinic personnel may not let them in in case of emergency. The aim is to maintain a balance between the site at which some women wish to deliver (home) and where the pregnancy and childbirth complications may actually force them to go for delivery (hospital). Whyte (1997:50) had similar findings in her study in Bunyole, Uganda where, few women give birth in hospital although the attendance at antenatal clinic is very high. She concluded that the high antenatal clinic attendance reflects women’s concern about the risks of pregnancy and childbirth. My findings are also consonant with those of Raikes (1989) in Kisii where she found antenatal care by modern health care professionals was more popular than delivery services.

6.1.1. Sexual conduct during pregnancy

A man’s sexual conduct during the period that his wife is pregnant may be a threat to good pregnancy outcome. If a man ‘goes outside’ when his wife is pregnant and he is also sleeping with his wife, it is likely to cause trouble.

I lost my pregnancy twice in 1997 and 1998 because my husband did bad ‘things’ that he should not have done when I was pregnant. He was ‘going outside’, sleeping with women he did not know well and this brought bad things to the home [25 year-old married woman with one child].

It becomes dangerous for a man to sleep with not just a woman, but a woman who is a stranger. Such strangers can transmit STDs and/or HIV/AIDS to him. Thus sexual trespassing of social boundaries becomes dangerous (Kielmann, 1997).
Sexual intercourse in the early stages of pregnancy is good as the man’s semen nourishes both the mother and the child. But also people know and say that a couple need not have sex in order for a healthy child to be born to a woman; a child is born healthy even when a woman has not had sexual intercourse during the pregnancy period. Davis (2000:54) found similar ideas about sexual intercourse and pregnancy among the Tabwa of Zaire. Some men said sex when a woman is pregnant is good, as it is a ‘simple exercise for the woman just like washing clothes and doing a bit of walking.’ However, a man should avoid sexual intercourse in late pregnancy ‘so that the baby is born healthy.’ As men in a group discussion put it: ‘a man should keep off his wife’ or ‘he should leave his wife alone’. Some men were said not to adhere to this and that is why at birth some babies have white patches on their skin. Chalmers (1990) and Taylor (1992) report similar notions about sex during pregnancy in Rwanda and South Africa.

During the period that a man should keep off his wife, some men said women should allow their husbands to go out once in a while ‘because you do not sleep with your wife after all, and you do not mix her blood with blood from other women.’ Pregnancy may thus offer a good opportunity, indeed, an excuse and incentive for men to go ‘outside’. However, none of the young women in the study said they would openly allow their husbands to go ‘outside’ when they are pregnant. Many said ‘things are bad these days’; this was in reference to HIV/AIDS, although others said they would understand ‘since men are like that.’ This is partly how male sexuality is constructed; as uncontrollable.

Elderly women told me that during their time, pregnant women used to allow their husbands to go ‘outside’ – to have sexual relations with other women but not strangers. Not sleeping with strangers avoided dangers of pollution
[thaavu] and its negative sexual and reproductive consequences. While such traditional practices are aimed at ensuring the health and wellbeing of both the mother and the foetus, they could also contribute to the very sexual and reproductive problems they are intended to avoid.

6.1.2 Food preferences, prohibitions and pregnancy

Traditionally, pregnant women were discouraged from eating certain foods. Such foods included eggs, fatty meat, and honey so as to avoid the baby becoming too big because that would cause problems during delivery, which may result in the death of the mother, the baby or both. An overlarge baby would require delivery procedures that were unavailable traditionally. Today women are still advised to avoid such foods in the advanced stages of pregnancy. In practice, however, pregnant women do not always avoid these foods because it may be what ‘one’s heart wants’ or ‘what she prefers’ (what one has appetite for). Besides, it depends on the status of the woman; meat and eggs have become status foods. Women are encouraged to eat foods high in fibre such as boiled maize mixed with beans [isyò]. These foods are said to give the woman the strength she needs during delivery. Honey still remains one food that is discouraged; it is said to cause stomach upsets. Just as in the traditional setting, honey is said to make babies grow too big.

6.2 Hospital or home birth?

In Mwala home birth is very common. Many women give birth at home and birthing is very much a private or family affair. Women give birth at home because of various reasons. Below are some responses and contradictions to my question on why women deliver at home:
I prefer home because at home you get good care. After you have delivered you are given warm water to bath; who would do that to you in hospital? [Dorcas, a 25-year-old married mother of four, who had all her four births at home, two with the help of her mother-in-law, and the other two with the help of her mother-in-law and mwisikya].

You eat what you want at home soon after birth; you are given hot food. The mwisikya is around to massage your stomach, gives herbs to clear the blood; it is convenient and they are not expensive [Caroline, a 25-year-old mother of two who delivered one child at home attended by mwisikya, her mother-in-law and a woman neighbour, and the other in hospital. She has attained Form 4 level of secondary education].

I would like to deliver at home with the help of my mother-in-law and mwisikya, not hospital [Janet, a 20-year-old married woman who is 8 months pregnant-first child and attends clinic regularly].

Some women find home delivery environment friendly and less stressful; there is physical, emotional and psychological comfort at home because new mothers are cared for in a way that enhances quick recovery. Besides, the birth is normal meaning a woman is allowed time to labour, because pain endurance is an important element of motherhood. Even some cases defy the received wisdom of the previous experience: that is, no/bad previous experience-hospital birth, good/previous experience-home birth model. In a sense, therefore, home delivery makes women feel fulfilled while they do not feel the same in hospital. This, I contend, partly explains why home births are popular. Other studies in Kenya (Olenja and Kimani, 1995; Raikes, 1989) and in Uganda (Whyte, 1997) have reported similar findings; that antenatal services are popular but delivery services less so.

Others prefer hospital delivery perhaps because of the perceived health benefits associated with modern health care including ‘equipment availability and medicines to deal with emergencies.’
I prefer hospital because it is clean and it can deal with emergencies. If you have no strength to push or complications develop, say prolonged labour or retained placenta, hospital can deal with that because there is qualified staff and medicines. Hospital also give advice to mothers [Milka, a 26-year-old mother of one and whose second child was born prematurely and died after 6 days. Both births were in Machakos general hospital. She has secondary school education].

Some people say TBAs are an unnecessary expense: ‘they just sit and wait for the baby to come out and get paid,’ said one man complaining that a TBA caused the death of his baby because ‘she had long nails’. In this case as in many others, the meaning of expense with regard to TBAs has little to do with financial cost as they are generally considered cheap in terms of the fee they charge; they are paid between Khs 200 and 400, sometimes less. The notion of expense has more to do with how safely a TBA delivers a woman.

Obermeyer (2000:178-90) observes that the change in the use of either hospital or home births is not hierarchical and the boundaries between them are fluid. For most women in Mwala, there is no apparent single pattern in terms of choice of birthing site because they alternate between home and hospital depending on circumstances. In any case, many women go for antenatal (and postnatal) services at a modern health facility in case they need it even when they plan to deliver at home.

Correa (1994:89) observes that excessive medical interventions such as caesarean births are attempts by biomedicine to control the female body. In Mwala, the fear of caesarean section seems real. However, unlike in the West where, medicalisation thesis is constructed in terms of power and control of the female body (Graham and Oakley, 1991; Miles, 1993), for men and women in Mwala, caesarean section is understood more in terms of its interference with a woman’s ability to perform her usual roles because it is perceived to weaken her body. The cost of caesarean delivery at Machakos general hospital is Ksh. 5,000 (about £50) excluding medicines while that of a normal delivery is Ksh.
300 (about £3) excluding medicines. These fees\(^1\) are beyond what the majority can afford. It is my contention that in this rural context, medicalisation is not so much about power and control, but its possibility of making women into patients, besides the cost involved. Of the nearly 3300 births recorded in Machakos district hospital in 1999, there were 8 pregnancy related maternal deaths caused by eclampsia, obstructed labour, and/or postpartum haemorrhage (PPH).\(^2\) Thus in Kenya as elsewhere in Africa (Obermeyer, 2000; Browner and Sargent, 1996; Sargent, 1989) neither home nor hospital birth is without hazards.

Home delivery is thus partly out of choice and partly a result of factors beyond women’s control. It is out of choice because women feel more comfortable with home birth. It is not out of choice because of the impracticalities of hospital option - the lack of transport in Mwala especially at night, and lack of good health care facility and specialist biomedical personnel. Combined, these factors make home birth common.

6.3. Traditional Birth Attendants (TBAs)

TBAs \[aisikya\] are not a homogenous group neither are their practices the same. There is variation in terms of skills and how they are acquired, knowledge and beliefs, and the type of help they provide, as well as personal characteristics, such as age, education, and religious beliefs. Such diversity needs to be recognised because it has a bearing on the success and popularity of a \[mwisikya\] (See also Good, 1987:138). In the matter of acquiring knowledge and skills on childbirth, some of the TBAs claimed their knowledge was a gift from God - derived from the supernatural world. Some of the elderly \[aisikya\] I interviewed said they were born holding small stones in their

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\(^1\) Figures obtained in Machakos general hospital medical record
\(^2\) see footnote 2 in chapter one.
hands. Such pebbles are associated with innate traditional medical knowledge. These powers may manifest themselves through illnesses including misfortunes such as barrenness or death of children. One can only get well if she puts this gift in to practice. The elderly aisikya tended to argue that traditionally a proper mwisikya is not trained on how to attend to a birth [kwisikya] or as they called it 'to pick a baby' [kwosa kana]. This knowledge is perfected through experience in delivering women. One elderly mwisikya said: 'I hear these days young women are 'picking babies' for women. I don’t think they know what they are doing. They cannot 'pick babies', just like that. Picking babies is not something you can buy, or be taught... It is a gift.'

As I have already shown in chapter three, the belief in the power of the spirits of ancestors to influence the life and affairs of the living is still prevalent (See also Mutunga, 1994; Johnson, 1999). Some aisikya acquire their knowledge from the spirits of ancestors. This gift may be passed on from mother to daughter or grandmother to granddaughter through certain experiences, which are often disturbing. One mwisikya narrated part of her personal experience in becoming a mwisikya.

No one taught me how to pick babies but my paternal grandmother was picking babies for women. The first baby I ‘picked’ was my stepmother’s [her father’s third wife]. When my father got to know what I had done he refused me picking babies as he thought I was very young. I was a small girl, less than twenty years old. But whenever a woman was giving birth in the village, I could not sleep, I would be disturbed... ‘somebody’ would wake me up to go and help the woman. I would see my paternal grandmother giving me a hand and asking me to hurry up.... On waking up I could not see anybody. I felt like I was going mad... I could not resist helping women to deliver. One time a woman lost her child because there was no one to help her and in my sleep my grandmother quarreled with me. She was angry because she said I could have saved the situation. I was also very angry but my father would still not let me do it. So I used to help women secretly. Even after my father refused me I would still secretly go to pick babies. When my father realised what was happening, he allowed me to do it freely [an elderly mwisikya].
Acquiring knowledge and skills to help women in childbirth is not always through mystical happenings. Many of the young and some elderly aisikya said that their skills were experiential, that is, they acquired them by helping their own relatives and neighbours to deliver. Some said they learned to deliver children by first, giving birth themselves without any help from anybody. Others acquired their knowledge through informal training from older aisikya. Two of the young aisikya learned how to attend to births from their mothers. Indeed, the younger TBAs perceived themselves differently and were quick to distance themselves from the older generation of TBAs.

My knowledge and skills are not like those of the old aisikya, who say they received their knowledge to help women deliver from a supernatural...There is nothing like that in my case. I got my skills through experience. I had interest in helping mothers to deliver...Except one child, I delivered all my children without any help [39-year-old mwisikya].

My findings support Githagui’s study on characteristics and practices of traditional birth attendants. In her study of three communities in Kenya, among them the Akamba of Kitui, Githagui found that TBAs acquire their skills through informal education from older TBAs or mothers or by mere participation in accidental deliveries (Githagui, 1985:9). But as evident in my study there are other ways of acquiring birthing skills.

Some TBAs treat pregnancy-related problems such as abdominal pains by herbal treatment, and loss of appetite or pain in the diaphragm through massaging. Others treat birth-related problems such as bleeding after birth by giving herbs to stop the bleeding. These skills were common with older generation of TBAs although the young ones said they also do. One elderly TBA informed me that she treated a man and his wife who had STD with herbal medicine. None of the young TBAs said they had treated STDs.
One of the reasons the younger TBAs perceive themselves different from the older generation is their level of education. Those with formal schooling considered themselves modern in their practice. The above 39-year old TBA has secondary education [up to F2]. She is also a community-based distributor (CBD) of family planning materials and contraceptives. According to her, she encourages women to use contraceptives and gives them advice on where to go for more information, including STD treatment.

In spite of the variations in the way the TBAs acquired their skills and practices, there was no indication from those I interviewed to suggest that religious rituals are important in prenatal and delivery procedures. The TBAs explained their practices for managing the various problems of pregnancy and delivery in empirical terms, for example, giving of herbs to stop bleeding, or massaging to position the baby properly and also to make delivery easy. A study by Kramer and Thomas (1982) had similar findings—that the use of religious ritual in the prenatal and delivery procedures was less important among the Akamba (ibid:195). However, they found cases where religious-medical specialists combined empirical methods such as the use of herbs for increasing lactation, with supernatural procedures such as the ng’ondo ritual (ibid). Today’s TBAs are not necessarily religious-medical specialists; few have anything to do with magical medicine, a domain of other traditional medical specialists.

My findings also indicate tacit tensions between the young and the old TBAs perhaps because of the competition for clients. Githagui (1985:9) observes about TBAs ‘...TBAs do not anticipate payments...helping a mother to deliver is more or less like any other tasks women perform....’ Further, Githagui notes that if TBAs are paid then these are not payments but rewards that may be in kind such as helping a TBA with her farm work, buying salt or sugar, or naming the child after her or her husband. While today payment in kind may
still be acceptable to a TBA, the economic realities of the moment make a compelling case for payments for their services. What has over the years been known as a traditional practice has now entered the market economy and like any other profession, many TBAs sell their services. I found that a TBA expects to be paid for her services and the people themselves said they expect her to be paid. The TBAs, however, said that they were not driven by money to become TBAs, saying that they sometimes get paid long after their services.

There exists a good relationship between the health personnel at Mwala health centre and the local TBAs. Many of the TBAs have a monthly meeting with the health staff at the centre. The meeting provides a forum for the TBAs to share their experiences of home birth among themselves and between themselves and the health personnel. The TBAs are not licensed by the government and do not require any licence to do their work perhaps because it is seen as part of the many services women give to their communities; may be because they are not considered full-time; perhaps because they do not require any regulation because their performance will.

6.3.1. The ‘maize’, the ‘beans’, and the ‘pigeon peas’: what makes a good TBA?

A good or bad TBA would be known in the villages because women talk about them in their social gatherings such as self-help meetings or as they walk to the market. A good TBA should not be scared of delivering women, and should assess and advise on those cases that she cannot handle. People said that a TBA should be able to provide antenatal and postnatal care; she should be able to massage the woman and position the child properly. The elderly TBAs were said to be good at these skills. Some of them said that they refer complicated cases to hospital.
For a TBA to be trusted she needs to be disciplined. A good one keeps her mouth shut and does not talk about the women she delivers. As the TBAs put it, whatever they see and however a woman behaves at the time of delivery they must not tell others. Telling others is a breach of trust and may result in a TBA being avoided by women. Most importantly, trustworthiness has to do with the belief that blood is a potent fluid that can be used for malevolent magical purposes including loss of fertility. A TBA should, therefore, be a person who can be completely trusted, a woman who does not engage in antisocial practices; does not take away a woman’s blood for other uses. Obermeyer (2000:181) had similar findings in Morocco.

Maintaining good personal hygiene is vital for successful traditional midwifery. Perceived poor hygiene practices made TBAs unpopular with some people. Any TBA who does not maintain a high standard of cleanliness risks having no work to do. Many of the TBAs I interviewed had good knowledge of and observed cleanliness; they use gloves [moko] in their work to avoid being infected and infecting the mothers. They keep them in their homes and once they have used them, they ask husbands for a replacement. In the absence of the ‘real’ gloves, they use plastic bags used to wrap bread. The TBAs, including the old ones, said they wash their hands before handling any birth and keep their fingernails short to avoid harming the baby. Those are the criteria for a TBA who observes cleanliness.

A major factor in birthing work is how successful and safely a TBA delivers women and how prompt she answers distress calls. A TBA who does not deliver women safely is avoided. To this end, aisikya in Mwala have coined a set of concepts that they metaphorically employ to explain and understand the outcome of their work. These notions are derived from the people’s interaction with the physical environment and are essential for understanding different aspects of reproduction and production among the Akamba. There are also
cultural meanings implied in these concepts. When a baby boy is born the TBA says it is a maize grain \textit{mbemba}. When it is a baby girl born, the TBA says it is a ‘bean’ \textit{mbooso} while she talks of ‘pigeon peas’ \textit{nzuu} if it is a stillbirth. Maize mixed with beans (any legumes) and boiled \textit{isyo} is the staple food for Akamba. For the Kamba, maize is the most important food crop so much that when the crop fails and the legumes do not, people would still say the harvest was bad. Without good maize yields the Kamba say they have no food but famine \textit{yua}. Maize crop also takes longer than legumes such as beans to mature; maize survives dry spells longer than beans. Dry maize grains also take longer than beans to cook. At the cultural level, boys are said to be rough in behaviour, difficult to control and this can be likened to a dry maize grain. At both sociocultural and the reproductive levels sons still remain highly valued just like \textit{mbemba} for production and reproduction.

Beans \textit{mbooso} are the most popular of the legumes grown in Mwala and Ukambani as a whole; they are nutritious and in a sense softer compared to maize. \textit{Aisikya} liken a baby girl to a bean because they are considered ‘soft’, meek and less troublesome even during pregnancy and delivery.

The notion of pigeon peas \textit{nzuu} is euphemistically used to refer to stillbirth. Pigeon peas are a biennial crop and takes longer than maize and beans to mature. Dry pigeon peas are unpopular especially with pregnant women and new mothers because they are less nutritious; also they often cause stomach upsets. It is also one of those food crops in Ukambani whose yields are normally low as most parts of the region rarely experience two consecutive good rainy seasons in a year. The use of \textit{nzuu} by TBAs to refer to stillbirths suggests that stillbirths are not common. I recorded loss of three babies from the 12 \textit{aisikya} that I interviewed. One \textit{mwisikya} claimed she delivered seventeen babies in 1999 one of which was stillbirth. The TBA blamed the woman’s husband who called her in when it was already late and when the
woman had started bleeding and the child 'had drunk the birth water.' The second stillbirth was blamed on the woman's refusal to push. The baby, according to the TBA, had a 'disjointed' skull. The circumstances surrounding the third still birth were not explained. The TBAs who had never 'picked pigeon peas' proudly said: 'I have never been followed by flies', or 'I have never picked pigeon peas,' meaning that in their career as TBAs, they have never delivered a dead baby or caused the death of a baby due to negligence or incompetence.

6.4 Men and childbearing events

6.4.1 Men and pregnancy management: barriers to their involvement

There are cultural and societal role expectations that exert pressures on men to behave in certain ways in the reproductive and domestic arenas. Also, the extent of male involvement in childbearing events depends on whether it is an urban or rural environment. Men are likely to encounter less cultural constraints in these matters if they live with their wives in towns, also because in town there may be no relatives to help. Even with the changed birthing location men are keen to protect their identity. Some men explained people regard a man who helps his wife with domestic chores as 'nothing' or 'weak' or 'sat on by his wife' or simply 'ruled by his wife,' and, therefore, not a 'real man'. The meaning in this context is that the man has no authority or control, as household head or just as a man. The following emerged in a focus group discussion with young married men:

A man should be fully involved during this time (of pregnancy). He should try to keep his wife happy during this time. A man should always help his wife, whether sick or not [a participant in FGD].
Are we saying when my wife is pregnant or sick I cannot cook because I am a man? I will have to cook and I do it. The problem here is when other people find you struggling with cooking pots or in the kitchen; they wonder where your mother or sister are! They think there is something wrong [another participant in FGD].

Men physically support their wives less because they do not want to be seen to interfere unnecessarily with the woman’s domain. As women variously and proudly put it, ‘we need our space’ or ‘men should keep off the kitchen, it is not their place’ or as men put it ‘women need freedom to do their things the way they want.’ Thus men recognise, as do women, that women have control over the domestic arena. It is not always the case, therefore, that the domestic domain (as opposed to the public domain) confers less power to women, as has variously been argued. Mundigo (1998) argues that it is possible increased male involvement in these activities may interfere with women’s position in the household) or, perhaps, cause gender conflicts. The point to make is that the male role in reproductive events is fraught with ambivalence. Societal attitudes, gender role expectation, and cultural pressures may not only impose limitations on the type of support, but the extent to which a man provides social support to his wife when she needs it in the domestic domain. The foregoing notwithstanding, these cultural barriers are not static.

There are less salient but eloquent ways in which men offer support to their wives. Men said they try to stay peacefully with their wives during this period and avoid doing things that would annoy, upset or worry their wives. Thus quarrel and conflicts are said not to be good when a woman is pregnant. Even though material support is important, work commitment may take men away from home making them emotionally and socially unavailable when their spouses need their help.
I heard women say that money was necessary but it would be of no use if they did not spend it wisely or the men did not 'treat their wives well'. In a sense, a poor man in the village who spends the little money he has and finds time to be with his wife may actually be more involved and providing more support to his wife than a man working away in town who, on the one hand, because of money and being away from his wife may have sexual relationships with other women to the extent that he neglects his wife in the village. On the other hand, the man's wages may not be enough and so he may not regularly send enough money to his wife in the village (see e.g. Levine, 1979 in Nelson, 1992:130). The woman may, as a consequence, engage in sexual liaisons with other men in the villages particularly the village elite such as teachers and businessmen who can readily meet her financial requirements. Alternatively, a man working away may be earning enough money but due to pressure of work and distance from home, sends letters and money regularly to his wife but he himself takes a long time to come home. This is what I call "husband by post". As a result of his continued absence, his wife secretly finds another 'husband' in the village to stand in his place to meet her sexual and perhaps emotional needs. Taken singly or together, the foregoing scenarios put the stability and future of the marital relationship in a predictably shaky ground because misunderstandings between the spouses are sure to occur as a result of accusations and counter accusations. If the wife left behind in the village becomes pregnant with another man then the husband not only refuses to take responsibility, he is most likely to divorce her. Some husbands have actually refused to take responsibility even when the pregnancy is theirs. Most importantly, such sexual relationships may result in STD/AIDS infections that may be brought into the marital relationship by one or both partners with fatal consequences to themselves, the marriage, and the family (see case study six in chapter eight).
6.5. Participating in birthing: men’s voices and women’s views

Much of the male participation in birthing is hard to quantify as their involvement may not involve direct assistance in delivery, that is, direct interaction with the mother at the birthing bed. Consequently, it is especially easy for survey researchers to lose sight of involvement that is in the form of emotional support, the time the husband spends waiting around to be told ‘it is over’; the mental anguish the husband goes through, including the anxiety and worry.

It is shameful [nthoni] and embarrassing for both the man and the women attending the birth for the man to be present. However, the extent and type of male participation in childbirth also depends on the location of birthing, home or hospital, village or urban setting. Romalis (1981:6) notes about birthing: ‘The act of giving birth to a child is never simply a physiological act but rather a performance defined by and acted within a cultural context.’ In light of this cultural context, home birth presents more limitations to the man because of the presence of his mother, sisters or women neighbours. It is shameful for a man to see his wife naked in the presence of his mother, sisters and other women. The TBAs send the husbands away from the birthing scene, but ask them to stay around just in case they need their help, say when the delivery proves troublesome and the woman needs to be taken to hospital. Similar findings about the role of men in birthing are reported elsewhere in rural India (Jeffrey and Jeffrey (1993:14), rural Mexico (Sargent and Bascope, 1996), and in rural Kenya (Olenja and Kimani, 1998).

One of the reasons women gave for the men’s (husbands’) absence at the scene of delivery was that men are cowards. The notion of pain during delivery is relevant in understanding the perceived male cowardice. Women explained that men cannot withstand the pain that their wives go through during labour
and delivery and that is why they are not around; many take to drinking waiting to be told the wife has had a safe delivery. The narrative below demonstrates the extent to which men are perceived to be unable to handle childbirth.

Before the delivery date of my third child [she delivered all but one of her 6 children herself] I prepared all I needed for the delivery including a razor blade and a string to cut and tie the umbilical cord after delivery. I strategically placed the razor blade and the string and showed my husband where I had kept them. I delivered safely by myself (although the husband was present) and asked my husband for the string and the razor blade. He could not find them. He touched here and there and in a fit of panic he dropped everything on the floor including the razor and the thread/string he was supposed to pick and give to me. You see, men panic, and are cowards and cannot get near the scene of delivery [a young TBA].

Some men said that they would want to help during this time but women participating in the childbirth ask them to stay away from the birthing scene. Other men said that is a woman’s domain: ‘Women know best how to deal with those matters.’ When I asked women whether they would mind the presence of their husbands during delivery, many responded: ‘That is something that does not concern him’ or ‘he should stay away’ or ‘what will he come to do?’ When I asked whether something untoward would happen if men were present at the scene of delivery, both men and women said nothing bad would happen except that both the man and the women present would suffer shame.

Interviews with the health care personnel revealed their attitudes and to some extent confirmed women's fears and perceptions about hospital birth. A nurse explained:
I would be happy to see men accompany women to the birthing bed, as they do elsewhere...I think in the west. The problem here is that some women become ‘hysterical’ during delivery when they see their husbands. Some do not even comply with instructions, I mean what we tell them to do. Some women even refuse to keep the correct posture/position so as to push. Women think we are rough, shout at them...we are sometimes forced by circumstances to slap them a bit. It is for their own good otherwise they go home with nothing.

Another reason why the husband is excluded from the birthing scene has to do with the notion that in labour, a woman loses control over herself and her choice of words. In Morocco people recognise and socially mark the liminality of the woman in labour by suspending the rules that define and establish social order or allowing a discourse that under normal circumstances would not be permitted. A woman in labour ‘can be a truth sayer’ and women take ‘advantage of this situation to speak their minds’ (Obermeyer, 2000:183). As is the case with women in Morocco so is it with women in Mwala. A woman in labour can and does speak the unspeakable: cry, shout and utter unprintable words that can be embarrassing to the husband if present. The aisikya said that this is one reason why they ask men to stay away—to spare them the shame and embarrassment. Thus home birth allows women to express pain socially and publicly.

Responsibility taking is one way of participating in birthing. The time the husband spends around waiting for his wife to deliver is part of the male involvement in birthing. A man’s contingency planning, for example, taking his wife to hospital if there are complications with home birth, or running errands, or saving (or borrowing) money to take her to hospital is integral to the actual birth process. Men are anxious when their wives go into labour. It was explained that this is why some men take to drinking to release anxiety and tension. But others said this behaviour is a sign of irresponsibility because ‘if things go wrong who will help?’ Men themselves said they worry when the
delivery process delays or when their wives take too long in labour. Thus there is psychological, emotional and physical involvement.

Men are keen to ensure wives deliver safely in the context of limited resources but what women expect of them is sometimes confusing. On the one hand, women would like to treat childbirth as a woman’s affair [and keep men away from the scene of birthing] while on the other, they would like the husbands to remain around the place of delivery whether at home or hospital for any support they may require. The point to make here is that men’s involvement in birthing process is through ways that are not self-evident.

6.6 Postpartum care

During this period a woman is recognised to require a rest and special treatment to recover her strength, hence the new mother is ritually accorded special status. Postpartum period which can be translated to mean ivinda ya kuvyuviw’a and beyond is, therefore, ritually marked by the type of (special) food given to the new mother. It is also the period that the new mother is recognised to be vulnerable hence no labour or sexual demands can be made on her.

Although the Kamba do not conceptualise health and illness in terms of the notions of hot and cold, there is a sense in which heat is perceived as important for convalescence during the postpartum period. The new mother is given special foods and beverages, which are taken hot. They include porridge made from finger millet or maize flour and beverages such as milo and tea. For relatively wealthy and the local elite, bone meat soup which is reach in iron and calcium, in addition to porridge, is given. Soup from goat’s meat is especially favoured as it is said to be rich in substances that restore lost energy and blood because of the food that goats eat. Soup prepared from cleaned and
boiled internal organs of a goat, such as intestines and the stomach, is therapeutic.

A man’s role is central after birth and the period of postpartum. He is expected to look after [kuvyuvisya] his wife after she has given birth so as to regain her strength. Translated directly the term kuvyuvisya would mean that the husband cooks for his wife until her strength is restored. However, the meaning is deeper. It means that the husband provides environment conducive to her recovery, including money to buy the required foods. These foods should be ‘soft foods’. The notion of soft food points to the perceived bodily state of a new mother - as vulnerable and requiring special care. A woman is not given, soon after birth, boiled dry maize mixed with beans or cowpeas which is the staple food for Akamba. This food is considered not soft for the tender stomach of a new mother. Thus as Olenja and Kimani (1998:140) found among the Kikuyu and the Luhyia of Kenya, the male role is central after birth and during the period of postpartum, since it is the responsibility of the husband to provide materially to ensure quick convalescence for the wife. Young women said that they expect their husbands to provide special foods and new clothes to fit their ‘new body shape’ after delivery. This ties with the value of warmth; it is important for the new mother and the baby and exposure to cold may result in ill health of both. It is the man’s responsibility to ensure that both the mother and the infant are adequately protected against the environmental hazards such as cold by, for example, clothing them appropriately.

The foods and beverages are taken when hot to rejuvenate the body and because hot foods are said to clear the blood left in the stomach after delivery. In a sense birthing chills a woman. Taking cold foods is considered not good for the convalescing new mother as they can cause stomach upsets or constipation. Besides, cold foods do not help to clear the blood inside the
woman's womb that may result in serious abdominal pains: they are not revitalising. In her study in Morocco, Obermeyer (2000) found that new mothers are given special hot foods during postpartum and that one of the things women did not like about hospital birth is that they were given nothing hot to drink (ibid:180). As in Obermeyer's study, I found one of the things that make hospital birth unpopular is their failure (or perceived failure) to give new mothers hot/special foods. It is worth noting that hot/special and 'soft foods' and beverages, that is, porridge and soup are the ones given to a sick person or somebody convalescing from an illness.

Postpartum is also ritualised by visits. Relatives, friends and neighbours who visit to see and 'hold' the baby are also given beverages especially 'tea' and it is the husband's responsibility to ensure enough supply of what is required. In many cases women who visit bring with them water and firewood because they recognise that the new mother will need some time to rest and recover before going back to collect these essentials. Today, many bring other household essentials such as sugar and beverages.

The length of time a new mother rests is from a few days to several weeks. It depends on individual circumstances, among them, economic ability, marital status, and social support. Women with few material and social resources at their disposal have shorter resting and recuperating period. Women are thus not a homogenous lot sharing similar experiences and circumstances. Whatever the length of time, kuvyuvisya is a period for convalescence and looking after the new mother. The woman returns gradually to her usual chores by starting with light ones.

Husbands do not just provide material support during postpartum, they also provide psychosocial and emotional support. Women expect their husbands to help with household chores and help in entertaining visitors, and generally being
around the home when they can. I argue this view is in part a reflection of the diminishing social support traditionally available to women after delivery. Women and men recognise the nature of the rural economy where men may and are away working or looking for work all day. Other men are long term migrant labour. Women do not, therefore, expect that their spouses will be around the home during the entire postpartum period. Some men and women said it was not necessary for men to remain around with wives after delivery. But the general feeling was that there is less social support for women now than in the 'good old days.' Men claimed that they help their spouses with work. Some said they accompany their wives to antenatal or postnatal clinics; I saw few at both clinics at Mwala health centre. But I also saw others who helped with chores traditionally performed by women such as fetching water from nearby rivers.

6.7 Managing barrenness

Barrenness like any misfortune is subject to multiple interpretations and there are always local gossips, contradicting opinions between family members, friends, relatives, neighbours, and among groups. Just as there are multiple explanations for the occurrence of infertility (see chapter five), so are there different management strategies.

People will try to deal with the misfortune of infertility in ways that are largely informed by theories of disease causation. As Whyte (1997:20) observes: ‘...the perils we undergo and the responses we undertake are mediated by the context of meaning we share with others.’ About barrenness, people share ideas about its causes and management.

If blood incompatibility between a man and his wife is the cause of infertility, then there is nothing that can be done about it except to wait for a given period of time during which it is hoped that the bloods of both partners will become compatible. Five years were thought by some to be the time required for the
bloods to be compatible. Blood incompatibility is said to occur if a man drinks a lot of beer for a long period of time. This makes his blood light. It can also be occasioned by a woman who started sex at a very young age mixing her blood with bloods of other men. From this point of view, infertility is managed in terms of the time taken by a man and a woman together. Some people know that blood incompatibility can also be ascertained in hospital and proper advice given.

Marrying another wife for purposes of procreation and perpetuation of one’s name is an option. About the Abanyole of Uganda Whyte (1997:125) writes that ‘for men the problem of infertility is solved by attracting and keeping (extra) wives.’ However, polygyny assumes that the problem is located in the woman and not in the man or the social world. People know that men can be impotent (see chapter five). However, man’s infertility is rather complex because if a couple does not know who between them has the problem, the man, as young men put it, can go ‘outside’ to try and see whether his ‘gun’ has bullets. If the gun does not give him a copy of himself, then he would know he is the one who is short of fire’. This option for the woman is limited although she can marry an iweto (see chapter three).

A less popular view is for a woman who suspects her husband is the cause of their having no children to secretly have another man to have children with, without divorcing her husband. Women who go ‘outside’ even when they suspect their husbands are infertile can only do so, I was told, at the greatest risk of being harmed and/or divorced altogether. Even the traditional way of managing barrenness by having a close relative, a brother, stepbrother or paternal cousin to father one’s children is most unwelcome by young people, a position that reflects changes in cultural practices and beliefs regarding sexuality and reproduction. The fear of AIDS infection has also lent weight to this changing view.
And yet the old generation maintained that one way for a man to perpetuate his name is to have his brother, stepbrother or paternal cousin to father his children. This helps to keep his name going while at the same time helping to avoid introducing a ‘foreign blood’ into the family.

The young and relatively educated women preferred adoption of children to polygyny. Many of the young men said if they knew they were infertile, they would rather marry a woman who already has children saying this is a more acceptable option (since it happens before marriage) than a woman having children with another man while in marriage.

A woman may also find it difficult to live with her husband if she has had a child with another man while still in marriage. One TBA said she once advised a woman whose husband she suspected was infertile to secretly look for another man when she knew it was ‘her time to catch’. She did it and became pregnant. However, according to the TBA, the woman did not stay in the marriage for long; she feared that should the man discover the pregnancy was not his, she would be in trouble. As some women put it, ‘a man would always want to hear that he is the father of his children. Any information to the contrary assaults the man’s ego and may result in violence or divorce. Frayser (1985:259) captures vividly the reasons why men respond to women’s infidelity with violence, sometimes death, but are less likely to kill their wives for being barren, ‘... because when a woman commits adultery she not only violates a social rule, she assaults her husband’s basic sense of social control.’

However, if infertility is considered a result of sexual misconduct or failure to perform certain rituals then the way to solve it is not to go to hospital but first, to consult a diviner to know the cause of the problem and, second, to advise on the steps to be taken. Cleansing ritual [ng’ondu] may be performed to correct things. Rituals to right things gone awry in sexual and reproductive arena are
found in other communities in Kenya and elsewhere (see e.g. Ocholla Ayayo, 1976; Whyte, 1997). *Ng’ondo* performance is, therefore, considered one of the efficacious ways of managing both sexual and childbearing misfortunes.

### 6.8 Improper sex and ill health: the power and place of the cleansing ritual in sexual and reproductive wellbeing.

In the previous chapters I have referred to *ng’ondo* as one of the rituals the Kamba use to solve or prevent sexual and reproductive problems resulting from certain acts that are polluting. *Ng’ondo* is a purifying medicine and the ritual is aimed at cleansing or ‘to cool things down’ or wash people of the dirt brought about by these acts. It is intended to normalise things. To demonstrate its relevance in sexual and reproductive wellbeing of individuals and a group of people, I describe below a *ng’ondo* ritual performed to cleanse both a man and his son’s wife after they had sexual intercourse.

#### 6.8.1. Purification ritual: the case of a man and his son’s wife.

In this case, a man had sexual intercourse with his son’s wife. The man is in his late 40s and well educated (F4 level). He is a trained mason and has a reasonable stable income. His wife is in late 30s. They have 9 children and two of their daughters are married. He has given his first born son a piece of land where he has settled. The son aged 26 and his wife 22, have been married for four years. They have one child, a boy. They belong to the clan of ‘X’.

The son caught his father sleeping with his (son) wife. The young man did not confront him but reported the matter to the locational chairman of the clan.

The cleansing ritual took place in October 1999 and began at around 8.00am in the young man’s (complainant’s) home. Part of the ritual was conducted at home and part of it in the bush. It began with a standard greeting from the

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3 Clan name withheld.
chairman to the clan members present. The chairman shouted the name of clan ‘X’ to which the congregation responded in unison: true [now'o]. This was a way of affirming their identity. The chairman requested all the women, except the young man’s wife (who was involved in the incestuous act), to leave but remain in the accused man’s compound until they were called back. Generally among the Akamba, women are excluded from the clan deliberations but women participate indirectly through cooking for the men present. However, this depends on the matters being deliberated upon and the clan in question, and age of a woman. In some cases elderly women participate in clan deliberations.

After the women left the young man’s home, the chairman of the clan once again greeted the congregation: ‘My fellow clansmen are you alright?’ to which they responded: ‘Yes we are alright’. Before any member of the clan congregation addressed the others, he had to greet them in this manner failing which may be construed to mean disrespect. A man was fined a he goat when he talked without first greeting the members in the aforesaid manner. The chairman briefly deliberated on what had brought them to the meeting saying:

The devil of desire has entered our clan and I am requesting that together we help to chase it away and cleanse those whom it has used so that in the future we do not experience misfortunes. At this point the chairman in a loud voice said: My clansmen true or not true? The members roared back in unison: It is true.

After this the chairman requested the clan elders who were going to question the man and his son’s wife to meet in order to take the oath of allegiance to the truth and justice in the matter. Five clan elders left the crowd and went into the bush to participate in this micro-ritual. The five elders must be people of integrity and trusted by the clan members. Some of these people, I was told, receive powers to administer or revoke the effects of an oath. The rest of the members were not allowed to observe the micro-ritual, which can be termed as
a ritual within a ritual. The five clan elders were given a fermented traditional porridge served in a piece of gourd [uuw'a]. They all drank from the same uuw'a symbolising togetherness - unity, for one course, justice. The porridge [ikii] must be prepared by a woman from a household neutral in this matter. As they drank in turns, they uttered the following words:

If I should judge any person of clan ‘X’ unfairly, untruthfully, and deceitfully, let those bad things befall me....

When they finished taking the porridge, the men stood in a circle and together held and buried a piece of long creeping grass [ikoka]. This symbolises unity and denotes that at that moment, one does not belong to any party, that is, he is not going to side with any of the parties (the man or his son’s wife). The five elders returned to where the rest of the people were. All the while, the man and his daughter in-law were at home waiting but not mixed with the crowd. The elders asked both of them to come in front, remove their shoes and sit in the sun, not under a shade. The month of October is fairly hot. They were not to utter any word except to answer the questions put to them by the five elders. The man was further asked to step inside a sack from where he would answer the questions. Stepping in the sack was a way of publicly humiliating him but it also symbolised that the man was polluted.

In full hearing of the rest of the male members, the young woman was asked to give details of what transpired between her and her husband’s father. It was necessary for the woman to give her version of what happened because this was going to determine the severity of the punishment the man would get. The punishment to the man would be more severe if the woman did not consent to the act. In this case the five elders adjudged that the woman was not forced into the sexual act, but somehow, she consented through what can be termed as threats and intimidation. The man had threatened to have the woman ‘chased away’ by her husband if she did not comply. It was also clear that the man
used economic threats on his son’s wife; he repeatedly reminded the woman
that the land on which they have settled was his and he could still repossess it.
Given these threats, intimidation and a feeling of social insecurity, it is not too
hard to see why the woman ‘consented’ to the incestuous act. However, the
elders felt that she had the option of informing her husband or mother in-law or
any other close relative but she did not.

The man agreed with what the woman said and both were taken away to the
bush-away from where the rest of the people were so as to be cleansed. A
ritual specialist, an elderly man in his late eighties, performed the cleansing.
The specialist prepared the purification medicine using most of the food grains
grown in Ukambani, seeds from all locally available edible fruits, powdered
barks of *Hymenodicty/Parvifolium* [mulinditi] and roots of *Sauseneria*
[kiongoa], all in a piece of gourd, added water into it together with intestinal
and stomach contents and blood from a he sheep provided by the man.
Branches of *Ocimum americanum* [mutaa] were used to thoroughly star the
mixture. A small piece of the lamb meat was dipped in the medicine and
swiped on the genitals of the man and his daughter in-law. They both were
holding their genitals and saying words after the ritual specialist. The words
were cursing the devil [iimu] that used the two to commit the incestuous act
and cursing anything bad that may result from such an act. They swore not to
be tempted again and cursed the incestuous desire appealing to the spirits of
their ancestors to forgive them, bring no misfortune to them, their families, and
the entire clan but to restore them into their former unpolluted state, and accept
their fertility again. The piece of meat was later carried by the ritual specialist,
taken away from the village and left at a crossroad near the main highway-to
take away all the pollution. After that the ritual specialist dipped branches of
*Ocimum americanum* in the prepared purification medicine and washed both
the man and the young woman. This last part of the ritual is the one referred to
as cleansing, that is, ‘to cool things down’ or normalising things by washing

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away *thaavu* [the dirt/pollution] brought about by the incestuous act. The ritual specialist had now finished his work and the three - the specialist, the man and his daughter in-law returned to the congregation. The man was fined a he goat by the five - clan elders, which he showed to the clan chairman. The goat was slaughtered by the relatively young men present and eaten by the men and the women who all this time were waiting at the man’s home. The whole ritual process took about seven hours-the ceremony ended in the late afternoon. The man and his daughter in-law were restored into their former social position and reintegrated into the family and the clan as ‘clean’ members.

6.8.2 Comments on this case and other cleansings.

Looking at *ng’ondo* ritual from both the micro (individual) and macro (lineage/clan/ community) levels, a few features important and relevant to sexual and reproductive health and wellbeing are discernible. At the micro-level the act of cleansing [*kuusya*] has positive psychological effect but also it brings about physical health of the individuals involved. Cleansing takes away the pollution [*thaavu*] brought about by those involved in transgressing sexual boundaries.

If the ritual was not performed, the belief is that one or more of the following would happen: The general health of the two and their spouses would be affected, but more specifically their reproductive health would be in jeopardy. The young woman would never give birth to any child alive and if she does, the child is less likely to survive. Similarly, the older man’s wife would never give birth to any child alive and if she had finished childbearing, then the man would, as a result of the pollution, waste away and eventually die. The same is likely to befall his wife.
A woman in her early 60s told me of a case of a woman who slept with her ‘brother’ (father’s brother’s son) but kept the act secret. Later the woman got married and gave birth to five children all of whom died at birth. When she was on her sixth pregnancy, the parents of her husband returned her to her parents saying they were tired of ‘eating children’ (meaning burying children). They told the woman’s parents to ‘eat the sixth one’ or ‘find out what sin’ she had committed. Her brother sought advice from a distant elderly relative, a man whom he informed that he had ‘sinned’ with his ‘sister’. A diviner was consulted and she confirmed the incestuous act was the cause of the woman’s problems. A ritual specialist was sought to cleanse the man and his ‘sister’ after which the woman had two sons and a daughter. Kramer and Thomas (1982:195) report a similar finding. In their research in Ukambani, they report a man who had lost two of his sons because, according to the man, his wife had had a miscarriage that she kept secret and that if the ng’ondu ritual had been performed, the man believed his two sons would not have died. Cleansing thus normalises things, that is, brings both psychological and physical healing.

At the macro-level, those related by blood, for example, the family, lineage and clan members are in real danger of the pollution being passed on to them. Indeed, an entire group of people may be at the risk of suffering ill health and misfortunes including death. Thus individuals become ritually unclean and carriers of misfortunes and would pass them on through sex to their spouses, those related to them by blood and those they have sex with (Mutunga, 1994; Mbula, 1982). But equally important is the fact that a ritual act can resolve social conflicts and illnesses that have moral and social dimensions by restoring harmony between the body-self and the social body [family, lineage, clan] (see also, Yoder, 1982:12; Boeck, 1991:160). Thus besides the restoration of the physical health, the ritual of ng’ondu brings about social wellbeing by healing the social body as its performance serves to resolve a
potentially explosive situation between the concerned individuals or groups of individuals. In this sense, health is about social wholeness.

But just as sexual intercourse can be a source of danger and ill health (Weeks, 1981:11) so also ritual coitus can symbolically be performed to prevent misfortunes and promote health and wellbeing of not only the individual partakers but also of a group of people. A man informed me of his close relative, a woman in her late 30s who had been married in another part of Ukambani but had separated from her husband 7 years before my interview with him. Some time back, the woman returned to her matrimonial home to perform ritual coitus with her former husband after the death of the wife of her husband’s younger brother. Although the husband married another wife, according to the Akamba traditions and customs, this woman still remained his first wife with all the obligations and rights because the man had not taken ‘a goat of refusal’ [mbui ya ulee] to her parents (see also Mbula, 1977). When the woman tried to refuse, the husband’s mother pleaded with her asking: ‘why do you want to finish my family?!’ (meaning if she refused to perform the ritual, the family would perish). She agreed and went back, and they performed the ritual. They were also washed with ritual medicine ng’ondu and it was believed the coitus not only cleansed them but also prevented similar misfortunes from befalling the home/family. The practice of ritual sexual cleansing is reported in some communities in Rwanda and Zambia (Webb, 1997). In such a situation the symbolism surrounding ritual cleansing is more crucial than the act of coitus itself (Heald, 1995; Ahlberg, 1994). But while such ritual coition is intended to promote sexual and reproductive wellbeing, they may also jeopardise the very health and wellbeing of the people in question by exposing them to dangers of STD and HIV/AIDS infection.
PART III
Chapter Seven

Terminology, Perception and Implications of STD and HIV/AIDS

In this chapter, I focus on the terms used to construct STDs including HIV/AIDS, signs and symptoms that people use to identify and define these infections, and their perceived consequences. Further, using STD case experiences I examine the meanings of STD infection, how STDs are experienced and perceived by both men and women. The chapter concludes with a discussion about perceptions of the similarities and differences between AIDS and other STDs.

7.1. Meanings and Perceptions of STD/AIDS

Sexually transmitted diseases have historically been stigmatised because they symbolise moral decadence and metaphorically social-cultural disorder (Weeks, 1989; 1995; Horton and Aggleton, 1989). STDs including AIDS are perceived as illnesses resulting from improper sex or, more appropriately, wanton sexuality that is evil. STD is, therefore, a disease blamed on the sufferer himself or herself because of violation of rules governing sexual behaviour.

Historically, metaphors have been used in discourse about STD which contribute to them and those who suffer from them being stigmatised (see eg. Sontag, 1989). In Mwala, the terms used to describe and define sexually transmitted diseases including HIV/AIDS are captured by responses to the question: *What names do people use to describe illnesses that are transmitted through sexual intercourse?* Table 7.1 shows five recurrent responses to this question: STD is a disease ‘of those who roam’; ‘of those with bad behaviour’; ‘of sin’; ‘of women’; ‘of men and women.’ These terms are laden with moral connotations. Sexually
transmitted disease is said to infect people whose sexuality is questionable or uncontrollable. Thus STD infection carries with it a host of moral meanings (Wallman, 1996).

Having sex with an infected person causes STD including AIDS and having many sexual partners helps spread these diseases. An infected woman can transmit both STD and AIDS to an unborn child. In Mwala, men who contract STD are thought to have had sex with 'market women', town women or barmaids. Women with STD are said to have had sex with men from big towns where STDs and AIDS/HIV are thought to come from. They could have also engaged in the outright sale of sex.
### Table 7.1. Terms for, signs/symptoms and consequences of sexually transmitted diseases

<table>
<thead>
<tr>
<th>STD type</th>
<th>Kamba/* Swahili**</th>
<th>Meaning</th>
<th>Signs/ symptoms</th>
<th>Causes/ Transmission.</th>
<th>Consequences/ complications.</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>Homa</td>
<td>Common cold.</td>
<td>*-Sex with infected person.</td>
<td>-Infertility(gon.)</td>
<td></td>
</tr>
<tr>
<td>Terms</td>
<td>Kya Ngiti</td>
<td>Disease of ‘dog’.</td>
<td>-Sharing towels</td>
<td>-Miscarriage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mowau ma kutembea</td>
<td>Diseases of those who roam.</td>
<td>-Failure to bath</td>
<td>-Bear sickly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mowau ma nai</td>
<td>Diseases of sin.</td>
<td>-Shaking hands</td>
<td>-Infant with children.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uwau wa Aka</td>
<td>Disease of women</td>
<td>-Through breathing.</td>
<td>-Infant with sickness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kuvya</td>
<td>Get burned</td>
<td>-Doctors know.</td>
<td>-Death (AIDS)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uwau wa kuu’a</td>
<td>Disease of bleeding.</td>
<td>-Shaking hands</td>
<td>-Stigma.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mowau ma mithumbi</td>
<td>Disease of bad behaviour.</td>
<td>-Sharing razors.</td>
<td>-Shame</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Zinaa</td>
<td>STDs.</td>
<td>-Sharing utensils.</td>
<td>-Divorce.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uwau wa kuu kwa</td>
<td>Disease of private parts.</td>
<td>-Mosquitoes.</td>
<td>-Econ. Cost.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mundu</td>
<td>Parts.</td>
<td>Can’t wear trouser properly.</td>
<td>-Irregular periods.</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Limping walk</td>
<td>-Isolation</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Walk legs apart.</td>
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<td>Abdominal pains</td>
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<td>Pain urinating.</td>
<td>-Inability to work.</td>
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<td>Fever. Genital sores.</td>
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<td>Pu. Irregular menses.</td>
<td>-Seen as immoral.</td>
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<td>Difficulty urinating.</td>
<td>-Relatives</td>
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<td>Urination not straight.</td>
<td>as sick</td>
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<td>Foul smell</td>
<td>-Mental ill.</td>
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<td>Discharge from private parts.</td>
<td>-Stillbirth.</td>
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<td>Backache</td>
<td>-Quarrels.</td>
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<td>Burning when urinating.</td>
<td>-Fears.</td>
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<td>-Orphans.</td>
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<td>Gonorrhoea</td>
<td>Kisonono</td>
<td>Get Burned.</td>
<td>-Incest</td>
<td>-Seen as immoral.</td>
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<td>Kuchormeka</td>
<td>Sores on body</td>
<td>-Absence</td>
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<td>Muluo</td>
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<td>Homa</td>
<td>Common cold.</td>
<td>-Improper sex</td>
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<td>Ikua</td>
<td>Common cold</td>
<td>Difficulty urinating.</td>
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<td>-Orphans.</td>
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<td>Syphilis</td>
<td>Kavithe</td>
<td>Hidden disease.</td>
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<td></td>
<td>Kaswende</td>
<td>Passing blood stained urine.</td>
<td>Most of above plus skin rash.</td>
<td>-Increased sex urge</td>
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<td></td>
<td>Kumaa Nthakame</td>
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<td></td>
<td>-Loss of sex interest.</td>
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<td>-No sexual</td>
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<td></td>
<td>AIDS</td>
<td>Ukimwi</td>
<td>AIDS</td>
<td>Getting thinner and thinner.</td>
<td>-Strength.</td>
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<td></td>
<td></td>
<td>Muthelo</td>
<td>One that clears/finishes.</td>
<td>-Frequent illnesses/sickly.</td>
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<td></td>
<td></td>
<td>Mbomu</td>
<td>Clears like a Bomb</td>
<td>-Persistent cough, diarrhoea.</td>
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<td>Mduudu</td>
<td>Virus.</td>
<td>Sores in the mouth and body.</td>
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<td></td>
<td>Uwau wa Ngai</td>
<td>Gods disease</td>
<td>Hair sheds. Vomiting.</td>
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<td></td>
<td>Uwau Muthuku</td>
<td>Bad disease.</td>
<td>Hair becomes light.</td>
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<td>Kanzesa</td>
<td>That which weakens.</td>
<td>Sunken eyes. Skin rashes.</td>
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<td>Uwau wa radio</td>
<td>Sickness of radio.</td>
<td>Weight loss.</td>
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<td></td>
<td></td>
<td>Thaavu</td>
<td>Pollution/Contamination</td>
<td>General body weakness.</td>
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<td></td>
<td></td>
<td>Ukuno wa Ngai</td>
<td>God’s punishment</td>
<td>T.B., headache, boils.</td>
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<td></td>
<td>Unclear</td>
<td>Kateko/teko</td>
<td>Itching disease.</td>
<td>Disturbing/persistent itching in the urethra.</td>
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</table>

Source: Field Data.

*Many of my informants mentioned sex with an infected person as the main transmission/cause of HIV/AIDS. **Some terms used in Kikamba include Kiswahili ‘loan’ terms.
The following statements from my informants capture perceptions of STD:

People with STD are immoral. STD is a very shameful disease and anyone who gets it is because his/her behaviour is not straight, especially if one is married. It is sinful, [40-year-old woman].

People say those who get STD sleep around with many people...Those women living in the markets and working in bars are said to bring these STDs, [25-year-old unmarried man].

The moralisation of STD and HIV/AIDS is strongly reflected in the response that it is a ‘disease of sin’, that one contracts STD as a result of sinful sexual behaviour. When I asked about the cause of HIV/AIDS some informants particularly the older generation said it is a disease of God and is only God who will take it away [meaning nothing man can do to change the situation]. As a result those who contract STD including HIV/AIDS become contaminated, unclean, hence stigmatised. The perceived contagiousness of STD compounds the problem of AIDS. Sufferers are feared by some and may be socially isolated so that they do not pass the contamination to those who are ‘well’, ‘clean’. The notion of STD as a moral disease ties well with another meaning that, it is a disease of ‘the other’. STD is also described/identified as ‘women’s disease’ implying that it is women who bring about the problem of STD and that they are the ones who transgress good morals.

You know men say women keep these diseases in their body. I hear it takes a long time before women notice signs and symptoms of STD. Some people say it can even take several months! [40-year-old woman].

The medical personnel at the local health centre agree that locally people perceive STD as ‘women disease.’

You know people here in Mwala say STD is woman’s disease. That is what they say and it becomes a problem when it is so identified because men do not come forward for treatment. And you know their wives can’t ask them to come for treatment...in fact they can’t even tell them they are infected! [Clinical Officer Mwala health centre].
The foregoing seems to present men as the moral community that is pure, polluted only when they come into contact with infected women. Blaming women as the cause of STD, it can be argued, is part of the wider gender power imbalance in the community. This is in accord with Nzioka’s (1994:35) observation that blaming a section of the community for contaminating others can be part of a more general imbalance in gender relations that show male domination. But even when STD is perceived as ‘women disease’, it is not a disease of every woman; it is a disease of those women who seem different from other women, the ‘market women,’ the ‘town women,’ the bar attendants and those who roam about. Of the fifteen male STD cases I interviewed, twelve of the cases claimed they were infected by women in Mwala town centre. The market, town or generally urban life is associated with social and moral decay (Gausset, 2001:512); ‘the other’ that who is different from ‘us’, in the village. These are women who do not belong to the category of the ‘morally upright’ women, the moral community; that of proper woman (Ogden, 1996; Wallman, 2000). Thus disruptions of traditions brought about by urban and Western/modern life is perceived as a major cause of the spread of STD including HIV/AIDS.

But STD including AIDS is also associated with young adults. Young people are described as having ‘hot blood’. Not only does ‘hot blood’ make them sexually active, it also makes them unable to control their sexuality and, therefore, make them more vulnerable to STD and HIV/AIDS infections. Youth sexuality - indeed uncontrolled sexuality - is perceived to evolve around dirt and, dirt, as Douglas (1966:94) argues, embodies disorder and formlessness.

In rural Vihiga, people use multiple terms referring to STD as ‘women’s disease’ implying the stigma attached to STD which becomes particularly important to women because of the possible treatment delay (Moss, et al., 1999:104), which
may result in other complications including infertility (ibid; Manhart et al. 2000:1370). The problem of STD infection becomes more complicated if a married woman gets infected and brings the disease to the marriage (Wallman, 1998:183; Moss et al., 1999:101). As Moses et al., (ibid) found in Vihiga, if a married woman acquires STD blame is often cast on the woman, not the husband. Men and women thus do not experience STD in the same way.

However, men are also worried when they get STD. They are concerned about their image and behaviour and they also consider STD to have serious health and social implications for them and for their spouses. Men are keen not to infect their wives with STD, and they are keen not to lose face before their wives.

Married men in a focus group discussion explained that if they were infected they would avoid sleeping with their spouses. ‘I would drink a lot of beer and come home to sleep;’ ‘I would buy sleeping tablets to make me sleepy;’ ‘I would have sex with other women first after treatment to find out whether I am cured of the disease before I go back to my wife.’ They were unanimous that they would take time for treatment and after treatment before having sex with their wives so as not to infect them.

Women are not always perceived as the ones who cause or transmit STD. Even though STD is described as ‘women’s disease’ and women carry much of the blame and stigmatisation, people in Mwala also recognise the role of men in the transmission of the infection. STD is also referred to as ‘disease of adult men and women’. For anyone to get STD, he or she must sleep with an infected person meaning that it is not found in children before the age of intercourse. People, however, said that an infected mother could pass on to a baby while in the womb or during delivery. Women themselves say that they are victims of men’s bad sexual behaviour; it is men who bring STD to them.
Below I present two women’s STD illness narratives that lend credence to the above assertion.

I have been having chest pains and a backache. But also I have been using family planning (a coil) and I thought is the one that has been causing the problem. That is why I came to hospital. But also I had another inside problem of mine. I have been discharging a foul smelling thick sticky like substance from my private part. There is also irritation. Passing urine is also not regular. I have had that problem for four weeks now. I think it is this disease passed on to women by men. I think I got the problem from my deceased/late husband’s brother. He came to my home and I could not say no…. My husband gave me the same disease in the 1990’s. (her husband died in January 2000 and at the time of death, he was complaining of chest pains and persistent cough) I have never had any extra-marital affair and so I could not have brought the STD to him. It is my husband who first gave me the disease and now my husband’s brother…! [40-year-old widow with STD]

And a 20-year-old married woman also with STD shared this view:

This problem has been there for one month now. I visited my husband at his place of work and when I came back, I started having irritation, then pains on the lower part of my abdomen. I did not suspect anything. I thought it was part of the pregnancy experience. After some time, I think two weeks, I started seeing a yellow-like discharge from my private part/vagina. I got worried, I knew there was a problem although I did not want to believe that it was gonorrhoea; I did not want to believe that my husband gave me the disease. But on the other hand I knew it was gonorrhoea because I had heard and learned about its signs while in school. However, I could not tell my husband that he gave me the STD because that is like accusing him or questioning his morals. I suspect that he sleeps with other women where he works but I can’t be sure because I have never caught him with any; I can’t prove it. You know men like having other women even when they are married and they get these diseases and bring them ‘home’, to their wives.

That men were identified as the source of infection for their spouses was found also to obtain in other communities in Kenya particularly when work takes them far away from home for long periods, as is the case in rural Kenya (Moses, et al., 1994; Moss et al.1999). And in Mozambique, the more serious sexually
transmitted illnesses are associated more with men than women (Green, et al., 1993 cf. Green, 1999:69).

7.2. Identification and Recognition of STD

A number of signs and symptoms are attributed to STD. Many of these signs and symptoms are general to all STDs but others are specific to a particular STD, including AIDS. Table 7.1 presents the various responses to the question on the signs and symptoms of STDs. Generally, STD is recognised on the basis of body parts it affects, the genital area/parts, but also through the commonly known signs and symptoms, foul smelling milky or yellowish vaginal or penis discharge (see 2 STD cases above, for example).

STD particularly in men is recognised through the illnesses experienced by the infected. Pain or difficulty in passing urine, sores on the genitals, and fever or headache were not only described as clear signs and symptoms of STD, but also illnesses caused by the infection. Recognition of STD is also based on the time taken between infection and onset of signs and symptoms. How does one know it is STD? The common response to this question was that 2 to 4 days after the infection, one feels a burning pain during and after passing urine, and there is pus-like discharge from the penis. A 30-year-old-man who had experienced STD said: ‘...they [housemates] asked me whether I had felt or seen anything. I told them I felt pain passing urine and that I had seen a milky discharge from my penis. They said it was gonorrhoea.’

Individual experiences with STD make it possible for them to recognise the infection. Other people can recognise STD in an individual on the basis of certain physical behaviours. STD infection interferes with an individual's clothing and/or normal walking style.
When one has STD, the tip of the penis does not like being touched by the trouser and sometimes you limp. In my case it was so painful that I had to wear my trouser hanging, [50-year-old man and a former STD case].

While it is easy to recognise STD in men on the basis of certain physical behaviours such as the way they walk and clothing, signs and symptoms of STD in women are said to take a long time before they show; in some women, they can take several months. During this period, a woman can without knowing spread the infection. This explains why people see STD as 'women’s disease'. In women STD is recognised more on the basis of the backache and repeated lower abdominal complaints they make.

In the foregoing discussion, signs and symptoms of STD become visible to others and thus public knowledge. This points to infections that take a long time before treatment. Moss et al. (1999:100) make the same point about STD in Vihiga that 'these public signs are not easily disguised and are readily apparent to people in the community.'

Symptoms and signs are used to distinguish the three well known STDs namely gonorrhoea [kisosono or muluo], syphilis [kaswende] and AIDS [muthelo or Ukimwi in Kiswahili]. Syphilis and gonorrhoea have similar and overlapping symptoms such as foul genital discharge and burning and/or painful experiences when passing urine. Gonorrhoea is said to show in the infected person within three days after infection. Syphilis is described as slow and can take several weeks, sometime months to show in an infected person. This is why syphilis is referred to as ‘hidden disease’ ‘because it can stay inside the body for a long time without showing.’ Its symptoms, when they do appear are described as very severe, perhaps because they stay in the body for a long time before they show. Syphilis in a woman can be recognised through the newborn baby—if the child has skin infection such as boils or is born with eyes discharging a ‘sticky’
substance. My finding echoes that of Moss et al. (1999:101) in Vihiga where, syphilis is associated more with ulceration, boils, swollen glands and skin lesions involving the entire body.

When I asked how a baby gets STD from the mother I was told that the child shares the same food and blood with the mother while in the womb and that is how the disease is passed on to the baby. Others said that since gonorrhoea affects the woman’s reproductive organ, the baby gets the disease during delivery. This finding shows a clear understanding by the Akamba of the relationship between the mother’s health and that of the baby.

7.3. Perceived consequences and complications of STD: threats to sexual and reproductive health

As intimated above, the physical consequences and/or complications associated with STD are often intertwined with psychosocial, health and sexual complications. The perceived seriousness of the various STDs and their symptoms is largely used to distinguish AIDS from other STDs. The young people refer to STD particularly gonorrhoea as ‘common cold’ [homa]. The term ‘common cold’ may suggest the prevalence of STD in Mwala. This may also point to the fact that compared to AIDS, STD is considered a less serious disease that is comparable to ‘common cold’. But to be able to clearly understand the perceived differences between AIDS and other STDs, we need to examine their consequences.

7.3.1 STD: threat to physical and reproductive health

The perceived physical consequences of STD run from the less visible mild symptoms to more debilitating conditions. The physical pain the infected person experiences when passing urine, the discharge, discomfort and the ulceration/wounds are enormous. STD if left untreated can make walking
difficult. But perhaps the most painful complication of STD infection is miscarriage and/or infertility which makes the social stigma more intense (Moss et. al., 1999; Manhart, 2000). STD infection is said to render both men and women infertile, as it is believed to weaken or spoil the blood. Gonorrhoea spoils blood and the pus may not completely drain externally. This is what causes blockage of tubes in a woman making it difficult for her to conceive or sustain pregnancy. STD can also affect the normal biological functioning of a woman's body; blocked tubes cause irregular, frequent, and/or prolonged bleeding. If left untreated STD in a woman destroys the eggs making it difficult for her to conceive and if she does, the baby may be deformed. STD in men destroys the 'seeds' so he is not able to 'give birth'. The association of STD with infertility partly reflects the concern with fertility, a situation found elsewhere in Africa (Manhart, et al., 2000; Moss, et al., 1999; Green, 1999:69). Infertility places stigma on both men and women. However, if the result of STD in a woman is sterility, then the stigma this carries is double. A marriage without children is always incomplete and is more devastating socially and psychologically to the woman. Barrenness can result in quarrels, neglect, marital problems and divorce.

7.3.2. Stigma and other consequences of STD infection

STD has serious psychological consequences for men and women. The shame associated with STD results from the fact it is a tabooed illness-caused by inappropriate sex (Manhart, et al., 2000:1375). STD affects the sexual/reproductive organs and it is these organs that define one’s maleness/manhood or femaleness/womanhood. When STD strikes men, both the married and the unmarried suffer mental anguish. Unmarried men are concerned about their future fertility-that STD may render them infertile before they have
children. They are also concerned that their future status as husbands is in jeopardy since they may fail to get a ‘good’ woman to marry. A 23-year-old man said: ‘I feared that my chances of getting a good woman to marry in future were minimised.’ The point is not just a woman but a good one. This is a woman with good morals; one who is not expected to have had STD. She is a woman with good behaviour and respect. If a man is to get such a woman, then he should also be good in terms of his behaviour; he must have good morals. Men especially the young without resources may have other concerns that make them disclose their infection to friends. Young unmarried men in a group discussion noted that a man has to tell a friend ‘because he may introduce you to a doctor friend of his who will help you or treat on ‘credit’ then pay him later when you get money.’

The concerns of married men who contract STD are different; they have difficulty in informing their wives:

At first no (I did not inform her). I quietly tried several therapies but when she became infected I told her there was a problem. I went to hospital for treatment and was asked to bring her for treatment too, [50-year-old man mentioned earlier in this chapter].

Attempts by a man to hide the STD infection from his wife does not reduce his mental anguish and anxiety, just as a woman who gets infected with STD and does not know what or, more correctly, how to tell her husband (Wallman, 1999: 183). But men do not always hide STD infection from their wives especially when they know their wives will soon discover either after they infect them or when they need their (wives) support. A group discussion with married men noted that a man should not hide any illness from his wife: ‘You may need her help or co-operation when you have no money and you have to sell chicken or a goat to raise money for treatment. There is need for forgiveness; after all you are a man and wife!’ However, it was generally agreed that STD presents a greater problem in a marriage than in any other relationship.
The shame that men experience and so try to hide STD infection from their spouses seems to disappear when dealing with their male friends. Men talked about their infection with their friends, roommates or workmates not only because they wanted support, but also, and most importantly, because they needed advice on what to do. Thus it is much easier for a man to tell a friend than his wife about his infection.

My housemates asked me what I felt when urinating and whether I had seen any discharge from my penis. I told them I had seen a pus-like discharge and that I felt pain/burning passing urine. They said it was gonorrhoea and we all decided to look for treatment because we had played a trick on each other and had sex with the same girl [30-year-old married man-former STD case].

A man may also discuss STD infection with the woman he thinks infected him partly because the psychosocial consequences for him [in such a relationship] are less severe, but also because he is concerned about the woman’s health. Of the fifteen men who had had STD, four discussed it with women who gave them the infection. This, according to them, was out of concern for their (women) health and a way of making them aware that they were infected so as to go for treatment. One gave the woman money to go for treatment. Only two men said they did not talk about the infection with anyone. Of the two men, one (a married man) said he already knew it was gonorrhoea and knew what to do with it-went for treatment at a private clinic. The other one said he did not want anyone to know that he had been infected.

Whereas men discuss STD with friends, partners and sometimes with spouses, it is not so with women because men and women experience STD differently (Wallman, 2000:199). Women find it hard to discuss STD with their spouses and persevere even when they know it is their spouses who brought the disease to them. Indeed, one woman informed me that she had been asked by medical staff at the local health centre to bring her husband so that the STD can be
successfully treated but she had been unable to communicate this to him. She would rather have the medical staff do it. The clinical officer in Mwala health centre confirmed this difficulty. According to her women have difficulty in breaking news of infection to their husbands and quite often, women ask her to break the news to them. Women cannot question their spouses’ morals because the social consequences could be severe.

However, women may not always keep quiet when their husbands infect them and this depends, among other things, on her behaviour and the relationship she has with her husband. From a group discussion with adult women it emerged that a woman should tell her husband about the STD ‘unless she has also been going outside.’ The women argued that a woman’s faithfulness should be her ‘weapon and security’ so that if her husband infects her she can ask him without fear. They added ‘a faithful and good woman will always have the support of other family members.’ This argument resonates with cultural expectations of men and women: men do not expect their wives to ‘go outside’ or to bring STD home. On the reaction of his wife on realising that he had infected her, one middle-aged man said his wife was angry but there was nothing she could do because she was married; she had to persevere. Indeed, of the three women who had STD, two were infected by husbands/spouses while the other was given the STD by her late husband’s brother. Her late husband had also given her the disease before. None of the fifteen men who had had STD claimed to have got it from their spouse, even those married at the time of infection. This finding is consistent with the contention that marriage does not always protect women from getting STD because of their husbands’ sexual behaviour (Moses, et al., 1994:1655). Nor is it protective for men if they do not maintain sexual discipline. Of the fifteen men with STD experience, three were married at the time of infection. Thus for many women in Mwala the psychosocial consequences of contracting STD outweigh the impact of the physical ones. Manhart et al. (2000) make the same point about their findings in Morocco.
In more general terms men are likely to discuss STD with less fear since, as we have already seen, STD in men is less shaming. By contrast, women find it shameful to talk about STD. Therefore, women would rather treat STD infection secret as those who get it are perceived as having bad morals. They find it extremely difficult to even discuss the infection with their female friends. To disclose to others she has STD is to say she is not morally upright; it spoils her identity (Goffman, 1963) as a woman or wife. Indeed, while men who had had experience with STD were willing to discuss it, no woman in the villages admitted to have had STD experience. This explains why I conducted part of my interviews with women who had STD at Mwala health centre. Discussing STD may expose women to further shame and public ridicule through gossip.

If people know you have that problem, they will think you are loose and immoral, you are everywhere! You tell a friend and the next day you hear the story with people. You better keep quiet, women do not know how to keep their mouths shut! [40-year-old woman with STD cited earlier in this chapter].

You don’t discuss such things with anyone. People will say you are not a good woman, you are loose, even if your husband brought the problem to you. And if your husband gets to know you will be in trouble, [20-year-old woman with STD mentioned earlier in this chapter].

My findings are consonant with the findings of Moss and others in Vihiga where they found STD is believed to result from inappropriate sexual behaviour. Such associations result in feelings of personal shame and become the basis of moral judgement and gossip by the community (Moss, et al., 1999:103).

As we have already seen, STD is described as a disease of those who roam. Both men and women roam but men seem to be excused when they do so perhaps because social norms and values regarding sexuality offer more freedom to men than to women (Frayser, 1989). But also this may be because of the socio-cultural and economic role expectations of men and women in sexual
and/or reproductive arena (McGrath, et al., 1993; Obbo, 1980). To some women, therefore, this is not entirely unexpected. Men seem to be excused when they cross the social and moral boundaries, that is, when they go ‘outside’. In the words of a 30-year-old woman: ‘You know you men how you are. You are all like you came from the same womb! You can never be satisfied by one thing (woman).’ And another: ‘You like to try here and there. You (men) can’t be trusted!’ Thus male sexual appetite is perceived by some as unquenchable.

Thus a ‘properly’ married man may get STD and even bring it to the marriage but face less severe consequences; less shame and stigma, and little chance of rejection by the partner. In contrast, women who roam, ‘market’ or ‘town’ women are not perceived as ‘proper women.’ The foregoing fits nicely with the notions that STD including AIDS infection are underpinned by the wider issues of social norms, sexuality, morality, poverty, and the power relations between men and women (Nzioka, 1994; Ogden, 1996; Manhart’s et al., 2000; Wallman, 1999; 2000; Farmer, 1997). The market women and/or town women are the ones who contract STD and bring it to their partners whereas ‘proper women do not suffer venereal infection’ (Wallman, 2000:199). A proper woman is constructed in terms of successful marriage, childbearing and acceptable sexuality and, generally, how she conducts herself in private and public arena. This is what the Akamba in the context of marriage refer to as *kiveti kiseo* which can loosely be translated to mean ‘good woman’ with all the positive attributes that a society accords a married woman, including respect for herself and others. She is a woman with good morals. It is comparable to *empisa*, a highly regarded social value in Kampala, Uganda (Ogden, 1996; Wallman, 1999).

### 7.3.3 STD infection: threat to sexual and social wellbeing

Social consequences of STD are equally severe. The presence of STD occasions tensions between partners; for a sexual relationship, whether longstanding or
short-term, it is its dissolution together with the loss of attendant benefits (Orubuloye, et al., 1993; Wallman, 1996; Kielmann, 1997). All the men I spoke to said the relationship ended on realisation that the woman had in their view, infected them. The following statements were typical responses to the question on what happened to the relationship after infection. ‘The relationship simply ended there because the fate of such an affair is usually determined by the man,’ or ‘I never saw the woman again.’ This, however, is not always the case, as some men cannot immediately identify the source of the infection. The relationship may, therefore, not be immediately dissolved. Four of the fifteen men who reported STD could not tell who infected them. One of them said that he could not exactly tell who infected him because he had slept with 3 women the previous weekend, while the other said he had ‘moved’ with three girls the same day. The third man said that he could not exactly tell who gave him the disease but he simply assumed that it was the woman he had sex with the previous day. The fourth man claimed he was too young at the time of infection to know the source of infection. Thus if a man has had sex with more than one woman and gets STD, he may not know who gave him the infection. Wallman (2000:195) makes the same point when she observes that a man who has had ‘sex for pleasure’ may not know who infected him.

The consequence of STD in a marriage is far more severe and the heaviest penalty is the dissolution of a marriage. Even though both the man and the woman have a price to pay incase of infection, regardless of who brings it, a woman pays a particularly high price if she is thought to be the source of the STD because she may be turned out of her home (Manhart, 2000:1375). Such an outcome is feared by women, especially a ‘proper woman’ because it entails loss of emotional and financial support to the woman and her children (Wallman, 2000:199). In a patrilineal society like the Akamba and a poor rural community like Mwala, marriage and successful childbearing remain important sources of a woman’s social, emotional and economic security; in sum social and by
extension physical wellbeing. The marriage gives the woman access to economic security such as land, livestock, a home for herself and her children, emotional support, support from her husband and husband’s relatives and other husbandly services. Successful childbearing gives a woman higher social status, earns her respect and assures her of social security in old age (see chapter five). When a marriage dissolves, therefore, the woman becomes extremely vulnerable because she is likely to suffer the loss of the primary sexual partner and all other benefits associated with a successful marriage.

7.3.4 STD infection: perceived health and other consequences

Sexually transmitted disease is considered a health problem because it is an illness. STD affects health. People explained that if a woman remains untreated for STD particularly syphilis and gonorrhoea, she can become barren. Besides causing fertility complications, STD is said to bring fever and wounds that require treatment. STD treatment means spending money that is not always available. A man who had had STD said, ‘generally one may spend a lot of money seeking treatment from several sources if cure from one source is not forthcoming.’ Furthermore, STD left untreated for a long time is believed to result in mental illness, another stigmatised condition (Scheff, 1967; Murphy, 1978; Maithya, 1992). STD is described as ‘adult disease’ but a mother can transmit it to the unborn child. STD ‘hidden’ in the woman’s body for a long time can result in giving birth to babies with deformities or with skin and eye infections. A young woman gave an example: ‘A friend of mine became pregnant and was infected by her husband. She delivered a baby who had a bad skin (literally flesh coming off). She used to feel pain in the lower abdomen and used to sleep a lot and never explained in hospital her problem. She was taken to Kenyatta National Hospital for treatment and was diagnosed with gonorrhoea.’
Perhaps one of the embarrassing and severe health problems of STD is that it affects one's sexual identity. Some men and women believe that STD diminishes man's maleness/manhood since one of the consequences of infection is said to be loss of sexual desire and/or sexual strength which are vitally important not only for a man's sexual identity, but also for sexual companionship/satisfaction of both partners (AbouZahr and Vaughan, 2000:657-8; see sub-section 4.3.5). Men who get frequent STD infection and are not properly treated are 'not able to perform.' Men lose strength and have no desire for sex; they become impotent, and/or infertile, I was told. If left untreated, STD is thought to result in total severance or damage of the sexual/reproductive organs. In the words of a young man: 'STD can cut one's penis if not treated.' Thus STD affects sexual identity, especially of men since a man's sexuality is partly socially constructed in terms of his sexual performance. The concern for future fertility makes some young men overcome the stigma associated with condoms to avoid STD infection (see chapter eight).

7.4 'Both are contracted through sex': perceived association of STD with HIV/AIDS.

The term *muluo* usually used by older people to refer specifically to gonorrhoea as opposed to the use of *kisonono*1 and *homa*2 by usually relatively young people suggests that STD has been endemic in Ukambani for a long time. Nationally, knowledge of STD particularly gonorrhoea and syphilis averages at 70 percent (KDHS, 1999:132-133). HIV/AIDS is by far the most widely known STD cited by 92 percent of both men and women and at the national level, AIDS knowledge for both men and women is impressively high-at 99 per cent (NASCOP, 1998:136). In Mwala AIDS, gonorrhoea, and syphilis were the frequently mentioned STDs (see table 7.1). People are acutely aware of the

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1 *Kisonono* is a Kiswahili word for gonorrhoea.
2 *Homa* is a Kiswahili word for common cold. It is used to refer to STDs but specifically gonorrhoea.
presence of AIDS, partly because they have seen or heard about a relative, a
friend or a neighbour with AIDS.\(^3\) Indeed, people said that STD is common in
Mwala because they had heard, seen and/or buried an AIDS case in their
neighbourhood. Many have also heard about AIDS on the radio: ‘Anyone who
doesn’t know about AIDS is a fool’ or ‘AIDS has killed many people in the
villages, so everyone knows about it.’ Others said that they had seen many cases
of young men infected seeking herbal treatment while others witnessed STD
cases at Mwala health centre.

According to a female community based distributor (CBD) who is also a TBA,
incidences/prevalence of STD in the villages are many. She claimed people with
STD both men and women including some married women come to her for
advice on what to do with it or where to go for treatment. But also the awareness
of the presence of AIDS in Mwala is a result of health education campaigns by
various organisations including government, non-governmental organisations,
the media (radio and Newspapers),\(^4\) community level networks such as schools,
and the church.

The relationship between STD and AIDS is thus better understood when we look
at the people’s knowledge and perceptions about their causes and/or transmission
and the consequences of infection. Both STD and AIDS are contracted through
contact with sexual fluids. AIDS and STD are, therefore, associated because
both are not only sexually transmitted, but are caused by ‘bad’ sex. Although
some people said AIDS is a disease of God, STD is not perceived as a
supernatural disease because it has a cure and is easily explainable. Some people
know there is a link between STD and AIDS saying that frequent infection with
STD can result in AIDS since STD weakens ones blood or body. In the words of

\[^{3}\text{At the time of research, the chief of Mwala informed me that he had issued 25 burial permits for people he suspected died of AIDS-over 5 year period.}\]

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a 36-year-old male informant who himself has had STD: ‘One can easily get AIDS if he/she has STD because it (STD) weakens the blood due to stress and pain.’ The stigma associated with AIDS may, therefore, enhance the stigma associated with STD.

Even though STD and AIDS are described as transmitted through sexual intercourse with an infected person, there is a belief that both are more generally contagious. Some people believe that casual contact through shaking hands with an infected person, using the same utensils or sharing cloths can transmit STD or AIDS (see Chapter eight case study 6). Passing urine on the same spot as a person with STD is believed to transmit it. Beliefs on the contagiousness of STD are found in other cultures. In Mozambique it is believed that some type of STD can be caught by stepping on urine or faeces of a person with the disease (Green, 1999:71). In Morocco there is the belief that one can catch STD if she/he goes to a public bath and sits on where an infected person was sitting without first cleaning it (Manhart, et al., 2000:1374). And in Vihiga Moss et al. (1999:103) found that part of the stigmatisation of people with STD is based on the perception that casual contact including washing clothes and eating meals together can result in infection. Beliefs on the contagiousness of STD are in accord with Sontag’s (1989:115) argument regarding beliefs on nonvenereal transmission of STD: ‘Infectious diseases to which sexual fault is attached always inspire fears of easy contagion and bizarre fantasies of transmission by nonvenereal means in public places.’ However, examined closely, some pollution belief may actually be more empirical than mystical because, as Green (1999:70) observes, it is based on the premise that one becomes ill when he or she comes into physical contact with an essence that is considered unclean or ritually impure. Another point to note is the association of STD with thaavu.

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4 See for example, the Daily Nation Newspaper May 1, 2001 Correspondent quoting the Machakos Medical Officer of Health saying that secondary schools in the district are hard hit by AIDS.
AIDS is associated with *thaavu* in so far as both are contracted through sexual misconduct and have similar signs.

One of the interesting findings in this study is that many of the people who had had STD said there is an association between STD and AIDS and they did not shy away from talking about STD and AIDS. The association is, however, somewhat ambiguous. AIDS is associated with STD only to the extent that the sexual behaviour causing both is perceived as immoral. Those who had had STD did not think their behaviour was immoral but innocent victims of 'the other'. When I asked those infected or had been infected whether they thought they risked catching AIDS at the time they said they did not think so. One of them said, 'I do not think about what I did in the past, I am concerned more with what I do now.' The association with AIDS (Wallman, 2000:199) further exacerbated the fear of other sexually transmitted disease. Those that cause ulceration such as clamydia, gonorrhoea, syphilis, and chancroid increase susceptibility to HIV infection (Grrosskurth, et al., 1995; Moss et al., 1999).

7.5 Is AIDS Thaavu?: explaining similarities and differences.

I have already shown the association of *thaavu* (contamination) with sexual misconduct (see sub-section 3.2.3). *Thaavu* is transmitted mainly through sexual intercourse but it is not an STD like gonorrhoea or syphilis neither is it a single illness; it is a single or a combination of maladies that are not easily explainable. Individuals affected by *thaavu* get thinner and thinner slowly but steadily; they become weak and boney. Death is the result unless they are treated with ng'ondu. The physical manifestations of *thaavu* are difficult to distinguish from those of AIDS (see section 7.6). AIDS and *thaavu* are associated in so far as they are transmitted sexually and the physical ailments resulting from both are similar. Both afflictions carry strong moral and social connotations (see also
Johnson, 1999). AIDS and *thaavu* threaten the health of the individual, reproduction and survival of family and marriage.

Johnson observes that *thaavu* is not brought only by sexual lapses of a man or woman; disregarding certain traditions can bring *thaavu*. Thus according to Johnson, it is in traditions that AIDS finds some explanations (ibid: 148-150). Like in Johnson’s study, some of my elderly informants felt that some of the problems [sicknesses] we are facing today are a result of people’s failure to do things according to Akamba traditions:

> This ‘thing’ we hear called *muthelo* [AIDS] has come because you young people do not listen; you have no respect for and do not adhere to our customs and tradition. People are doing ‘things’ with people they do not know. That is why there are all these troubles [Elderly woman].

The persistence of AIDS and its failure to respond to traditional medicine [ng’ondu] has made people class AIDS as a different affliction from *thaavu*. If ng’ondu ritual is performed on people affected by *thaavu*, they are cleansed and become well. Their bodies regain strength and they no longer die. This is not so with AIDS, I was told. Unlike *thaavu* and STD, AIDS is seen as a new health challenge in the community.

7.6. ‘AIDS is like a bomb, STD is like homa: perceived differences between STD and HIV/AIDS

Even though ordinary STD is common in Mwala, people do not perceive it as one of the serious health problems to worry about. However, HIV/AIDS is perceived as a new threat to health. It is considered a new disease that is inevitably lethal. The perceived differences between ‘ordinary’ STD and AIDS are presented in table 7.2.

Perceptions about the difference between HIV/AIDS and STD are based on the perceived signs and symptoms, affected body parts, disease characteristics and
treatment, and consequences and/or complications resulting from the infection. Like sexually transmitted disease, AIDS is contracted through sex but unlike STD, it does not affect specific parts of the body, the sexual and reproductive organs and is not described as a cause of infertility. STD can result in miscarriage and is considered a cause of infertility. The presence of HIV/AIDS is not considered to interfere with sexual and reproductive health as such but to affect health in general. ‘Even people with AIDS can give birth to a healthy baby,’ was a response from some people.

Table 7.2: Classification of perceived differences between STD and HIV/AIDS

<table>
<thead>
<tr>
<th>Classification of Perceived Difference</th>
<th>STD</th>
<th>HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body parts affected</td>
<td>-Sexual organs</td>
<td>-Not specific but many parts of the body.</td>
</tr>
<tr>
<td></td>
<td>-Reproductive organ</td>
<td>-Sometimes all body.</td>
</tr>
<tr>
<td>Symptoms and signs</td>
<td>-Specific and well defined/identifiable.</td>
<td>-Non-specific, many concurrent or serial ailments.</td>
</tr>
<tr>
<td>Disease characteristics &amp; Treatment.</td>
<td>-Less severe, but sometimes severe</td>
<td>-Severe</td>
</tr>
<tr>
<td></td>
<td>-Curable.</td>
<td>-Incurable.</td>
</tr>
<tr>
<td></td>
<td>-Less costly to treat.</td>
<td>-Costly to treat.</td>
</tr>
<tr>
<td>Consequences</td>
<td>-Infertility</td>
<td>-Death, miscarriage.</td>
</tr>
<tr>
<td></td>
<td>-Miscarriage</td>
<td>-Emaciation</td>
</tr>
</tbody>
</table>

Source: Field Data.

The seriousness of AIDS is, however, well known in Mwala. Signs and symptoms of AIDS are described as markedly different from those of ‘ordinary’ STD. People know that AIDS is a combination of many ailments. Those infected with AIDS are said to suffer many illnesses that do not respond to treatment both biomedical and *kikamba medicine*, traditional medicine. The well known and frequently mentioned signs and symptoms of a person suffering from AIDS is general body wasting. The specific illnesses associated with AIDS include incurable cough, skin rashes, boils/wounds on the whole body, hair changing colour - becoming light and eventually falling out, and a combination
of other ailments. A common description was, 'people with AIDS get ailments that do not cure even after treatment, they just get thinner and thinner and finally get finished.' These are the 'public' signs and symptoms or physical appearance of an advanced case of AIDS and this is the main reason the people of Mwala would only talk about AIDS and not HIV. The signs and symptoms of the latter may not be physically visible. This distinction between HIV and AIDS is also reflected in reported AIDS cases in Kenya which represent only the visible part of the epidemic - what most people see (NASCOP, 1999:2). But some young and educated people also know that a person can be infected with the AIDS causing virus and appear perfectly 'healthy'. Indeed, both AIDS (HIV) and STD (gonorrhea/syphilis) were sometimes referred to as kavithe (the hidden one). The former 'hides' in a seemingly healthy person for many years before one becomes sick while in the latter the sufferer hides the STD until he can't hide it anymore.

However, the major difference between HIV/AIDS and STD is its consequences. Even though people spend money to treat both AIDS and the ordinary STD, AIDS is defined as a new disease without cure and lethal whereas STD is described as easily curable. The fatal nature of AIDS is well captured by metaphorical language adopted by people to talk about it. AIDS is muthelo, meaning a disease that 'exterminates' or 'annihilates' or that which 'finishes'; or uwau muthuku 'the bad sickness'. Its devastating nature was captured by the young, 'AIDS is like a bomb, it clears everything where it lands, nothing is saved. We only hear announcements,' or as an elderly woman put it: 'This has never been seen before. That sickness (AIDS) is closing homes! (meaning causing deaths in the same family). I have seen it.'

The foregoing reveals a number of things associated with HIV/AIDS infection but not STD. Whereas the 'ordinary' STD may only be experienced as a private-individual disease, the effects of AIDS do not stop at the afflicted/infected. It is
possible that unless one tells somebody perhaps a friend that he or she has STD, the infection may not be known to anyone else. The physical signs and symptoms of STD can, therefore, remain ‘private’ (at least at the initial stage) and be managed at the individual level. Indeed, young people said STD was like ‘common cold’ [homa]. A 20-year-old man said: ‘When I told my friends I had been infected, they told me not to worry as it was a simple thing, just like homa.’ STD is comparable to ‘common cold’ because it is easily treatable. This implies two things: one, STD is perceived as less serious and, two, STD is a common problem so people know how to deal with it. Another STD case, 36 year-old man confirms this: ‘I informed my friend about it, he told me to go for treatment. To him it was just like having malaria [ndetema].’ Malaria whose major symptoms include fever, sweating, weakness and shivering is not only considered as a fairly minor illness (Kramer and Thomas, 1987:165), it is also the most commonly cited and well-known health problem in Mwala and Ukambani as a whole. STD is likened with malaria because like malaria, fever is one of the symptoms used to describe STD. However, in both private and public space people talk less about STD but more about AIDS. The emergence of AIDS and greater fear of the disease has, to a certain extent, resulted in the trivialisation of STD - so that far from being perceived as a threat to health, it is considered a minor illness, only comparable to common cold. Indeed, people talk more about AIDS than STD suggesting that the concern for STDs has diminished with the emergence of AIDS. Moss, et al. (1999) report similar findings in rural Vihiga, Western Kenya. And in the Kampala area, Uganda the emergence and greater fear of AIDS appear to minimise people’s perceptions of the seriousness of STD (Wallman, 2000).

AIDS carries double stigma because it is STD but one with a difference. It is a sexual disease but one that affects both the infected and his or her relatives; the primary stigma rests with the infected but the relatives suffer secondary stigma. The health of the infected deteriorates, but he/she also suffers socially and
psychologically. The family, relatives, and friends and even neighbours are also affected socially, psychologically, emotionally, economically and even physically by AIDS (Barnett and Blaikie, 1992; Nzioka, 1994; Kielmann, 1997; see Chapter eight). The secondary stigma associated with AIDS stems, in part, from the perceived contagiousness of the disease as some people may think that relatives are also infected. Consequently, neighbours and friends may isolate relatives of AIDS sufferer in terms of not visiting their homes, sharing with them food, and generally interacting with them in a normal village life. In a sense, AIDS brings social disaster.

But most importantly, people know AIDS is lethal and there is no cure. It kills men and women in their productive and reproductive years threatening family and society existence. The death of a partner/spouse, father, mother, brother, sister, and relative is a big loss to the family. The family loses a breadwinner, a decision-maker, a comforter, a companion, or a loved one. This is particularly true for the spouse or partner. It becomes extremely difficult to negotiate a HIV/AIDS free status; quite often people engage in gossip about health status of the partner/spouse. Thus death from AIDS or, more appropriately, illnesses associated with it become shameful and demeaning (Sontag, 1989:126) not only to the afflicted, but also to the affected. This partly explains why a family and relatives try to keep the knowledge of the cause of death resulting from AIDS to themselves. But it is also because doctors do not record a diagnosis of AIDS much less indicate that one has died of AIDS partly because of the very stigma attached to AIDS (see also NASCOP, 1999:2, Nzioka, 1994). It is also because of the ambiguous nature of illnesses associated with AIDS; generally, no one dies of AIDS. Similarly, the religious leaders who preside over such funerals do not talk about the cause of the death, lest they are put in an awkward situation when called upon by relatives to prove it.

\[5\] See Daily Nation Newspaper, 19 July 2001 for the first funeral notice in which the cause of death was clearly identified as AIDS.
I have officiated at 10 burial ceremonies of people I know died of AIDS because all but one had T.B as the main complaint before death. But you cannot stand before people and say so and so or the person we are burying here died of AIDS! What proof do you have? That is the work of a doctor. Our main concern is to comfort the suffering and give them some hope [Local Church Pastor].

Just as other STDs, AIDS is described as a disease that an individual 'goes looking for.' One elderly man put it more candidly, 'AIDS [muthelo] is not rain so that it rains on your farm even when you do not want it; if you shelter you won’t be rained on.' This implies that it is avoidable as people have a choice to get it or not to get it. AIDS is a disease that is still associated with prostitutes, urban life, and not village/rural life. As Mogensen (1997) and Gausset (2001) found in Tonga and Bujira (1999) in Lushoto Tanzania, that AIDS is perceived as originating from urban areas, so is AIDS in Mwala. Towns are considered reservoirs of AIDS; thus it is said to come from urban areas, not in the rural areas because in the rural villages there are no prostitutes or, more appropriately, they should not be there. It is in the towns where social and moral control is perceived to have completely broken down; urban life is disordered as people are perceived as not respecting any longer cultural values and traditions such as those that prohibited sex with strangers. Life in the Villages is described as more traditional and by implication less disordered or less polluted; contaminated only when villagers come into contact with urban life. Rural-villagers largely perceive themselves a moral community—at least in so far as sexual relations and AIDS is concerned, where social and traditional codes still hold. The commonly held view is that people return to their rural homes with AIDS from Nairobi, Mombasa and other big towns to die there; ‘they return home when they are already ‘finished’, very skinny.’ The medical personnel at the local Health Centre expressed similar views; they informed me that many of the confirmed AIDS patients are discharged from Machakos District Hospital or other hospitals for home-based terminal care.
Those with STD are not said in the strictest sense to always get it from prostitutes, although both STD and AIDS are diseases of sexual excesses. Some people describe STD in Mwala as endemic; it is in the villages throughout the year as both men and women are in constant interaction with the smaller market centres or towns. Those who get it may buy or sell sex but this does not necessarily make them prostitutes. The association by some people of AIDS with STD is somewhat paradoxical. AIDS is considered a disease of ‘the other,’ whose morals are at the lowest ebb. Sontag (1989:114) writes: ‘The sexual transmission of this illness (AIDS), considered by most people as a calamity one brings on oneself, is judged more harshly than other(s) - especially since AIDS is understood as a disease not only of sexual excess but of perversity.’

Some people, therefore, constructed AIDS as a disease of God; others as a disease sent to punish those who disobey him. An elderly Traditional Birth Attendant said, ‘AIDS is a disease from God and only Him can take it away,’ a view shared by some of my other informants, particularly religious leaders.

People are getting this disease because they continue to disobey God’s word. AIDS is not just affecting the youth only, but also very strong Christians are not spared. The society is becoming secular and we are now witnessing moral decline. Even in the Akamba traditional customs, sexuality was well controlled; now it is uncontrollable [A local Evangelical Church Pastor].

This view is consistent with Christian teaching that sex should be consummated in marriage and anything short of that is sexual immorality; it is sinful. It is also in accord with the Akamba traditional customs and practices which discourage individuals from having sex with ‘strangers’ and/or marrying from a family whose background one does not know well. The breakdown of traditional social and moral control perhaps due to Western influence and exemplified by urban
life is, therefore, perceived by some, particularly the older people to precipitate many problems including AIDS.

Some church leaders do not, however, share this view of Christian spiritual and moral decline. STD has been there and traditional social and moral codes have not always remained intact. But AIDS seems to have exposed the extent to which these have broken down. A Catholic priest had an informative view:

Christian virtues are today not any weaker than they have been in the past. The AIDS disease is just exposing how people have been living all along. AIDS is just exposing the other side of people's lives including Christians.

This rather philosophical view resonates with Sontag's (1989:112-113) contention: ‘...to get AIDS is precisely to be revealed...The illness flushes out an identity that might have remained hidden from neighbors, jobmates, family, friends.’

There has emerged a 'public/social' diagnosis of AIDS and description of the journey of the infected to the grave is rather systematic (see case study chapt.8). Those with money are said to go to private clinics/hospitals first, they then go to the general (public) hospital after they exhaust their money. Finally, they return home when they are very ill; they are discharged from hospital to come and die at home. These findings echo Nzioka (1994) on how people with AIDS in Kenya manage the problem. They also echo the findings of Barnnett and Blaikie (1992) in Uganda on how households and the community manage AIDS.

I discuss the management of AIDS and other STD in chapter eight. What is pertinent here is how people are knowledgeable not only about the relationship between STD and AIDS, but also how they distinguish between the two. Also AIDS knowledge is sometimes used for social diagnosis that may stigmatise the perceived AIDS cases and by extension their relatives. While this identification
and social diagnosis of AIDS is based on people’s experiences and the physical appearance of the infected, it is also informed by the initial and long standing presentation of people with AIDS in the medical and media discourse in Kenya (Nzioka, 1994) as emaciated, wasted people. Indeed, such presentations of people with AIDS have resulted in people employing bodily appearance as one of the strategies to manage AIDS (ibid). Things have tremendously changed especially in the last few years including knowledge and attitudes toward AIDS since the identification of the first case in Kenya (NASCOP, 1999:V). The foregoing notwithstanding, the presentation and perception of people with AIDS still remains largely skewed to the negative. Taken together or singly, these factors impact negatively on its management.
Chapter Eight
STD and HIV/AIDS Management and Prevention Strategy

This chapter focuses on the strategies employed by men and women to manage and prevent STD and AIDS infections. The management of STD is examined in the context of the available treatment options in Mwala. The chapter pays special attention to where men situate themselves in the prevention and management of STD. The point is made that in spite of the men’s perceived “don’t care” attitudes, the presence of AIDS and STD has become an incentive for sexual behaviour change. I conclude the chapter with a discussion on the prevention and management of AIDS.

8.1 STD treatment options in Mwala

Therapy and management of STD begins at home with self-awareness and, depending on knowledge of signs and symptoms, perceived causes and seriousness of the illness, direct self-treatment in consultation with friends, or kin may be the first step taken in search for cure. Within the self-treatment category, individuals may choose not to take action for two reasons. Firstly, they may lack knowledge of signs and symptoms of the infection. As we have already seen in the preceding chapter, STD in women is very shaming. A woman with STD may choose to keep quiet about the illness to avoid gossip and ridicule about her perceived sexual misconduct. Individuals may also not recognise the signs and symptoms of STD if it is a first-time infection and especially for women as STD infection in women is often asymptomatic.

Secondly, individuals may recognise STD, but still choose to take no action. Since ordinary STD is ‘invisible’, at least at the initial stages of the infection, a person may ignore the infection for some time, perhaps because they do not
consider the symptoms ‘serious enough’ to require treatment (Wallman, 2000:195). Others may take no action or delay action for fear of the shame associated with STD. Thus perceptions about STD and those suffering from it influence the action people take when infection has occurred.

As is common everywhere in the world self-diagnosis/home remedy is an important first response for many illnesses (Good, 1987) and STD is no exception (see e.g., Wallman, 1996). STD illness is initially dealt with individually and/or with advice from others including friends, neighbours, workmates, and roommates. These others constitute a ‘therapy managing group’ (Janzen, 1978:4). These are consulted to provide new information or confirm what one already knows about STD and to advise on management: where to go for treatment, what medicines to buy, etc. However, as the case of the 50-year-old man (this chapter) demonstrates the choice of treatment for one illness episode may vary with individuals even within one treatment option. In fact, there is discrepancy between what people say should be done about STD and what is actually done about it (Wallman, 2000:193).

Home remedies include herbs and medicines bought from shops and chemists. Medicines that are commonly bought at the shops or market centres include painkillers such as panadol, hedex, and paracetamols. Anti malaria tablets such as nivaquine, homaquine, and chloroquine are sometimes used, perhaps because STD gives fever which is associated with malaria. These medicines are available at the local shopping centres. If medicines from the local shops do not help, people may go to the local drug shop to buy antibiotics most of which are of generic type but nonetheless are more powerful. Antibiotics such as septrin are easily sold over the counter without any prescription at chemists. At the local chemist a full dose of generic septrin cost between Ksh.40-80 (about £0.40-0.80). The non-generic ones could cost up to Ksh. 200 (about £2) which is way beyond what the majority of the people can afford. The local chemist, therefore,
stocks both non-generic, that is, 'original' and generic drugs. Some people said capsules are good for treating STD but no specific one was mentioned. Buying or selling of prescription medicines including antibiotics without prescription is a widespread practice in Kenya just as it is elsewhere, for example, in Uganda (Wallman, 2000:197).

If one has had STD previously he may not consult others because he knows the treatment for it. In my study two of the men who had had STD did not inform or seek advice from anyone. One said he did not want anybody to know about the STD while the other said he already knew what was the problem and how to deal with it.

For women the influence and consultation with others in the management of STD is far less common. Because women experience STD differently from men, they keep news of the infection to themselves as involving friends and/or relatives may result in further psychosocial suffering including shaming, ridicule, and rejection. Also it is because women want to protect their marital relationships by not exposing themselves and their spouses to gossip, rumours and speculations. None of the women in my study sought advice on STD from friends; they did not discuss or inform friends or relatives about their infection. Thus the involvement of a therapy managing group is to some extent dependent upon the perceptions and the nature of illness (whether shaming or not) and who is suffering (man or woman). For women with STD a ‘therapy managing group’ is non-existent. In this study the women who had STD said they preferred to go to hospital because in hospital there is less exposure to shame than in the village. There is no separate STD clinic at Mwala Health Centre so it is not easy for other patients to know what one is suffering from. It is also because the health centre staff are said to be friendly. The clinical officer in-charge is a woman and women said she was very understanding in dealing with them. The officer informed me that some women ask her to reveal the infection to their husbands.
She tried with one couple but the man quietly disappeared from the waiting room. When it was their turn to be seen, the woman was alone: ‘Men are elusive because they know what they have done...I now give the medicines (or prescriptions) for both through the women...’

One important factor in the use of modern health facility by women is the very nature of STD in women; it remains asymptomatic in women for a long time. Thus women may be informed about it when they go to hospital seeking treatment for other complaints.

8.1.1 The place of traditional healers in STD treatment

Traditional healing is an important therapeutic option. There is a strong belief that traditional medicine is efficacious in the treatment of STD and many other illnesses. There are three therapy options - herbalists, diviners, and Traditional Birth Attendants (TBAs).

Herbal medicine is by far the most popular in this category. Herbalists who treat STD are preferred because herbs cure the root cause of the infection (Moss et al., 2000). Also, herbs are believed to cure faster than Western biomedicine. One male local herbalist was famous and favoured for treating STDs. Some people claimed that he even treats and cures AIDS. I was also told that the herbalist himself makes similar claims as one middle-aged woman neighbour of his put it.

He [the herbalist] treats successfully many diseases and people come from all over the country to see him. Some of the people come very sick. Even very rich people come for treatment. You find many cars especially on weekends. He even claims that he cures AIDS and says he can show 4 people he has cured of AIDS but I do not think this is true because I know AIDS has no cure. I think he has confused symptoms!
However, even though he treats many illnesses, some of which, according to him, have symptoms similar to those of AIDS, he did not, during my interview with him, claim to treat HIV/AIDS. Among the diseases he treats are general bodyache, stomach, arthritis, skin diseases, typhoid fever, malaria, intestinal worms, high blood pressure, and sexual and reproductive problems such as impotence, infertility and STD. He says STD is common in the area and a day hardly passes without treating STD cases, both men and women.

Young men said that the herbalist is different from others because he is young (forty years) and educated and they felt he is like one of them. This particular healer has a private consulting room for his patients away from the waiting area. Thus the way a healer handles his patients is a factor in choice of therapy (Wallman, 2000:192). Moss, et al. (1999:107) make similar observations about STD treatment in Western Kenya. According to these authors, people with STD favoured traditional healers and self-treatment. They also sought treatment from traditional healers away from home/village to avoid gossip from friends and relatives. As in Moss and others’ study, desire for privacy could also explain why people came from far places to see this particular herbalist. In this case the concern is not about accessibility, but one’s social and moral image.

The notion of privacy is somewhat fluid because a local TBA who is also a CBD told me that people with STD, many of them women, seek her advice on what to do. To some extent, therefore, while privacy is of paramount importance to all those with STD, gender may play an important role. Another factor that is important is the consequence of STD infection on fertility. Thus where fertility is at stake, privacy may be less important.

Those favouring traditional medicine said it was less expensive. In terms of money it cost more. According to the young herbalist, a full course for treating an ordinary STD episode is about one jerrycan of five litres of medicine in liquid
form, which cost Ksh.200 (about £2.00). But he said it could take up to six jerrycans of five litres to successfully treat one STD episode bringing the cost to about Ksh.1,200 (about £12). The cost of and time taken treating one STD episode depends on how long it has been ‘in the body’. If one has had STD for a long time then it requires more time and medicine to treat. Those who cannot afford to pay at once are allowed to pay in small instalments as they take their medicine.

Comparatively the user fee at the local health centre is much less - about Ksh.20 (about £0.20) for registration/consultation and Ksh.50 (£0.50) for every type of medication received. The problem is that there are always many people and it takes time to be seen by the only clinical officer, sometimes a nurse. After one is finally seen, there may be no drugs especially antibiotics and often patients have to buy in the local pharmacy/chemist. Furthermore, there is no laboratory to examine specimens to confirm infection or the type of STD so, according to the medical personnel at the health centre (and also my informants), treatment is based on presenting signs and symptoms. Sometimes patients are referred to Machakos district hospital over 40km away; they spend money on transport and treatment costs. Referral to Machakos district hospital may actually compound the problem because of the specific clinic for STD/HIV, which does not conceal individuals’ identity. In fact, the contrary is the case - a separate STD/HIV clinic makes it more than obvious what one is suffering from [or suspecting infection]. Although Machakos is far away from home, people always go there for treatment or other business. The trouble is that ‘one may be found on the benches waiting for treatment by somebody who knows him or her,’ I was told. My findings echo findings in Kampala, Uganda by Wallman (2000:195) where people with STD or suspecting STD feared to go for treatment at the nearest health facility for fear of being found or recognised by people who know them (including spouses). Although no one in my study said people with STD might avoid
hospital for fear of being tested for HIV as they say in Kampala, this is implied in their knowledge of the relationship between STD and AIDS.

Usually a diviner is not consulted for STDs. However, when the result of STD complication is infertility the advice of a diviner is sought. In this case then, it is not the STD per se that takes one to a diviner, but infertility. The interest here is to find answers to the root cause of infertility part of which could be STD or a combination of other causes which include human and non-human agency such as broken taboos, strained social relationships or disobedience to ancestral spirits (Nyamwaya, 1992). Biomedicine (or even herbal treatment alone) is incapable of resolving these underlying problems. Only specialists such as diviners who take a holistic approach in dealing with a particular problem, including finding out why and/or how a particular ailment occurred can do it (Ndeti, 1976; Green, 1993; Last, 1996; Wallman, 2000; Moss, et al. 1999; Sindiga, et al, 1995).

Similarly, people do not consider TBAs to be directly involved in the care for persons with STD. Some TBAs said they deal with STD in the course of helping women to deliver. If a baby is born with eye infections, they may suspect that the mother has STD and has transmitted it to the baby while in the womb. They advise the mothers to take their children to hospital for treatment. Some TBAs initially try to treat the eyes using herbal solution. One TBA told me that she recently treated a man and his wife who were suffering from gonorrhoea [muluo]. ‘Their private parts were swollen and discharging watery-pus-like substance. They thought it was AIDS but from the symptoms I knew it was gonorrhoea. I gave them herbal medicine [muti] - the man one-litre jerrycan and the woman 5-litre jerrycans of herbal solution. They got cured and are now well.’
In practice, choosing a course of therapy is less straightforward. Below I present some aspects of STD illness narrative/experience to capture strategies employed to manage STD.

Case study 5: STD illness narrative by a 50-year-old man

**How did you know it was STD?** I did not know I had it. After three days, I had difficulty passing urine. It was painful and burning and urine was coming out in two lines. I was also discharging pus-like substance from my penis. I knew those were STD symptoms.

**Did you go for any treatment?** No, for some time I did not use anything; I did not go for treatment, I hid the problem.

**Why did you hide it?** You know that sickness is not good; here I am with a wife and I get this disease! I was still thinking of what to do. I treated myself for three days using herbs and it helped me a bit.

**Did you tell anyone you had STD?** Yes, I discussed the problem with my friends. You know one must tell a friend when they get such a problem. They told me not to worry, as it was just *homa*. Some advised me to go for herbal medicine, which they said, is good for curing STD. I told them I had used herbs without much help. Two of my friends insisted I see a herbalist. I told them they were being childish and that what they said was not true because herbs do not completely cure STD. Another of my friends advised me to use capsules, as they were good.

**Which capsules?** I just bought them from the shops, I did not know the name, but my friend knew. I took them for sometime but I discovered that was also a lie because the capsules did not help me. I told my friends that the disease is cured in hospital [sivitali], by injections. The condition worsened and I developed sores on the tip of my penis. I decided to go to hospital. I was treated in Mwala Health Centre by a female ‘doctor’ [ndakitali]. She asked why I had taken so long before going to hospital and I knew I had been sick. She gave me some tablets and referred me to Kangundo hospital. I was given several injections and advised to refrain from intercourse and from drinking alcohol. I got cured.

**Did you discuss the infection with your wife?** At first no; only after I infected her. I was also asked in hospital to bring her for treatment.

**What about the woman who gave you the disease?** I never saw her again. She was a town woman [naka aya ma soko]. We met in Mwala in a pub; she lives around there. We did not know each other before then. I bought her beer and roast meat and we became close. We ended up doing it...you know about beer...

There is no single pathway to the treatment of STD (Wallman, 2000, 1996; Green, 1994), indeed any illness (see e.g. Ngubane, 1992; Sindiga, 1995). In Kampala Uganda, Wallman (1996) shows how people use a variety of strategies in the management of STD. As in Kampala, so is it in Mwala. Therapy options

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1 This is the same STD case referred to in Chapter 7
2 When referring to medical personnel, most people in the villages do not distinguish between a doctor and a clinical officer. They refer to them as ndakitali a corruption of the Kiswahili word daktari, which means doctor. Indeed, nurses are also referred to as ndakitali and any one wearing a white doctor’s coat passes for a doctor. In this case the man is referring to the
are used in a variety of ways even during the course of a single STD illness episode. The point here is that in search for cure the boundaries between different therapies are non-existent.

8.2 Preventing and managing STD: behavioural change as a strategy

8.2.1. Perceived change in sexual behaviour

Some people say men and women have changed their sexual behaviour. Others think nothing much has changed. The general feeling was that men and women were now becoming more careful in their sexual conduct. This was attributed to knowledge and the presence of AIDS. People noted that spouses had become more responsible and faithful to each other and few married people were engaging in extra-marital sex; AIDS has rendered sex ‘outside’ dangerous. In discussions on AIDS it was not uncommon to hear men and women say ‘things are bad these days, it is not like in the past’. It was said that men drink in the company of other men and avoid women they do not know, and lodgings were not doing good business as in the past. One long-time male resident of Mwala town so eloquently captured this:

"A lot of men these days bring their salaries home; men drink and go home to their wives. In the past at the end of the month, these bars would be full of men accompanied by women, ‘buying rounds’ until they finish all the money."

Implied in this is that men now have sex ‘inside’, that is, at home with their wives. This was the general feeling of some bar and hotel owners and attendants in Mwala. One bar attendant commented: ‘Our lodgings used to be full with men with women especially on Wednesdays and Saturdays,’ adding ‘men these

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clinical officer in Mwala health centre. Also any health facility is referred to as hospital/sivitali whether a health centre or hospital.

3 There is a big and famous livestock market on Wednesdays and Saturdays in Mwala. The market draws business people including butchers and hoteliers from as far as Machakos town (40km away) and Makueni.
days hire rooms and spend the night without a woman. My own observations support this view. Barnett and Blaikie (1992:104) describe similar change in men's behaviour in Rakai Uganda due to the presence of AIDS.

However, in Mwala the fear of AIDS is only a part explanation of the change in social and sexual behaviour. A change has also been occasioned by hard economic times that Kenyans have been going through as a result of Structural Adjustment Programmes implemented in the past one and half decades (ROK, 1997:4; ROK, 1999); people do not have money to engage in activities intended to procure pleasure.

The foregoing notwithstanding, change of sexual behaviour was said to be rather slow. And some people felt that sexual behaviour has not changed. Men are said to lapse in their sexual behaviour after they have taken beer (e.g. case study 5 earlier in this chapt.). For some, prayer, trust and hope have become part of the management strategy of especially AIDS. Many women, especially those with migrant husbands said that they pray ceaselessly so that their husbands will see and know the danger posed by AIDS and change behaviour. Many more said they trust their husbands will be careful not to bring the disease home, as they cannot 'police' them. It was pointed out that the very fact that a brand of socially marketed male condom called Trust was strategically being advertised all over in Mwala as elsewhere in Kenyan towns was a clear testimony that sexual behaviour had changed, but for worse not for better (see sub-section 8.3.2). One way to assess sexual behaviour change is to look at what those who have had STD had to say.

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4 See Daily Nation 24 September 2001 in which a nationwide survey commissioned by the Media Institute, a Nairobi based NGO shows that knowledge of AIDS is near universal but a significant number of people has not changed their sexual behaviour.

5 Trust is a socially marketed condom by the Kenya government through Population Service International. There are paintings and pictures of it all over the country on the walls of shops, bars and restaurants. It has a picture of a man and a woman negotiating to use the condom. On it is the message: 'Let’s Talk' (Sema Nami).
8.2.2 Changing sexual behaviour: STD a catalyst of behaviour change and safe sex?

Although STD infection is most often seen in a negative light, the consequences are not always negative (Manhart et al., 2000:1377). STD experience may make people, especially men adopt a safer sex behaviour. STD makes men, especially the young and unmarried, limit sexual contacts to avoid infection. A young male informant said that after infection with gonorrhoea, he became choosy and decided not to ‘talk’ to girls again until he was old enough ‘to understand these things.’ Another, a 20-year-old unmarried man who had been infected with gonorrhoea said he will only befriend one girl ‘whom I intend to marry in the future.’

STD makes men more careful in the selection of their sexual partners. Men try to probe and establish a woman’s background before making a decision whether to have or not to have sex with her. One of the men who had had STD even claimed that he had his wife medically examined before he married her! Some reported not having sex with women they did not know well. For example, a 35-year-old man said that after his second STD infection, he decided not to have sex with a woman he did not know well or trust. Again knowledge of the partner (not a stranger) and trust s/he is not infected become good prophylactic strategies for men as it is for women. A young unmarried man (19 years) claimed that he carries a condom in his pocket whenever he goes out, partly because one of his male friends had recently contracted STD that could make one ‘not have children in the future.’ He also carries condoms because he knows HIV/AIDS is present in Mwala and as a preventive measure. STD can make married men abandon extramarital sex in favour of the spouse as a 38 year-old-man informed me: ‘after that incident (STD infection) I decided to be faithful to my wife…and you know

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6 At the time of my discussion with him, he had been married for 8 months.
there is this “thing” (AIDS). Thus STD can become a catalyst for spousal or partner fidelity.

For some men it may require more than one STD experience to see the need of changing their sexual behaviour. Two of the male STD cases reported change in sexual behaviour after second infection. One of them explained: ‘I got it again… after my first infection, I promised myself to be more careful and not to repeat the same mistake but I picked on the same behaviour again. It is after my second infection I realised that if I do not change I will get into trouble.’

Talking and discussing STD with the sexual partner is an important step in the management and prevention of STD. However, if the sexual relationship is temporary/short lived, it may be difficult first, to identify the source of the infection and, second, to look for the sexual partner to inform her/him about her/his infection. Nearly all the men said the relationship from which they got infection was not a longtime one. In fact most of them said they had known the sexual partner for a very short time; some met in social places, mainly bars. Only four said that they knew their sexual partners; they were some kind of girlfriend, although one was having a relationship with a friend’s girlfriend. Thus in a temporary relationship, each partner takes responsibility for their own sexual behaviour. Most of the men said that the relationship ended soon after they got infected ‘because the fate of such a relationship is determined by the man;’ it is one of the strategies to avoid reinfection. They did not discuss it or inform the woman about it. Men advise friends to avoid sex with the woman they thought infected them so as to avoid infection. However, even with temporary relationships men may show concern for the health of their sexual partners by informing them so they can go for treatment. It may also be because they would require her sexual services in the future. If men have the means, they can provide money for their partners to seek treatment. One of my cases, a 33-year-old soldier said he gave the woman he thought infected him money to go
for treatment at a private clinic but the relationship ended. Thus ending a sexual relationship is one of the strategies men employ to avoid further infection and reinfection.

Within a marriage, preventing but more so managing STD is more complicated and not just a one-way affair. Discussions with men revealed that they have a variety of behavioural strategies to avoid infecting their spouses. Men can feign illnesses to avoid having sex with their wives and to buy time to treat the STD. They can go to drink and come home late and drunk thus avoiding sex with their spouses. Some even suggested that they could use sleeping pills to avoid sexual intercourse. If they did infect their spouses, they would take them for treatment as a 38 year-old married man put it: ‘if I know that I am infected, I would not accept to have sex with my wife even if she insists. If by bad luck I transmit the disease to her, I would give her money to go to hospital.’ Men are thus willing to take responsibility if they are the source of the infection. Indeed, STD/AIDS prevention is seen as the responsibility of both men and women. The point to make is that the culture that frees men to get STD also frees them not to infect their partners.

STD experience functions to motivate some women to have greater control of their sexuality, and by extension sexual health. A widow with STD from her late husband’s brother (cited in section 7.1) informed me that she would never again yield to his sexual demands. Indeed, determination to control her own sexuality was so strong that she said if sex was the only thing that brought him to her home, then she would never allow him to stay adding that ‘there was nothing to gain from him because he does not bring me anything.’ The important thing for her, she said, was to avoid sex with anyone when she is infected.

Against this, however, several people told me sexual desire for men with STD increases and a man experiences constant erection. Although none of the men
took pride in the infection partly because they now know STD and AIDS are associated, such an association of STD with virility seems to remove or lessen much of the stigma attached to STD infection. Manhart et al. (2000:1375) report similar findings in Morocco. Wallman (2000:199) makes the same point that the traditional pre-AIDS use of the phrase ‘disease of the brave’ to refer to STD ‘actually implies something to be proud of - but only among men.’ By contrast, women never take pride when infected with STD, as evidenced by their unwillingness to discuss the infection, and no one praises them when they get infected, even in the pre-AIDS era. STD in women is not a ‘disease of the brave’, but a disease of the weak, both physically and morally; and of the wicked, precisely because it symbolises moral decadence and a woman’s sexuality brought in to the public when it should be consigned to the private domain, the bedroom. Thus a woman who displays her sexuality in public and/or gets infected is dangerous; and can only be condemned, not praised.

In some cultures, for example, in Nigeria and Liberia, there is the belief that in order for STD infected person, especially a man, to be successfully cured, he must sexually transmit the disease (Green, 1994 cf. Moss, et al., 1999:109). And among the Luhyia of Vihiga, Kenya there is the belief especially among traditional healers that for a man to get completely cured he should ‘give out’ the STD infection by having sexual intercourse with preferably 3 women (Moss, et al., 1999:109). In this ritual sex it is believed that only one woman, the first one, will get the disease. Undoubtedly, this is based in part on traditional beliefs about disease causation.

8.3. Preventing and managing HIV/AIDS

The people of Mwala are acutely aware of the presence of AIDS. They know it is an STD, which is incurable with fatal consequences. They also know a number of strategies that they can employ to prevent HIV/AIDS infection.
8.3.1. Avoiding ‘going outside’/sex with ‘strangers’

The best prevention strategy is to avoid ‘going outside’ (i.e. sex outside of marriage) and/or avoiding sex with strangers. Perception of strangers in the context of sexual relations is varied. Strangers include people that one does not have proper information about their past or current sexual behaviour. Within the local area, therefore, a known man or woman may not be treated as a stranger in the context of sexual relations. The implication is that he or she can be trusted. For example, some male informants said that they prefer to have sexual relationships with rural/village women (*eitu ma mashambani*) because they know them unlike those in Mwala and other towns whom they believe have many sexual partners. This gives a false sense of ‘security’ in the context of sexual relations because the urban and rural boundaries are fluid as there is constant interaction between people in both places. Men and women themselves said that ‘town’ men could ‘spoil’ girls. Perception of rural women as morally pure and less polluted in times of AIDS was also found to be common among men in urban Kenya (Nzioka, 1994). In my study many people felt that religious commitment could strengthen morals thereby acting as a preventive strategy. The general feeling was that AIDS has made many people more religious and the married less prone to extramarital affairs.

For young and unmarried people, delaying sex debut is seen as a good preventive measure. Delaying sex debut reduces the chances of having many sexual partners in one’s sexual life. This has two benefits: it reduces the risk of STD/HIV/AIDS infection; and it helps young people avoid ‘mixing blood’ with many sexual partners. Having sex with many partners especially older ones weakens a young girl’s blood and spoils her future chances of having children (see chapt.4). Even though a few people said the best strategy was to avoid sex altogether, most did not think abstinence is a feasible option. The married must have sex for procreation and/or pleasure. Abstinence is not a feasible option for the young
unmarried because 'they have hot blood'. Indeed, a widow wondered whether it was possible for one 'not to have sex unless they are not normal.' In the circumstances some people see condoms as an option, especially for the young and unmarried, though also less popular.

8.3.2. 'Technologising' sex: how much trust is there in Trust condom?

In spite of the church opposition, condom use is one of the major strategies officially adopted in Kenya to deal with the AIDS epidemic (NASCOP, 1999; MOH, 2001). Some people see condoms as an alternative for the young and unmarried if they cannot abstain from sex until they marry. Marriage does not always provide protection for the married if they do not remain ‘inside’ (see also Moses et al., 1994:1655). For the men who cannot stop going ‘outside’, it is better to use condoms than to bring AIDS home. That is, they can be used in outside relationships; with partners whom one does not trust but not at home because this is where more trust is (see also Bujra, 1999). The case material I have presented in this thesis, however, provide compelling evidence that trust is also broken at home.

Condoms could be used as a last alternative by the young married couples if they want to prevent unwanted pregnancy or space their children. Consequently, some said they would advocate condom use as a strategy to control STD and AIDS and as a birth control strategy. When discussing AIDS and childbearing one middle-aged man explained: ‘Those things (condoms) can only be used by the unmarried or young married couples to help them space births since young people of these days seem unable to control themselves.’ Another wondered: ‘Can people use those “things” throughout the year?’ A number claimed to have used condoms. Others said they knew friends who had used a condom. One young man (mentioned earlier in this
chapter.) claimed that he sometimes carries one in his trouser pocket ‘just in case it became necessary to use it.’

Generally a condom is not seen as a preventive measure against AIDS for the married. They are expected to remain faithful to each other, not to go ‘outside’. Numerous studies have reported the difficulties of condom use within the domestic union and other regular relationships because of the meanings people attach to these relationships (Bujra, 1999; Wojcicki and Malala, 2001; Ogden, 1996; MacGrath, et al., 1993; MacPhail and Campbell, 2001; Nzioka, 1994). Within a marriage, condoms symbolise mistrust, unfaithfulness and promiscuity. Rather than induce trust, an essential part of the normative expectations of marriage, they induce mistrust because they imply sexual misconduct whose consequences can be disastrous.7

In Mwala attitudes towards the condom seems to be changing but the symbolic meanings and associated problems remain similar to those already documented. Even the social marketing of the brand Trust condom has not changed much of the people’s negative perceptions of condoms. There are 9 paintings of Trust condom on the walls of bars, shops and restaurants in Mwala town. The painting of the walls was commissioned by PSI/MOH in collaboration with the local town council in 1999. Professional artists hired by PSI/MOH did the work. The role of the council was partly to require all the shop owners to paint afresh their shops before the Trust advert was painted on. Those who could not afford to paint their shops had it done for them by PSI/MOH on condition that they carried the brand Trust condom advertisements on their shops. The shopkeepers were also to be supplied with a free stock of condoms but they had not received them at the time my fieldwork ended. The shopkeepers, however, feared that stocking and

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7 See Daily Nation 10 October 2001 reporting a man who slit the throat of his lover over the use of a condom. They had been drinking in a Naivasha town bar and had agreed to spend the night together. When the woman insisted on condom use, the man declined. A fight started and the man slit open the woman’s throat.
selling condoms would make people think they were immoral or promoting immorality. Condoms are associated with shame and many are embarrassed by the mention of the name condom whose Kikamba translation is *muvila*, which has different meanings in other contexts. For example, it is the same term used for ball.

People say that the message 'Let's Talk' inscribed on Trust condom advert has impacted negatively on young people's sexuality. Some claim that the use of the word 'trust' [kuikiia] means that one does not need to use the condom but only 'trust that all will be well' or 'trust that the person you have sex with is fine'. People, including church leaders say the 'Let's Talk' message is inappropriate because it has corrupted morals of not just young people but of the adults also. Some added that despite many people being literate enough to understand the message, the majority did not carry the message beyond the wall. Thus the very social marketing of brand Trust condom to some extent defeats the very purpose for which it is intended - to create trust in them and their use in the HIV/AIDS prevention.

The theory of conspiracy against Africans by the West continues to linger in the minds of many. Some people suspect that condoms are smeared with the HIV virus that they are supposed to prevent so that Africans will die and the Whites can exploit their resources. This perception builds on the age-old notion that condoms are laced with contraceptives that make men and women infertile. This conspiracy theory in part explains why people in Mwala think condoms are supplied free of charge, something Nzioka (1994) and Ogden (1996) found in their studies. This is reinforced by the fact that 'nothing else is given for free, not even medicine for malaria that is so common in Mwala.' Thus this perception is in the context of a government’s inability to provide essential

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8 See Daily Nation Newspaper 24 September, 2001 reporting results of a survey by Media Institute, that over 50% of the people surveyed believed condoms encouraged immorality.
services such as health care. Recently, the government published a policy document to introduce user fee for condoms in health care facilities and other places such as social places for 'those who need and want to use them' (MOH/NACC, 2001). Perhaps this is one of the strategies to change people's attitudes towards condoms. It would be interesting to see how many people want to use them, much less need them, and at a fee.

Conflicting messages given by media, church leaders and medical personnel about the effectiveness and acceptability of condoms in general and in controlling AIDS in particular has made their use problematic: 'Some people including doctors say condoms can have pores that can allow HIV, others say they are good; the church says other things, whom do we believe? There must be something not good about them and we are not told.'

It was said that condoms could protect a woman from getting AIDS from a man but cannot protect a man getting AIDS from a woman. A young woman reasoned: 'A condom does not cover the entire private area and thus the vaginal fluids can still come into contact with the penis. It can only protect a woman but not the man.' Some said a man could wear two or more condoms but this would increase the size of the penis so that it hurts a woman when playing sex thus making it not only unenjoyable but also dangerous.

A condom can also slip off inside the woman causing anxieties and harm to her health. Besides, a malicious man who wants to infect a woman or impregnate her can secretly pierce a hole at the tip of the condom and pass on the virus. One of the major arguments against condom favoured by young people is that it interferes with sexual pleasure: 'How do you eat a sweet with its cover on, you never test its sweetness; you have to remove the cover.' Other studies have found similar notions - that condoms kill pleasure, for example, Nzioka (1994) and Muganzi (1994) in Kenya, Ogden (1996) in Uganda, Civic and Wilson
(1996) in Zimbabwe, Bujra (1999) in Tanzania. A man in a group discussion wondered: ‘Can one always use condom when they want to have sex!?’ The point to make here is that condoms are still regarded as ‘things’ that make sex, which is supposed to be natural, unnatural; they ‘technologise’ it.

8.4. AIDS in a household and family

Case study 6 - Alik (AIDS)

Alik is a 49 year-old married man with 6 children. The first born, a daughter is married. Compared to his peers, Alik was relatively educated, having attained form two level of secondary certificate. He moved to Nairobi in the early 1970s and was employed as a shop attendant. In mid 80s Alik started his own stationery business in Nairobi. The business did very well and soon he invested in public transport by buying a mini-bus. Alik became wealthy. His wife was living in the rural home while he ran the business in the city where he was also having affairs with two women. Meanwhile Alik’s wife in the village was also having an affair with a man working with a rural development project. In 1993 she became pregnant and people suspected the lover was the ‘owner’ of the pregnancy. Alik got to know about this fairly late partly because he was not coming home frequently. He ‘chased’ her away but after 3 months they reconciled and she returned.

Alik began having health problems in 1995. He got boils and pneumonia that were successfully treated at a private clinic in Nairobi. These problems recurred in early 1996 and were difficult to treat. Alik was tested for HIV and was found to be sero-positive. He did not inform his wife for a long time. In 1996, Alik’s wife aged 43 contracted a strange infection on her neck that never healed. He took her for treatment at a private clinic near Athiriver. She was not tested for HIV/AIDS; indeed, she was never. Her illness continued to become worse and she lost many of her teeth, which was attributed to the rash-like infection. Alik’s illness also worsened and his business suffered as a result of frequent illnesses
occasioning absences and medical costs for himself and his wife. The transport business collapsed and finally he closed down his stationery business and moved out of his residence in Nairobi and went to live in a relatively cheaper town near Athiriver.

Alik’s wife continued to live in the village occasionally coming to town (where he was) for treatment. Alik’s condition remained relatively stable until late 1999 when he suffered from severe diarrhoea. Alik’s health deteriorated rapidly and one of his younger brothers took him to Murang’a district hospital, a public health facility. Murang’a is over 80 km from where the man was living and over 160km from his rural home. This is where his young brother works and could afford medical care and support. Alik stayed in hospital for two months, his condition improved after which he was discharged in February 2000. His brother met all the costs including hospital and medical bills. Occasionally, a male cousin living in Nairobi would send money to help buy drugs. Alik felt a bit better but not for long. His brother now had no money left so he could not afford to buy medicines anymore. Alik suffered from diarrhoea again, heavy sweating and boils on his body. His brother suggested that he go to his rural home and continue with treatment at the local health centre. Alik’s wife although also sick would take care of him. The brother also promised that he would be sending him and his wife money whenever possible.

Meanwhile the husband to Alik’s maternal cousin sent a word that he could take him to a herbalist he said was treating such illnesses. The herbalist had treated a brother to the cousin’s husband suspected to have AIDS and his health condition was said to have dramatically improved. Alik was taken to his rural home in June 2000. At home Alik was almost deserted by his own relatives including his own mother who did not want his [the man’s] family to share household things including utensils. Alik’s mother did not even want his wife to use her axe to split firewood! Ironically, he is the one who bought it for them. The mother
accused his wife of being responsible for her son’s illness. Alik could not understand why his own mother would treat his family so badly when he is the one who used to support them and educated his siblings and found them jobs. Due to illness his family’s food production was extremely poor and they had not had any meaningful maize harvest for two seasons I was in the field because his daughters who cultivated a small piece of land spent most of the time caring for them. Besides, he had sold his two oxen to raise money for treatment and school fees. The few times I visited them, the family was nearly going without meals. Alik spent most of his time lying on a mat outside under a tree. They largely lived on food handout occasionally brought by neighbours and relatives, especially his maternal aunt who brought food and other basics such as salt, sugar, and bathing soap. Alik lamented that during his hey day, whenever he came home from Nairobi, he had many visitors, but few people now visited them to see how they were faring (he even appreciated my visits). He also lamented that if he had resources and strength [vinya] he would have supplied the local primary school with stationery to educate his children.

His second daughter finished secondary school in 1999 but the school withheld her certificate because she owed it huge school fees balance. She was at home taking care of her parents. His third born dropped out of school in Form 3 because of lack of school fees and to help her sister take care of their ailing parents.

In July 2000, Alik’s maternal cousin (wife to the man who had offered to take him to a traditional healer) took Alik and his wife to the herbalist. The herbalist asked for Ksh.1225 (about £122.00) for the man and Ksh.612.50 (£61.00) for his wife. The brother in Murang’a and a younger sister to the maternal cousin who took them to the herbalist met part of the treatment cost. They paid Ksh.1000 for two five litre jerrycans of herbal medicine and were asked to go back after two weeks with the balance and for more medicine. On his part, the healer told me
that AIDS [muthelo] has seven 'divisions' and each division has distinct illnesses. In other words, AIDS is composed of seven illnesses. The healer said that in division one and two, the disease is not 'straight' and not easily understandable while in third and fourth division, the patient has stomach ulcers that cause bad breath and cannot eat well because of lack of appetite. He can cure AIDS if it has not gone beyond division three. He said divisions four and five are problematic because the ulcers have caused a 'big damage inside' with the tongue turning white [kivuti] while there was nothing that could be done if the disease is in division six and seven. The disease in these two divisions, according to the healer, is at an advanced stage and the patient 'is coughing a lot, the chest is painful, having diarrhoea, and feeling like there is fire in his stomach.' The healer diagnosed Alik to be in division six while his wife was in division four coming to five and said after treating them: 'God will do his part.' The healer did not say the two patients would be or would not be cured.

At the time of treatment, Alik had a painful boil around his anal opening and was sweating a lot, had diarrhoea, looked dehydrated with little light hair left on his head. He had unusually good appetite but was very emaciated. Comparatively, his wife was less frail but had also similar symptoms plus the neck infection. After taking the herbal medicine for sometime, his condition and that of his wife improved. Alik thought that he and his wife would get cured. He cited some friends of his who had been very sick but were treated and became well even though people used to say they had AIDS. Alik was trying to remain strong although sometimes his speech would be incoherent. For example, in the middle of my discussion with him he said to me: 'We pray for you to get well soon and for God to be with you.' I do not know whether Alik and his wife went back for more medicines because fieldwork terminated at this point. However, I received information that he passed away at home after an evening meal in November, 2000. His wife passed away during Easter holidays April 2001.
Barnett and Blaikie (1992:87) point out that the impact of AIDS illness and deaths on the household and community is different from other disasters and illnesses because 'it is gradual and incremental and occurs over a period (of time).'</span> Besides draining resources of the household and family, AIDS can strain good social relations within a family and community. To a large extent, illness and death are the concern of not just the family but the community in many African cultures (see Bockie, 1992). AIDS threatens the very communal approach to the way communities organise and gather their resources to deal with misfortunes and disasters. In other words, AIDS is a social disaster because, besides the poverty of health and material that it creates, it also produces social poverty or what Last (1999:77) calls 'poverty of peoplelessness'.
In Conclusion

This section concludes the issues I have been discussing in this thesis regarding childbearing, sexuality and STD/HIV/AIDS. In bringing this discussion to an end, I find Keesing’s remark relevant, that anthropology is more “concerned with meanings rather than measurement, with the texture of everyday in communities, rather than formal abstraction” (quoted in Helman, 2001:270). This thesis began by setting out to examine and understand the meaning of sexual behaviour and childbearing in the context of rising HIV/AIDS.

I) Sexuality

Communities have complex ways of maintaining order in a seemingly disordered social environment. The traditional Akamba sexuality may appear free with little control imposed on it. However, what may seem uncontrolled from outside is not necessarily so from within the community. The traditional Akamba sexuality is more constrained than would appear because of the many dangers associated with sexual contact and conduct, particularly improper sexuality. It is regulated by prohibitions that compel individuals to be careful because their actions could result in their own misfortune or misfortunes of others, including death (chapter three). The partakers had to have self-control and conduct themselves in ways acceptable to the community.

The most important aspect of this sexual freedom is childbearing. The point here is that traditionally, what is at issue is not so much the sexuality, as what to do with it. In a culture where the numbers and types of children are needed for social, economic support, psychological satisfaction, and for perpetuation of one’s name, any man or woman who is not prepared for the future role of bearing children becomes a misfit. In a sense, he or she rejects the society and
the society is likely to reject him or her; it is only through sexual relations that men and women can realise both their reproductive and productive goals. Traditionally, free sexuality is as much to ensure pleasure as it is for effective fertility and reproduction. Repressed sexuality would inhibit these reproductive goals. Thus the Kamba sexuality was designed to improve reproduction and was not as wild and as insatiable as is suggested by some authors who write about so-called ‘African sexuality’ (e.g. Caldwell, et al., 1989).

Historically, when this sort of sexuality is faced with new challenges resulting from the changing socio-political and economic contexts, a number of dilemmas are produced. The dilemmas of STDs and other sexually transmitted diseases of the twentieth century have exacerbated the challenges posed by labour migration. New dangers set in, as the mechanisms for controlling this sexuality became less effective. These have threatened the core of Akamba sexuality, which is childbearing and pleasure.

As elderly people say, sexual relations not with ‘strangers’ was the best way to avoid dangers associated with or occasioned by improper sex. Traditionally, sex with strangers threatens the wellbeing of not just the individual partakers, but others as well, including the yet to be born. The Kamba emphasised sex ‘within’ certain and ‘outside’ certain social boundaries. The society developed this sort of sexuality to keep disasters ‘outside’ the community and ensure successful childbearing.

II) Childbearing

In chapter five I discussed the meaning of childbearing and wellbeing. Childbearing is associated with both strength [vinya] and lack or loss of it. Reproductive strength has to do with producing the desired types of children.
Reproductive success or failure is not about numbers alone; it is also about the types of children. Men and women are considered reproductive failures if they do not have the right number of children. They are also reproductive failures if they do not have the types of children needed. It is the types more than the numbers that seems to be important today.

For women childbearing has further implications; it results in the loss of both physical and social strength. This loss of strength has to be understood against the backdrop of firstly, a changed sexuality that is less controlled by taboos and at the same time threatened by AIDS and, secondly, the diminishing social support from the extended family to help with household chores. It is in these contexts that today women see uncontrolled childbearing as a threat to their health. Consequently, young men’s and women’s attitudes toward the use of contraceptives are becoming positive.

Childbearing remains important to both women and men. However, there are individual variations in terms of sexuality and childbearing. The value placed on children is not necessarily economic as the economic realities of the moment have taught people that the economic benefits of children are not always realisable (see also Bradley, 1997). Universalising these experiences and meanings is to simplify a very complex issue. The individual’s experience is reflected in the way people perceive children. To some, children are a source of joy but to others, it is not always the case given the current economic realities. This is particularly so if the children are many and closely spaced. These variations are important in understanding what childbearing means, and what the role of men is regarding this process. Sometimes when there is undesirable reproductive outcome, such as bearing girl children only, some men blame their wives because they believe that it is women who determine a child’s sex. Thus male children have a social value; they are needed for social reproduction.
I have examined the meaning of poor reproductive outcomes in the contexts of multiple explanations of misfortunes, disease and illness as well as limited resources, particularly health care. The thesis has shown that there is no single model that adequately explains the occurrence of misfortunes associated with infertility. Indeed, cases that I have presented (chapter five section 5.4) show that causes of infertility are multiple. There is a considerable variation between individuals in the meaning and explanation of poor pregnancy outcomes. People shift in their explanations depending on the context and individual experience and so is the blame for childlessness. Childbearing is good and desirable, but it is not without some ambiguity. There are strong feelings that childbearing at the wrong time is bad and brings shame to an otherwise successful reproductive life of a woman.

One of my research interests has been to understand how people manage childbearing and events associated with it. While women generally view reproductive events as not an isolated aspect of their life experiences, my thesis has demonstrated that universalising the experience and meaning of these complex events of a woman’s life is simply to ignore variations that exist between women themselves. There exist subtle tensions between young women and the older ones in terms of their perceptions about childbearing processes, particularly the management of pregnancy. Men and women in Mwala are aware of the dangers associated with childbearing. Women find home birth fulfilling but they also know the dangers that it entails. Hospital birth is not considered free of dangers either. Some unnecessary hospital birth procedures can interfere with a woman’s productive and reproductive capacity.

In this thesis I have put particular emphasis on the role of men in childbearing processes. I have focused on three main areas of childbearing: pregnancy, birthing and postpartum period. This study has shown that the extent of male
participation in these events is constrained by cultural expectations as well as the availability of resources. While this is the case, the study also demonstrates that assessing male participation in terms of physical presence during birthing is largely inadequate. Men are involved in various ways, some of which are subtle. The worry, the anxiety, the contingency planning and generally ‘being around’ are part of male involvement in the birthing process. Generally speaking, however, men’s role is not institutionalised during birthing, but it becomes central in the postpartum period, as it is their responsibility to provide for their wives’ quick recovery. There are, however, variations between men. Young men’s attitudes towards some roles traditionally performed by women are changing.

III) STD and HIV/AIDS

One of the themes that run through this thesis is that of dangers associated with sexual contact and conduct. Part of my thesis has, therefore, been about how the Kamba prevent, cope and manage dangers associated with sex. In the traditional setting improper sexual conduct is shaming (see case study 6.8.) and sex with a stranger is potentially fatal. Sex with a stranger can result in the loss of pregnancy, children or fertility. In the extreme it results in death. Thus these dangers go beyond the individual to affect others.

It is possible that over the years, familiarity with STD, especially gonorrhoea enabled the Kamba to find solutions to the illness without necessarily altering their sexuality. Sexual freedom within the villages as opposed to ‘outside’ helped to keep dangers outside. Sexual and marital relations between people who were not strangers served to avoid contamination, thereby keeping the occurrence of misfortunes at a minimum.
In chapter seven the meanings of ‘ordinary’ STD to men and women were discussed. In Mwala the meaning of STD is different for men and for women. STD is a shameful infection. Even though STD is shaming, men can, and as I have shown in my thesis do, talk about their infection with friends. However, the STD cases I have presented in chapter eight (see e.g. case study 5) also show that married men have difficulties in revealing STD to their wives. They suffer physically and psychologically for they do not know what to say to their wives. But I have also argued that the culture that frees men to be infected with STD also liberates them to the extent that they can avoid infecting their wives. Thus men engage in a variety of behaviours to avoid infecting their wives. For women, however, STD infection causes other problems in addition to those suffered by men. They suffer physically, psychologically and socially. Women suffer STD but do not talk about their infection because talking about it puts their morality into question; it is a stigmatising infection. For these reasons, women manage STD differently.

The emergence of HIV/AIDS in the late twentieth century, which is largely transmitted through sex, has added a new dimension of danger to one of the most creative aspect of human life, sex. HIV/AIDS has brought in a danger different from that posed by STD, though they are both sexually transmitted diseases.

IV) Putting AIDS prevention and management in context

The presence and seriousness of AIDS and its consequences including the fatal nature of the illness seems to lead to changes in the perceptions of AIDS and those afflicted by it. The government has effected measures to control the spread of the epidemic. I have shown in chapter one some of the measures that the government has employed to control AIDS, including education and information, and the promotion of the use of condoms. These measures have
gone a long way in creating awareness of the presence of HIV/AIDS and the way it is transmitted. On 25 November 1999, AIDS was declared a national disaster (see chapter one). Since then, Kenyan politicians, government ministers, administrators, religious leaders, the media, and the medical personnel have seized every opportunity in the public arena to engage in the AIDS discourse. AIDS is, therefore, undoubtedly the illness that is now openly talked about in virtually every social and public space in the country. Talking about AIDS essentially entails talking about sexuality also. In Uganda, political and religious leaders have long been talking about AIDS and this coupled with health education messages has made AIDS appear to people as a ‘common, communal, public health issue’ (Wallman, 2000:198). As in Uganda, the discourse of AIDS in Kenya has focused on AIDS not just as a problem of those afflicted or infected, but also as a public health issue and, therefore, a community health problem that can only be successfully dealt with not just by an individual, but by the whole community.

The people of Mwala are aware and know that AIDS is spread mainly through sex. They are also aware that AIDS is lethal. Some know friends or relatives, neighbours or other persons who have been affected or infected and have died or will die from it. As a young woman (quoted earlier in chapter seven) put it, anyone who does not know about AIDS is a fool. Yet, all those getting infected are not fools. Getting HIV/AIDS means death of the afflicted/infected; those not afflicted are affected by the illness or death of a close relative, friend or neighbour. Making AIDS a people’s problem, a community problem rather than an individual’s problem is an attempt to destigmatise the illness and those infected and/or afflicted by HIV/AIDS, and by extension reduce prejudice against them (also Wallman - personal communication). It is an attempt to retire the moral judgement - that, AIDS is only a disease of the morally bad. The moral boundaries are slowly becoming fluid.
In the early years of the disease, it was treated by both biomedical personnel and the public as a contagious disease as reflected in the way bodies of those who were suspected to have died of it were handled and buried (Nzioka, 1994). Relatives of the infected were also suspects; they became contagious by association. Today, however, people with HIV/AIDS are now accorded better treatment; they are treated with considerable compassion rather than prejudice and fear. Also their families do not always have to negotiate AIDS-free status:

People fear cholera\(^1\) because unlike AIDS, you can get cholera even through greeting somebody who has it. In church we are told how AIDS is contracted. It cannot be transmitted through body contact, but through sexual intercourse with somebody who is infected. Before people used to be scared. During burials the coffin carrying the remains of the dead person (AIDS) would be wrapped up in a black polythene paper bag. We were not even allowed to view the body. Today things are different. They are buried decently and we view their bodies. Friends and relatives visit them in hospital and at home when they are discharged. [32-year-old woman].

The increasing number of people in the recent past openly coming out to declare their HIV/AIDS status is a compelling testimony of the changing perceptions and attitudes toward AIDS, the afflicted and the affected.\(^2\)

But giving people information about AIDS may not be enough for them to avoid behaviours that expose them to risks of infection (Nzioka, 1994) unless this is dealt with in the context of other things that happen in people's lives.

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\(^1\) See for example, Daily Nation 15 January 2001 Correspondent reporting six people who died of cholera outbreak in Mwala.

\(^2\) See for example, East African Standard Newspaper 20 February 2001 in which Ngero Siteti reports a 35 year-old widow in Kisumu declaring in public that she is HIV positive. She also reported that her last born had the virus. Her husband died of AIDS. The widow refused to be inherited. Daily Nation Newspaper 22 September 2001 Correspondent reporting a mother of 3 declaring at a public meeting to launch Constituency AIDS Control Committee in Murang'a Central Kenya that she has AIDS and her husband died of the same in 2000; Also see footnote 5 chapter 7.
(Wallman, 1999; 2000). Otherwise the AIDS campaign may have unintended consequences:

Here people do not bother with anti-AIDS campaigns any more. They say everyone knows about AIDS. They say AIDS is like many other diseases. If one is to die through AIDS, then that is it; people do not die twice! (24-year-old unmarried and unemployed man).

Statements as the above are loaded with meanings. People do have other, perhaps more pressing concerns including poverty, school fees, unemployment, drought and famine, food and water shortages, and endemic and 'serious' diseases such as malaria which account for most of the morbidity and mortality in Mwala\(^3\) and Machakos District as a whole (ROK, 1996:54). Nationally, Machakos is top on the list of districts whose rural population is poor - over half of the households is categorised as poor (ROK, 1999:16). The poor have little or no education, are unemployed; they have weak social capital, lack clean and safe drinking water; they have no access to proper health care; they lack money; they lack food and have high incidence of malnutrition; and generally lack the material means to improve family circumstances. Poverty, therefore, begets diseases and illnesses, just as disease and illness produce poverty (see AIDS case study); both result in despair and loss of interest in life.

In the course of my fieldwork, I heard many people especially the young say ‘AIDS is like an accident,’ or ‘AIDS is a sickness of radio.’ ‘AIDS is like an accident’ is an idiom that points to the helpless situation in which the majority of the people of Mwala, indeed Kenyans, find themselves when travelling by public means which they often have no control over in terms of speed and carrying capacity; the conductor overloads the vehicle and the driver goes too

\(^3\) In 1999, for example, out of 13,027 recorded patients seen at Mwala health centre, 3876 were malaria cases accounting for nearly 30% of all out-patient cases.
fast (see Swinderski, 1995 on road accidents in Kenya). With regard to HIV/AIDS, it implies that some individuals do adopt fatalistic attitudes toward the disease and either assume they 'cannot control the risk of catching it' or they are not personally responsible for the infection and should, therefore, not be personally disgraced (Wallman, 2000:198). Individuals thus shift location of the blame of AIDS infection from their own shoulders to the society or, more specifically, to the 'drivers' of the economy who create conditions of poverty that force people to engage in behaviours that expose them to dangers of infection.

To construct AIDS as 'a sickness of radio' is to point to 'public ownership' of the disease as radio is one of the leading sources of knowledge about AIDS (KDHS, 1998). But also it is to suggest, at least in part, that people may listen to these messages but see little in them other than that they are part of government information supply - it is just normal to hear such messages. This argument is supported by soaring HIV/AIDS infections in the country even though knowledge about AIDS and the key transmission mechanisms appears to be universal - at 99 per cent for both men and women (KDHS, 1998; NASCOP, 1999:37). There are AIDS programmes on the national broadcasting station, in English, Kiswahili and cultural languages, in this case Kikamba. As I pointed out earlier, knowledge is also based on people's first-hand experiences - personally knowing a neighbour, a friend or relative who has died of AIDS (NASCOP, 1999:37) or will die of it.

AIDS information also contains STD information. However, a close examination shows that much emphasis is put on HIV/AIDS as a community/public problem while STD remains an individual problem; STD still remains a private disease, a moral one that is shameful and not talked

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4 Fatal road accidents are common in Kenyan roads; are reported every other day in the print and electronic media. The accidents involve mainly buses and mini-buses popularly known as
about publicly except through AIDS discourse. But also it is because in Mwala, indeed in Kenya (Moss, et al., 1999) as in Uganda (Wallman, 2000:198), the emergence of HIV/AIDS has overshadowed the seriousness of STD. There is more information and better records for AIDS than there are for STD, both at the district and national level (personal communication with the District AIDS and STD coordinator, DASCO, and a NASCOP official). People in official and non-official circles, including my informants, talked more about AIDS than STD, a suggestion that the concern for STDs has diminished with the emergence of AIDS. Over-emphasis of the dangers of AIDS at the expense of diminishing the perception of STD as serious illness may, in the long run, be counter-productive (see also Moss, et al., 1999). Indeed, the Government's Policy Framework Paper on AIDS of 1997 says everything about AIDS but little about STD (MOH, 1997: 162). On the other hand, some people do not think there is any relationship between STD and AIDS. Any perceived connection of STD with AIDS may keep people away from STD treatment for fear that they may have HIV/AIDS; they would rather manage it by not knowing about their AIDS status. In fact, some people feel it safer not to worry about, much less know, their HIV/AIDS status. This may be understood as a form of denial (Wallman (2000:198).

A lot of emphasis and resources have been invested in the social marketing as well as the provision of condoms. While my research suggests that attitudes toward condoms as prophylaxis for HIV/AIDS may slowly be changing, their success in the control of the AIDS epidemic is open to conjecture. My research has shown that condomisation is not considered an option by the majority. Even if condoms were acceptable to the majority, there would still remain a problem because sex is not just for pleasure; sex is also for procreation. The statement made by a man in a group discussion (quoted

*matatu*
earlier in chapter eight), wondering whether it was possible for men to use condoms every time they had sex carries a deeper meaning.

Less effort has been directed to the ‘real’ cause of the spread of AIDS, which is not sex, but the social and material conditions that people, especially the young live in. Many have little or nothing to occupy themselves with; they have no employment and have no means to meet their requirements. Simply put, poverty seems to be the main culprit. It is to this that part of the attention and campaigns against AIDS should be directed.

AIDS has altered the way men and women have viewed sexuality. My elderly informants but also others talked of sex ‘outside’ as being dangerous. Sex ‘inside’ has been given a new and greater meaning. Sex outside is sex with a stranger, which may be exciting but also dangerous. Sex inside is not free of danger but the dangers are few. One of the reasons, I think, my elderly informants discussed with me so freely about the traditional Akamba sexuality is that they intended to give me this wisdom and knowledge so that it can be passed on to others so as to avoid dangers associated with sex with strangers. As an ‘insider’ turned ‘outsider’, I was also in the danger of forgetting this cultural value. To them I am grateful for teaching me this aspect of the Akamba culture. This is the message that I would carry as a concluding remark in this thesis: That ‘outside’ sex or sex with a ‘stranger’ is potentially lethal; sex ‘inside’ is safer and requires self control from both men and women. This seems, in the Akamba context, and by extension the wider Kenyan context, to be the best strategy to control and avoid disasters such as that posed by AIDS.
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### Appendix – Glossary

**Kikamba word**

<table>
<thead>
<tr>
<th>Kikamba word</th>
<th>English meaning in this context.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bomu (also Kiswahili, also English bomb)</td>
<td>AIDS</td>
</tr>
<tr>
<td>Eitu ma mashambani (Mashambani also Kiswahili)</td>
<td>Rural girls (seen safe, no STD)</td>
</tr>
<tr>
<td>Homa (also kiswahili)</td>
<td>Gonorrhoea</td>
</tr>
<tr>
<td>Ilombo</td>
<td>Many men having sex with one woman</td>
</tr>
<tr>
<td>Ivu Kwitika</td>
<td>Miscarriage</td>
</tr>
<tr>
<td>Ivyuuya</td>
<td>Food for recuperation</td>
</tr>
<tr>
<td>Kana Kukelana</td>
<td>Baby not well positioned in the womb</td>
</tr>
<tr>
<td>Kavithe</td>
<td>STD</td>
</tr>
<tr>
<td>Kilumi</td>
<td>Kamba traditional dance</td>
</tr>
<tr>
<td>Kisonono ni kituua mundu</td>
<td>Gonorrhoea can castrate a man or cut his penis</td>
</tr>
<tr>
<td>Kisonono</td>
<td>Tuberculosis / coughing / chest problems</td>
</tr>
<tr>
<td>Kithui</td>
<td>A woman has no say – cannot object</td>
</tr>
<tr>
<td>Kiveti Kiingulyo</td>
<td>A woman</td>
</tr>
<tr>
<td>Kiveti</td>
<td>A boy is a dog’s younger brother.</td>
</tr>
<tr>
<td>Kivisi ni muinae wa ngiti</td>
<td>Avoid sex with many sexual partners.</td>
</tr>
<tr>
<td>Kuekana na tambaya</td>
<td>Crossing boundaries / Sex outside marriage</td>
</tr>
<tr>
<td>Kukila muvaka</td>
<td>Extra marital sex/sex with many partners</td>
</tr>
<tr>
<td>Kukuna mithumbi</td>
<td>To see/ bringing presents for baby after birth</td>
</tr>
<tr>
<td>Kukwata mwana</td>
<td>Passing blood stained urine.</td>
</tr>
<tr>
<td>Kumaa Nthakame</td>
<td>Bilharzia</td>
</tr>
<tr>
<td>Kumaa nthakame</td>
<td>Developing breasts</td>
</tr>
<tr>
<td>Kumea nondo</td>
<td>Still birth</td>
</tr>
<tr>
<td>Kusyaa kana katevo</td>
<td>Birthing is painful</td>
</tr>
<tr>
<td>Kusyaa kwii woo</td>
<td>Prolonged labour</td>
</tr>
<tr>
<td>Kusyaa na vinya</td>
<td>Poor pregnancy outcome/stillbirth/caeserean.</td>
</tr>
<tr>
<td>Kusyaa nai</td>
<td>Breech birth</td>
</tr>
<tr>
<td>Kusyawa na mauu</td>
<td>Little girl having sex with many older people</td>
</tr>
<tr>
<td>Kutalingwa</td>
<td>Miscarriage</td>
</tr>
<tr>
<td>Kutambaika</td>
<td>Having sex with anybody</td>
</tr>
<tr>
<td>Kutangatanga (also kiswahili)</td>
<td>Walking leg apart due to STD (gonorrhoea)</td>
</tr>
<tr>
<td>Kutembea mauu matanda mele</td>
<td>Sex with many people</td>
</tr>
<tr>
<td>Kutembea nai (Kutembea also in Kiswahili)</td>
<td>Caesarean section</td>
</tr>
</tbody>
</table>
A girl looking attractive / maturing
Taking hot foods to clean the womb after delivery
Sex with a stranger
Becoming close (Having sex)
Menstruation
Cleansing rituals for miscarriage and breaking sexual taboos
To have sex
Cutting and tying umbilical cord
Private parts (genitals)
Tubal ligation.
Having sex with someone one should not have.
Having sex with many different people
Menstruation
STD/Sick private parts.
Backache
Menstruation
to be moody
To stop having sex with wife in late pregnancy
Menstruation/menstrual cycle.
Menstruation
To pick a baby – TBA assisting in delivery
Herbal medicine for treating ulcers
Pelvic area
Evil spirits.
Infertility.
Having extra marital sex
Ova getting finished / infertility from use of contraceptives
Ova
STD/Ilness of sin.
Pelvic area
Traditional treatment that prevents conception
AIDS
Rules / prohibitions
Falopian tubes; Veins
Menstruation
Condoms
Gloves
STDs
Measles
Herbs for treating common colds
<table>
<thead>
<tr>
<th>English</th>
<th>Swahili</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muluo</td>
<td>STD (Gonorrhoea)</td>
</tr>
<tr>
<td>Munduume</td>
<td>A man</td>
</tr>
<tr>
<td>Mung'athuko</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>Musyawa</td>
<td>natural infertility / genetic infertility</td>
</tr>
<tr>
<td>Mutaa na mukondu</td>
<td>Herbs for treating stomach pains when mixed together</td>
</tr>
</tbody>
</table>

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<tr>
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<tr>
<td>Muthelo</td>
<td>AIDS</td>
</tr>
<tr>
<td>Muuku</td>
<td>Yellow fever</td>
</tr>
<tr>
<td>Mwanake</td>
<td>A young man</td>
</tr>
<tr>
<td>Mwiitu</td>
<td>A young woman / girl</td>
</tr>
<tr>
<td>Mwiue</td>
<td>Co-wife</td>
</tr>
<tr>
<td>Ndanda</td>
<td>semen that does not contain mature sperms.</td>
</tr>
<tr>
<td>Ndetema ya kung'athuka</td>
<td>Celebral malaria</td>
</tr>
<tr>
<td>Ndetema</td>
<td>Malaria</td>
</tr>
<tr>
<td>Ngai syake</td>
<td>Ancestral spirits.</td>
</tr>
<tr>
<td>Nyungu ya mwana</td>
<td>Uterus</td>
</tr>
<tr>
<td>Tamaa ya nza (tamaa also Kiswahili)</td>
<td>Extra marital sex.</td>
</tr>
<tr>
<td>Tambaya</td>
<td>Prostitution</td>
</tr>
<tr>
<td>Ualyuku wa mwii</td>
<td>Physical changes during adolescence</td>
</tr>
</tbody>
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<td>Uao</td>
<td>Utem</td>
</tr>
<tr>
<td>Ukimwi nuvingaa musyi</td>
<td>Extra marital sex.</td>
</tr>
<tr>
<td>Ukwati</td>
<td>STD</td>
</tr>
<tr>
<td>Ula wia woo</td>
<td>Itching urethra</td>
</tr>
<tr>
<td>Uoi</td>
<td>Bleeding disease/ Bilharzia.</td>
</tr>
<tr>
<td>Uwau muthuku</td>
<td>Disease of the radio (AIDS)</td>
</tr>
<tr>
<td>Uwau wa kunyeewa</td>
<td>All traditional healers are witches</td>
</tr>
<tr>
<td>Uwau wa kuuw'a</td>
<td>Man strength; Sperms</td>
</tr>
<tr>
<td>Uwau wa radio</td>
<td>Having sex with somebody with STD.</td>
</tr>
<tr>
<td>Vai mundu mue ute muoi</td>
<td>Heavy menstruation</td>
</tr>
<tr>
<td>Vinya wa munduume</td>
<td>STD.</td>
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<tr>
<td>Wakomana na mundu muwau</td>
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<tr>
<td>Wia woo mwingi</td>
<td></td>
</tr>
<tr>
<td>Zinaa (Kiswahili)</td>
<td></td>
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</tbody>
</table>