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HIV/AIDS, FOOD INSECURITY AND THE BURDEN OF HISTORY:

An ethnographic study from North Eastern Tanzania

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DEDICATION

This thesis is dedicated to Nemu, Maria, Mary, Bi Tembu, Charles, Mathias, Benson, Shali and Bi Mbuguni, whose lives and tragic deaths during my fieldwork changed my life.

University of Cape Town

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ABSTRACT

Uneven land distribution and food insecurity in Tanzania adversely affects rural economies. For people living with HIV/AIDS, the burden of poverty and the impossibility of consistent diets create serious obstacles for the use of life saving drugs such as antiretrovirals. The main argument in this study draws on ethnographic research conducted in Maramba, a rural community in north eastern Tanzania, with poor people living with HIV/AIDS who struggled to obtain food, care and support in spite of the availability of free treatment.

The study is based on a year of ethnographic fieldwork. Its analytical framework is structured on theories of political economy of health. It traces both global and local historical processes from colonialism to the postcolonial period, in re-structuring the social relations of production and reproduction and their effects on health and food security in the community studied. It shows how these processes formed the basis of food insecurity, contributed to the vulnerability to HIV transmission, and affected poor households' capabilities to effectively absorb the impacts of HIV/AIDS. A complex farming system in the community affects poor households' capacity to produce food. As a result, household members, including the sick, are forced to use famine survival strategies, activities that task their fragile bodies. Poor people are caught between maintaining their health through antiretroviral treatment and ensuring household food availability, forcing themselves to forego important clinical requirements. When people on treatment die, their deaths lead to debates filled with uncertainty and without clear conclusions about the effectiveness of ART. Further, the long-term processes of social and economic differentiation suggest that social relations of support, especially family networks that poor and HIV/AIDS affected households could depend on for care and support in times of hardship, are compromised. The study concludes with the need for critically engaging contextualized research that locates the social and economic needs of the HIV/AIDS affected population as people rebuild their livelihoods in the long term

CHAPTER ONE

INTRODUCTION

HIV/AIDS remains a critical health problem affecting the wellbeing and livelihood of the majority of poor people in sub-Saharan Africa. An estimated 70 percent of global HIV infections are found in this region. The impact of HIV/AIDS is one among many factors that intensify the effects of poverty. The effects of the epidemic in the Tanga region of Tanzania where this study was conducted have been devastating. Most individuals are touched by the epidemic, many having lost family members. Current research argues that the way forward is to broaden access to ARV treatment¹ (Nguyen 2005, Geffen 2010, Roura et al 2009i). My fieldwork in the village of Maramba indicates that poverty and the politics of land distribution contribute to a climate where biomedical treatments, such as ARVs, are insufficient to combat sickness. Poor nutrition as a result of minimal access to land and reduced food production not only increases disease progression, disables labour participation, but also acts as a barrier to ARV adherence. Members of poor households accordingly lack the appropriate resources to provide sufficient support to those who are sick.

Of the 2.6 million people living with HIV/AIDS in Tanzania, 130,000 received antiretroviral treatment (ART) during the period 2004-2007 (Somi et al 2009). Current literature shows that in sub-Saharan Africa the uptake of prescribed doses of ART has reached more than 90%, a number said to exceed the levels of adherence documented in North America (Ware et al 2009, Mills et al 2006), which dispelled initial fears that adherence would not be feasible in settings of extreme poverty (Harries et al 2001, Popp and Fisher 2002).

Despite these achievements this study questions the impact of structural inequalities among poor households affected by HIV/AIDS in a rural community in north eastern Tanzania. My research

¹ Also known as HAART (highly antiretroviral treatment), or ‘combination therapy’ which is a made up of different antiretroviral treatments. It works by strengthening the immune system through inhibiting the replication of HIV, which in turn slows down its progression and reduces or eliminates symptoms. www.tac.org.za accessed September 5, 2010, and www.nacp.co.tz accessed December 10, 2008.

broadens the work of critical medical anthropology (CMA) as a means to highlight local configurations of illness in the everyday. (Baer, Singer and Susser 1997; Setel 1999).

The role of food security and nutrition in determining wellbeing for people with HIV/AIDS is well established (Piwoz and Preble 2000; Haddad and Gillespie 2001; Gillespie and Kadiyala 2005), as is the importance of access to farmland for rural household reproduction (Maxwell and Wiebe 1999). This is yet to be well documented and understood in Tanzania. My research seeks to analyze the relationship between access to farmland for people with HIV in a community with contested land ownership patterns. My guiding research questions revolve around the general themes of food insecurity, ARV treatment, and models of caregiving.

This study has been inspired by ethnographic work on the ‘social life of medicines’ (Whyte, Van der Geest and Haddon 2002) which explores how people imbue medicine with social meaning. It builds on the idea that adherence to ART medication is overdetermined by socio-economic factors, and is not always a simple case of following a medical protocol. ARVs arrived in Tanzania at a time when HIV/AIDS had already claimed many lives, creating uncertainty and fear for remaining household members. The question of family and community care and support which gained momentum during the pre-ART era seems to have boiled down, again, to the assumption that surviving family members could now support each other since ART had brought the sick ‘back from the dead’ (Russell et al 2007). I revisit this question by situating the phenomenon in a community in Tanga, with the absence of a modern social welfare system. Like the research conducted by Oleke, Blystad and Rekdal (2005) among the Langi of northern Uganda, I link the current configuration of care in households within an historical framework that accounts for this absence.

HIV/AIDS in Tanzania

The literature on HIV/AIDS in Tanzania and indeed in similarly affected countries can be roughly divided into two periods: pre- and post- ART. Before I engage with the current debates around AIDS treatment and food security, I revisit the period before ARVs to shed light on how social scientists have addressed the epidemic, and how my study in north eastern Tanzania

articulates with their works. After the discovery of the first AIDS cases in Kagera region in north western Tanzania in 1983, a National AIDS Task Force was established in 1985 by which time all regions in the mainland had recorded a case (NACP 1994). By 1995 there were significantly more cases of AIDS in Tanzania (over 100,000) compared to any other African country, with total cases reaching 600,000 by 1999 (Setel 1999). This demonstrated the need to invest in more epidemiological, behavioural, as well as social studies, to document local people's experience and knowledge of the disease at interpersonal and community levels (Setel 1999: 18-19).

Studies during the pre-ART period in Tanzania and other African countries, concentrated on situating and describing the notion of risk and vulnerability among different population groups, cultures and settings, and explaining the experiences of the sufferer (Setel 1999; Haram 1995; Dilger 2003; Weiss 1993).² They aimed to transcend biomedical and epidemiological reasoning that was said to reduce explanations to individual behaviours, such as frequency of sexual intercourse, condom use, number of partners, and age of sexual debut, using mainly knowledge, attitudes and practices (KAP) surveys (Kapiga et al 1991; Mwaluko and Urassa et al 2003; Klepp et al 1994). Biomedical approaches assumed that other groups were not in danger of transmission, creating a discourse of blame and stigmatization and resulting in discrimination towards certain groups and individuals (Setel 1999; Dilger 2003). Risk was described by epidemiologists as 'something impersonal, linked to statistical inference and probability' (Haram 2005: 3). However, focusing on individual risk was considered redundant, the assumption being that 'a well informed individual will strive to reduce risk and, in the context of AIDS, will choose not to be involved in risky sexual behaviour' (Haram 2005; also Ingham, Woodcock and Stenner 1992). Despite these surveys, researchers could not explain the increase in rates of HIV transmission despite the increase in people's knowledge about the causes of HIV infection and the use of protection such as condoms (Dilger 2003; Setel 1999; Craddock 2004).³

² Anthropological literature on early incidence of HIV/AIDS in Tanzania is undeveloped and available works focus on a handful of regions, notably Kagera, Kilimanjaro, Arusha and Dar es Salaam.

³ The delay of social science researchers in studying the pandemic in Africa was also linked to the silence of politicians who associated AIDS with economic interests and international public image, especially in tourism and investments (Schoepf 2001; also Nzokia 1994). Further, HIV was construed as a biological problem involving only ministries of health (NACP 1994).

For anthropologists the concern was the fact that epidemiologists ignored other contextual social as well as cultural processes that increased risk of infection (Schoepf 2001; Douglas and Wildavsky 1982; Douglas 1994). There was a need to move from 'at risk' approaches to 'risk in context' approaches, targeting individuals as social persons (Haram 2005: 9). In Tanzania I have found useful anthropological studies conducted on these debates among different social, cultural and geographical settings, for example the Haya of north western Tanzania (Weiss 1993; Kaijage 1993, 1989); the Meru of northern Tanzania (Haram 1995, 2005); the Chagga of Kilimanjaro (Setel 1996, 1999); the Luo of east of Lake Victoria (Dilger 2003, 2006, 2008), the Sukuma south of Lake Victoria (Mshana et al 2006i) and among the Shambaa in Lushoto, Tanga region (Bujra 2000). The aim was to discover how local explanations of disease causation and the different sets of possibilities evolved in their social-cultural environment. Generally, these studies argued that individual behaviour in negotiating sexual relations was affected by contextual factors such as power and gender, among others. The dominant position of men in the spheres of economy and culture was seen as paramount in explaining 'risk' and 'vulnerability'. For example, among the Meru of Arusha, women allegedly failed to negotiate condom use, fearing branding as prostitutes. In the Luo, infection was explained in the existing complex cultural, religious and moral norms that included witchcraft and taboo violations (Dilger 2003; also Mshana et al 2006i). A common feature of these studies was the role of modernity and globalization characterised in migration processes and socioeconomic disparities. This made it difficult for the disenfranchised, especially women, to avoid infection as a result of the 'lures of modernity' (Diliger 2003; also Lyons (2004).

On linkages between broader social economic factors and cultural notions of HIV infection and individual 'moral agency', I have been inspired by the descriptions in Philip Setel's *A Plague of Paradoxes: AIDS, culture, and demography in northern Tanzania*. Setel combines an array of approaches such as demography, social history and anthropology, epidemiology and political economy, to explain how HIV/AIDS emerged and spread in the Kilimanjaro region during the 1980s and 1990s. He shows how modernity, with its origins in colonial and postcolonial relations, brought internal contradictions to the region, hence 'paradoxes', although for many it was perceived as a form of development and much associated with vulnerability (Setel 1999: 2-3). "Vulnerability" and "risk" he argues, were 'as much born out of demographic and economic

necessity as individual behaviour' and to understand the nature of AIDS in Kilimanjaro is to follow its history as the disease was 'enmeshed in *historically shaped* social environments' (1999: 4, italics original). For example, he shows how the economic crises of the late 1970s, 1980s and 1990s that engulfed Tanzania, further marginalized youth and especially women, who were historically excluded from ownership of the means of production such as land, and accordingly were forced into prostitution, becoming vulnerable to HIV. Others, in their pursuit of independence and economic freedom, cohabited with married males and entered into informal relationships (cf. Haram 2004). Equally, evidence about the situation of women and social economic histories of differentiation has been documented in other places in Tanzania, especially the Kagera region (Tibaijuka, 1997; Kaijage 1989, 1993; Weiss 1993)⁴ and as far away as Haiti (Farmer 1992). In this study I consider also the importance of social and economic history in tracing the spread of HIV in Maramba and I compare my findings with some of these studies.

Parallel to works around transmission and vulnerability to HIV, a body of scholarly work from different disciplines such as economics, raised the alarm about the socioeconomic impact on affected households. The debates around the impact on poor households were straightforward: long term illness diverted the labour of household members, especially women, to nursing the sick and dying, destroying household economies (Tibaijuka 1997; Mtika 2001). By 1995 AIDS was the leading cause of death among adults in three districts in Tanzania (MOH and AMMP 1997, cited in Setel 1999: 1). The deaths of adult members who were breadwinners caused severe strain on remaining families' ability, particularly that of older women and children, to produce food. This contributed to a steep decline in agricultural output and affected social and economic mobility (Tibaijuka; 1997; Gillespie 2006; Bryceson and Fonseca 2006; Gillespie and Kadiyala 2005; Haddad and Gillespie 2001; Barnett and Whiteside 1992; Loevinsohn and Gillespie 2003). The combination of HIV/AIDS and food insecurity has been called a 'new variant famine' by De Waal and Whiteside (2003). Scientific and nutritional studies show HIV positive people have higher dietary requirements since nutritional deficiencies negatively impact

⁴ Prostitution among the Haya women of Kagera has been noted to be a long historical phenomenon following oppressive gender relations from the pre-colonial and colonial period, without the inheritance rights to land including property (Kaijage 1993). While Swantz categorized prostitution as constitution of 'their sense of independence' from sexual exploitation and oppressive males (Swantz 1985, cited in Kaijage 1993: 290) Kaijage refers this labelling to 'feminist reductionism' and argues this phenomenon must be situated in a broader colonial transformation the society was going through, especially the fact that the ultimate ambition upon returning from prostitution for these women was acquisition of real estate over above other material goods (Kaijage 1993: 290).

on the immune system. Further, food insecurity accelerates susceptibility to infection and transmissions, and accelerates the decline to full blown AIDS (Kadiyala and Gillespie 2004; Gillespie and Kadiyala 2005; Haddad and Gillespie 2001; Stillwaggon 2006).

Home care for HIV/AIDS patients

The impact of HIV/AIDS on the health system from the late 1980s through the 1990s was catastrophic and raised concern about its capacity to care for people with AIDS. By 1999, data from hospitals in Tanzania showed that almost 50 to 60% of hospital beds were occupied by patients with HIV/AIDS related illnesses (Garbus 2004). This overstretched the meagre resources allocated to the health sector. According to Osborne et al (1997) the decision to shift care in sub-Saharan Africa to families by the mid 1990s was mainly due to the lack of treatment available to AIDS patients. This came at a time when structural adjustment programmes, including the reduction of government support for social and health services, were underway (ibid; also Tibaijuka 1998; Lurie, Hintzen and Lowe 2004; Kanji, Kanji, and Manji 1991; Sanders and Sambo 1991).⁵

Even before this ‘official’ shift took place, studies had been documenting and debating the effects of AIDS on traditional African welfare support networks, especially the clan and the extended family network (Tungaraza 1994; Urassa et al 1997; Ankrah 1993; Williamson 2000; Seeley et al 1993; Lloyd 1988; Barnet and Whiteside 1992; Tibaijuka 1997; Ntozi 1997). These debates have been twofold. On the one hand the African family network is argued as ‘coping’ satisfactorily with the impact, and supporting affected members despite the material, psychological and social problems facing the poor (Ankrah 1993; Ntozi 1997; Williamson 2000). Recently, studies on community ‘coping strategies’ further argue that HIV/AIDS may ‘portend more, not less community cohesion’ (Foster 2007: 60; cf. Besley 2005), citing the role of social support systems like grassroots organizations and nongovernmental organizations, and that despite the dwindling capacity of these networks, safety nets will continue to function ‘even when burdened by large numbers of AIDS-affected households facing destitution’. (Foster 2007:

⁵ National Multi-Sectoral Strategic Framework on HIV/AIDS of Tanzania emphasizes this decision observing that HIV positive people are a burden to the facility based health-care system (URT/TACAIDS 2003: 48).

60). On the other hand, scholars have documented the failure of affected communities to adequately support family members (Tibaijuka 1997; Tungaraza 1994; Seeley et al 1993) to the extent of causing severe food insecurity especially when the problem impacts many households in a community (Mtika 2001). Emerging studies have questioned the sustainability of safety nets, especially from donor funded organizations, given funding dynamics and prevailing poverty (Belsey 2005). However, anthropologists and sociologists have argued that there is a need to situate the extended family and other safety nets in their historical contexts (Madhavan 2004; Oleke, Blystad and Rekdal 2005; Nguyen and Peschard 2003; Bray and Brandt 2007; Emirbayer and Goodwin 1994; Hunter 1990).

ART and anthropology

Since the availability of ART, the tide of studies seems to have shifted. Recent debates in anthropology have focused on the social lives of ARVs and biomedical protocols and how patients and the community negotiate treatment (Van der Geest and Hardon 2006; Ezekiel 2009; Meinert et al 2009; Nguyen 2005). A range of debates in medical anthropology following the availability of ARVs have focused on new forms of sociality and subjectivity emerging as a result of globalization. These studies show how the epidemic has led to global social movements forming alliances to ensure wide access to treatment (Friedman and Mottiar 2004).⁶ These have been conceptualized differently as ‘therapeutic citizenship’ (Nguyen 2005), ‘bio-citizenship’ (Rose and Novas 2005) and ‘pharmaceuticalization of citizenship’ (Biehl 2007). Paul Rabinow's (1996) concept of ‘bio-sociality’ has been instrumental in formulating these concepts, describing it as new forms of collectives and groupings that are shaped in relation to a biological or medical shared identity.

According to Nguyen, these forms of citizenship have emerged as a response to the paucity of availability of ART to the poor (Nguyen et al 2007: 31; also Richey 2006)⁷. Specifically, ‘therapeutic citizenship’ is designated as a ‘political claim to belonging to a global community that offers access to treatment for the ill, as well as a personal engagement that requires self-transformation’ (Nguyen

⁶ I am aware of the literature on the early but long history of the scientific development of ART before they were made affordable to the poor in developing countries, when these drugs were still accessible to the few rich persons in these countries, creating inequities. Examples exist from Tanzania (Mshana et al 2006) and Uganda (Whyte et al 2004).

⁷ Nikolas Rose and Carlos Novas term these forms of activism to fight for access of services as ‘rights bio-citizenship’ (Rose and Novas 2005).

et al 2007: 34). He cites experiences from West African countries such as Burkina Faso and Cote d'Ivoire where local organizations in collaboration with European activists became a vanguard for others in the country to obtain ARVs by holding UN organizations accountable (2005: 135). South Africa is among the most cited countries where the notion of 'therapeutic citizenship' and the 'moral politics of HIV/AIDS activism' has been said to function positively (Geffen 2010; Robins 2004, 2006). In that country the scaling up of antiretroviral treatment faced a number of obstacles globally and nationally. AIDS activists such as the Treatment Action Campaign (TAC) and Medecins Sans Frontieres (MSF), in collaboration with northern activists used courts, mass action and mass media, and grassroots organizations to press for price reduction from pharmaceutical companies. They were successful in compelling the World Trade Organization to relax its regulations to allow the production of generic ARV medications for poor nations. As a result prices were reduced by more than 98% by 2001 (Robins 2004; Friedman and Mottiar 2004). Steve Robins contends that the activism around ART has not only created 'empowered citizens' but also knowledgeable and 'responsibilized' client-citizens (Robins 2006: 321).

Joao Biehl's work on treatment of HIV/AIDS in Brazil sets a different tone and should be an inspiration to government programmes in sub-Saharan Africa. Employing a multiple array of ethnographic methods within a span of ten years (2007: 3), Biehl manages to go behind the scenes of the much heralded 'Brazilian ART success story' citing complexities in the interaction between institutional practice, NGOs and the targeted patients. His work on 'pharmaceuticalization of citizenship' illuminates how poor people, the main beneficiaries of the public health system, become consistently marginalized by the programmes, forced to engage in what he terms the 'micro-politics of survival' (2007: 49), where the poor are narrowly considered medically as 'non-compliant' hence they become invisible:

ARVs are now embedded in these pastoral sites, novel ideas of citizenship and modes of subjectivity travel and gain currency among those who use or who refuse to use them. This is not a top-down form of control – one could call it market-based biopolitics [...] Poor AIDS populations acquire temporary form through particular and highly contested engagements with what is made pharmaceutically available (Biehl 2007: 285)

In Tanzania the level of activism has not been as high as in other countries in Africa. My experience with initial ART enrolment from the government can be compared to Meinert and colleagues' (2009) assessment of ART disbursement in Uganda where ART is considered a 'gift' and the patients are at

the mercy of the government. Government efforts in Tanzania aimed to increase the number of ART centres, initially targeting selected regional facilities,⁸ while the general scholarship has been to look at how people with HIV face obstacles and barriers to ART adherence (Mshana et al 2006ii; Watt et al 2009; Irunde et al 2006) aiming at adherence to programmes (Krebs et al 2008; Roura et al 2009ii). These studies are mainly confined to the realm of the health facility and programme based. Accordingly, findings and arguments generated from these studies focus narrowly on individual constraining factors such as distance to facilities and stigma.⁹ In Tanzania for example, follow up studies on ARV efforts have been to alleviate these barriers especially towards ensuring collection of pills, while socio-economic factors are treated as obstacles to be overcome at any cost: ‘One outcome of the interaction of all these social influences is individuals’ self-efficacy...that in the case of ART relates to the ability to identify a feasible treatment plan and remain compliant to it by persevering in the face of obstacles and integrating it into day-to-day routines’ (Roura et al 2009i: 205). Structural barriers like poverty are narrowly viewed as the inability to secure money for transport and resulting interventions to ensure compliance include the provision of fare to cover transportation and escort from home based care (HBC) providers (ibid.; also Watt et al 2009).

I have found that scholarship on ARVs has documented how the drugs have been viewed by both patients and community members, constituting different meanings to those in treatment and those who are not. In communities in Tanzania ART appeared to overlap with locally shared meanings of clinical functions of ART (Ezekiel et al 2009) and perpetuate stigma towards those taking ART (Roura et al 2009). In other resource-poor settings ART has been shown to achieve extensive reduction in mortality, morbidity and stigma (Farmer et al 2001; Castro and Farmer 2005). In general, findings from these studies advocate for public treatment education about the benefits and

⁸ I point out here that although the debates on biosociality have tended to circle around ART, very little research documents the use of traditional medicine in the early days of the pandemic. For instance, traditional healers and biomedical doctors in Tanga regional hospital have since 1992 employed scientifically proven herbal remedies to treat HIV associated symptoms long before ARVs became available, a practice ongoing today (Scheinman 1992; Scheinman 2002). Currently, the debates around herbal use are entangled between biomedicine as science and modern vs traditional medicine as ‘unscientific’, with the former perceived as aiming at undermining traditional medicine capacities using big pharmaceutical companies aiming at making profits (Geffen 2010; Wreford 2008). Currently, discussions on the subjectivities and biosocialities around traditional medicine and HIV/AIDS remain low (McMillen 2004) or are ignored.

⁹ A recent study from Tanga regional hospital discovered that only 10% (9/91) of women returned to clinic after their children were exposed to HIV between February and March 2008, while a larger number, 64% (58/91) never attended CTC at all (Arreskov et al 2010). Stigma was the main reason suggested to influence the low turnout. However, distance to facilities could also be a problem as there is a high disproportion in the distribution of CTC in the country. For instance, with an estimated population of 1,636,280, Tanga region has only 8 CTC while Arusha region with a population of 1,288,088 has 15 facilities (Somi et al 2009).

limitations of ART to foster increased access to treatment especially to those who are yet to test. However, these programmes can be seen as targeting biological factors alone while the broader social and political factors responsible for producing and sustaining ill-health among the marginalized remain intact.

Compared to industrialized countries where treatment of AIDS is considered a manageable illness rather than a terminal one (Gifford and Groessl 2002), in sub-Saharan Africa, where ARVs have reached poor areas, fears are mounting as families and poor people with HIV are facing ‘particularly difficult social and economic challenges to managing and living with HIV as a chronic illness, challenges less commonly seen in more affluent settings’ (Russell et al 2007; also Russell 2004). These challenges are both financial in terms of over reliance on donor support and also the fear in the development of drug resistance (Russell 2004; Russell et al 2007; Kalofanos 2010; Hardon et al 2007).) They argue that rather than ensuring access alone there is a need to consider broader social economic interventions that support the reconstruction of people’s poor lives. According to Russell and colleagues ‘If people must struggle to pursue viable economic lives, then their management of their HIV infection is likely to be undermined’ (Russell et al 2007: 344).

Challenges to poor people with HIV include fears of food security, which were common in the pre ART period, but which surfaced even more strongly with the onset of HIV/AIDS. However studies are still emerging but are limited to few countries especially Uganda (Kaler et al 2010; Russell et al 2007) and Southern Africa (Leclerc-Madlala 2006; Kalofanos 2010). The activism in facilitating access to affordable ARVs to many poor countries seems to have clouded, at least for a while, the concerns by nutritionists on the need for food for infected people (Kadiyala 2003). As Kalofanos writes from Mozambique, a scenario that can be exemplary to other areas in sub-Saharan Africa, that since the number of people taking ARVs increased there is a wider political economy underlying the HIV/AIDS epidemic:

The rising count of ‘lives saved’ seems to portray a success story of high-tech treatment being provided in one of the poorest contexts in the world, as people with AIDS experience dramatic recoveries and live longer. The ‘scale-up’ has had significant social effects, however, as it unfolds in a region with a complicated history and persistent

problems related to poverty. Hunger is the principal complaint of people on antiretroviral treatment. (Kalofonos 2010: 363)

Kalofonos continues to argue that rather than a form of solidarity towards a common good, 'therapeutic citizenship' was perceived negatively, and embodied a critique of ARVs as causing hunger (2010: 364). ART itself has been shown to increase resting energy expenditure (Shevitz et al 1999, cited in Kalofonos 2010: 364). Interestingly, other studies project a different perspective on the hardships patients face when on ART. These studies project poor people as striving to adhere to treatment by sacrificing other important needs. A multi-country ethnographic study on ART adherence in Tanzania, Uganda and Nigeria concluded that the 'success' in these countries is explained 'as a means of fulfilling social responsibilities' (Ware et al 2009: 39). The authors term these as 'deliberate strategies' to ensure adherence, for example 'begging' or 'doing without' in favour of treatment. As a result some patients end up in debt, fail to eat and become sicker. While persistent food problems still remain in affected communities, malnutrition and food insecurity have been linked to adherence problems (Gillepsie 2006). In their study conducted in Uganda, Kaler and colleagues conclude that while ARVs may have led to dramatic returns to immunological health projected in clinical records, treatment does not always translate into other areas of patients lives such as ensuring access to food (Kaler et al 2010; 517).

As the above studies argue, my research shows that the fundamental problems people with HIV encountered before ART became available are still important and the need to ascertain the kinds of subjectivities that arise in response to these crises is also crucial. These issues need to be addressed equally as they have received little attention in Tanzania where the focus has largely been urban settings, health systems, and limited to specific regions. In my approach I also attribute great explanatory strength to the fact that structural factors do have a powerful and determining force upon individual agency and shape the course of action of subjects. My investigation of poor people's experiences of HIV/AIDS in Maramba indicates how individual and communal agency is shaped by political and economic power interests, decisions which Farmer argues, 'come to be translated into personal distress and disease' (Farmer 1996: 262). In other words, my analysis does not lose sight of individual agency or cultural factors entirely, but integrates analyses of global processes with ethnographic detail (Wolf 2002; Baer et al 1997;

Morsy 1990). Incorporating a socioeconomic and political framework allows me to provide a holistic picture in which cultural and social economic factors shape everyday life experiences of the poor, which have a strong bearing on both individual risk and collective food security, a crucial ingredient in the lives of PLHIV especially in a period of ART.

My fieldwork in Tanga, conducted at the time that ARVs were first introduced into the site, demonstrates that the history of land alienation profoundly shaped people's food security and their ability to care for one another in states of sickness. Taking the longer view and following in the footsteps of other scholars in Tanzania (Setel 1999) and Africa more broadly (Barnett and Whiteside 2006; Schoepf 2001) and elsewhere (Farmer 1992), I argue that the existing HIV/AIDS crisis in Maramba can be understood by paying attention to its social, economic and political origins.

Building on recent anthropological works on ART and food insecurity (Kalofonos 2010) and the situation of living with a chronic disease in rural communities (Russell et al 2007), the thesis also examines the local reception of ARVs, demonstrating the ambiguities of health in the context of food insecurity and HIV among the poor in Maramba. My work departs from analyses limited to subjectivities and socialities that emerge as patients try to access treatment, or studies that focus on barriers to adherence faced by people with HIV. Poor individuals are caught between maintaining health through antiretroviral treatment and ensuring food availability for themselves and that of their household. I analyze how patients perceive ARVs as gatekeepers impinging on their social and economic goals. At the individual level I see local meanings and conceptualizations of being well and of health as conditioning patients' desires to enter or remain on treatment, moreover these collective ideals are structured by patients' and households' ability to satisfy their food needs. In some instances I argue that people explore the possibility of getting ARVs in order to respond to specific symptoms and needs.

This study further argues that social relations of support for people with HIV are compromised by fear, lack of resources, hunger, and the historical processes of land alienation and migration. My aim in revisiting social relations of support, especially extended family networks, stems from the view that there seems to be an overstatement of the ability of current traditional social

security systems to address the burden of care and support in household affected by HIV/AIDS. The availability of ART to revive patients who were dying and returned to 'normality' seems to suggest that household care is no longer a problem. My research reaches this position by going beyond what happens when patients 'return to normalcy'. I critically assess the position of the individual within the household and beyond, including the individual's relations to household and community economies. I argue that government and non-governmental programmes miss the point that networks of support are tied to historical factors that long affected the ability of families to support themselves. My findings further show that there are uneven experiences and ambiguities when it comes to extended family's role in support and care issues.

Methodology

To understand how people experience events that affect their everyday lives it is not enough to ask what those people feel, but also to accompany people in the everyday. As Fiona Ross aptly puts it, 'ethnography differs from other social scientific accounts in that it attempts to make sense of people's experiences using people's own everyday categories and models' (Ross 2010: 9; see also Spradley 1979). It was important to undertake long term fieldwork to understand people's everyday experiences of public health programmes; this differed from the methods I had become accustomed to at my work place (see also Pelto and Pelto 1990: 284).¹⁰ The fieldwork enabled me to not only observe people's activities but to critically examine power relations that continue to affect health outcomes of mostly poor community members (Grbich 1999: 160), relations that are impossible to capture in short term studies (also Barnett and Whiteside 2006: 204). I spent a total of 19 months (September 2007 - March 2009) in and out of Maramba, staying in the field for between a week and a month at a time with short breaks at my home in Tanga.

Since my work dealt with a sensitive topic I had to take great care in selecting informants, ensuring appropriate research ethics, and maintaining anonymity. Pseudonyms are used

¹⁰ Before embarking on this study I was accustomed to rapid appraisal studies of no more than two weeks, questioning respondents during the day and leaving the site at night. I do not wish to imply that short term studies are not useful in health research, depending on need and focus. Long term ethnographic studies, apart from enabling the individual to observe a phenomenon as it happens, offer a deeper and contextualized picture of subjective experiences of the individual, and record social change (see Bernard 2006: 344; Grbich 1999: 158-67). As far as I am aware, until the writing of this thesis there was no published, or unpublished, study using ethnography to study people's experiences of HIV/AIDS linking with broader social economic and political factors in the Tanga region.

throughout the thesis (ASA 2005).¹¹ Officials at the local government health facility responsible for home based care services linked me with families affected by HIV/AIDS, and I also worked through the local VCT centre. Some approached me after hearing about my work. I became a member of a local church where I met people directly involved in caring for sick family members. I participated in organizations and groups that provided services to the sick through which I met patients. In total I was acquainted with 30 patients and their families. I later concentrated on nine core households (which had 12 patients in total: see Appendix 2 for an in-depth description of each household)¹² to obtain data, what Patton calls ‘critical case sampling’ (1990: 182) without losing sight of the rest. I spent most of my time with the sick and their families as they went about their daily lives in homes, farms, market, and health facilities. I worked closely with village leaders, health workers and district officials as well as the local health facility. I took part in community gatherings including weddings, birthdays and baptisms.

I observed some of my participants suffer through sickness and die. I played multiple roles assisting in caring, and sharing bereavement with family and community members, which were sometimes emotional and painful experiences.¹³ However, my own emotional feelings did not negatively affect the data collection process as Ellis and Flaherty (1992) have argued can occur, but helped me gain understanding of my participants’ meanings, a process Denzin (1984) calls ‘emotional intersubjectivity’; entering the worlds of the participants through sharing their experiences and projecting them into our frames of reference.

My participation in a faith based organization providing HBC to HIV positive patients (between March and July 2008) enabled my study to encompass sites other than my study villages. I travelled with health providers to villages outside of my field site.

Maramba’s social and economic status has intrinsically been linked to the western world for over a century, mainly as a result of colonialism, which, as I show later, laid the foundations for

¹¹ Before meeting a prospective patient a HBC provider talked to him/her about my research and the patient was left for up to three weeks to discuss this with their family before I approached them. However, as I became known to the community some patients approached me themselves.

¹² Not all patients agreed to be visited regularly in their homes since I was known to be working on ‘AIDS issues’ (*mambo ya UKIMWI*) they feared disclosure.

¹³ Five of my informants died while I was in the field. Three others died immediately after. Some of those who died were the main pillar of sustenance and stability in their households.

disease and food problems (Farmer 1992; see also Erikssen 2003). Post-independence policies had a profound impact on these communities. To understand the effects of this history I engaged a processual perspective advocated by Sally Moore (1987) which ‘considers a time oriented perspective on both continuity and change’ (Moore 1987: 729). For Moore, time oriented fieldwork shows:

how local events and local commentary on them can be linked to a variety of processes unfolding simultaneously on very different scales of time and place, and to note the difference between what might be called the ‘foreground preoccupation’ of the actors or commentators on these events, and the ‘background conditions’ informing their situation that figure much more prominently in the preoccupations of the historically minded ethnographer. (Moore 1987: 731)

I spoke with elders who had witnessed the past differently. Some were sisal estate managers during the colonial and postcolonial periods. I was taken on walks through the community being shown changes that had taken place over the years and we discussed how these have affected current livelihoods. To compliment the interviews, I consulted national archives and conducted a literature review of the region and its relation to the history of the country and world at large.

I combined different techniques in data collection, from formal and informal interviewing, collecting life histories, group discussions, conversations, interweaving these with observations (Pelto and Pelto 1990; Bernard 2006). I was invited to observe meetings, contributing to discussion. Whilst in the field I conducted preliminary analysis and their outcomes shaped my focus, informing future observations and interviews. To supplement observation, especially with regard to the participants’ health, I collected health records of those attending the local health facility. The data was useful for understanding the community health profile which supplemented my observations.

Further details of method, sample and ethical considerations are provided in Appendix 1.

Outline of the study

In Chapter Two the field site is introduced. It will receive detailed attention in Chapter Three.

In Chapter Three I focus on the historical processes involved in the creation of Maramba community from the pre-colonial to the colonial period in the late 19th century to the post-independence period. I show that pre-colonial Maramba was a self sufficient community with ecologically valuable traditional social security structures and agricultural development, assuring food security and sustaining healthy social relationships. The colonial period marked the beginning of major structural alterations of local people's mode of production through the introduction of plantation economies that depended on migrant labour and destroyed traditional structures of sociopolitical and economic support. I show that colonialism created a dependency system that forced villagers to rely on cash crops rather than food crops whilst robbing them of their most productive land and destroying their capacity to produce food. While the post-independence pro-socialist period aimed to address colonial injustice through presupposed egalitarian policies, I show how these further marginalized and increased socioeconomic differentiation and poverty locally. Post-socialist, externally induced structural adjustment programmes (SAPs) not only exacerbated food insecurity and poverty but also provided fertile ground for HIV/AIDS transmission and its impact among the poor in Maramba.

Having introduced the social and political history that has formed present day Maramba, Chapter Four examines the day to day experiences of poor people living with HIV, their households and their struggle to secure adequate food supply in the context of farmland scarcity. Emphasis is given to the articulation of the complexities involved in negotiating between existing farming arrangements and securing off-farm income in a competitive environment that advantages those formally employed who have more economic and cultural capital. I show how the problem of land has increased chronic food insecurity and affects the eating patterns of poor people living with HIV/AIDS and subsequently their nutrition intake. I argue further that presupposed pro-poor development projects initiated by the government to improve income and the nutritional status of the poor in fact, marginalize them, in particular those living with HIV, simply because of their lack of land and their poor health conditions.

In Chapter Five, the focus is on the experiences of people living with HIV and their struggle to secure food in relation to attitudes towards, and experiences of, taking antiretroviral treatment, which had become available in the community for the first time. The chapter has three main but overlapping parts. First, I show how ambiguous and uncertain people become, and how their positions on ART shift over time before and after ART treatment, which has acquired both positive and negative connotations in relation to perceived notions of wellness. I argue that the decisions of patients to begin treatment are shaped by the patients and their families' perceptions of the benefits of ARVs in the face of food problems, and against biomedical demands on the timing of beginning treatment. In the second part, I dwell on the experiences of patients who are already on ART by demonstrating that despite the well known benefits of taking ART, the implications of treatment for the economically impoverished and marginalized places them in precarious positions as they struggle to become well and fight hunger, amidst scarce resources and opportunities, thus creating further uncertainty. I end the chapter by discussing people's perceptions of the death of patients who were on treatment.

In Chapter Six, I explore the importance of support networks for people living with AIDS, focusing on the family, so often identified as the major pillar in the fight against HIV/AIDS in rural communities. Addressing the crisis of HIV/AIDS demands strong support networks which, as my research shows, is often not the case in settings like Maramba. I argue that insufficiency of family networks among the poor in Maramba is intrinsically linked to the historical processes of the creation of Maramba as a migrant economy destination, and a source of cheap labour. The available networks represent different levels of ambiguities and complexities as members struggle to secure support elsewhere amidst poverty in the community.

Chapter Seven is the conclusion of the study where I provide a summary of the thesis arguments and an analysis for the way forward.

CHAPTER TWO

THE FIELD SITE

I conducted my fieldwork in the Tanga region, one of the 21 regions of Mainland United Republic Tanzania,¹⁴ a country with a total population of roughly 41 million people by 2007.¹⁵ Most of the population of the country (almost 80%) reside in rural areas and are mainly subsistence farmers (URT 2008). In Tanzania agriculture constitutes the most important sector of the economy, providing about 27% of GDP. Tanga region, with an estimated population of 2.5 million people within six districts, is situated in the most north eastern part of the country, endowed with Tanzania's second largest port, where the major city of Tanga, with a population of 261,613 sits. My study was confined to the Maramba ward located in Mkinga District¹⁶ with a total population of 117,758. The district has two divisions, Mkinga and Maramba, with eight and five wards respectively (TRSEP 2008: 8).

The most salient feature of the Tanga region is the vast area of sisal estates and plantations that stretch virtually across all its seven districts, reflecting a significant colonial legacy. Other notable estates include those of coffee, capamia, cotton, grapes, moringa, rubber, tea and copra (TRSEP 2008). As detailed in Chapter Three, the history of Tanga and its people is inseparable from that of sisal and these other crops. Although sisal production came to a halt from the late 1970s until the late 2000s, the crop has historically shaped the relations of its people.¹⁷ However, agriculture remains the mainstay of the economy. According to 2006 estimates, agriculture absorbs 77.4 percent of the total labour force, most of whom are subsistence farmers.

¹⁴ Tanzania was formed following the unification of Tanganyika and Zanzibar in 1964.

¹⁵ The number is based on statistical projections, but the last census conducted in 2002 put the number at 35 million. The population of the country increased by 49.1% (11.3 mill) from 1988 to 2002 (NBS 2008)

¹⁶ During the period of this study, Mkinga district with a size of 2948 km² was still part of Muheza district until it was divided in July 2007 (TRSEP 2008; also, see Appendix 1).

¹⁷ The industry was slowly being revived during my fieldwork following privatization (see Sabea 2001).

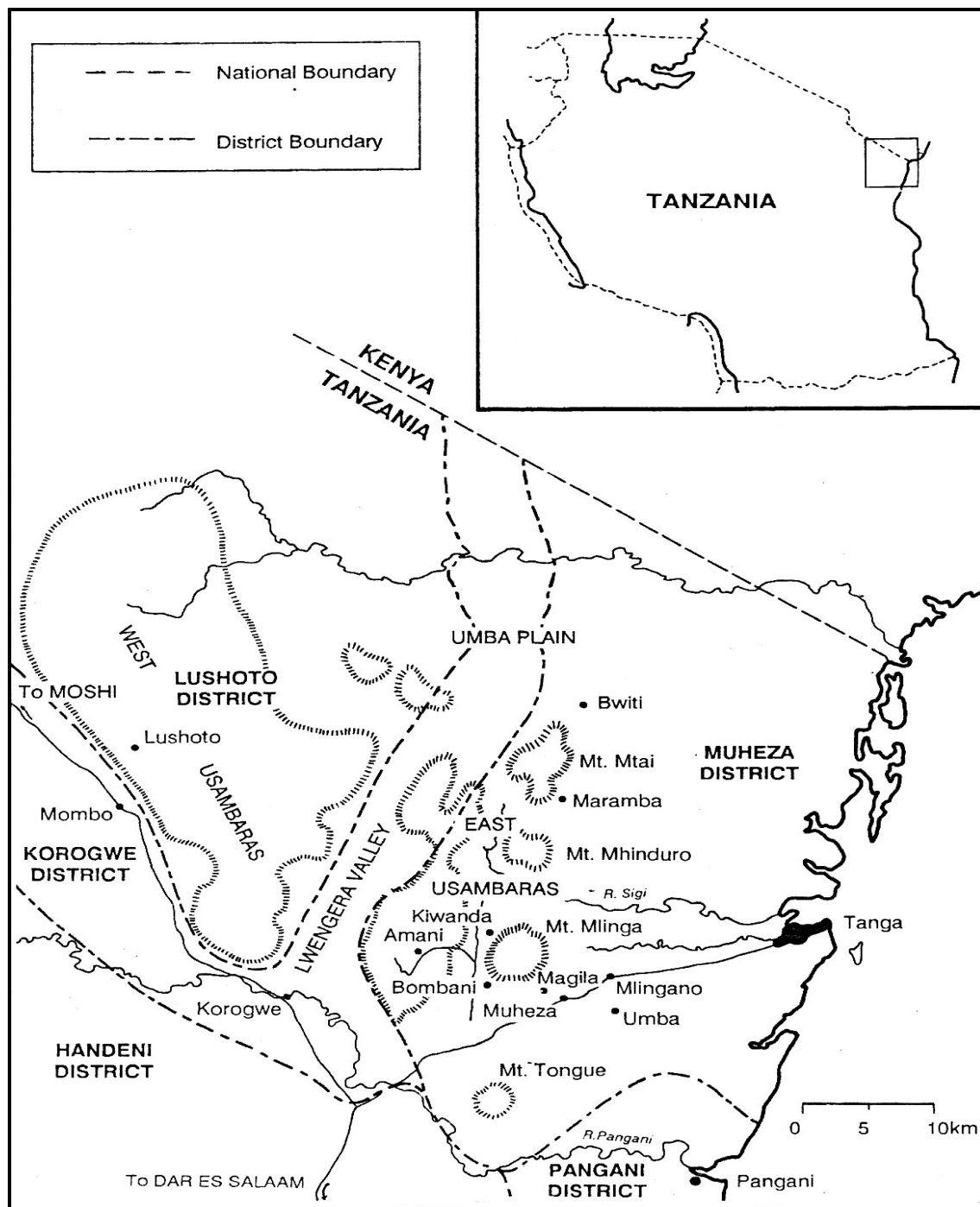


Figure 1: Maramba, the East and West Usambara Mountains in Tanga Region (Insert: Tanzania Map)

Source: Hamilton A.C; Bensted-Smith, R. (1989: 2)

Compared to the 21 regions of mainland Tanzania, Tanga was highly ranked economically at number four, with a per capita income of 475,835 shillings (396 USD) in 2006, rising from per capita income of 165,576 shillings (180 USD) in 2000 (URT 2008: 24).

I conducted fieldwork in Maramba A and Maramba B villages¹⁸, 50 kilometres from Tanga city. They are part of 12 villages forming Maramba ward. Both are positioned at the foothills of the most north eastern peak of the East Usambara mountain chain, Mount Mtai. My first impression of Maramba was the problem of land use for major social and economic development needs. Local people used to refer to it as ‘island’ (*kisiwa*), with repeated complaints about population pressure, such as ‘we are so full here’ (*tumejaa sana*) or ‘we are too congested’ (*tumebanana sana*) (see Appendix 1). The villages, with a total size of 829ha (8.29 km²), were home to 12,622 people by 2007, from 7,732 in the 2002 national census, the highest population per village in the district of Muheza (See Table 1). Hence population density was 1,523 people per km², or 15 persons per hectare, contrasting sharply with Tanga city with a population density of 488 persons per km² and which was said to be high.¹⁹ The average population per village for Muheza district, per 2006 population estimates of 294,326 people, stood at 1,682 people (TRSEP 2008: 9). This estimate excludes a number of Maramba secondary school students who rent in the village during school terms.

Table 1: Population of Maramba A and B villages (2007)

Item	Maramba A	Maramba B	Total
Population	4,042	8,580	12,622
Males	1,781	3,775	5,556
Females	2,261	4,805	7,066
Number Households	697	926	1,623

Source: Maramba A and Maramba B village office data

The term overpopulation, used when the populace in a given area has insufficient available natural resources, does not adequately characterize Maramba’s population pressure plight. The ‘island’ is virtually surrounded by large estates with much unused agricultural land, and by forest reserves (see Plate 1). On the west it borders the Mtai Mountain Forest Reserve (3,107ha), while

¹⁸ Because of their closeness, villagers never referred to them as separate villages. Separation was administratively imposed. Accordingly, I will for the most part refer to both as Maramba.

¹⁹ Dar es Salaam is the only other region in the country characterized by an extremely high population density of 1,786 persons per km² (TRSEP 2008)

in the north lies Mwele Seed Farm estate with 960ha (utilizing only 46ha); further east and south they border Lugongo sisal estate (3669ha) and part of Maramba JKT estate (2,444ha), cultivating less than ten percent.²⁰ These estates were privately owned and partially out of bounds to the villagers, but not the other way round. For example, the JKT estate camp, comprising a population of not more than 1,000 servicemen and women,²¹ freely accessed village land through buying the already meagre farmlands from poor villagers, building houses and forcing villagers to resort to squatting and renting.²² The term oppression is more suited to characterize these land use relations, an outcome of specific historical processes I detail in Chapter Three. The major social and economic dynamics of food (in)security and HIV/AIDS I engage with in this thesis revolve around the interactions between these two groups (JKT and local villagers) and how their relationships shape the geographic space they occupy.



Plate 1: Sisal plantation surrounding the village with Mount Mtai in the background

²⁰ All data on farm and village sizes was obtained from the Mkinga district land files as well as the village offices.

²¹ JKT-A wing of the Tanzanian army turned the farms into a national camp to train school leavers in skills such as farming and military defense before joining university. At any time the camp accommodated around 1,000 people, trainers and trainees, living in the barracks and the village. However, for 'security reasons' the exact number of the JKT members could not be provided. Together with the village population the number approximates 14,000.

²² During my time in the field there were an estimated 105 JKT members with their families living in the village, farming private farms and conducting various businesses. Ironically, the villagers are said to put pressure on the biodiversity of Mtai Mountain forest reserve (see Doggart et al. 1999).

The first hint of poverty in Maramba is perceived in the congested living space and poor housing along a 300 metre long strip of the major road from Tanga city that cuts across the village from JKT estate and back to Mwele estate to the hinterland (see Plate 2). Concentrated mainly in Maramba B village, houses are built from either mud (locally known as *nyumba ya miti*)²³ or soil blocks (*bloku* or *matofali ya kuchoma*) and contain sundry businesses from guest houses and bars, to small restaurants (*hoteli*), shops selling consumer goods, mobile phone vouchers and accessories. The same houses provide rental space in the rear, while in front and in between, small street vendor businesses are squashed together, such as makeshift fuel spots, bicycle and motorcycle repair handymen, or chips and egg (*chips mayai*) sellers and men and women with mobile sewing machines repairing and making clothes. This strip area is called town (*mjini*).

Most of the houses beyond the main road can only be reached on foot. People have to negotiate their way in and around other people's houses, gardens, gravesites, makeshift and unroofed bathrooms and pit-latrines, to reach their homes. Some of the very poor reside in Maramba A, far from the road, locally categorised as village (*kijijini*) in reference to the concentration of many dilapidated mud-built houses with poor sanitation and no electricity or running water (see Plate 3). Those who dwell in such houses usually have no major assets. On the other hand, the few better-off inhabitants own and live in housing built from blocks mostly in Maramba B. They have assets such as cars, bicycles, motorcycles and livestock which they are able to feed daily without needing grazing rights (See Table 2).

To a casual observer the above description may provide a sense of Maramba as a space with abundant and 'worthwhile' business opportunities obscuring the realities of social economic differentiation. Most major business operators were people such as existing and former employees (including their family members) of the JKT, estate officials, secondary school

²³ Inhabitants differentiate between two types of houses *nyumba ya miti* (translated to 'trees' but implying houses built of trees and mud), and *nyumba ya bloku* (block houses - this can either be of burnt blocks or cement blocks - the former by far outnumber block houses).



Plate 2: Main road Maramba B with Mount Mtai in the background

teachers, religious leaders and health workers. There were also a few business owners who lived in Tanga city and commuted to Maramba daily. However, the majority of the unemployed village population had to struggle to obtain income to buy food (see Table 3).²⁴

²⁴ Some better-off business owners operated more than one venture. For instance there was a retired soldier who owned three bars and one who owned three minibuses. In approximation, better off villages do not exceed 200 persons in total.



Plate 3: A settlement in Maramba A

Table 2 Facilities and ownership patterns in Maramba A and Maramba B villages

Item	A	B	Total
Consumer shops	23	68	91
Drug shops	0	3	3
Health facility	0	2	2
Market	0	2	2
Traditional healers	45	12	57
Hair salons	0	14	14
Churches	4	9	13
Primary schools	2	2	4
Secondary school ²⁵	0	1	1
Vocational training	1	1	2
Mosques	4	3	7
Guest houses	0	9	9
Bars (including local brew)	2	6	8
Motorcycle and bicycle repair posts	2	6	8
Milling machines	2	6	8
Carpentry posts	5	11	16
Motor vehicle owners	1	9	10
Motorcycle owners	12	26	38
Households with livestock (cattle's, goats or donkeys)	31	70	101
Houses with electricity	75	243	318

²⁵ Due to insufficient space and increasing population the Maramba secondary school (the first secondary school in Mkinga district) was built on a sisal estate in 1987 and an additional primary school was constructed on JKT estate.

Despite being categorized as a peasant community, access to farmland is among the major socioeconomic problems. The most striking feature of farming in the area was the arrangement between villagers and the JKT estate owners, whereby the estate owners lend pieces of plots (mostly an acre) for farming non-permanent food crops alone, such as maize and cassava. Access to these farms was however highly unequal and insufficient as a limited area was designated for this arrangement. They benefited those with capital, who could amass more plots and who hired labour from other villagers. Where a small space was available in the village, land crops were highly intercropped, but more food had to be imported and bought in the local market. Accordingly, the increase of farmland from neighbouring estates, which was historically claimed to belong to the village, was the major goal for the villagers as a path to development since the country gained independence in 1961.²⁶

Table 3: Household Capacity for self-subsistence in Maramba A and Maramba B villages

Status	Maramba A	%	Maramba B	%
Good	41	5.9	82	8.9
Fair	102	14.6	308	33.3
Poor	554	79.5	536	57.9
Total	697	100.0	926	100.0

Source: Maramba A and Maramba B village office documents

²⁶ During my fieldwork, villagers were concerned with insufficient space to bury the dead.

CHAPTER THREE

HISTORY, POLITICAL ECONOMY AND HIV/AIDS IN MARAMBA

It is inexcusable to limit our horizons to the ideally circumscribed village, culture, or case history and ignore the social origins of much - if not most - illness and distress. An interpretive anthropology of affliction, attuned to the ways in which history and its calculus of economic and symbolic power impinge on the local and the personal, might yield new understandings of culturally evolved responses to illness, fear, pain, hunger, and brutality (Farmer 1988: 80).

Epidemics, such as HIV/AIDS, are social as well as economic processes that spread along the faultlines of societies 'to the poor and disinherited' (Schoepf 2004: 15). The current deadly combination of HIV and food insecurity has been linked to the degradation of people's systems of food production and social support systems (Rugalema 2000; Barnett and Whiteside 2002), often missed by NGOs and public health facilities, which tend to relegate solutions to the realm of the individual patient and provision of treatment while disregarding the social context. These needs, shown in this chapter, are anchored in a people's history. I draw from anthropologists such as Paul Farmer and Randall Packard who have argued that ethnography and epidemiology inadequately address 'the *origins* of neither contemporary conditions, nor can they reveal the processes that have shaped, over time, the AIDS pandemic and their social responses to it' (Farmer 1994: 152). They stress the importance of taking a long view on how patterns of political and economic shifts have evolved over time and how particular sets of political and economic interests shape how governments and its people address health and diseases (Packard 1989: 20; also Wolf 2002; Morsy 1990).

Following this line of argument, I argue here that the articulation of HIV/AIDS and food insecurity in Maramba is best understood by taking a longer view. Before the advent of colonialism in Tanzania, and Tanga region in particular, the people of this region constituted a self-sufficient community with stable farming systems and social networks suited to the ecology of a mixed vegetation zone, supporting a number of staple crops. Compared to the current market economy in Maramba where major food items must be imported, people in the area produced

almost everything they needed. Factors such as rainfall, wild animals and drought affected food insecurity, but by far the most pernicious was the role of colonial conquest, and subsequent postcolonial policies which instituted new forms of social relations and an exploitative plantation economy that depended on migrant labour. This set the foundation for food insecurity and the spread of disease, including sexually transmitted diseases. Postcolonial rural development policies and subsequent liberalization policies of the 1980s and 1990s heightened the vulnerability of people to infection with HIV and laid the foundation for community members' inability, especially that of the poor, to absorb the impact of HIV/AIDS.

***'WaShambaa ni watu wa milimani'*²⁷: Maramba in the pre-colonial period**

The main indigenous group are the Shambaa people, believed to have settled in the Usambara Mountains before the 18th century. To the north, they border with the Segeju, while the Digo and Bondei groups are their neighbours on the east and south respectively. Currently over 20 ethnic groups from all over Tanzania and beyond inhabit Maramba. Most arrived during different historical epochs mainly as estate and plantation workers over a hundred years ago and have had a considerable role on the villages' growth.²⁸

Maramba was not the area first settled by the Shambaa. Their original settlements were strategically positioned at the top of, and on the slopes of, the East Usambara mountains, the closest being Mt. Mtai. However, the history of these settlements and of Maramba cannot be understood independently of that of the Shambaa Kingdom whose headquarters were found in the present day Lushoto District prior to colonialism. According to the renowned Shambaa historian, Steve Feierman, these settlements were ruled from the 18th century²⁹ by a king with the title *Simbamwene*, under a single dynasty of the Kilindi clan (Feierman 1974; cf. Winans 1962). The German missionary and explorer Johann Judwig Krapf, the first European to reach Usambara in 1848, noted that the Kingdom extended approximately 60 miles from north to

²⁷ 'The Shambaa are people of the mountains.'

²⁸ I have excluded the JKT personnel from this composition as these are locally considered to be more recent 'aliens' (*wakuja*) together with other government employees such as school teachers and health workers.

²⁹ Other historians have suggested that the East Usambara mountains were settled by man at least 2,000 years ago (Hamilton and Bensted-Smith 1989; Kimambo 1969; Soper 1967).

south, and 140 miles east to west (Krapf 1865).³⁰ Winans (1962) further characterizes the Shambaa in relation to political and economic structure, noting that the group was highly organized and had ‘a corporate structure of authority, and cooperate economic and religious interests’ (Winans 1962: 23). Control of the political organization of the kingdom was maintained in part through ensuring abundant food production. The most successful king was said to be Kimweri ye Nyumbai, who ruled from 1815 until 1862, at the time when colonialism was about to begin. He abhorred war and is regarded as one of the greatest rulers in pre-colonial Tanzania’s history (Feierman 1968: 8). His sons from his many wives were made chiefs and sent to distant settlements such as Maramba (cf. Hemedi I’Ajemy 1963).³¹ The survival of the chiefdom depended on tribute which these chiefs collected from their subjects from all over the Kingdom and sent to the capital in Vuga. Tribute mostly took the form of food and livestock because the king and his courtiers did not directly participate in food production (Feierman 1974: 100-121).

The local phrase ‘these are people of the mountains’ (*hawa ni watu wa milimani*) was used to refer to the local Shambaa by people of other groups during my fieldwork. They teased Shambaa people, saying, ‘Why don’t you return to your home in the mountains? What is making you cling here?’ (*si mrudi kwenu milimani, mna ng’ang’ania hapa kwa nini?*)³² More than just being used to designate their ‘original homelands’, the phrase carried connotations relating to adaptability to the mountains. Feierman (1974) notes that the Shambaa were originally agriculturalists and their agricultural output was supported by a particular type of environment with particular ecological characteristics, found only around the Usambara mountains (see Hamilton and Bensted-Smith 1989, for a detailed account of the vegetation and biosphere of the Usambaraa).

The main social unit of the pre-colonial Shambaa was the family, consisting of a man, his wife and children. Most villages contained a whole clan, comprising descendants from a common

³⁰ The Shambaa ruled over different ethnic groups in the area, such as the Bondei, found in present day Muheza; the Segeju, confined to areas around Bwiti; and the Digo, who settle along the coast.

³¹ The local historian and aide to King Kimweri, Hemedi I’Ajemy, in his book mentions Hungula as the chief that was sent to Maramba. My informant Mr. Ramadhani mentions chief Mzimhiri to have arrived before Hungula, suggesting that people had already formed permanent settlements generations.

³² The phrase was repeatedly uttered to Shambaa by people from other ethnic groups in heated debates regarding the problem of space for farming in the community, with the Shambaa claiming to belong to the area more than other groups.

ancestor living closely together. The family was connected to other social groups via affinity or descent, and through this people gained access to land for farming. The Shambaa subsistence farmers were patrimonial, the man being endowed with sole responsibility for ensuring the growth and stability of his family. Before the arrival of Christianity, a man was expected to have many wives, to provide for them and protect against calamities such as disease and famine. He had to be well versed in agriculture. It was a man's duty to ensure that he passed his skills to his sons so that they would prosper, providing them with property and wealth.

Apart from the available documented scholarship, some elders in the community shared with me their own views on this past, much coloured by nostalgia and romanticised. A respected 82 year old traditional healer in the community named Sadui Mlekwa underscored the situation:

The past was not like now. Our forefathers had no problems at all with farmland or having to worry what to give their sons when they die. For us, if your father was a healer he may call you and start teaching you his craft...for others you just wait when they want to marry and they show you where to cultivate. After marriage your father will tell you to 'clear that land' (*vunja lile pori*) and cultivate, the land was plenty, but now you have to buy...When starting a family the father gave his children plenty of goats and cows. Even banana trees, you know how it is easy to plant them, back then it was not dry (*kame*) like nowadays, you just put it and it grows on its own, but now you have to water it.

In pre-colonial times, if children did not inherit land directly from their father it did not mean that they got no property at all. Land was readily available. The chief of an area would allocate land to them. Feierman also notes that during the Kilindi dynasty, foreigners who wanted to join the community were given land by the chiefs to start their own gardens.

When the Shambaa migrated to the East Usambara mountains they chose to settle in areas which in many ways resembled the ecology of the West Usambara mountains, 'the Switzerland of Africa', as a 19th century missionary described them (Farler 1879). The Shambaa settled strategically on the eastern slopes of both the West and East Usambara mountains. These sides face the Indian Ocean and guaranteed rainfall up to three seasons a year, unlike the west-facing slopes with only two (also Doggart et al 1999: 8; Hamilton and Bensted-Smith 1989).

According to Feierman, their preference for settling in the mountains did not mean the Shambaa never travelled to the lowlands. Living on the slopes that border the lowlands was strategic. The Shambaa considered the plains to be wild (*nyika*) and barren, mainly because the area did not support their main staple crop, the banana. However, they could not entirely do without *nyika* (Feierman 1974: 21-24). In West Usambara mountains, where the Shambaa in Maramba originate, the area they occupied is 4,000ft (1219.2 metres) above sea level and the area they designate *nyika* is 2,150ft (655.32 metres) above sea level. Maramba village is 876 metres above sea level. To use Feierman's assessment of the Shambaa food production conditions around Mtai Mountain, they lay in a mixed vegetation zone.

Because the zones had different rainfall patterns, certain crops thrived in the mountains and others in the plains. Lowland crops like cassava were important root crops because of their ability to sustain long periods of drought. Other crops include maize, pigeon peas, beans and sorghum. Moreover, certain agricultural techniques worked well in the mountains and were more familiar to the Shambaa than the lowlands, which also offered meat from game. Families who had plots in both areas were better able to sustain themselves during periods of food shortage (Feierman 1974). The rainfall patterns differed in concentration and time span, dictating when to plant maize in the highlands and lowlands. There were three rainy seasons, *mvua za mwaka* (March – May), *mvua za vuli* (November – December) and *mchoo* (August or September). As Mr. Ramadhani Mchau (77), a village elder I spoke to explained:

In the past there were three seasons unlike these days where sometimes the rain falls only twice in a year, in the mountains the rains were plenty...there was *mvua za mwaka*, *mchoo* and *vuli*. During *mvua ya mwaka* it falls for three months and we harvest on the third, *mchoo* it pours for one or two months and *vuli* we harvest on the fourth month...you could harvest maize three times in a year if you were not lazy, but if on the *mwaka* rains you harvested a lot of maize you do not have to farm on *mchoo* because you have enough, you wait for *vuli*, the rule with the *mchoo* rains you plant maize in August, which were the good rains, but *huku chini* (in this low land area) these days we depend on *mwaka* rains.

Preferred seasons differed by zone with *mvua za mwaka* for lowland and *vuli* and *mchoo* for the highlands (Feierman 1974: 25). During *mwaka* rains for example, maize thrived faster in the lowlands than in the highlands where it took more time to ripen. Because the crop needed a lot of rain just after planting and long dry spells after it was fully grown, the lowlands yielded good

results if the rains were not long. Mr. Ramadhani said that in the Eastern Usambara mountain region banana³³ (cf. Steere 1867: 15; Farler 1879: 92; Krapf 1865: 276-77)) was the staple crop together with rice (*mpunga*). Other food crops included millet (*mtama*), sorghum (*uwele*), yams, pigeon peas (*mbaazi*), sweet potatoes, sweet potato leaves used as a vegetable (*matembele*), cow pea (*kunde*), green gram (*choroko*), sugar cane (*miwa*) and tobacco (*tumbaku*) (cf. Fleuret and Fleuret 1980). The current staple crops such as cassava and maize were less popular than banana.

The mountain areas were also preferred by the Shambaa because they were safe from wild animals, diseases like malaria, and were strategic in times of war. Before colonialism, there were many wild animals in the lowlands where Maramba is located. These included elephants (*tembo*), lions (*simba*), buffalo (*mbogo*) and leopards (*chui*). Elephants were most feared because they destroyed farms, hence cultivating in the mountains ensured food security. According to Feierman (1974), long before it was established that mosquitoes caused malaria the Shambaa preferred the mountain areas to the *nyika* as there were no mosquitoes because it was cool. Apart from avoiding health risks the mountains provided strategic security from raiders, in particular the Maasai raiders who migrated southward from present day Kenya in the early 18th century (Feierman 1968: 4-6). As Feierman puts it, the mountains were for the Shambaa 'healthier, less dangerous, and more fertile' (Feierman, 1974: 19). The agriculturalist, geographer and historian, Phillip Porter concludes that farmers in the Tanga region prior to the middle of the 19th century 'had worked out an economy that was generally in balance with nature' (Porter 2006: 7).

The age of differentiation: the colonial economy imperative

The first man to settle here came from a place named Paramba in Muheza. He was running away from the Germans taking their land and starting sisal plantations (*mashamba ya katani*) and forcing them to work. After arriving, he built his hut here. People came from the mountains and found him and asked him 'what is your name and where did you come from?' To conceal his identity he said my name is *Maamba (naitwa*

³³Banana was the most important source of vitamins and other important nutrients. Other than its suitability to the mountain ecology, banana was preferred for its good yield and demands less labour than maize (Miracle 1966:213, cited in Flueret and Flueret 1980: 321). A hectare can produce around a ton of maize per annum while the same hectare is estimated to produce up to 15 tons of bananas (Miracle 1966: 207, cited in Flueret and Fleuret 1980: 321). It also provided more calories than maize per hectare (Jones, 1959, cited in Flueret and Flueret, 1980:324)

Maamba). Other people then slowly began to follow him and will live with him because they saw it was not dangerous, if he survived. People from the mountains and elsewhere, will say 'I am going to *Maamba*'s area' (*nakwenda kwa Maamba*). As more estates reached this side they brought people the place eventually bore his name. (Interview, Ramadhani Mchau, 2009).

Historians of Tanzania³⁴ have theorized and presented colonial relations of the country from different standpoints. The most influential, notably John Iliffe and Walter Rodney, have taken their stance from dependency theory. Iliffe views the colonial state as a tool for western imperialists, especially plantation owners and settlers, to secure raw materials for their own developments (1969), but emphasized that colonialism was a vehicle for modernization through education, improving cash and food production and infrastructure that African elites aspired to imitate (1979). Rodney, on the other hand, contends that colonialism is part of a world capitalist system, purposefully subjugating African economies to depend on western capital, markets and technology. By mainly establishing plantations³⁵ in the colonies, Africans became producers of raw materials in an unequal exchange which systematically destroyed the coherence of indigenous social formations (Rodney 1983: 9). Other historians have departed slightly from the positions outlined above, arguing that the interests of the colonizers were shaped by a number of imperial forces, with development being the crucial one (Koponen 1995). Recent historians, notably Thadeus Sunseri (2002), depict the colonizers, particularly the Germans, as representing specific economic interests that were conditioned by their home state. For example during the latter part of the 18th century, although other products were sought, Germany was keen to satisfy the needs of its textile industry; sisal and cotton were central to their pursuit. A common point of agreement between the above historians is that colonialism established relations based on the need to obtain particular products through the direct exploitation of African labour and land. As I will show, the existing social relations of poverty and ill health in Maramba are part of these processes, with most of their roots in this period.

Tanga and the great landscape change

Tanga region was the first part of Tanzania to become involved with the economies of western countries before and during colonial rule. Sunseri documents that plantation contacts and the

³⁴ Present day Tanzania was an outcome of the unification between Tanganyika and the island of Zanzibar in 1964. Tanganyika was first colonized by Germany from 1884 to 1919, and then the British, from 1920 to 1961.

³⁵ For Rodney, the plantation 'represented the cornerstone of dependency' in Tanganyika (1983:7).

need for cheap labour dates back to the 1890s in the hinterland of the coastal towns of Tanganyika, notably Tanga, Pangani, Bagamoyo and Dar es Salaam. By 1895, 15 coffee, rubber and sisal plantations had already been established in East Usambara (Sunseri 2002: 53). In total there were roughly 50 estates growing coffee, tobacco and coconut palms (for copra), rubber and kapok, with about 10,000 workers. The number climbed to about 120 estates in 1905 (Ibid). Iliffe notes that the German East Africa Company (*Deutsche-Ostafrikanische Gesellschaft* (DOAG))³⁶ alone had, by 1911, managed to annex a total of 110 square kilometres in the Usambara area (Iliffe 1979: 127).³⁷ In total, throughout the German period, 1,235,300 acres were appropriated, mainly in Usambara (URT 1994: 13). When the British took over, between 1923 and 1926, hectares became the new measurement. By 1957 a total of 230,850 hectares more had been alienated in the country (URT 1994: 14).

The manner in which land alienation was undertaken by DOAG was not controlled by the German government because DOAG had concessionary rights in the Usambara area. The force employed was so blatant that the then governor of Tanganyika, Von Wismann, had to intervene in 1895 and 'ordained that Africans owned the land they cultivated, that they (DOAG) could not alienate land without the governor's approval, and that all the land was "ownerless Crown Land" which only the government could distribute' (Iliffe 1979: 126-27). More settlers arrived in the late 1890s and continued annexing the temperate West Usambara area where the governor had to limit alienation to 200 hectares per settler. By 1912, there was a shortage of arable land in the Usambara region (Iliffe 1979: 127). The settlers appropriated land from the local population such that it threatened famine for villagers. As Iliffe describes it, more than half the arable land then remaining to Africans was said to be cultivated at any time, fallow periods were falling to destructive levels, and food production was declining (Iliffe 1979: 142-143). The local Shambaa in these areas were thus compelled to move to less populated areas such as Maramba. During both the German and the British colonial periods, sisal became the most important crop. By Independence in 1961, of the 162 sisal estates listed in the country, 71 were in Tanga region (Rodney 1983: 8; see Figure 2).

³⁶ A German society for colonization led by Dr. Karl Peters, the most mentioned individual in the early colonial history of Tanzania who spearheaded German foreign policies (Iliffe, 1979: 89-90; Gwassa 1969:102-03)

³⁷ See Appendix 1 for a map of the extent of land alienation around Maramba.

The labour question

Sisal production was labour intensive and Tanga was referred to as a 'plantation labour magnet', due to the amount of labour it absorbed in the country (Tambila 1983). As a way of securing cheap labour the Germans introduced a cash economy. Iliffe documents that by 1900 coins were the normal currency utilized in Shambaa markets. Together with the cash economy, a tax system was introduced that included hut and poll taxes which totally changed the economy of the region and eventually subjugated further the villagers who suddenly had little choice but to supply their labour to plantations. 'Introduced in 1898 as an annual levy of one to four shillings on each hut, tax was designed to...make people use money, sell surplus crops, work for Europeans, and obey a distant government' (Iliffe 1979: 132-133). Together with the tax system from the mid 1890s, first efforts to manage labour included a series of laws (master-and-servant ordinances) which introduced labour contracts and legislation that criminalized contract breaking and desertion (Sunseri 2002: 52). Those who failed to pay tax were penalized and forced to provide labour.

The manner in which tax was collected was violent and aggressive, involving hut burning and seizing peoples' livestock (Rodney 1980: 130).³⁸ The local historian Lwoga documents how during global economic crises such as the 1930 Great Depression, many subsistence farmers could not earn cash and were forced to work in government and on plantations to pay tax (Lwoga 1989: 182). Many men had to flee from regions in which the colonial system was effective and left women to bear the burden of tax and, at times, to provide their own labour and food crops as compensation, disrupting household relations. However, in plantations around Usambara a rumour arose that taxation was hindering labour, since villagers preferred to sell their livestock, such as cattle and goats rather than to work for a wage (Sunseri 2002: 66-67).³⁹ Sunseri however argues that compared to other colonies like South Africa or the then Belgian Congo, the tax charged in Tanganyika was very low. This was strategic because the state administration depended on the populace to produce food and forest products, which earned much more revenue than plantation commodities (Sunseri 2002: 67).

³⁸ Due to male out-migration, hut tax was left to family members who bore unrealistic burdens, factors such death, warfare and low birthrate affecting their ability to pay (Sunseri 2002:65).

³⁹ The forced taxation of subsistence farmers led to widespread resistance, culminating in the Maji-maji war of resistance in southern Tanzania, from 1905-6 (Sunseri 2002; Iliffe 1979).

[illegible]

With the creation of new estates the labour question became critical. Creation of estates coincided with other projects that demanded labourers, such as building roads, railways, ports and government buildings. With the cash economy taking root, people living in areas without plantations were forced to migrate to Tanga. Accordingly, the colonial state developed a

dependency relationship between the labour producing regions or 'tribal areas', administered by 'native authorities', and the mainly sisal industry areas (Mbilinyi 1986: 109).⁴⁰

By 1910 most if not all ethnic groups in Tanganyika were involved in the migrant economy in the Tanga region. A 1910 list of labourers in Pangani (Tanga), a dormitory settlement for sisal estates, shows members of 52 different tribes (Iliffe 1979: 162). Other labourers were immigrants from beyond the borders of the colonies, from as far as Northern Rhodesia (now Zambia) and the present day Rwanda and Burundi (Ibid.). To control labourers, colonial administrators administered long contracts: two years for Tanganyikans and three years for those from outside the colony (Lawrence 1975: 110-118). A consequence of staying for longer periods in the plantations was that many labourers, for reasons discussed below, started new communities or joined local villages on the margins of estates hence affecting the plantation processes of production. Thus migrants from different parts of the country and from outside of the country became part and parcel of the communities they settled, affecting the social and economic relations of destinations as new ways of relating were established and negotiated.

Maramba village: a colonial economy creation

I have described major shifts in land alienation and the creation of migrant labour, imposed by the colonial regime, in Tanganyika and specifically Tanga. The origins of the people of Maramba followed similar patterns. Specific conditions, discussed below, that existed between plantation owners and labourers, brought new forms of living. Since labour was cheaply bought and could be easily disposed of, migrant and indigenous labourers were forced to adapt to new ways of survival. Historians have argued that since plantation work was insecure employment, many labourers were compelled to start their own *shambas*⁴¹ on the margins of the sisal plantations (Lawrence 1975: 118; also Sunseri 2002). However, local elders I spoke to claim that people settled in the village long before the plantations in the area were started. According to them Maramba was first settled by escapees from the construction of the Tanga-Korogwe railway before 1910, and during early land alienation process.⁴² Large numbers of labourers arrived after

⁴⁰ Rodney terms this the 'labour reserve economy' (1983: 7).

⁴¹ Small farms or gardens approximately one hectare in size suited to family labour.

⁴² The largest settlement in Maramba of such people includes the Zigua hamlet, with its name bearing the name of an ethnic group originally from Handeni who were involved in the railway construction.

the establishment of mainly rubber, sisal and kapok plantations in the area.⁴³ Migrants seem to have commenced permanent settlement in Maramba, starting with Lugongo and Mwele sisal estates, before the First World War.⁴⁴

Those who stayed in these villages were more likely to be casuals who worked on the estate during the day and cultivated or conducted small businesses in the village after work, on weekends and holidays. Lawrence refers to a study conducted in a number of sisal estates in Tanga region in the early 1960s, which showed that 64 percent of casual labourers resided outside of the camps. It was assumed that they lived in the vicinity of the camps on their own *shambas*, or in the villages surrounding the camps (Lawrence 1975: 118).

Apart from the insecurity of employment, conditions on the estates were reported to be extremely harsh, another reason for moving outside of the estates (Sunseri 2002; Ferguson 1980). Brutality, flogging, bad housing, hunger, overwork, poor sanitation, diseases, and death were common (Tambila 1983).⁴⁵ Plantations were reported to be sources of major diseases and created poor health environments with epidemics of syphilis, cholera, dysentery, and hook worms caused by unsanitary water and congested living conditions (Sunseri 2002: 157; Ferguson 1980: 321).⁴⁶

In her study, *The Political Ecology of Disease in Tanzania*, Meredith Turshen documents how rife venereal diseases such as syphilis became in the sisal plantations under colonialism (Turshen 1984). Similar accounts of sexually transmitted diseases were given by former sisal labourers in Maramba. Since many, mostly male, labourers came to the plantations alone, they flocked to villages to find local women (cf. Rugalema 2004). Many ended up cohabiting and intermarrying with them, though some already had wives back home. During early colonial days, farm owners

⁴³ Although rubber production ceased at the end of the German period a few of the trees can still be seen, especially in Mwele estate.

⁴⁴ As the German stronghold, the fiercest battle was fought in Tanga where many lives were disrupted as thousands of locals died fighting for the Germans. (Iliffe 1979).

⁴⁵ According to Tambila, most houses were rudimentary huts that did not stand for more than a season and even when improved were still declared inadequate (Tambila 1983: 34-5).

⁴⁶ There were very few health facilities, and those only on big estates, themselves heavily understaffed and with poor facilities (Tambila 1983: 37). For a broad account of colonial economy and the linkages to diseases in Tanganyika see Meredith Turshen (1984).

employed recruiters to procure women from up country. Missionaries saw this as a 'necessary evil' if 'one wants to retain workers continuously' (Sunseri 2002: 155). In the British period villages near the plantations grew, labourers preferring to settle permanently with local women.

Other diseases included pneumonia, malaria and typhoid, endemic in some sisal growing areas (Tambila 1983: 36). Sunseri writes that worm infestations, for example, 'were so rife that failure to build proper outhouses was perhaps the single most widespread criminal infraction directed against Africans in some regions' (Sunseri 2002: 157). Ferguson (1980) notes that labourers' conditions worsened and that farm supervisors complained of the 'semi-starvation' of workers. Workers regularly suffered from malnutrition as a result of food rationing, the available food being mostly rotten and inedible causing vitamin deficiency and susceptibility to disease (cf. Tambila 1983). On the other hand, workers who lived in their own huts with local women, who procured their own food from their own *shambas*, were found to be healthier than those who lived on the plantations (Sunseri 2002: 157).

The poor working conditions caused labourers to continuously migrate between plantations and to different parts of the region, leading to absenteeism on estates. Absentees and deserters were said to be well accommodated in settlements adjacent to the prisons existing on all estates (Tambila 1983: 50). Many of these first settled among tribesmen and women in the villages surrounding the plantations as transitory spaces before seeking work elsewhere. The estate houses, built like military barracks with restrictive rules, did not provide a sense of community. The lack of community centres for workers made life in the camps even more trying and settlements such as Maramba provided immediate solace, including sex (Turshen 1984; Rugalema 2004; Lawrence 1975: 125). The villages provided alternative freedom and have become in many ways 'a sub-system of the plantation system, economically and socially dependent on the plantation economy for survival' (ibid 125).

Lawrence (1975) and Sunseri (2002) argue that while the colonial state aimed to preserve labour sources in the newly created villages, labour needs gave labourers the upper hand in determining their own fate. Labourers became freer to decide whether to remain if they found village life and peasantry more rewarding than wage labour, especially in times of crises of sisal production.

Some historians (Sunseri 2002) and anthropologists (Ortner 1984) see such decisions by labourers as possessing agency and potentialities, and thus a sense of freedom to choose the kind of life to live. The anthropologist Eric Wolf, however, shows that while it might seem that individuals exert their own forms of power, these take place within broader confines of power to control ‘the settings in which people may show forth their potentialities’ (2002: 222). Wolf uses this form of power to speak of the role of ‘structural power’ to ‘organize and orchestrate the settings themselves’, where he borrows from Michel Foucault’s notion of power as the capacity ‘to structure the possible field of action of others’ (Foucault 1984: 428; cited in Wolf 2002: 223). While it seemed labourers were shaping how the colonial state acted towards them, the truth was labourers were actually compelled to invent ways of circumventing the labour economy on which they still had to depend for survival. This was further detrimental to people’s relations in the villages since males’ moving away to work exerted pressure on the women who had to become casual labours as well as caretakers of the house and children, while the male labourers moved from village to village or from estate to estate, in search of better wage and working conditions, with many failing to return to their houses and new families. This phenomenon was still common during my field study. It had led to the presence of many single women headed households, child headed households burdened by adult responsibilities long before the impact of HIV/AIDS on the community.

Maramba and the colonial economy

By 1948 all the village land was considered to be suitable for the growth of cocoa. The Tanga provincial leader allowed a British parastatal company CDC (Commonwealth Development Cooperation) to alienate much of the village land. The villagers resisted, despite promises of compensation, but alienation occurred and compensation did not follow. The encroachment pushed the villagers to only 829 ha of current village land. The turning point came when the estate owners later discovered only a portion (less than 100 acres) of the estate was suitable for cocoa production. Villagers were then allowed conditionally to continue farming on ‘their land’ but not to farm close to farm operations.⁴⁷ The establishment of the cocoa plantation demanded more labourers, recruited up country. A former farm manager of Maramba estate informed me

⁴⁷ For similar experiences in other villages in Tanga see Machiela von Freyhold (1979: 19).

that local Shambaa increasingly worked as casual labourers (cf. Lawrence 1975). Maramba as a marginal settlement became even more popular as the new plantation brought electricity⁴⁸ which made the place more lively and entertaining and attracted labourers to settle there.

The Native Authorities Act of 1937 was coercive towards peasant farmers as it specified a minimum acreage for certain crops and specified working hours with the aim of ensuring that villagers also provide labour in plantations (Sarris and Brink 1991: 23). This law further determined what types of crops could be produced in village lands. For example, the new cocoa estate demanded plentiful shade. So kapok trees were planted in the estate. Kapok was planted strategically as it also produced cotton-like material. Villagers were also asked to grow cocoa, kapok and copra in their own village plots (see Appendix 3). Copra was needed following the establishment of a copra oil processing industry in Tanga town that manufactured soaps and body oil. According to Mr. Shemakula (82), a former migrant labourer from Iringa (south west Tanzania), many people did not know what they were in for, but felt the impact years later:

We did not have any kapok (*mi-sufi*) and coconut trees (*minazi*) here! People needed money so they planted them... But the kapoks as you see take too much space⁴⁹ and their shade killed other plants. *Minazi* are worse, whenever it is grown you cannot grow enough maize or bananas. Its roots are so long and drain all the water in the ground. Now we cannot grow enough maize or bananas in our plots. (Interview, Mr. Shemakula, 2008)

By the time I conducted my fieldwork the traditional use of copra had changed. It was no longer a major cash crop for sale to the local industry, and cocoa production had died out. Copra extract was now used as a spice. Young coconut trees were tapped to produce a local brew known as *mnazi*. Other crops that locals were encouraged to grow in the area were coffee beans (*buni*), pepper, and cardamom. However cardamom, which was said to fetch high prices internationally, was forbidden because it competed with foreign settler farmers (cf. Iliffe 1979). Since some people still lived in the mountains where the vegetation was dense, crops were grown

⁴⁸ To date, the village is the only one in the ward with electricity.

⁴⁹ It is the most notable topographical and vegetation feature in the community. It grows to a height of up to 60-70 metres (200-230ft) with a very extensive trunk sometimes four metres in diameter with buttresses. Its branches are wide and densely crowded with large, robust thorns. The leaves comprise 4-10 palm shaped leaflets, each up to 20 cm (8 in). They produce numerous seed pods; up to 200 I was told. It has many uses internationally but in the village was occasionally used only to manufacture mattresses.

surreptitiously.⁵⁰ As Mr. Shemdoe Mbicha, a local teacher during the colonial period, further explained, ‘when they were told not to grow cardamom people had to go further in the mountains in a place called Kigongoi, Nsanza, Kwebago, and plant it so that they were not caught’. During my field work pepper was no longer a necessary plant for the Shambaa. Ironically, it is now considered a wild crop as it grows on its own in the bush without any need of proper care.

These shifts in agriculture did not affect only Maramba village. In the Usambara in general food crops such as bananas had started to disappear as staple crops because of overreliance on cash crops. Maize and rice were favoured over the traditional staples such as bananas, sorghum and millet (Flueret and Flueret 1980). Flueret and Flueret point out that by the beginning of the 20th century in the Usambara area ‘the primary position of the banana began to be eroded,’ (1980: 320-322), and maize was demanded, primarily to feed plantations workers. Further, maize was preferred for labourers since ‘weight for weight maize is about four times as calorific as bananas’ (Ibid: 322). Rice and maize were demanded by the colonialists because they could be used for food and as well as exported for profit (Iliffe 1971). Moreover, banana was unsuitable for transportation due to its bulk and difficult storability.

Nutritionally the shift of staples from banana, millet and sorghum to maize and rice was detrimental to the health of the local people because the former provided richer sources of protein and other essential vitamins than the grains (Ferguson 1980). Further, it is claimed that the process of milling maize and rice causes it to lose vitamins so that when eaten regularly without supplements it leads to vitamin deficiency diseases (Ackroyd 1970: 17-34, cited in Ferguson 1980: 317).⁵¹ For example a disease such as pellagra, noted during the colonial period, was the result of consuming milled maize for the most part. The need to meet government requirements, especially taxation, inclined the Shambaa to cultivate maize which gradually

⁵⁰ In sharp contrast to the present, the locals speak of the past when the East Usambara mountain of Mtai were densely covered and attracted rainfall throughout the year. They attribute deforestation mostly to logging activities that were intensified by Asian businessmen during the British period. This they said led to ‘disappearance of rivers, streams which fed many fish ponds at the mountain bottom’ (see also Hamilton and Bensted-Smith 1989) and affected rainfall patterns in Tanga (Von Freyhold 1979: 19). Also colonial government enforced laws to protect forests with the aim of forcing locals to provide labour on estates (Sunseri 2002).

⁵¹ Ferguson argues that because maize is not drought resistant, in its absence people were susceptible to periodic famines (see Ferguson 1980:317).

became their main staple, however at the expense of disease (Flueret and Flueret 1980). A diet of only milled rice resulted in beriberi (Ferguson 1980: 317).⁵²

According to Sunseri (2002), in 1891 Tanzania exported 2.75 million kg of rice (2002: 126). However, by 1909 the German East Africa Company imported more than 13 million kg of rice (ibid).⁵³ A series of devastating famines hit Tanga between 1880 and 1940 and cassava was then strongly advocated by the government for its ability to withstand dry periods (Giblin 1986). It was willingly adopted by the Shambaa not only because it guarded against famine but also because of its social and economic advantage in the face of external and internal negative factors. These factors included population pressure as a result of land shortage. Writing about the Usambara, Flueret and Flueret assert:

Given these circumstances of land shortage, it seems reasonable to suppose that there would exist strong pressures on farmers to extract the maximum in food products from the land at their command. A hectare of land planted in maize can be expected to produce about 7 million calories per annum; the same land planted in bananas should yield more than 11 million...but if planted in cassava the same land will produce... perhaps as many as 27 million calories per annum (Flueret and Flueret 1980: 324).

However, it has been noted that cassava is less palatable and less profitable than maize, and farmers in the Usambara who possessed enough land cultivated more maize than cassava (Attems 1967). The current preference for cassava as an important staple in Maramba (see Chapter Four) is likely to be associated with these socioeconomic and historical developments. Villagers tended to grow cassava in their own smallholdings and grow maize on estate farms where they are not allowed to grow permanent crops. Cassava did not generate as much cash as maize, so if land was available for maize, cassava remained an important staple for those who cannot afford to cultivate maize.⁵⁴ During fieldwork the villagers referred to 'food' (*chakula*) when they spoke of cultivating maize. The loss of banana as a staple resulted in food shortages

⁵² Aside from nutrition related diseases, historians have found a correlation between outbreaks of many new diseases and the arrival of the colonialists. These include smallpox, cholera, tuberculosis and influenza (see Iliffe 1979: 270, 181 and 386; Ferguson 1980: 307-343).

⁵³ According to Sunseri, some Tanzanian communities had long established trade links with the Indian Ocean countries, exporting grain before the Germans arrived (2002: 126).

⁵⁴ Migrants who settled in villages such as Maramba were also divided according to social economic class. Better off workers, such as section heads, imposed this hierarchy in the village and could amass better and more land than labourers. In Maramba, some of these former managers still control some land and houses in prime village areas and became progressive farmers who hired cheap migrant labour (also Hyden 1980: 113).

and chronic malnutrition in the Usambara and elsewhere in Tanganyika (Fleuret and Fleuret 1980; Ferguson 1980: 336; Little 1991).

‘The imposition of structural power by the colonizer’, to use the words of Eric Wolf, shaped the social field and rendered ‘some kinds of behaviour possible, while making others less possible or impossible’ (Wolf 2002: 223). The outcomes for food production were devastating as their efforts were directed towards producing for the colonialists’ needs. In the process, locals succumbed to disease and also changed households’ members’ ways of relating and support.

The postcolonial period and Maramba

The questions [about agriculture development] are important because people’s health status depends to a great extent on the availability of food for a balanced diet, and availability is mainly determined by government policy. Answers can be found in an examination of past and present agricultural policies only if one takes into account the transformations of social relations (that is, the creation of capitalist class structures in the colonial period) and the effect of political independence on those relations (Turshen 1984: 65).

To understand the impact of food insecurity and poverty in the Maramba community it is necessary to account for the shift in ideology and concomitant policies that the postcolonial regime implemented. Very large studies have been, and continue to be, conducted on the social experiment of Ujamaa (familyhood or collectivization) pursued by the pro-socialist regime under Julius K. Nyerere between 1964 and 1985. This section does not aim to recount that history. My account will focus on some of the Ujamaa policies, especially those on rural development and how they shaped food (in-) security and population dynamics in Maramba.

After the political independence of Tanganyika in 1961, the country adopted pro-socialist principles guided by principles of personhood based on presupposed traditional African ways of life where people worked together and shared the fruits of labour as a community. Nyerere was said to employ peasantry concepts to modernize development, described by some as ‘modernization by traditionalization’ (Mushi 1971, quoted in Hyden 1980: 98). The philosophy behind Ujamaa was guided by one main objective, and that was the attainment of a self-reliant socialist nation (Ibhawoh and Dibua 2003: 60). In other words, Ujamaa was a new form of

structural power, albeit imposed by the local government, and not the colonial state, that aimed to structure people's ways of living. Its principles were elaborated in a 1967 policy document under the Arusha Declaration called 'Socialist and Rural Development' (*Ujamaa na maendeleo vijijini*) whereby Ujamaa was geared towards rural development aimed at doing away with social and economic disparities manifested in the racialized ownership of means of production by a few.⁵⁵

Two major steps were taken by the government; first, by nationalizing⁵⁶ the commanding heights of the economy mainly those privately owned such as plantations, banks, insurance companies and big industries⁵⁷ and the formation of rural cooperatives to buy and sell farmers' crops. According to Lugalla (1997), the dominant politics of the day considered private entrepreneurship to be evil and, therefore, unwanted (Lugalla 1997: 432). Secondly and more importantly, was by villagization.

The policy aimed to increase rural agricultural production by permanently settling the rural population into communal villages. It was the largest resettlement scheme to be implemented in an African country at that time (Hyden 1980: 130). The programme was justified by the then prevailing development discourse which recognized that in order to develop and mechanize agriculture there was a need for people to live together closely so that it would be possible to provide basic social services such as water, health and schooling. In these villages peasants were to have their own plots for private household subsistence and also communal plots to earn surplus income for all (Hyden 1980: 115). The scheme was said to be heavily funded. The funds were to be used for social services including building roads and cash payments to support farmers until the first harvest (Ellman 1975: 313).

In the first two years (1968-69) people were asked to start communities voluntarily but only a few did so. By 1969 only 650 villages had been formed countrywide (Hyden 1980: 102). In

⁵⁵While Nyerere's version of socialism was described as paternalistic, idealistic and utopian (Boesen, Madsen and Moody 1977: 12; Von Freyhold 1979: 72-7), others have perceived Nyerere as having genuine and 'legitimate intentions and aspirations that informed Ujamaa as a development strategy' (Ibhawoh and Dibua 2003: 60).

⁵⁶ The term has been defined as the utilization of all or part of the means of production to benefit society as a whole (rather than individuals) to the improvement of their material, cultural and moral spheres, not simply economic (Bolton 1985: 2-8).

⁵⁷ Not all industries were nationalized. Sometimes the state collaborated with former owners. For example, only 60 percent of the dominant sisal industries were nationalized (Arkaide, 1973: 37; cf. Shivji 1974).

November 1973, Nyerere changed his mind and declared all Tanzanians must live in villages by the end of 1976 (Hyden: 1980: 129). According to James Scott, Nyerere believed the poor masses in the rural areas 'did not know what was good for them' (Scott 1998: 231). Nyerere stated, 'it may be possible and some time necessary to insist on all farmers in a given area growing a certain acreage of a particular crop until they realize that this brings them a more secure living, and then do not have to be forced to grow it' (Nyerere 1968: 356). In other words, where voluntary movement was not feasible, force was necessary to effect change.

When I asked people about their experiences of Ujamaa, narratives focused on this settlement process. The government used the army to carry out the operation: 'People's houses in the mountains were broken into pieces and all their belongings were left in the rains...some soldiers even beat the women and people had to run and hide', explained a village elder. Another said, 'they would come to the house they did not care if you are old and you can actually bear him as a child, they drag you, they were saying we do not want development, that we are perpetuating poverty, and I remember they burnt a house of my neighbour' (see also Porter 2006: 73; Von Freyhold 1979: 125-141).⁵⁸ Elders complained that there were no preparations for the move, and no houses to move into. Further, they claimed they were removed in the middle of planting, and sometimes the harvesting period, losing entire crops, a situation recorded in many parts of the country (cf. Hyden 1980). According to Lofchie (1978), 'coercion was so widely employed...that it became a far more conspicuous feature of the relationship between bureaucrats and peasants than mere poor planning' (Lofchie 1978: 474). And in times of food shortages, food relief was given to only those who joined Ujamaa in parts of Tanga (Porter 2006: 74; Von Freyhold 1979).

In Maramba villagers tried to resist the programme. Elders told me stories of how witchcraft was used to attack soldiers who came to remove them. In Iringa a progressive farmer became famous after shooting and killing the regional commissioner for trying to take his land and enforcing communal work (Nindi 1990: 63-68). A man in his 60s asked me, 'Who told Nyerere that those living in the mountains were suffering? If they were suffering there would not they come on their own, didn't they know Maramba existed before? Why force them?'

⁵⁸ While the government of Tanzania was uprooting its own people in the name of development, an almost similar situation was taking place in South Africa in the name of apartheid (see Bonner, Delius and Posel 1993), which Nyerere's government condemned.

Given the wide political campaigns against colonialism and labour exploitation in plantations, people in Maramba who were compulsorily removed from their homes had high expectations that the surrounding estates would be divided among them as had happened in other areas (Sabea 2001; Wisner et al 1975).⁵⁹ It should be remembered that some plantations surrounding the village (especially Maramba estate and Mwele) were once part of village land and so villagers expected that it would be returned. However, Maramba estate was one of the plantations that was not nationalized and remained under the control of CDC. The locals continued to farm on some of the open land on which cocoa did not thrive.

As a result the problem of land for farming resurfaced. Those who moved to Maramba had to squeeze into other people's houses until they could build their own. Those who had established themselves in the villages were forced to divide their plots to accommodate newcomers' houses since they were not allowed to build on the estate lands. Mr. Ramadhani Mchau who was among those who faced this challenge, elaborated his situation to me:

I received 26 families from the mountains on my land. We gave them a place to build their houses, but for farming I told them they had to find elsewhere, because if I gave them a place to farm as well I would remain with nothing ...as you can see all this land from my house to the mosque and party offices (about 8 acres) I gave it out. If I refused they would have said I did not want development! I used to harvest plenty of food until Ujamaa came. But now I cannot harvest enough to satisfy my family.

Mr. Ramadhani had opened several cases to have some of his plots returned to him.⁶⁰ Linked to the problem of land in the village, the government also launched many coconut and cattle schemes, which echoed colonial policies, but which also failed. According to Von Freyhold's observations of Tanga's Ujamaa villages, these benefited the few privileged peasants with cattle (Von Freyhold 1979: 21). The schemes subsequently failed because of inadequate arrangements regarding land rights, water sources and veterinary services (Ibid.).⁶¹

⁵⁹ Ujamaa villages were also started in areas where there was open land. In Tanga individual smallholder and cooperative schemes to redress racial imbalances in the sisal industry were initiated, but all had collapsed by the early 70s due to, among others, bad management and the decline of sisal prices worldwide (Von Freyhold 1979; Wisner et al 1975).

⁶⁰ The land laws during villagization did not clearly deal with legal ownership of the land of individual peasants. The act did not clarify rights accorded to former landowners and did not provide directives to village heads and council members on how best to allocate land (Kiondo 1999: 45; URT 1994).

⁶¹ In Maramba, only better-off farmers owned cattle. I detail this phenomenon in Chapter Four.

One plausible explanation for villagers not being given farms was the fact that Tanzania was, and still is, a dual economy. There is a plantation mode of production, supplying raw materials to advanced nations, and a peasant sector with limited technology. Dependency theorists argue that for such an economy to prevail, a good supply of manual labour must be ensured through maintaining low prices of peasant products (Rodney 1983).⁶² The political scientist Michael Lofchie (1978) contends that since the plantation economy depends on migratory labour, low producer prices work indirectly to ensure a supply of labour since peasants will be unable to secure their cash needs and will be forced to seek wages in plantations.⁶³ On the other hand, Lofchie argues, the increase would have benefited progressive farmers with large capital and widened income inequality in the rural areas, and since the theory of rural socialism was premised against exploitation the low prices were necessary (Lofchie 1978: 465).

Apart from the problem of land in Maramba, those who were moved were said to have difficulty adjusting to the new environment (Hyden 1980; Von Freyhold 1979). Having moved, the skills and local knowledge that enabled them to adapt to areas they once lived in were lost. For example, mountain ecologies in the Usambara were different from lowland areas and required knowledge about new soils and rainfall patterns. In Rufiji, Hyden documented how peasants would return periodically to their former villages (Hyden 1980). According to Lofchie government officials did not consider the fact that ‘the settling-in process was even longer for villagers who had been relocated to a different ecological milieu where they had to become accustomed to cultivating other crops under un-familiar conditions’ (Lofchie 1978: 468). In the words of James Scott, ‘administration convenience, not ecological considerations, governed the selection of sites’⁶⁴ (1998: 35).

⁶² Lwoga writes on the challenge of converting former sisal villages into Ujamaa-compliant ones since these villages were ‘based on living, not producing, cooperatively, and still economically dependent on supplying labour to the estates’ (Lwoga 1989:126).

⁶³ Although socialism was introduced the country had inherited the colonial economic structure, migrant labour was still needed. According to Lwoga (1989), although the government advocated against labour migration in order to garner support from the masses in the independence struggle, it still needed labour in the plantations. In order to ensure labour supply the government employed nationalistic sentiments such as ‘Freedom is work’, but since the labour reserves were not developed economically people still migrated to plantations (Lwoga 1989:200).

⁶⁴ This experience is similar to that of forced settlements in Ethiopia where Clay, Steingraber, and Niggli reported that Ethiopians who were moved were transformed from ‘an agricultural expert to an unskilled, ignorant labourer, completely dependent for his survival on the central government’ (see Clay, Steingraber and Niggli 1988).

Socially, many networks of kinship support were destroyed as the same clan and lineage which lived together before resettlement ended up in different areas across the country. In Maramba I found similar scenarios; for example, one family with lineage members who were transferred to four different locations across the region and the country. Networks of support also affected community farming in Ujamaa villages. For instance, while wealthy farmers could employ labour, villagers with networks had to assist families without networks causing much resentment in the process (see Van Velzen 1975).

Countrywide, the villagization programme was declared a failure. Of the approximately 5,000 officially established villages by January 1974, roughly only eight percent (400) were said to have reached the third stage of Ujamaa development, a stage categorically defined as the status which communal farming would have major economic impact on a village for it to be legally registered as a cooperative society (Lofchie 1995: 451). In her conclusion after a decade of Ujamaa studies in villages across Tanga region, Von Freyhold, acknowledging the failure of Ujamaa, describes her findings as follows:

What looked in 1971 to be the difficult and distorted beginning of communalization turned out to be the climax of the development towards Ujamaa, a development which was halted and reversed in the years that followed [...] For the majority of peasants the decade after the Arusha Declaration was [...] simply a period where they had been subjected to many government directives and orders without witnessing much economic development. (Von Freyhold 1979: 191)

The economic crisis and the need for adjustment

Tanzania faced severe diminishing of its grain reserves, specifically maize, during the height of the villagization period from 1973 to 1975. The country was said to be on the 'brink of starvation' (O'Neil and Mustafa 1999; Lofchie 1978). From August 1973 to July 1975 the country imported 500,000 tons of maize. Contrastingly, three years before (1968-1971) Tanzania was a net exporter of maize (See Table 4). A short while before the crisis (1972) the country had substantial foreign exchange reserves⁶⁵ but they collapsed by the end of 1973 and its balance of

⁶⁵ URT: The Economic Survey, 1973-74 (Dar es Salaam, 1975) (cited in Lofchie 1978: 455).

payments deficit grew from \$125 mill, to calamity levels of approximately \$350mil.⁶⁶ International lenders worried that the country was on the edge of bankruptcy as its remaining balance could sustain financially only one month's of imports (Campbell and Stein 1991).

Table 4: Tanzania's External Trade in Maize, 1968-1978⁶⁷
in thousands of metric tons

	1968-9	1969-70	1970-1	1971-2	1972-3	1973-4	1974-5	1975-6
Imports	Nil	46.9	Nil	92.3	78.9	183.6	317.2	42.3
Exports	51.8	Nil	53.4	Nil	Nil	Nil	Nil	Nil

Source: URT (1976)

Both internal and external factors have been outlined as the cause of the food and economic crisis. Internal factors include the failure of the villagization programme that aimed to raise production for villages to become self sufficient, and poor climatic conditions such drought.⁶⁸ The decline was also associated with, among others, the reduction of producer prices which Nyerere described in his book *The Arusha Declaration Ten Years After* (Nyerere 1977: 20). However, for many analysts, the fact that there was enough opposition that force had to be used, and villages had to be heavily subsidized, explains why peasants were unwilling to produce to surplus and ultimately resulted in the food crisis (Boesen, Madsen and Moody 1977; Hyden 1980; O'Neil and Mustafa 1999). Failure was further attributed to bad management, poor planning, public overspending, corrupt and unskilled bureaucracy (Ponte 1999: 5). On the other hand, leaders were said to attribute the failure of villagization to peasant conservatism, as they were viewed as 'inherently distrustful of programmes of modernisation', and as traditionalists unwilling 'to change age-old techniques of agricultural production' (Lofchie 1978: 464).⁶⁹

⁶⁶ URT: The Economic Survey, 1974-75 (Dar es Salaam, n.d.), p. 2 3. (cited Lofchie 1978: 455)

⁶⁷ Marketing Development Bureau, Ministry of Agriculture, Price Policy Recommendations for the 1977/78 Agricultural Price Review, Vol. I (Dar es Salaam, 1976), p. 3. (cited in Lofchie 1978: 454)

⁶⁸ The country was hit by drought in 1976, 1980, 1983, and 1984 (Ponte 1999).

⁶⁹ James Scott (1999: 223-261) branded social experiments of the 20th century as 'high modernist aesthetic', describing their failures as 'tragic episodes'. He observes three main characteristics of 'high modernism': 1) weak civil society which cannot object to the plans imposed; 2) using the power of the modern state as an instrument 3) 'aspiration to the administrative ordering of nature and society, raised to a comprehensive and ambitious level'.

The economic crisis, Tanga region and Maramba

The accounts above show another backdrop against which the lives of people in Maramba and surrounding communities can be viewed. Sisal was the backbone of the economy of Tanzania, and particularly so in the Tanga region. To its people it became not just a source of income but had become a 'way of life' for more than 90 years (cf. Sabea 2001). Towards the late 1960s the prices of sisal dropped (from £143 in 1963 to £69 a ton in 1967 for fibre grade 3L (Sabea 2001: 292)). This was linked to normal international market behaviour but was also influenced by the advent of synthetic fibres (polypropylene) which took more than 50 percent of the market share (ibid.). But the collapse of the industry in Tanzania was said to be caused by more than external impulses. These offer only a partial picture because those external forces did not similarly affect other sisal producing countries such as China, Brazil and South Africa, and associated with what the anthropologist Hanan Sabea, drawing on David Harvey (1985), calls 'the historical geography of capitalism' and its arrangements of 'geographical restructuring' (Harvey 1985: 141, cited in Sabea 2001: 293).

Some studies linked Tanzania's sisal decline exclusively to the nationalization of industry, after which new operators lacked the capacity to effectively manage its means of production (Bolton 1985: 156). In her extensive study of the history of the sisal industry in Tanga region, Hanan Sabea argues that, apart from international market dynamics, the death of the industry in the 1970s was a complex process compounded by unskilled technocrats and politically motivated managers, and control of labour. Corruption and mismanagement, she states, were one of the major 'nails in sisal's coffin. (Sabea 2001: 296).

The death of the plantation industry meant the 'slow death' of local people's livelihoods, an aspect largely ignored in many studies.⁷⁰ Most villagers I spoke to linked their current poverty to the 'death' of the plantation industry during Ujamaa period. Village elders and workers in the industry referred to those days as 'days of torture' (*siku za mateso*) from which they have never fully recovered, many workers going for months without pay or health benefits (cf. Sabea 2001).

⁷⁰ Most accounts of the crisis of nationalization have overlooked experiences of the workers immediately after the collapse of industry in Tanga. This has been noted by Sabea (Sabea 2010: personal communication). Instead the focus of the analyses of the post-Ujamaa period shifted to discussion of the infamous structural adjustment programmes that affected the whole country, a theme I discuss below.

More joined surrounding villages and commenced new lives of unremunerated peasantry. Many, particularly foreign labourers, could not return to their countries of origin and were forced to squat in the estate houses or work as labourers in peasant farms surrounding the estates (Von Freyhold 1979: 173; also Faber 1995). Family disruptions were frequent as income was desperately needed, as illustrated below.

Mr. Abdallah Mkenda (72) was a former sisal cutter in Magunga estate in Korogwe. He is now the watchman of a primary school in Maramba. After their estate was closed down he and others heard there were some jobs at Lugongo estate bordering Maramba village and left Korogwe in 1976.⁷¹ He then had a wife and three children from his home land in Iringa, southern Tanzania. He had to walk to Maramba (more than 40 kilometres) while begging on the pathways to reach Maramba: 'It was tough because I needed money to buy food and there was no work... my wife and children looked up to me because I was the provider and I could not give them anything; I had to leave, many like me did leave. Along the way I found some menial jobs on "locals" (wenyeji), like to clean farms but the pay was not good. After I reached here there were no jobs so I joined this village and stayed in abandoned estate houses... I was not able to return until today because I had no money.'⁷² More settlements of former labour migrants became villages. In Maramba ward, this included, Mbambakofi, Kiumbo, Mtakuja, Bantu, Number *saba*(seven), Number *sita* (six), Churwa and others.

Compounded by the lack of jobs after the closure of many industries, basic goods such as sugar, cooking oil, maize, beans and soap could not be found because of the country's economic crisis, and especially government's inability to cope with rising import prices (Ponte 1999). By the late 1970s and early 80s many shops had closed and Regional Trading Cooperation was given the mandate to commence rationing consumer goods countrywide. The situation forced government to rethink its economic and social policies, villagization in particular (Ponte 1999: 5-6).

⁷¹ Maramba cocoa farming under CDC was hit by the crisis and closed all operations in 1976 when the estate was handed not to the villagers, but to a government parastatal: National Agricultural and Food Company (NAFCO), causing resentment.

⁷² The collapse of sisal in Tanzania and its impact on the local population can be compared to the collapse of the sugar plantation economy in Brazil where Nancy Scheper-Hughes describes how dependency on sugar resulted in poverty and destitution to many (Scheper-Hughes 1992).

The need for adjustment

Financial assistance to address the long structural imbalances was needed to purchase consumer goods, especially grain and vital spare parts. This was so urgent that the Nyerere regime had to reconsider its social economic programmes (O'Neil and Mustafa 1990). The notion of structural power as used by anthropologists (Wolf 2002), best describes these experiences. Tanzania was still connected to global capital forces and its principles of Ujamaa were in contradiction to capitalistic forces that controlled much of the world economy. As a result, a series of structural adjustment programmes were undertaken by the government from the early 1980s. Under the directorship of the International Monetary Fund (IMF), in the period 1981-1982, Tanzania designed its own programme called the National Economic Survival Programme (NESP) which was succeeded by locally a formulated structural adjustment programme (SAP) in 1982-1985, supported by the World Bank (Stein 1991: 98-101; Gibbon 1995: 9-17).

In 1986 a full Economic Recovery Plan (ERP) package with directives from IMF was implemented, but many development analysts saw it as reversing Tanzania's gains since independence as it came with strict conditions (Luggalla 1995; Lurie, Hintzen and Lowe 2004; Kiondo 1999; Ponte 1999). Conditions included devaluation of the currency by 50 to 60 percent; abolition of price controls and reduction or withdrawal of subsidies; wage freezes; cutback of workers, and deregulation of laws protecting job security; moving activity towards an export rather than domestic economy; increasing prices of goods and services in line with world market prices; individual consumption tax increases; removal of tariffs for foreign investors; political liberalization; privatization of the formerly nationalized industries;⁷³ the introduction of private ownership of land – previously the state owned the land in its entirety. The measures included reduction of government expenditure particularly on social services and the introduction of cost sharing in education and health. In general, they were seen as aiming to stimulate growth in the private sector rather than the public and enhancing the security of western loan providers hence benefiting international lenders over the local population (Lurie, Hintzen and Lowe 2004: 206)

⁷³ Although the state-owned sisal estates and factories were not fully privatised until April 1998 (Sabea 2001), a government agricultural policy of 1982 along with the 1982 SAP, included provisions allowing the private selling and buying of land and saw an enormous rush of private land alienation (see Kiondo 1999: 47).

These conditions had a great impact on the social and economic lives of citizens. The national health budget, for example, declined from 7.23 percent to 4.62 percent from 1977/78 to 1989/90 respectively (Lugalla 1995: 44). The impact was sharply felt as during Ujamaa the government provided free health services. Devaluation of the currency compounded the situation with drug prices going up by 300 to 400 percent by 1988 (Lugalla 1995). In his review on SAPs' impact on health, the Tanzanian sociologist, Joe Lugalla, analyzed how the overall crisis manifested itself in a situation where the government could no longer provide adequate health services, failed to establish enough health facilities, trained insufficient doctors and nurses, leading to overcrowding in health facilities, decline in both curative and preventives services, amidst a rising population (Lugalla 1995).

At the height of these crises in Tanzania, the spread of HIV in sub-Saharan Africa proliferated. Lurie and colleagues (2004) contend that although socioeconomic forces are responsible for the spread of HIV transmission in poor countries, IMF and World Bank policies played a critical role in promoting the risk for transmission in poor countries (cf. Setel 1999; also Susser 2009, for a South African account). As argued below, the spread of HIV in Maramba must be analyzed in relation to both global and national factors, and also, and more importantly, in relation to specific dynamics related to land ownership patterns in Maramba.

‘We are living on an island’: Maramba and current food insecurity

Following the crises of the 70s and the introduction of liberalization, the question of land ownership in Tanga, once in the hands of the colonial state and, thereafter, the government, was revived. New contradictions between the ‘public’ and the ‘private’ emerged, brought on by liberalization (cf. Sabea 2001). On one hand, the government seemed to justify its actions as responding to privatization, whereby it was relinquishing its role as a public provider, while on the other hand villagers expected it to be the ‘guardian’ of the public. This dichotomy becomes significant when viewed against the background of the Ujamaa policy whereby government was pursuing equity policies. Writing on the privatization of the sisal industry, Sabea argues that the dilemma on the estates ‘remains the political and cultural implications of the public-private

divide or the reconstitution of the domain of the ‘public’” (Sabea 2001: 305). Stated differently, the government divorced itself from its responsibility to its people, without officially informing the masses or revamping its constitution.⁷⁴

The collapse of estates such as Maramba and Mwele caused by the economic crisis revived the hopes of villagers to regain ‘their land’ on which they depended for their main source of food. Most of the land now lay unused, so many villagers, mainly unemployed, planted crops and ‘illegally’ started farming there. To their dismay Maramba and Mwele estates⁷⁵ were handed over to JKT⁷⁶ (1982) and the Agricultural Seed Agency under the Ministry of Agriculture (1986), respectively (cf. Kiondo 1999). Elders told me they were promised relocation so they could build houses and continue farming (cf. Kiondo 1999).⁷⁷

The manner in which JKT took over the estates was cruel. Throughout the late 1970s and early 1980s, before the arrival of the JKT, a team of village leaders was selected to report on distribution of the farms to district and regional authorities. However, to the villager’s surprise, the leaders ended up in jail. Mr Shemdoe Mbicha explains:

They were told they are disturbing peace by mobilizing people to demand for the farms. People were so surprised. How the government could be doing this to its people? The commotion was so rife between us and representatives of the estates who by then were closing down due to under production. One day in 1982, early in the morning we started hearing strong noises from the road. As the noise became bigger we saw tens of lorries full of soldiers, they invaded the farms and started slashing all our crops, everything we planted! We had planted oranges, mangoes, coconuts, maize, potatoes and others. When they (the soldiers) came and find you in the farm they tell you to leave immediately, many people were beaten. If they find you with your cassava they ordered you to remove it and give it to them. If you did not remove, they did, but it became theirs now, and put it in their tractors and fills them and took them in their base. After harvesting everything they

⁷⁴ Although Tanzania is a multiparty democracy and liberalized her economy the constitution still contains clauses referring to it as an Ujamaa country.

⁷⁵ The previous sisal estate of 960 hectares. Its role now is to produce various kinds of seeds for farmers according to demand. During my field time it was utilizing only 42 hectares for production.

⁷⁶ The case of suddenly handing over to JKT was unique to Maramba in that, elsewhere in Tanga region, according to Tanzania Sisal Authority (1995), more than 37,000 acres were returned to villages.

⁷⁷ According to an official at the sisal authorities in Tanga (Katani Limited) there are many court cases between the estates on one hand villages on the other, each claiming the right to land. Private companies claimed their right because of liberalization and villagers uphold their right as ‘original owners’ (*wamiliki wa mwanzo*), even before colonialism (also Sabea 2001: 306).

cut all the plants to the ground. People could not compete with them, they had guns! We believe they brought the army to shut us up.

Some people's narratives echoed comparable scenes of violent removals encountered during the imposition of the Ujamaa policies. The villagers, apart from losing an important source of food, also lost access to some of the uncultivated land in the JKT estate which comprised dense vegetation. This had been their source of wood for fuel and sometimes building materials. More than food production for them was jeopardized. Moreover, the manner in which the boundaries were created was violent and humiliating to the powerless villagers. Speaking of the aftermath, with anguish in his voice, my informant Ramadhani said:

They (soldiers) truly punished the citizens (*wananchi*) when they caught them in their farm with a bundle of fuel wood they were forced to carry it in their head and run, from Churwa⁷⁸ to Maramba while forced to sing songs 'I am stupid! I am stupid!' Afterwards they were taken to the local court and charged with trespassing, there was neither bail nor pardoning.

People's ordeals after the arrival of the JKT should be read against the background of the period through which the country was passing. These were the country's most turbulent years, including a drought in 1983 and a scarcity of consumer goods (Ponte 1999). The impacts of JKT's takeover of the farms, over and above the impact of SAPs that affected most people's source of wages, were manifold. Many of those who could not farm decided to leave the community, a trend reflecting migrant behaviour since colonial times. Drawing from Pottier (1999: 29), 'local history is a critical factor in explaining varied responses to policy' and thus such patterns of land ownership in Maramba show how 'policy interventions ignore local contexts and especially the local imbalances in power and resources use' (Pottier 1999: 27) which are bound to hinder the improvement of people's lives. SAPs may have affected the whole country but the arrival of the JKT and takeover of Maramba estate added salt to the wound, as Mr. Shemdoo further narrates:

Many people were frustrated, some left to wherever...For us we did not have anywhere else to go. We were suddenly living 'on an island' (*kisiwani*), controlled farms around us and the mountain behind us now under strict forest conservation! We saw that we will die from hunger (*Tuliona tutakufa njaa*) if we continue fighting we decided we just have to live with them and therefore we begged them to think of us and our food problems. The

⁷⁸ The distance from Maramba to Churwa village is approximately 12 kilometres; the extent of JKT estate farm from Maramba. Villagers from Churwa also lease plots from Maramba JKT.

JKT agreed but after twelve years (until 1993), but issued very strong conditions that we could grow non-permanent⁷⁹ crops alone, and only maize and maybe cassava, until today.

During my fieldwork, some JKT members had turned to farming 'their land' and had the upper hand in securing plots. While villagers used their family for labour, soldiers and rich peasants hired labourers, mostly former sisal workers and other villagers. At some point soldiers used their position, albeit unofficially, to sub-lease their own plots to villagers in return for cash payments or in kind, such as a sack of maize per hectare sub-leased. The new control of land for farming by JKT in Maramba signified the shift of power of control from the government during Ujamaa, to the JKT during the liberalization period.

It is pertinent to point out that the restrictive arrangements by JKT and Mwele estates denying villagers the right to grow permanent crops was an outcome of the historical institutionalization of a cash crop economy in village spaces by both the colonial and postcolonial states, which the government sought to maintain. Whilst studies have indicated linkages between land tenure and enhanced security of land, tenure for farming enables more efficient sustainable crop production and hence good income (Maxwell and Wiebe 1999) This could not materialize in Maramba. The inability of villagers to grow permanent cash crops that they could sell regularly (in case maize failed) positioned them in a continuous dependency on the JKT and Mwele seed farms. In August 2008 there were concerns by villagers following the JKT plans to utilize its land. It was already borrowing villagers to undertake commercial maize farming and cattle ranching. Most of the hay to feed livestock was obtained from the villagers' plots. They were forced to relocate to the margins of the estate at the same time as the numbers of plots allocated to them were reduced. Without warning, soldiers confiscated all villagers' livestock such as goats and cattle that had grazed in these open lands. Much of the livestock was owned by villagers who could not afford zero grazing.⁸⁰

⁷⁹ Similarly, Mwele seed farm restarted in 1986, although utilizing only 46 of its 960 hectares, unofficially allowing villagers to farm non-permanent crops at their own risk since the management could decide to use any part of the farm at any time when local or international demand for seeds arose. Accordingly, the villagers who might be cultivating any part at that particular time are bound to lose their crops.

⁸⁰ I personally found the land problem to be highly politicized, with no solutions in sight despite endless discussions on the issue at many village meetings I attended. The president of Tanzania, Jakaya Kikwete, stopped at Maramba on a regional tour of Tanga, to meet with the villagers on 19 July 2008 and promised to address the land problem by instructing the regional commissioner who was there. I spoke to a high ranking official of the JKT who said they own the land legally and it can never be redistributed and that the leader of the country was merely paying 'lip service', as it was after independence.

Origin stories about HIV/AIDS in Maramba

The sudden arrival of JKT changed the population dynamics of Maramba in remarkable ways, shifting the political economy of the village after villagization.⁸¹ The JKT had, in the main, two categories: permanent and ‘service’ (trainees). The permanent consisted of militarily ranked staff who were the trainers and support staff. Permanent soldiers numbered around 400, while trainees, who arrived yearly, numbered around 1,000. Of all of these there were about two percent women. Soldiers eventually became part of the community, interacting with the locals and others such as former plantation workers. Maramba was enhanced by it being a small business centre and a major station for commuter buses. Truck drivers would stop there, some to relax or buy food and forest products from inland villages, a practice existing to date. Following the decline of sisal and cocoa, youth from the area and former plantation workers flocked to Kalalani and Mwakijembe areas (located almost 60 kilometres from Maramba) following the discovery of minerals in the late 1970s and 1980s.⁸² The minerals attracted people from around the continent, as far as Kenya, Uganda and West Africa. Maramba was their initial stop having the most vibrant social scene in Mkinga, with guest houses, modern bars and a bank.⁸³

The movement of people within a country, or between countries, has been a major factor in the spread of HIV-1 virus in east, central and southern Africa (Schoepf 1993: 51; Rugalema 1999; Serwadda et al 1985; Hooper 1999). The disease was first reported in east and central Africa concurrently and it spread rapidly along trade routes (especially by truck drivers), through wars, and vulnerable sex workers (Lyons 2004). At the heart of the HIV spread in southern Africa, was historical labour migration where poverty compelled people to seek elsewhere, leaving their wives at home while establishing new relationships with women at other destinations, creating a ‘culture of urban and rural wives’ and ‘sexual liaisons spanning the continuum, from “town

⁸¹ Though there are no official statistics for the village, the population of Tanga region has been increasing hugely since the colonial period from 462,000 in 1948; 512,000 in 1957; 771,000 in 1967; 1,280,00 in 1988 (66 percent increase); 1.6 million in 2002 (an increase of 28 percent from 1988) (Porter 2006: 7).

⁸² Many kinds of gemstones were discovered in the late 70s. The place is nicknamed locally *komasho* implying many gemstones were present. During my fieldwork there were tensions between small miners and new foreign operators who the government privatized. Many complained about these act which was seen as robbing them of their only source of livelihood. As a result many moved to mines as far distant as Morogoro region to try their luck.

⁸³ The National Bank of Commerce operated countrywide but closed operations in Maramba after liberalization.

wife” to “prostitute” (Barnett and Whiteside 2002: 163; also Campbell 2004; Evian, 1994: 6). Such relationships are said to be the core of rapid spread of the epidemic in southern Africa.

The case of HIV/AIDS in Maramba is no different. As an inter-village centre, the arrival of the JKT introduced a set of migrants. While SAPs have been heavily associated with providing the background for the ‘risk’ factors for the spread of HIV in parts of Africa and Tanzania (Setel 1999; Schoepf 2004; Rugalema 2004; Lurie et al 2004), the arrival of JKT in Maramba provided an additional platform for spread of HIV by community members. Accounts of villagers varied, with the older generation citing the economic hardships of the 1970s and 1980s, the arrival of the JKT and the ease with which they were able to establish sexual relationships with local women and girls. The views of Mr. Shekilavu, a former employee of the then Tanga port authority summed up most elders’ perceptions:

During that period (JKT arrival) life was very difficult, I was redundant and had no income. We were receiving food rationing from the government. There was almost nothing in the cooperative shops. Even a bar of soap was a problem to obtain. So, when you heard that your daughter was going out with a soldier, first ‘you get a headache’ (*kichwa kina kuuma*), why? Because the man in question is a soldier, the man with a gun! So then the girl would sometimes bring soaps or food in the house you bath and eat, you keep quiet. If you reprimand them so much she might decide to leave...the problem happens when she comes and tells you she is pregnant! There are many children here born from these trainees who came here and left.⁸⁴

The reported inability of the elders to control their daughters’ behaviour, and the perception of JKT as the originator of AIDS in Maramba, were conflated. JKT’s role was overemphasized because of its control over land and food production. Apart from arriving during the height of SAPs and the economic crisis, they were the major income earners residing in the village. Trainees were given a government stipend during their year of training as well as free meals daily. Permanent soldiers were in an even better position than the trainees to establish both permanent and casual sexual relationships with local girls. Apart from being salaried, they had pensions and benefits such as free health services, with a separate health facility at the base, better equipped with drugs than the village facility. They received free transport for referral to

⁸⁴ Indeed the high number of ‘orphans’ in the community was sometimes linked to this phenomenon whereby seasonal sexual relationships by both migrants, but especially JKT trainees who spent less than a year in the camp and left, were established. These were called ‘JKT children’ (*watoto wa JKT*).

the regional hospital during emergencies. They had their own supermarket which sells half price goods not found at the local markets, including beverages and alcohol. Most permanent soldiers settled permanently inside the village through buying land from poor villagers.⁸⁵ During my field work many cohabited with or had married local women. Again, in this context, JKT courting of local women denoted a shift of power from local males, such as migrants and former estate workers, to the better off soldiers.

There were specific reasons for JKT being blamed for 'bringing' HIV/AIDS into the community. The perception of soldiers as the 'originators' of HIV in Maramba happened in a remarkable way. Tanzania had recently ended a war with Uganda and at the same time it was documented that the first cases of HIV/AIDS in Africa were noted in Rakai district, Uganda and Kagera region in Tanzania (across the border from Rakai) immediately after the liberation war in Uganda (Serwadda et al 1985; Hooper 1999; Barnett Whiteside 2002). Kagera⁸⁶ and Rakai is where the battles with Ugandan armies were actually fought and the Tanzanian soldiers remained in the war zones for a while after the war ended (Kaijage 1993). The historian Kaijage notes the role of soldiers from both sides in HIV transmission in that area, stating that the 'risks of HIV transmission in respect of a footloose soldiery, unaccompanied by spouses, cannot be overstated' (Kaijage 1993: 298). Less than a year later JKT arrived in Maramba. In my conversations with villagers, this historical fact was constantly brought up. For this reason people linked the 'origin' of AIDS in the community, including the remarkable spread, to JKT's presence. A retired soldier, Mr. Stanford Kabona (78), who was a medical attendant by then, and chose to settle in the community after retiring, having married a local woman, commented thus:

I was among the first batch of soldiers posted here to start this 'camp' (*kambi*). I also participated in the war with Uganda though not at the frontline. Even some soldiers came back with women from there (he mentions their names).⁸⁷ Back then we did not know

⁸⁵ Coupled with hardship, locals decide to sell their lands and have turned to squatting or renting. During my time in the field there were an estimated 105 JKT members with their families who resided inside the village space. Most had settled permanently and conducted businesses of various sorts. Currently they constitute the largest land owning group inside the village, thus occupying a social class of not just soldiers but business as well as land (both public and private) owners. Some, like former plantation migrants, have settled permanently after retirement.

⁸⁶ In 1992 Kagera region was shown to have the highest concentration of HIV infection in the world (World Bank 1992: 16). By 1991 it also had the highest prevalence rates in the country, by 20 percent. In the region, women are to this day perceived and stigmatized as 'HIV carriers' (Kaijage 1993; Rugalema 2004).

⁸⁷ It was common for my informants to openly name people suspected of having died from AIDS or who were alive but infected. They also kept mentioning the sexual networks of people who were perceived to have slept with them,

there was this ‘problem’ (*tatizo* - referring to HIV/AIDS). When we arrived here, officers in the camp were involved with girls from the community...many died from the *tatizo* later (he names about seven officers who he claims died from the disease). I was at the camp dispensary and therefore I remember well their health problems since they slimmed a lot. Some, when they became too sick they were transferred to Dar es Salaam Lugalo Hospital ⁸⁸and never came back. They left their women behind who also went out with other soldiers and community members. They say one can stay with the disease for many years without showing so they may have spread it as many soldiers came here bachelors and married or cohabited with local women. Mind you then AIDS was not known very much until people started dying in the 1990s and the news spread...I started recalling most of the officers’ symptoms and I could tell it was it. Many have died and will continue to die.

This view seemed to be held strongly by many community members. I see parallels in the conditions of spread in Kagera as expounded by Kaijage (1993) and Rugalema (2004), with that in Maramba. Coupled with the impact of SAPs, the war in Kagera disrupted lives and sources of income rendering people, especially women, susceptible to infection. In Maramba, the collapse of the plantation economy disrupted many lives and the arrival and forceful takeover of farms and the ensuing control *modus operandi* left most people hopeless and dependant on the mercy of the soldiers. For Rugalema, in Kagera, goods were extremely scarce and most likely sex was the ‘only item’ women could barter (Rugalema 2004: 196). These unequal relations of power between the villagers and the JKT still prevailed in Maramba during my fieldwork. While the older generation could recount their encounter with the JKT, and their socioeconomic problems of the past 30 years, the youth recounted their experience of the existing relationships and their interaction with the new forms of migration and ways of relating that had now become permanent in the community. For most of the women I conversed with, while HIV/AIDS was indeed a problem, it was also important to find a person who was economically better off, and JKT soldiers and a few businessmen were in that position. Entering into sexual relationships with soldiers meant that what they earned will trickle down to their relatives. Ana (24), a small shop operator, explained to me why and how women decide to weigh their options in an environment with limited opportunity:

even though I repeatedly stopped them from doing so. Drawing from these networks, people always seem to reach the conclusion that everyone in the community is or would be infected. Inquiring further, I was informed that this ‘times of openness and truth talking’ (*zama za uwazi na ukweli*), a phrase popularized by the former president Benjamin William Mkapa who used the phrase to popularize neo liberal policies and the fight against HIV/AIDS and graft. Openness about HIV/AIDS also echoed prevention campaigns in the country

⁸⁸ The largest military hospital in the country located in Dar es Salaam.

Soldiers (*Wanajeshi*), are not like ‘street boys’ (*vijana wa mtaani* - to mean other local village males) they do not have many words when they want to go out with you; they have *kisu*⁸⁹, if he does not have a house they are provided with space in their base and the shelter problem becomes solved. Besides, street boys are most likely not to marry these days, they say it’s costly, and the street boys will impregnate you and not care for your child, they leave us with our mothers.

Ana’s story above suggests that women in the community enter relationships which can help them and their families financially, something not available to many local males who mostly stayed with their parents. Living in one’s own house was highly aspired to, conferring a status signifying achievement.⁹⁰ The mobility of local men who have to be out of the community for longer periods of times was said to give soldiers a better opportunity to court local women. Local males had to migrate to work in mines and the cities to earn an income.⁹¹ Women were likely to stay at home participating in household roles of reproduction and production especially when the men did not send remittances, a pattern that echoed labour producing regions during colonialism. Drawing from Barnett and Whiteside’s study (2002), the epidemic in Africa reflects the history of the region where ‘migration and mobility have created patterns of sexual behaviour and mixing which are perfect for the spread of sexually transmitted disease’ (2002: 164).

While the community tended largely to associate the epidemic with the JKT, my conversations with infected people revealed a mixed picture. In my broad sample of 30 HIV positive persons, most claimed they were not necessarily infected by soldiers as most had entered into relationships with partners who were seasonal migrants, or business persons. Of the 25 women,⁹² 23 had been in sexual relationships with a migrant.⁹³ All 25 had partners who had left to seek greener pastures in a failing economy. Of these, 20 have had partners who had been out of the community for over three months without returning to their female partners. Most had travelled for more than six months without returning to Maramba. Sixteen women had had sexual encounters with a soldier, while 12 of the 25’s partners had been away for more than a year, mostly without communicating or sending remittances. Women left behind, together with their

⁸⁹ Slang for ‘money’, but literally meaning a knife.

⁹⁰ I interviewed 50 men about their life aspirations. 48 said they will build a house, even if it was just one room, but have to buy a plot first, a task many failed to accomplish.

⁹¹ Following the revival of some plantations after liberalization in the late 1990s and early to mid 2000s, demographics have changed, but men have more mobility than women who must stay at home to care for children.

⁹² Interestingly, all the males’ partners had been local women and had been in the community throughout their lives.

⁹³ Including a soldier.

grandmothers, became responsible for childcare. This pattern echoed the migration patterns of males during colonialism described above (cf. Rugalema 2004).

The story of Neema Barongo (42), a HIV positive mother of three, who lived with her grandmother (a former labourer) illustrates part of this phenomenon:

My first partner I settled with working in the Lugongo sisal plantation. The good thing he was also from where my parents came from (Songea - southern Tanzania). We had two children but labouring was not enough to sustain us so he said he will go to Tanga and look for a job. He came back twice in 1992 and stayed for a month and left again without communicating to date. I went out with a soldier in 1995, a Chagga by tribe, and we had my third child. The soldier was very helpful because I was struggling with my two children. He even gave me capital (*mtaji*) to start my fish business but he got sick, and he was transported to his homeland in Kilimanjaro and never came back. Officers here told me he had died. I think he was the one who gave me this 'problem' (*tatizo* - HIV)...when a man comes to you and tells you they love you and can provide for you, can you refuse? But it is very difficult to tell if they are telling the truth or not.

Local people's, especially women's, explanations of their hardship (*maisha magumu*) and poverty (*umaskini*), were cited as the major reason compelling women to enter relationships that did not conform to cultural norms of marriage. Women specifically cited men failing to fulfil their provider roles, especially of food and providing for children because of long absences (cf. Rugalema 2004). On the other hand males tended to blame the women for being the cause of bringing HIV to the community from *wageni* (visitors and newcomers), especially soldiers. The most common statement from the men was 'these women brought us the disease from JKT because of "their lust for money" (*tamaa zao za pesa*) and "bad moral character" (*tabia mbaya*)' (also Setel 1999: 3-4, for similar descriptions in Kilimanjaro region). Courting local girls caused tensions between the local males and the JKT, which often turned violent and mostly harmed the local men as soldiers retaliated with random beatings.⁹⁴

Migration, HIV/AIDS and food problems in Maramba need to be viewed through both a socio-economic and gender lens. In the words of the anthropologist Susan Craddock, 'depressed economies and struggling agricultural sectors resulting in part from African countries' location in

⁹⁴ For example, in July 2008 soldiers severely injured eight villagers aged 32 - 65 with machetes because a trainee soldier was beaten by local boys over a local girl in a disco the previous night. Although the matter was reported in local media, the soldiers were not charged, though local boys and the girl were. Some of the boys ran away.

the global economies today....underlie continued migratory circuits that heightened vulnerability to HIV primarily through family dissolution and concomitant shifts in sexual economies towards casual, extramarital, or remunerated relationships' (Craddock 2004: 6-7; also Sanders and Sambo 1991). Socioeconomic relations that affected migration patterns which subject women and poor men in Maramba still existed during my fieldwork as they did in the past. The epidemiological studies categorizing women as 'risky' groups ignore the fact that the spread of the disease is 'along the socio-economic fault-lines, some of which are as old as society itself' (Rugalema 2004: 198).

Conclusion

In this chapter I have attempted to describe and explain the changes that have had affected the livelihood of the people in Maramba from an anthropological perspective of structural power. By revisiting the past I have been able to show why and how food insecurity and HIV/AIDS in Maramba became a problem. The imposition of a colonial economy in Tanganyika that depended on migrant labour dramatically shifted people's way of life, from an economy based on food production to that of cash crops for colonial needs. Since sisal estates did not always satisfy labourers' needs, migrants were compelled to settle in villages alongside the estates and established farms. However, these settlements did not necessarily satisfy their needs since people's lives were already constrained by the demands of the colonial economy. The postcolonial period brought new forms of structural control by promising development through collectivization but did little to alter the socioeconomic structures that the country inherited from colonialism. The estates, which the villagers looked to as a source of food, were subsequently handed to local parastatals such as the JKT, amidst a crumbling national economy. The JKT imposed land control mechanisms that threatened villagers' food security. It was during this period that villagers, especially women, became highly vulnerable to HIV transmission, as sources of income became scarce. HIV/AIDS in Maramba must therefore be considered as a culmination of the social and economic ills that have afflicted the area for the last century. With the impact of HIV/AIDS becoming commonplace in the community, the role of care and obtaining food amidst the lack of land were the central problems that poor infected women and men face, a subject with which I engage in the next chapter.

CHAPTER FOUR

‘THE HOE NEEDS FOOD TO GENERATE FOOD’: LAND AND FOOD INSECURITY IN MARAMBA

Maramba is atypical of other poor peasant communities in Tanzania, which have access to their own farming plots. This chapter considers how the persistent problem of limited access to land in Maramba, raised in the previous chapter, is intrinsically linked to food insecurity and the health of people living with HIV/AIDS. In Maramba, HIV infected women are particularly affected by this lack of access (Piwoz and Bentley 2005; Mutangadura 2005; Urassa et al 1997; Tibaijuka 1997; Kerner and Cook 1991: 259). The means that people employ to obtain food are often detrimental to their health and ensure limited supply for their households. Inadequate diet further affects their eating patterns and nutritional intake, crucial for the immune system and ARV adherence (Gillespie and Kadiyala. 2005; Haddad and Gillespie 2001; Edström and Samuels 2007; Piwoz and Preble 2000; FANTA/AED 2005). De Waal and Whiteside have dubbed the deadly combination of HIV/AIDS and food insecurity (exacerbated by natural disasters such as drought) in sub-Saharan Africa as the ‘new variant famine’ to signify how HIV/AIDS affects the poor who already face severe food shortages.

The Maramba case study explores ‘famine survival strategies’ as reported in the literature (Shipton 1990; De Waal 1989), which suggests an accompanying downward progression of social mobility (De Waal and Whiteside 2003; Rugalema 2000). HIV positive people in Maramba are doubly disadvantaged by their limited capacity to produce food. According to Tibaijuka (1997), the effects of AIDS in communities may not be easily perceptible as they may be ‘catastrophic for the families affected but...not for the entire village’ (Tibaijuka 1997: 973). Their predicaments, as Barnett and Whiteside note, become ‘unnoticed by agencies and politicians’ (Barnett and Whiteside 2002: 227; also see Chileshe, 2008). This new variant famine differs from famine caused by natural disasters, such as drought, with which people in the long run are said to be able to cope (Downs et al 1991; Rahmato 1991; De Waal, 1991).

In his book, *Anthropology of Food*, Johan Poitier argues for the relevance of sharpening a focus on food insecurity by considering the social and economic factors that shape it. He writes, 'Taking stock of how anthropology informs the social, economic and political dimensions of food insecurity can be a way of reflecting on its preparedness and engagement in a fast-changing world' (Poitier 1999: 4). He discusses questions related to factors critical to food production and food access, and about land accessibility and its relevance to livelihood. For Sidney Mintz and Christine du Bois, the interest of anthropology in food relates to the fact that food 'is important both for its own sake since food is utterly essential to human existence (and often insufficiently available)' (Mintz and Du Bois 2002: 99). Drawing on the works of Poitier, (1999) Mintz and Du Bois (2002), Shipton (1990), Barnett and Whiteside (2002), and Loevinsohn and Gillespie (2003), this chapter brings experiences of living with HIV/AIDS in Maramba into conversation with other literature on food insecurity and how it impacts on the HIV infected poor in rural areas of north eastern Tanzania.

HIV/AIDS affected households and borrowed farmland

Colonial and post-colonial social relations in Maramba shape a fragmented and hierarchical order resting on land usage patterns. As detailed in Chapter Three, villagers must borrow or rent plots from the JKT, and are limited to growing seasonal crops, namely maize and manioc. In his paper *The Impact of HIV/AIDS on Rural Households and Land Issues in Southern and Eastern Africa*, Scott Drimie asserts:

HIV/AIDS and land tenure are extremely complex and sensitive issues. One cannot generalize from specific cases as unique local manifestations of the impact of the epidemic on households and communities in terms of access and rights to land. However, case studies are extremely important as they reveal the real issues facing individuals living in the face of HIV/AIDS. A major problem for counteracting the development impact of the epidemic is the lack of hard data on real changes. (Drimie 2002: 25)

As a local leader and home-based care provider, Jimmy Shem has witnessed and experienced the decrease of available farmland since the early 2000s. He said, 'We are slaves here and we cannot do anything about it...what can we do?' (*sisi hapa ni watumwa tu na hatuwezi kufanya lolote...tutafanya nini?*). This was not the first time I heard a reference to slavery with regard to the presence of the JKT, Mwele seed farm, and other private entities that monopolized land

around their village; it was an utterance used by locals to express their collective frustration over the dramatic shift in land use patterns and chronic hunger.

For Mama Mu (58), a resident of Maramba village since 1978, access to productive land is central to her livelihood. Diagnosed with HIV in 2005, her husband abandoned her and left the village in the same year, and then died the following year. Mama Mu battles to feed the two grandchildren in her care, Issa (10) and Zamia (8), and her disabled son Mu (36).

Mama Mu rented a single room in a compound, in the densely populated part of Maramba B. She began renting after she was forced to sell her assets (such as her bed, sheets and her house) to support treatment for her HIV/AIDS related illness, and was bedridden for a year and a half in 2006/7. Assisted by her grandchildren, she cultivated half an acre of land on JKT owned land where she grew maize. One March day in 2008, I accompanied her and her grandchildren to her borrowed plot, almost three kilometres from her rented room. The walk took us nearly 90 minutes because she had to walk slowly: 'If I walk fast like these other people by the time I get to my plot I will be dead tired and fail to work, or I will have to rest much longer before I start working', she said.

We worked for almost six hours on her small plot (almost three quarter of an acre). Issa and Zamia worked sporadically but mostly they played and Mama Mu had constantly to remind them to work. She claimed the plot was too small to satisfy her household's need saying, 'in the past (*zamani*) when I had my strength I would not leave the farm until the sun had set... Doctors have advised me I should not work hard but I have to fend for myself'. Over a one year cycle Mama Mu worked by 'preparing the farm' (*kukata bua*) for the planting season in March, when the first rains are expected, returning a month later to weed (*palizi*). Weeding was one of the most trying activities for her because it required her to work the whole plot twice; first when the maize was about two feet high and later when it reached six feet. This task took her at least thirty working days over two months. During the farming season she went three times a week:

During weeding I have to make sure I do not get sick because if I do the grass will grow so tall and with my health I cannot work fast. Sometimes it rains and the soil becomes so stiff to hoe. I also need to bring enough food for me and the kids every time I come

because this work demands a lot of strength and it tires us a lot, but what can we do? If I do not farm how can I feed myself and these kids? That is why I always pray to God I do not fall sick.

In Tanzania, Tibaijuka (1997) documents how productive labour in HIV/AIDS affected households was diverted to caring. Barnett and Whiteside further assert that 'Illness of productive adults is especially feared among farm households' because 'it reduces labour supply suddenly and has short and long term consequences' (Barnett and Whiteside, 2002: 239). The relationship between rural areas and HIV/AIDS Loevinsohn and Gillespie note, is such that 'the consequences of AIDS-linked illness and death, which reverberate through households...are shaped by features of agricultural and livelihood systems.' (Loevinsohn and Gillespie, 2003: 3).

Mutale Chileshe's (2008) ethnographic study from Zambia depicts how TB and HIV/AIDS affected households which, in order to ensure household food security, decided to divert farming to plots close to their own homes while caring for their sick members (Chileshe, 2008: 80-81). However, in Mama Mu's case, the reduction in time for productive labour was not a result of other family members needing to care for the ill, but the fact that she did not have strong able members in her household to assist her. The reduced time for work was as a consequence of her having three dependants with little support. Even had her taking of ARVs facilitated her ability to work sufficiently long hours, the political economy of land distribution constrained her ability to farm. Unlike the affected households reported by Chileshe (2008), she and other poor women in Maramba did not have the option of plots close to their houses but had to walk long distances, further jeopardising their already fragile health.

The case of Mama Mu resembles that of Christina Lugolugo (43). Christina stayed with her older sister Gisela Lugolugo (45) and both were HIV positive. Christina raised three children who depended entirely on her for food. Her husband, a former migrant labourer, had disappeared and was presumed dead. She was intermittently sick when I knew her but she forced herself to go to her borrowed plot so that her children would eat:

I know I am sick with this disease but who will feed these kids? If it was not for the drugs I would not have been able to go back to farm. But we only get maize from these plots, nothing else. ...it saps my energy and I do not have enough money to make sure it

will produce enough to feed me and my children.... Sometimes I just sit down, 'I think a lot' (*nafikiria sana*), until my head hurts. I do not know how they will survive and who will help them.

Not all people who had recovered their health after taking ART were able to return to farming, however imperfectly, like Mama Mu and Christina. Some had had other household members they could rely upon to make ends meet. Nevertheless, these networks were generally too weak to bring the household members enough food. Haddad et al (1994) and Mtika (1996) use household size as an indirect indicator to predict food insecurity in HIV affected households. They argue that the more people in the house, the more food secure the household becomes. Nevertheless, among those with whom I worked in Maramba, it was as if the greater the number of people in the household the more difficult it was to provide adequately. The sickness of a family member affected the entire household, even after ART enabled them to feel well enough to work. Most of my informants' households did not include adult men, and mostly comprised young dependants, who did not fully participate in income generating activities (see Appendix 2 and Table 9).

When I visited the house of Neema Barongo (38), her grandmother, Mbutai (79), always seated outside on a mat, would chip in to affirm her granddaughter's stories while Neema's sister Sheila (21) braided a customer's hair outside their two-roomed, dilapidated mud house. Neema emphasized how prominent she had been in her fish business in the past and how she used to assist Mbutai and Sheila during the farming seasons:

I was also young and energetic...since I fell sick life has been very difficult because only Sheila can farm...Mbutai was a very good farmer in this village, she used to farm all these lands (pointing to the area of almost two acres in front of their house which is now full of houses) and the plots in the JKT with her own hands, until she fell in 2002 and dislocated her shoulder.

When Neema recovered her mobility after her battle with tuberculosis, she tried to assist Sheila with farming because she could not go back to her fish business after using all her savings for medication and hospital bills:

We had a serious shortage of food in the house and because we did not have money to hire a labourer to till the plot so I felt I had to go and assist Sheila to clear the farm because the rains were coming.... I walked with difficulty to the farm but I had to sit for a while before I started farming. I took the hoe, tilled but for less than a minute my heart

was pounding so hard and my chest was squeezing so hard! I felt like my TB was coming back...until I get better, I will not farm now.

Their borrowed plot in the JKT was much bigger than that of Mama Mu's, about an acre in size, but Sheila said she could never finish clearing it on her own: 'Mbutei and Neema are not there I only cultivate a quarter of it ...but this year I have been getting some few customers to braid so it covers up our earnings.' During the 2008 farming season she was working on the farm for longer hours before returning home to prepare meals for the household. Neema's children, Aisha and Simon, often had to forego their classes to assist Sheila on the plot or with cooking.

While Neema was assisted by her sister and her children, Flora Shemdilu (49) was assisted by her grandmother, Bibi Shemdilu, of 76 years, and her daughter Mary (32) to farm on their borrowed plots of less than an acre. When I met Flora for the first time she had not started ART treatment yet. She was emaciated, with pronounced cheek and shoulder bones. She had most of the symptoms of a malnourished person with HIV, which included low weight, loss of muscle tissue and subcutaneous fat (Piwoz and Preble 2000: 9). Though she walked with difficulty, her condition did not hinder her working to ensure food for their household. In our conversations she acknowledged the role of her grandmother Bibi in tending the borrowed plots: 'I cannot hold a hoe in this condition. My mother still farms and we get something from the plots. Not much but it is something. When I get better I will also assist her, but I have to do other things to get money'. One person in my sample was better off. John Majamba was a 45 year old JKT retiree and the chairman of a local HIV/AIDS group called Hope. He owned three big houses in the village which he bought and built when he was still employed. He also owned a minibus which commuted daily between Maramba and Tanga city. He bought a piece of land in the village years ago where he grew different crops such as banana trees, coconuts, papaws, mangoes, maize and yams. He also received a government pension of 300,000 Shillings (230 USD) every six months. Mr Majamba was open about his successes in his ventures including his farming:

I have to say I thank God for blessing me, I do not have many problems apart from my commuter minibus (*daladala*) breaking down sometimes. I am not a big farmer, unlike other army officers, I only farm three acres. I put day labourers (*vibarua*) to farm it. With my condition I never set foot there, I concentrate much in my *daladala* as it brings quicker profit than the plots.

Majamba's social and economic position highlights the fact that there are social differentiations among PLHIV in the rural areas. The social and economic impacts of HIV/AIDS do not affect people in the same way; most often it is the poorest who are most affected in coping with the brunt of the epidemic (Mutangadura 2005; Haddad and Gillespie 2003). In Maramba, the structural forces created by resource control led to the employed and the business persons being better off than peasant farmers. Among my informants, especially those without a reliable source of income, they struggled to cope with obtaining enough food for their households from the borrowed farms.

Scholarly work on 'coping strategies' of the poor have been vehemently critiqued. According to Haddad and Gillespie (2003), it is an illusion to use the concept of coping with food for rural households since 'it implies homogeneity on the part of households or communities, when in reality is often that some individuals (e.g. women) from some households (e.g. the poorest) are hit much harder by HIV/AIDS' (Haddad and Gillespie 2003: 20). I also find useful the analysis on coping as provided by Gabriel Rugalema (2000). For him poor people facing the impact of HIV/AIDS cannot be said to be 'coping' but 'struggling' because most poor households 'are barely able to respond to unremitting pressure on livelihoods' (Rugalema 2000: 543). He attributes this to the fact that the term 'coping' implies a household is managing a crisis progressively.

Scholars have used the concept of 'resilience'⁹⁵ to explain the precarious measures poor people affected by AIDS employ in their search for better livelihoods. In her ethnographic study in northern Tanzania, Ruth Evans employs the concept to frame her analysis. She argues that situations like women heading households unsupported by relatives; children leaving school to do agricultural labour; and children emigrating to the urban areas, were coping strategies. She includes begging, going without food, survival sex - hence risking sexual abuse and infection - as demonstrations of resilience (Evans 2002). The Oxford English Dictionary defines resilience as

⁹⁵ According to Evans (2002) the concept of resilience has been taken from the field of psychiatry where it is used 'largely in response to recognition of the need to understand individual differences in people's responses to stress and adversity' (Evans 2002: 113; see also Rutter 1990). But whether the concept is useful as a framework in which to speak of experiences of people affected by HIV/AIDS, and failed to bounce back to their normal livelihoods, is debateable.

‘the quality or fact of being able to recover *quickly* or *easily*’ from a misfortune, shock or illness.

Foster, on the use of the term ‘resilience of the poor’, cautions:

The much-heralded ‘resilience of the poor’ has its limits. The assumption that the poor can continually adapt to changing conditions and still survive must be questioned. This analysis frequently underlies oppressive economic policies of some international agencies and governments. Safety net policies based upon the premise of the poor supporting the destitute are an unsustainable and unacceptable form of social welfare (Foster 2007: 61)

The experiences of some of my informants suggest they were struggling to obtain food rather than coping progressively. Before falling sick with HIV/AIDS related diseases they coped, participating in farming and other income generating activities (see Appendix 2). As the ethnographic material below reveals, most were not coping but struggling to obtain food, in an environment with limited opportunities.

Harvests from farmland

Drought has been the major cause of poor harvest as shown in food insecurity and famine studies (Shipton 1990: De Waal 1989). But following the impact of AIDS in rural communities the poor with HIV who depended on the JKT farms were more affected than other households. As the tables demonstrate, peasant households produced considerably less than households where there was a member with formal (usually state) employment. And households which were affected by HIV/AIDS produced considerably less than those where there were no people living with HIV/AIDS.

Table 5: Maize harvest from borrowed plots: HIV/AIDS affected households

Household	Kilograms of maize	Amount in Tshs 1kg@ 500 Tshs	Number of people in the household
Mama Mu	76 kg	38,000	4
Neema Barongo	81 kg	38,500	9
Flora Shemdilu	24 kg	12,000	6
Mathias Mtunguja	67 kg	39,500	8
Anita Shaija	46 kg	23,000	7
Gisela Lugolugo	56 kg	40,500	6
Hamisi Hamidu	Nil	NA	5
Shabano Mstaafu	Nil	NA	6
John Majamba	2178 kg	1,089,000	5

Table 6: Maize harvests from borrowed plots: not HIV/AIDs affected; employed⁹⁶

Household	Kilograms of maize	Amount in Tshs 1kg@ 500 Tshs	Number of people in the household
Samson	3125 kg	1,562,500	4
Maroki	2458 kg	1,229,000	4
Saudia	2265 kg	1,132,500	6
Ramadhani	1566 kg	783,000	5
Stuart	1890 kg	945,000	5
Kijazi	1768 kg	884,000	3
Msamwe	3623 kg	1,811,500	8

Table 7: Maize harvests from borrowed plots: non-HIV/AIDS affected peasants

Household	Kilograms of maize	Amount in Tshs 1kg@ 500 Tshs	Number of people in the household
Raymond	326 kg	163,000	3
Sigifrid	578 kg	163,500	5
Machupa	456 kg	164,000	5
Chama	443 kg	164,500	5
Mwanahawa	414 kg	165,000	3
Mpemba	443 kg	165,500	6
Rasuli	501 kg	166,000	8

The non-affected households were able to harvest more maize than the affected households because they commanded different forms of capital and therefore could access larger farm plots. For example, because of their position in the army, JKT employees could obtain bigger plots by virtue of being soldiers and commanding a salary that they used to pay labourers to cultivate for them. On the other hand, peasants, who depended on their own labour had to depend on their own labour to cultivate the plots.

One day in August 2008, my neighbour, Samson Mshana, a soldier employed by the JKT, was supervising five sweating and tired *vibarua* (day labourers) employed to offload maize from a full two ton trailer anchored to a noisy tractor. He cultivated four acres of maize on the JKT farm

⁹⁶ Four were JKT members, two primary school teachers and a health officer.

land. I greeted him and he cheerfully chatted with me: ‘Peter you should congratulate me on my harvest as you can see...I was not as lucky as I managed to harvest only four acres this year, the other two did not come out so well...Now I will store the maize and wait for only six month and I sell them, you know what that means? And he went on to answer himself, ‘Double profit! (*Faida mara mbili!*) because no one else will be having maize but me.’ At that very moment I was returning from visiting Mama Mu and I was struck by the extreme contrast between her experience and that of Samson Mshana. A shop owner was bothering her because he had given her food on credit and she had not paid for a week, unable to raise the 1000 shillings (0.77 US) she owed him. The shopkeeper refused to extend further credit, so she asked me if I could assist her: ‘I have not eaten since morning...and I wanted to cook *ugali*⁹⁷ with *mchunga*⁹⁸ and I need oil and kerosene and he will not give me any more,’ she lamented. It was neither the first nor would it be the last time I assisted. Gisela and Christina always reminded me before a scheduled interview to bring five kilograms of maize or maize flour for the house to use: ‘If you do not bring I would not talk to you’, Gisela would add, jokingly but insistently.

To benefit substantially from the borrowed plots, farmers needed capital, especially money to hire labourers, which many poor peasants did not have. It was thus less rewarding for the poor and the sick like Mama Mu, who used a hand hoe and her own family's labour amidst other household responsibilities. However, because Mama Mu was always sick, she could not effectively utilize her labour to produce for her family. Jimmy told me what is required to become food secure through JKT:

It requires investment in time and body before you go to the farm. One person consumes a sack of maize for five months. An acre produces 7 sacks, and we know that when the rains are not good you can get on average 5-6 sacks. The hoe needs food to generate food – it takes three months until you harvest. In those three months you have to prepare the farm by clearing the bush, buy seeds, plant them and wait for the rains. After the first rain there is weeding, all this planting and weeding needs money. To clear one acre is 25,000 TSHS (approximately 19USD); that is a price of one sack of maize. To weed you pay almost the same price, it means the second sack has gone. You have to pay for transport after harvesting, you also have to guard it against thieves and hungry monkeys while it is in the farm.

⁹⁷ Stiff porridge cooked from maize flour.

⁹⁸ *Launaea cornuta* - a wild leafy vegetable known for its bitter taste. *Mchunga* comes from the Swahili word ‘*chungu*’ which means sour. To eat it one has to boil it for a long time and mix with coconut juice to remove the bitterness. It is not difficult to find because it grows on its own in the bush, mainly during the rainy season.

According to farmers in Maramba, the total labour costs for preparing an acre of a borrowed plot from the JKT cost an estimated 124,000 Tshs (approximately 100USD). This includes preparing and clearing for 52,000 Tshs; planting cost 8000 Tshs; weeding 25,000 Tshs; harvesting 14,000 Tshs and transporting 25,000 Tshs. This amount was unthinkable for peasants with no reliable source of income. Poor households had to compete with other established labourers, like casual sisal workers, to secure contracts during farming seasons. In the absence of these opportunities, families were compelled to seek off-farm activities to survive, a theme I discuss below.

Means of survival in off-farm activities

According to Maxwell and Wiebe (1999) vulnerability arises from different factors (1999: 828), some of which are predictable, and some, such as drought or militarized conflict, less so. However, they single out *chronic vulnerability* as affecting specific categories of the poor, in particular, the ‘landless households with insufficient employment’ (Ibid), a category into which all the woman headed households in my sample fell.

Apart from being landless, my informants also lacked sufficient labour power inputs, caused by amongst others the loss of key members of the house. They thus had neither access to sufficient household labour nor financial resources to secure labour. This dilemma diversified their strategies to ensure the household necessities for their survival. For Rugalema such households ought not to be described as ‘coping’ because the term ‘obscures the real experience and suffering of individuals, households, communities’, whose livelihood crisis has been induced by morbidity and mortality (Rugalema 2000: 540: also Drimie and Casale 2009). His critique rests on the fact that ‘coping’ describes the ability of households to overcome difficult situations and regain or even surpass their former living standards. This, he argues (2000: 538) is done through strategizing, whereas many poor households affected by the disease do not have plans but react to immediacy of need.

The very fact that HIV/AIDS kills strong people and leaves behind the weak undermines the capacity of households and communities to cope, especially in the long term. In other words, AIDS renders households more vulnerable to future shocks than, say, famine (Rugalema 2000: 543)⁹⁹

⁹⁹ In *Famine that Kills*, De Waal (1989: 227) notes that during the famine in Sudan between 1984 and 1985, farmers went hungry for months rather than disposing of their livestock because they knew that in the long term those

On the other hand, Drimie and Casale retain the use of the term ‘coping strategies’ but distinguish between what they call ‘erosive’ and ‘non-erosive’ strategies, with ‘erosive’ implying strategies that are unsustainable ‘and [which] undermine resilience in the long run’ (Drimie and Casale 2009: 30; see also Davies 1993). The debate about terms is important because it directs policies and responses. Davies (1993) differentiates between ‘coping strategies’ and ‘adaptive strategies’ while Haddad and Gillepsie (2003) avoid the term ‘coping’, preferring to use ‘responding’ to HIV/AIDS because, for them, it is a ‘value-neutral’ term (Haddad and Gillepsie 2003: 20). Anthropologists Frédéric Le Marcis and Rehana Ebrahim-Vally use the term ‘tactic’ (borrowing from Michel de Certeau) to show how HIV/AIDS positive people in South African townships, whom they define as the ‘socially weak’, survive despite limited opportunities. According to Marcis and Ebrahim-Vally (2005) the poor are compelled to invent means of survival because of, among others, structural constraints: ‘if people are located in an environment limiting their choice and structuring some of their logics, they nevertheless develop tactics and show agency’ (Marcis and Ebrahim-Vally 2005: 219; also Maxwell 1996: 295). Michel de Certeau uses the term ‘tactics’ to show how individuals circumvent the pressures of everyday lives, pressures from economics and politics to try and assert their agency and autonomy. He writes:

Tactic is a calculated action determined by the absence of a proper locus. No delimitation of an exteriority, then, provides it with the condition necessary for autonomy. The space of a tactic is a space of the other. Thus it must play on and with a terrain imposed on it and organized by the law of a foreign power. It does not have the means to keep to itself, at a distance, in a position of withdrawal, foresight, and self-collection [...] It operates in isolated actions, blow by blow. It takes advantage of “opportunities” and depends on them, being without any base where it could stockpile its winnings, build up its position, and plan raids. [...] It must vigilantly make use of the cracks that particular conjunctions open in the surveillance of the proprietary powers. It poaches them. It creates surprises in them. It can be where it is least expected. It is a guileful ruse. In short, a tactic is an art of the weak. (De Certeau 1984: 37)

With limited farm plots and insufficient labour inputs, people found other means to obtain income for food. A common feature of these means of survival was that they were undertaken

livestock will ensure their survival. In Maramba poor and HIV affected households had little if anything to sell to begin with.

with uncertainty and fear. Uncertain because most of these sources were fragile, which caused fear of not knowing what the next day will bring, forcing them to resort to tactics such as borrowing, which eventually led them into debt.

Coupled with the poor harvest in 2008, the price of maize skyrocketed. In the normal harvest a kilogram sold for 500 shillings; in 2008 it jumped to 700. By January 2009 it reached 800 shillings. While their stock of maize finished quickly, people needed cash for necessities such as sugar, soap, and kerosene (to light *koroboi* for light at night) and to buy *mboga*.¹⁰⁰ Money was needed for medicine to treat opportunistic infections: ‘As you know our health facility only dish us out these ARVs but when you fall sick from chest pains or fevers many times they tell us there are no pills’, Gisela once told me. This was also common in the other households with patients on HIV treatment.

The need for immediate cash and the lack of secure jobs meant that sometimes the small maize harvest was sold to obtain cash and to exchange for other goods. For instance, Anita Shaija (43), used to exchange salt for maize: ‘I used my maize and finished it all, we are a big family and I have to feed my children and my grandchild. I get salt from a friend who trades and I go house to house to ask for (i.e. swop it for) maize. When I get the maize I cook some and some I do sell... It’s not a business as such because there is no profit at all and I have to return the money to the person who lent me the salt.’ Non-iodized salt was cheaply available from the coast and she took advantage of this to obtain maize. Neema’s household used some of their maize to obtain tomatoes or oil at a local shop. The exchange was never in her favour but she felt she could not do anything about it: ‘We are the people in need of money (*Sasa sisi ndio tuna shida*), but they have the money. So we are not in a position to demand what amount they should give us.’ When money from this kind of trade is obtained it is immediately used to purchase what is needed on that day. Trade of this nature is often overlooked, both by scholars and also by those with power in local communities. For example, Jimmy, the community home based care provider told me he did not know people with HIV exchanged maize for other food products in order to survive. These are the subtle ramifications of the disease, rendered ‘socially invisible’

¹⁰⁰ A meal in the community consists of mainly a staple eaten together with a relish such as vegetables, meat or pulses. The name is generally referred to any of a relish eaten with a staple.

(Kadiyala and Gillespie 2003: ii) and affecting only the socially weak. The sale of their own food to obtain cash to buy other things was an option that showed the limited nature of people's access to conventional means of survival and their impotence in the face of a shift in farming practices from multi-cropping to maize production. The cultivation of maize was the result of structural forces beyond their control. Plots were under the control of the JKT, preventing villagers from growing permanent crops, which they could multi-crop with maize. I asked Anita why she would sell her meagre harvested maize: 'by then I will not have any other options, I will have the maize but I will also need something to eat it with, and I do not have money then.'

Food insecurity is not gender neutral. According to Mutangadura, the impacts of HIV/AIDS 'on rural livelihoods are not gender neutral' because 'they deepen and widen existing gender inequalities...resulting in increased vulnerability of women to poverty' (Mutangadura 2005: 1; also Gillespie and Kadiyala 2005). Similarly, Pottier argues that, 'loss of valued land (or even a type of land) can bring problems that have far reaching consequences for the management of women's time and for the nutritional status of their households' (Pottier 1999: 70).

This is true for Maramba where poor women who were HIV positive and their carers had few options. Since they lacked energy they resorted to the lowest means of survival in the community, the collection and selling of a grass called *lukina*, and picking of kapok, an activity that was widely despised and was associated with widows with nobody to care for them. Among my informants, seven of the nine households tirelessly worked to collect these products. Complicating matters was that the grass grew only in the JKT; the same applied to kapok trees, which were heavily concentrated in the JKT estate. Above this they faced competition from other poor women and other products such as *pumba*.¹⁰¹ *Lukina* was seasonal, mainly during the summer as its preparation required drying before selling, seemingly a light activity compared to farming maize. For the unwell this sapped their energy, requiring a degree of physical strength that taxed their bodies. Both demanded spending a whole day, or two, to fill a 20 litre bucket for *lukina* or a hundred kilogram pack of kapok, while working in the sun. The product had to be

¹⁰¹ *Pumba* is the chaff that comes from maize after being milled- both with *lukina* are specifically used to feed cows during milking. *Pumba* was however available throughout the year unlike *lukina*. Although *lukina* was nsidered much better content wise, its price was sometimes lowered to compete with maize milling machine operators.

carried home three to four kilometres, on the head, and thereafter waiting for it to dry. A bucket of *lukina* fetched 400 shillings (0.36USD) in the local market while kapok fetched 1,000 shillings: 'I can only get maize flour (*unga wa mahindi*) from that plot but I also need *mboga*, if it is sweet potato leaves (*matembele*) or *mchungu* fine, I have to eat them, even without oil, well, that is okay... I have to buy these things and the *lukina* business sometimes helps, it is not stable but at least it is something' Flora once said.

Selling of *lukina* by the poor with HIV required special tactics due to stiff competition from *pumba*. Given the small numbers of cattle owners in the village, the *lukina* collectors would try to make sales by eliciting pity in potential purchasers. As Flora put it, 'I approached Mama Kayayi and I told her our condition of food at home and that I have this disease, she said every time I get *lukina* I should take to her.' However, she and the other women could sell *lukina* when there were households with cows being milked. Some JKT personnel with bigger plots and cows use their own *pumba* from the maize they harvested. Such dynamics constrained even further the few options accessible and of benefit to the poor.

When the news came that the JKT was planning to expand its production, including clearing the areas where *lukina* grew, these women knew that another important source of their meagre income was vanishing: 'What will I do? When is this suffering going to end? They want to really kill me now. To get *lukina* is itself difficult now they want us not to collect it', Mama Mu once lamented. There were also anecdotal reports that the Mwele seed government owned farm, on which most members of Maramba A (such as Flora's household) resided, was going to be sold to a private operator and converted to agricultural land. This news was discussed one day at Flora's house: 'Where will we go?' asked Flora's mother. 'If we do small business (*biashara ndogo ndogo*) we need capital which we do not have', replied her daughter Mary. Flora then chipped in, 'We really suffer in the villages... We will pray to God he will help us from hunger (*njaa*)'. After Flora's words a long silence followed. These words, the tone in their voices, and the silences, suggested their uncertainty about the future.

Tactics differed between households, not always succeeding. Factors affecting success included family size, support networks, skills of individuals and the status of the sick individual.

Table 8: Sources of income from off-farm activities: Flora's household¹⁰²

Source of income	Earnings: In shillings (1 USD = 1300sh)	Year availability	Conditions	Responsibility
<i>Genge</i> : Coconuts & tomatoes	300 per day	Unpredictable	Depended on availability of capital	Flora
<i>Sufi</i> collection	1500 per sack of 50 kg	September-December	Collection took 2 days to fill a sack; competition from other women	Mary/Flora
<i>Lukina</i> collection	500 per <i>debe</i> (A 20 kg bucket)	August – November & January –March	Depended on getting orders from cattle owners. Sometimes fodder decomposed unsold	Flora/ Bibi/ Mary
Handouts	400	At least in two weeks	When relatives or well wishers visited	Flora
Borrowing	500	At least in a week	Happened	Mary/ Flora
<i>Viungo</i> making	150 per <i>kiungo</i>	All season but mostly dry seasons	Depends on the order and customer availability. Could sell 10 in a day	Flora/Bibi
Remittances from Bibi's son	5,000	Once a year, or never	At the mercy of the sender	Sent to Bibi or Flora
<i>Hailali</i>	2,500 per piece work	Mostly during rainy seasons	Depends on availability; competition from other labourers	Mary
Sand and blocks collection	1,000 per day	During summer October-November ;January-March	Required network with builders. It happened once in 2008	Mary/ son
Asking for financial assistance		Yearly		Flora

Table 9: Sources of income from off-farm activities: Neema's household

Source of	Earnings:	Year	Conditions	Responsibility
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¹⁰² These are estimates of the household income collected through observation and from interviews with Mary and Flora.

income	In shillings (1 USD = 1,300sh)	availability		
Braiding	200 per day	Three times a week	Subject to customers	Sheila and Neema
Remittances	6,000	Per month	Depends whether brothers work	Brother
Selling charcoal	100 per day	Rarely	Subject to customers/competition	Mbutei
Borrowing	500	Weekly	Through local shops and subject to repayments	Sheila and Neema
Handouts	400	Weekly	Depending on availability	Mbutei/Neema
Luggage carrying	300 a day	Weekends	Activities dominated by older boys	Neema's son
<i>Lukina</i> and kapok collection	2,000	Monthly	Performed during seasons and when demanded to pay debts	Sheila and Mbutei assisted by Neema's daughter
Asking for financial assistance	500	Weekly	Not always successful	Sheila/Neema/Mbutei

As indicated in the above tables, for most families to earn a quick income meant engaging in small scale business. However these few options demanded some sort of capital which was difficult for them to raise. Flora, despite her emaciated condition weaved *viungo*¹⁰³ and operated a *genge*¹⁰⁴. *Viungo* involved a taxing process of felling heavy hanging coconut tree branches (*makuti*) and carrying them home. Getting customers depended heavily on builders known to her since many households engaged in this activity, predominantly by men. Her *genge* was always in crisis being highly seasonal. It was never at any given time worth goods above 500 shillings (0.38USD). Also, neighbours regularly borrowed goods and took days to pay back or never paid at all. She also often used the goods for household food: 'Sometimes I will need to eat and we have not sold *viungo* or *lukina* for days, and food is staying there without being bought, what can I do?'

¹⁰³ The process of weaving dry branches of a coconut tree to make a *kiungo* (*viungo* - plural) used for roofing house made from mud.

¹⁰⁴ Vendor stall: selling mostly vegetables such as tomatoes and coconuts.

The tendency of customers not to pay for goods at small household operated businesses was common. This led to a cycle of poverty whereby in order to operate their small business they had to borrow capital or food, from neighbours or shop owners, in the hope of repaying when they sold their own products or when remittances were made available. As the above tables shows borrowing and asking for financial assistance was common in the households of Flora and Neema, as in other households. Known sources of remittances were often used as leverage and guarantee for getting a loan or getting food from a shop. The shopkeeper or the lender had to have prior knowledge that a relative could send money.

However, remittances were highly unpredictable so borrowing and asking for favours was employed to offset debts and guarantee future borrowing, with consequences for the household's survival. For example, Sheila assisted by Neema's daughter had to resort to collecting *lukina* and kapok after failing to repay a debt of 10,000 shillings to a local shop. They managed to come up with only 6,000 shillings from a two week job. The rest they resorted to begging and borrowing from neighbours and friends, putting them further in debt. 'In this house we are always in debt... what can we do?' Neema once lamented. At one time they had some of their belongings (a bucket and two pots) confiscated until they had paid their loan. This experience was not limited to one household and although they did not like to borrow, difficult living conditions forced them to:

Sometimes I do not like to sit and wait for assistance. The habit of going to people and cry and ask them to assist you is not good...when you turn around you will hear people talking behind you, saying 'this person now is too much. (Mama Mu)

Mama Mu's statement above echoes analyses by Barnett and Whiteside on the effects of HIV/AIDS on social networks. These, they argue, tend to decline because, 'the sicker your family member becomes, the more money you may have to borrow from relatives and friends, the more you may seek their assistance. In the end, they say "No more"' (Barnett and Whiteside 2002: 239).

Poor HIV affected people in Maramba were faced with the task of securing on and off-farm incomes as well as performing other activities at the expense of their fragile health. These

included food preparation; washing dishes and clothes; cleaning and house repair; nursing children; bathing, feeding, carrying, toileting, or just being there to watch the children or take them to school; fetching water and wood; participating in funerals.¹⁰⁵ They tended to ignore medical directions requiring them to rest. Some withstood bodily pains to get food: 'I persevere (*navumilia*)...what will we eat if I just cry sickness and pain?' Flora once told me as I found her struggling alone, soaked in the rain, looking for coconut tree branches to weave *viungo*.

In November Flora was suddenly hospitalized, suffering from abdominal pain and was diarrheic. This spelled disaster for the household as labour supply was suddenly reduced. Mary was lucky to get *hailali*¹⁰⁶, but the payment was only due when she was done with work.¹⁰⁷ She left for work early, leaving her two children with a neighbour and returning home at eight in the morning to make porridge and take food to Flora at the health centre. Mary then went back to *hailali*, returning home at one to cook lunch for her children and to take to Flora. She had collected *mchungu* on her way to cook *ugali*. Flora told me of her daughter's efforts to feed her:

It's true she experiences a lot of hardships because of me – (emphasizes by repeating the phrase). When she goes to *hailali* if she gets it then 'we are lucky' (*tuna bahati*) then we won't pass the day and sleep hungry, where would you get 1,000 shillings every day? ...in *hailali* it does not mean she will finish the same day, and if you do not finish they do not pay you a single cent.

The following day Mary was paid in the morning only after much pleading because she had not finished her piece work the day before. 'I had to cry about my mum's health situation for them to pay me'. She used the money, 1,000 shillings (0.7 USD), to buy a kilo of maize flour, spinach, sugar, tea leaves, a bar of soap, cassava, cooking oil and kerosene from a retail shop. The foodstuffs were enough for the house for one day. Counihan (1998: 2) argues that to be in control of sources of food production and consumption is the key measure of women's and men's power. The uncertainty of their income earning sources put poor families in precarious positions.

¹⁰⁵ Interestingly, in the male household samples, all these were performed by women. Majamba's wife attended to the household, Hamis was assisted by his mother while Shabano was cared for by his sister.

¹⁰⁶ Literally meaning 'it does not sleep'; local use generally describes a day's piecework, usually on a 20 square foot piece of land. A labourer must complete the job to be paid on the same day. But *hailali* was restricted to farming seasons and was highly competitive especially from traditionally male labourers. Similarly, in Malawi women performed what is called *ganyu* (cash earning piecework) to earn quick cash for their affected HIV/AIDS households, traditionally male work (Bryceson and Fonseca 2006).

¹⁰⁷ Because of juggling work with caring for her ailing mother she could not finish her *hailali* on time.

Options available for the poor were decreasing and affecting their continued food security which in turn jeopardized eating patterns in poor households. My conversation with Mary the next day illustrates how the off-income activities are difficult to describe as a strategy for survival:

Mary: I do not know what I would have done if they did not pay me?

Peter: But the money you get is only enough for one day, what about tomorrow?

Mary: Tomorrow is another day, let it come and we will see what it will bring, what can we do? We just leave tomorrow to God (*Mungu*).

What can we do? (*Tutatafanyeje*) was a phrase often repeated as details of precarious situations were related. No answer was required. Mostly the respondent would start change the subject or immediately negate the question: 'There is nothing we can do'. For AIDS affected families the ability to return to their normal living standard was impossible when a household member fell sick. Despite the availability of ART (as described in the next chapter), most HIV affected households in which I worked failed to 'resiliently' bounce back; their ability to obtain food was drastically reduced. As argued below, these limited sources of income to obtain food affected eating patterns and the types of food eaten in poor households when compared to households that were not HIV affected. This is important because food insecurity intertwined with malnutrition 'increases susceptibility to HIV as well as vulnerability to AIDS impacts' (Kadiyala and Gillespie 2003: ii).

Food eating patterns

Nutritionists recommend that people with HIV eat three meals and two snacks daily (RCQHC/FANTA 2008: 18), but this is impossible in many poor HIV/AIDS affected households. Studies in eastern and southern Africa reveal that food regimes required for effective ART treatment are difficult to achieve (Senefeld and Polsky 2006; Drimie and Casale 2008). In rural Zimbabwe, Shannon Senefeld and Ken Polsky document that 79 percent of study participants skipped meals at least once a week while 55 percent of adults restricted their meals so that the children ate normally (Senefeld and Polsky 2006: 130).

Eating patterns were strongly interlinked with daily activity to secure income, three meals a day a rarity. Mary told me that working for the day was ‘to make sure that you have eaten in the morning, you have eaten in the afternoon, and eaten in the evening...I have to make sure that in the morning my mother has had porridge, in the afternoon she has eaten *ugali* and in the evening too’. This applied only on days when money had been earned. When compared to others, people in households affected by HIV/AIDS consumed fewer meals per day. On average poor HIV affected households had 15.2 days of food compared to 23.8 days of the non-affected households. The non-affected households consumed an average of 2.64 meals per day against 1.5 meals per day of the poor people with HIV (see Tables below).

Table 10: Frequency of meals eaten by PLHIV: November 2008

Household	Morning	Afternoon	Evening	Total	Days with food	Average meals/day
Mama Mu	3	18	23	44	15	1.5
Neema Barongo	6	16	23	45	15	1.5
Flora Shemdilu	5	20	21	46	15	1.5
Mathias Mtunguja	10	21	26	57	19	1.9
Anita Shaija	2	17	22	41	14	1.4
Gisela Lugolugo	4	18	22	44	15	1.5
Shabano Mstaafu	3	20	20	43	14	1.4
Hamisi Hamidu	7	30	29	66	22	2.2
John Majamba	28	30	30	88	29	2.9

Table 11: Frequency of meals eaten in non-affected households: November 2008

Household	Morning	Afternoon	Evening	Total	Days with food	Average meals/day
Samson	30	30	30	90	30.0	3.0

Maroki	29	30	30	89	29.7	3.0
Saudia	29	30	30	89	29.7	3.0
Ramadhani	27	30	30	87	29.0	2.9
Machupa	21	27	25	73	24.3	2.4
Chama	19	25	25	69	23.0	2.3
Mwanahawa	18	29	26	73	24.3	2.4
Mpemba	19	27	30	76	25.3	2.5
Rasuli	16	22	30	68	22.7	2.3

Aggregate data do not expose different trajectories such as intra-household inequities in the distribution of food (Bentley and Pelto 1991; Pottier 1999: 16) and particularly do not say much about complexities forged by individual positions in the household (Foster 1992; Maxwell 1996). The practice of skipping meals among poor HIV affected households that I observed differed from one household to the other. Eating schedules related to the sick patients' food needs. This influenced the number of meals other household members consumed on a particular day. For instance, adults and older children knowing that HIV positive household member were required to eat three meals, might give priority to them. Talking about Flora's needs, her daughter Mary said, 'We know my mother needs to eat because she is sick so sometimes when she gets money from her *'genge'* she can go and buy food for herself when we also have something to eat. We know she is sick so we cannot force her always to bring money for us'. Flora, who was present during the conversation, added, 'the doctors tell me I need to eat much because as you can see my weight is so low...when I get some money I go to the street vendors and buy something for myself'. But money was scarce and Flora was seldom able to buy food

To deal with food insecurity, poor households combined meals, particularly breakfast and lunch. Breakfast would be skipped and dinner was taken early. A meal was taken at around ten, although this was still referred to as breakfast or tea (*kifungua kinywa* or *chai*). 'We do not take breakfast in the morning, where will we get all that money to eat breakfast and lunch everyday...?' When I asked Anita why breakfast was not prioritized, she told me meals were eaten only once a day:

Those who eat three meals a day are the wealthy, people who are employed, business owners, and big farmers. For people like us eating three meals it's difficult, and I am sick...buying maize flour is difficult, even during harvest we eat one meal in the evening, in the morning we take *kifungua kinywa* which I cannot really call it a lunch.

In this household, and that of Mama Mu and Neema, two meals were consumed, mid-morning and sundown. Research in similar households in Uganda found two meals daily satisfied people (Maxwell 1996: 295). However, people with HIV in Maramba were emphatic that their meals were not satisfying: 'We just eat (*twala tu*) to have something in our stomach so that the day passes and see what tomorrow will bring...two meals a day? You can never be satisfied. The human body (*mwili wa binadamu*), since I was a kid I know, it is designed to go to the toilet three times a day, that is when you have taken three meals, not one!' Neema said in her usual empathic tone.

Another common trend in these families was that meals were taken depending on the day's activity especially during farming seasons. For instance, when Mama Mu was going to farm alone on weekdays she made sure she took food for herself. Issa and Zamia who went to school did not eat in the morning, instead Mama Mu returned in the afternoon to cook for them, which was the children's first meal for the day. When she did not go to farm she ate when food was available or reduced the size of the meal (see below). Often the children came back to eat from school but found none:

If I do not have food to feed the children there is nothing I can do, I tell them to *vumilia* (*persevere*), when it is available I tell them and they come to eat...they persevere but I feel bad because it is painful, but what can I do, should I tell them to go and steal? I can't. I know they cannot force me to give them food although they know I cannot, 'I just keep quiet and feel pain inside me' (*nabaki kuumia tu kwa ndani*).

People attributed their feelings of non-satiation to their HIV status. As Mama Mu put it, 'before these problems (HIV/AIDS) my house was full with everything, I had relatives all over, they ate until they could not finish the food.'

Eating before a particular task was also noted in Neema's and Gisela's households. After losing her capital from the shop she owned Gisela had to resort to giving new clothes to people, mainly farm labourers, on credit, expecting them to pay at the end of the month after they were paid. Before she started the journey to collect her debts she went to a nearby restaurant, early in the morning and ate a heavy breakfast while the rest of the household members ate their meals at ten in the morning:

You know some of these labourers stay far away, it is a long journey, the meal we cook at home is not that good so I wake up early to go and buy food at a restaurant and '*nashindilia tumbo chakula*'¹⁰⁸...It is difficult following my debtors, some of them tell you to come another day and again, and they make me tired and I give up...yes, if they do not pay me leave it to God.

Food insecurity in children of households with a chronically ill adult has well been documented by Greenblot and Greenaway (2006). What I noted in the field however, is that the diverse activities performed in poor households, together with their poverty, gave individuals agency to determine how to use their incomes, especially for the older children. One evening I visited Anita and her daughter Akudo (8), who was epileptic, who had just arrived from school to discover there was no food. She left the house saying she would buy food from street vendors. She sometimes earned a little money from walking around the village with a tray on her head selling bananas, the seed money for which she got after picking up 5,000 shillings on the footpath on her way to school. Anita said, 'It's her money it's her own business, she can decide to do whatever she likes, she sees there's no food here and she knows I cannot give her whenever she wants'. She was not reprimanded as this was seen as a way of relieving her own burden. 'It helps when children decide to depend on their own because they know I am sick and cannot work, I am always sick to bring money in the house.' She said.

During the mango season in December the children spent the day among the trees or in distant villages picking mangoes, selling some and bringing some home. However, availability depended on tree owners. Neema's son told me, 'Not everywhere you can pick mangoes, some owners of plots sell to earn themselves so if he catches you he takes you to the police'. These are 'coping strategies'; sometimes dangerous, but sometimes successful (cf. Shipton 1999). The sons

¹⁰⁸ An expression that implies eating a lot of food – 'stuff food in the stomach'.

of Neema and Flora and the grandson of Mama Mu sometimes performed menial jobs that earned them some money to buy food from street vendors. They did this when food was not being cooked at home. ‘When I get my money I may bring home but I earn so little, like three hundred shillings for instance, if I did not eat in the morning I may bring home food or give to mum and buy, but it depends with what I earn for that day’ Neema’s son, Simon, once told me.

While I have noted above that due to the recognized needs of the patient in the households and how different ways of access to resources affect individual decisions about where and when to eat, when meals were cooked from the household pot the patients were not given any special preferences. In the household of Neema and Gisela for example, when *ugali* and sardines was cooked it was dished out on one plate and eaten comunally. ‘We know she needs good things like eggs or meat, but we cannot afford them.... maybe once a month’, Sheila once told me. This is in contrast to Chileshe’s (2008) ethnographic accounts in Zambia where patients were always served first and preference was given to them with better foods than the rest.

The independence of older children meant that the women had the role of ensuring that the younger children were fed. The sick women in my sample tended to forgo their own needs, putting those of their children first, jeopardising their own health. When Mary went to work and left her toddlers at home Flora made sure they ate first, ‘If I do not feed the babies they will just cry the whole day, I can persevere for a while or we share the little we have, these are children they need to grow’. Restriction of meals is potentially harmful to the sick person because it exacerbates the disease. Restricting consumption of adults for the sake of the children was also noted in the study by Senefeld and Polsky (2006), however restriction of food was at the expense of non-working members (Senefeld and Polsky 2006: 130).

People with HIV, nutrition and land dynamics

Arriving at Mama Mu’s house one morning, I found her taking tea and plain maize for breakfast; we discussed food. Describing a good breakfast Mama Mu said, ‘A proper breakfast consists of tea with milk (*chai ya maziwa*), two chapattis, soup with boiled meat either cow meat or goat meat, fruits on the side and a two slices of bread with butter..... If we had farms we could plant

our own varieties and sell or grow different kinds of vegetables'. While Mama Mu admitted that even though she could not manage to eat meat for breakfast before she fell ill with HIV/AIDS, it did form part of her breakfast at least three times a week, when she used to operate a tea room specializing in selling breakfast. When Flora earned some money and ate at a restaurant she says she must eat a good meal, 'First I order boiled meat with soup, I like it when the meat is boiled with potatoes. Then I make sure I get rice mixed with coconut milk and beans, I used to be a good chapatti maker so I will have two with a glass of milk.' Maize with tea alone or eating a mango with porridge for breakfast, a common meal in the households of Anita, Mama Mu and Flora, were considered a poor person's meals but could not be avoided due to their poverty.

Paradoxically, health officers repeated the rhetoric to ensure food intake for patients attending the clinic. The local health officer asserted, 'We advise to eat food that is available in their area'. When I asked for clarification about food accessibility he told me, 'Food that is accessible in that place, such as fruits, rice, cow peas ...a lot of foods are available in the local shops and on the farms'. The health officer assumed that some foods were unavailable, however in Maramba most foods are present. The health officer expressed surprise that people in the area complained about a lack of food in a fertile area with farmland available for lease. He felt that the problem was that people are *wavivu* (lazy) to work on farms (cf. Kalafanos 2010). What the officer seemed unaware of was the different social economic statuses that patients held, coupled with the dynamics of access to farmland in the village. Further, as I have argued above, because of HIV/AIDS related illnesses, patients could not fully return to work even after taking ARVs.

The health officer's answers were exemplified by a poster portraying food requirements for HIV affected people hanging in his office (see Plate 4 below). This was one of many posters commonly referred to in the public health discourse as 'IEC materials'. A similar poster was on one of the notice boards above the bench where patients queued. The heading translates as 'A full meal for persons living with AIDS virus - a good nutrition is prevention'. Of the foods shown I could identify green bananas, fish, beans, string beans, chicken, yam, carrots, eggs, beef (which resembled a drumstick), corn, 'milk' (or soy milk), green leaves and a mango. Ironically almost all the foods depicted were not a normal part of the diet of most families I had visited. I asked Flora and some of her family – Mary and Bibi – to tell me what they thought of it. Mary

smiled wryly, but her mother could not understand what the poster said. Mary translated. They studied the photo carefully and discussed it. While I could identify thirteen types of food, they could name only ten.



Plate 4: Foods for people with HIV¹⁰⁹

Bibi: What are these? They look nice

Mary: I have seen this at the hospital... These are foods that people with HIV have to eat...

Flora interrupted: I have seen it many times when I go to the clinic but these people are really joking.

Peter: Why?

Mary: Where can we get that food, while the situation is like this?

Flora: *Mchungu* is difficult to obtain these days. Where will I get the chicken to eat every day? If you rear the chicken here they steal even the chicks, the price at the market is untouchable - expensive

Mary: So we are not giving the patient a full meal... and what about us? (*na sisi je?*)

Bibi: If that is a full meal then how can we get it while the farms here we have to borrow.

Mary: That's true

¹⁰⁹ See Appendix 4 for a full list of foods recommended for people with HIV/AIDS.

The discussion about the poster centred on the reality of food in their household and the village at large. It communicated the dilemma which poor families of persons with AIDS face. While the poster sends the message of what HIV affected people should eat, Mary asks, 'What about us?' Her question, though rhetorical, communicated another predicament. She was asking 'How can we give Flora all these foods when we ourselves, do not have them?' The comment from Flora's mother regarding ownership pattern of farms revealed how people connect their difficulty in accessing food with historical realities about land and its use. In this case sustainable access to food also meant access to land. Flora's mother accentuated the fact that these farms need to be permanently owned, not leased from the private estates for crop cultivation. Ownership of plots would have enabled villagers to plant both food and permanent crops.

According to Daniel Maxwell (1996) to understand household food security it is important to analyze not only consumption patterns since food security is a 'necessary but not sufficient condition for adequate nutrition. [...] Food security at the household or even individual level is an "in-put", not an "outcome"- hence the distinction between food security and nutrition security' (Maxwell 1996: 292; also Babu and Pinstrup-Andersen 1994; Haddad, Kennedy and Sullivan 1994). The tendency to reduce the number of meals in my sample was coupled with the fact that the poor limited their dietary intake. Piwoz and Preble (2000) write that dietary and nutrition intake for people with HIV is important because unlike other infectious diseases, the HI virus specifically targets and destroys the cells that protect the immune system. People with HIV are required to consume a variety of foods, and require increased nutritional intake, for instance of 'up to fifty percent greater for protein and fifteen percent for energy' (Loevinsohn and Gillespie 2003: 17; also FANTA 2004). The Food and Nutrition Technical Assistance Project (2004) specifies:

Good nutrition for all individuals, but especially PLWHAs, requires the consumption of an adequate amount in the appropriate proportions of macronutrients (e.g., proteins, carbohydrates, fats) and micronutrients (e.g., vitamins, minerals). It is important to remember that many people in resource limited settings are experiencing pre-existing malnutrition and that HIV will worsen the situation. (FANTA 2004:15)

The significant difference between the affected and non-affected households was that the latter consumed a greater variety of foods than the poor affected households

Table 12: Food types most eaten in poor HIV affected households

	Mama Mu	Anita	Mtunguja	Flora	Gisela	Neema	Shabano	Hamis
1	<i>Ugali & mchunga</i>	<i>Bada & dagaa</i>	<i>Ugali & matembele</i>	<i>Ugali & mchunga</i>	<i>Ugali & dagaa</i>	<i>Ugali & mchunga</i>	<i>Ugali & samaki</i>	<i>Ugali tea & fish</i>
2	<i>Bada & dagaa</i>	<i>Bada & mchunga</i>	<i>Ugali & mchunga</i>	Porridge & mangoes	<i>Ugali & fish</i>	<i>Ugali & matembele</i>	<i>Wali & beans</i>	<i>Ugali & beans</i>
3	Porridge & mangoes	<i>Ugali & mchunga</i>	<i>Ugali & fish</i>	<i>Bada & mchunga</i>	<i>Ugali & mchunga</i>	<i>Ugali & mchicha</i>	<i>Makande mchunga</i>	Rice, beans & tea
4	<i>Ugali & beans</i>	Porridge & mangoes	<i>Makande & tea</i>	<i>Bada & dagaa</i>	<i>Ugali & matembele</i>	<i>Ugali & nyanya chungu</i>	<i>Ugali, & spinach</i>	<i>Ugali dagaa & mchunga</i>
5	Buns & tea	Buns & tea	Banana & tea	<i>Ugali & tea</i>	Buns & tea	<i>Ugali & mangoes</i>	Rice, tea & fruit	Buns, tea, milk
6	<i>Makande & tea</i>	<i>Makande & matembele</i>	<i>Ugali & dagaa</i>	<i>Ugali & nyanya chungu</i>	Banana & tea	<i>Makande & tea</i>	Rice, meat, tea, milk	Rice, meat & tea

Table 13: Food types most eaten in non-affected households

	Samson	Maroki	Saudia	Ramadhani	Machupa	Chama	Mwanahawa	Raymond
1	Rice, <i>mchicha</i> peas & fruit	Rice, beans, potatoes tea/milk	<i>Ugali</i> , <i>mchicha</i> & tea/milk	<i>Makande</i> <i>Mchicha</i> & tea/milk	Rice, beans, <i>dagaa</i> & fruits	<i>Ugali</i> , beans, <i>mchicha</i>	<i>Ugali</i> , sorghum <i>dagaa</i>	<i>Ugali</i> , beans & <i>matem-bele</i>
2	<i>Ugali</i> , fish & tea/milk	<i>Ugali</i> , fish & <i>mchicha</i>	Rice, meat, <i>mchicha</i>	<i>Ugali</i> , fish, okra, fruit	<i>Makande</i> <i>mchicha</i> , tea/milk	<i>Makande</i> , tea, milk <i>dagaa</i>	<i>Ugali</i> , fish, peas	<i>Ugali</i> , <i>mchicha</i> <i>dagaa</i> , tea/milk
3	<i>Ugali</i> , meat, <i>matem-bele</i>	<i>Ugali</i> , meat & beans	Potatoes, <i>makande</i> & fruits	Rice, okra, <i>dagaa</i> , <i>matem-bele</i>	<i>Ugali</i> , meat, <i>matem-bele</i>	<i>Ugali</i> , <i>mchicha</i> , fruit	<i>Makande</i> potatoes, <i>mchicha</i> , fruit	<i>Makande</i> , banana, tea
4	Banana tea/milk, potatoes & fruit	Rice, meat & <i>mchicha</i>	<i>Makande</i> <i>mchunga</i> potatoes & tea	<i>Ugali</i> , <i>dagaa</i> , <i>mchicha</i>	Chapatti, tea/milk, beans	Rice, <i>matem-bele</i> , beans	<i>Makande</i> fish, <i>matem-bele</i>	<i>Ugali</i> & beans, tea
5	Buns, tea & beans	Banana, beans & tea/milk	Chapatti, tea/milk, & beans	<i>Ugali</i> , beans, okra, fish	<i>Makande</i> <i>mchicha</i> , tea	<i>Ugali</i> , okra, <i>dagaa</i>	Bada, <i>mchunga</i> <i>matem-bele</i>	Rice & beans
6	Chapatti, porridge, tea/milk & beans	<i>Maan-dazi</i> , chapatti & milk	<i>Ugali</i> , beans, <i>dagaa</i> & <i>mchunga</i>	<i>Ugali</i> , meat, fruit	Banana, tea/milk, fruit	<i>Ugali</i> , <i>dagaa</i> , <i>mchung</i> a	Buns, porridge & tea	<i>Ugali</i> , <i>matem-bele</i> & tea

*Meat- beef or chicken

*Fruits- fruit or juice

As the tables show, repetition of meals was common in HIV affected households. They consumed more starchy foods than other necessary kinds, which were sold in the local markets and consumed mostly by the non-affected households. Starchy foods such as maize and cassava reflected their accessibility, being obtainable from the borrowed plots. In Anita's household *bada* was eaten regularly because maize was difficult to obtain after JKT harvests had been consumed. *Bada* was regarded as food of the poor by the community; it was never eaten in the non-affected households and was not sold in restaurants (also Fleuret and Fleuret 1980). While *ugali* was a staple food in diets irrespective of HIV status, the substitution of *bada* was related to insufficient

access to maize by the poor and affected households. Anita's daughter, Akudo, did not like *bada* and complained of the monotony of the meals. In November 2008 I visited the family to find a commotion between Akudo and her mother, ending with Akudo refusing to eat and crying. Her mother was helpless. 'I cannot give you what you want, the situation in the house is as it is...if you want *ugali* you can go and buy'. Normally, Akudo had money from her little business but on that day she had not sold her bananas which had gone bad. She slept without eating.

Apart from their low nutritional value, foods eaten in households with an HIV positive person also reflected the dynamics of land tenure in the community and suggested how land access and ownership status is important in ensuring food security among the poor (Maxwell and Wiebe 1999). *Ugali* was the most common main dish eaten by both the affected and non-affected because of the accessibility of maize and cassava that could be grown on borrowed farmland. Some foods were eaten because of their seasonal ease of access and not for nutritional value. The most commonly eaten vegetables, *mchunga* and *matembele*, were available in the village area or uncultivated plots in the bush especially the area surrounding the Mtai mountain forest reserve during rainy seasons. *Matembele* grew in marshy swamps where people disposed of dirty water, and were rarely sold on the local market.

Food security studies use the frequency of eating less preferred meals as a measure of poverty (Maxwell 1996: 295). *Mchunga*, like *bada*, was considered a poor person's food. Even families that ate it frequently disliked it. 'To enjoy *mchunga* you have to boil it and then "mix" (*unga*) the stew with coconut milk (*tui la nazi*) ...that itself is an added cost you know...we prefer to eat it like this. Sometimes we just boil it even without oil when we do not have it,' Mary told to me as they offered me a bowl of *mchunga* with *ugali*. I was able to finish the *ugali* and forced myself to eat the *mchunga* not to embarrass them, although I had been warned of its bitterness. In the homes of Flora, Neema and Anita, *mchunga* was eaten four or five times a week. 'It's the only easily available *mboga* we do not need money to buy it', Flora emphasized. During rainy seasons when maize is scarce, *mchunga* is widely available and sells cheaply in the local market, a 20 litre bucket costing 200 shillings (0.15USD).

Mchunga is rich in minerals such as calcium and iron, proteins and dietary fibre. It also has vitamin C, important for iron absorption (Mtango and Mahunnah 1998). However, Ndossi (1982) notes that its nutritional value is decreased through lengthy cooking and recommends that it be supplemented with fruits such as oranges. However, due to population pressure and changing land use dynamics it is safe to suggest that its availability in the near future is unlikely. Access to fruits such as oranges and papaws demands money, as these are brought in from distant villages. Local fruits such as mangoes and banana were found in a few private plots. Even these had mostly to be bought from the plot owners.

The difficulty in obtaining good *mboga* in the many poor households made them rely heavily on tea. It was taken with staples such as *bada*, banana, boiled maize, rice or *ugali*, wheat foods, mostly buns, ‘to help swallow’ (*kushushia*) the food. I noted that, although it did not appear as part of foods eaten frequently, there were days in the households of Flora, Neema, Gisela and Mama Mu when tea was taken alone. Apart from *kushushia* it was considered a ‘cooling’ agent for hunger as this narration from Flora asserts:

Without tea it would have been difficult, tea helps us a lot, we might go around all over to look for something to eat with food, sometimes even *mchunga* becomes scarce, what will you take? Tea of course...I will boil my two pieces of cassava with a tea, sometimes there is no sugar but it will still go down my throat, what can you do if you do not have what you like then? When we fail to get anything for the day we take it alone, what will we do? ‘It cools the stomach’ (*Inapooza tumbo*), when we go to bed by the time we fall asleep we forget we were hungry.

Despite being on ART, people in my sample group knew the need for nutritious meals; an unattainable goal.¹¹⁰ There were repeated complaints from affected households on the insufficient balance of meals, cited as one of the reasons for skipping meals. In my conversations with these women the connection between owning land permanently and the ability to access important nutrition was explicitly highlighted. A narration from Neema sums up most similar assertions:

¹¹⁰ The relationship between food needs for poor people with HIV, antiretroviral treatment and work, is a subject I consider in Chapter Five.

In the past before being sick we used to eat well, but we still had to work hard to get what we wanted. I did business but business is not always good and capital is difficult. Instead of borrowing us plots, if we owned these farms and decided on what to grow, if its coconut, oranges, okra, peas, keep chicken or goats, banana –I love banana, you can have it as a fruit or cook it...there are seven different varieties, my favourite is baby banana's (*kisukari*). But it is not possible with the arrangements with JKT. These problems of food that we have, we try to forget, but it's difficult to persevere with these drugs I am taking, what can I do?

Maxwell and Wiebe state that the conceptualization of food security should be broadened to emphasize livelihoods and also 'more *emic* or subjective perceptions of food security rather than the emphasis on bio-medical definitions' (Maxwell and Wiebe 1999: 829), since what matters is not only the quantity of food entitlement but also the quality of entitlement (Maxwell 1996: 159). None of the households I observed was happy with the quality and quantity of foods which they ate because of, as they put it, poverty (*umasikini*) and because of lacking farms of their own.

Development and poor people with HIV

The problem of land for poor HIV affected people and their families, and their lack of assets, especially immovable ones, persisted despite programmes geared towards development of the poor. They included projects such as modern livestock keeping, vegetable gardening and credit schemes. I have not dealt with these programmes which barely existed during my fieldwork time. The only gardening project, with land provided at the hospital premises, collapsed because of funding problems and conflict with the health facility over the use of its space. Major previous projects such as AXIOS and Rapid Funding Envelope (RFE), targeting AIDS groups and orphans by providing school fees and uniforms, and sometimes periodic food parcels, had been phased out by mid 2007. They were allegedly marred by corruption, not addressing the real need of households. People purporting to work on socioeconomic projects around AIDS were mainly perceived as '(con-) artists' (*wasanii*), enriching themselves at the expense of the poor. A culture of skepticism towards individuals or groups purporting to initiate AIDS programmes had taken firm root in the community of AIDS sufferers from whom money was demanded to have their names put forward for potential projects. Despite these circumstances, poor people with HIV formed 'biosocial' groups which engendered identity, targeted potential financial support as required by the state and NGOs. A common character of these alliances was fierce competition and mistrust among its leaders, leading to accusations such as 'stealing my patients', as people

battled to access limited resources, a situation Scheper-Hughes termed ‘biosociopathy’ (2004). For similar experiences elsewhere in Tanzania see Mpunga (2007) and Kafalanos (2010) for Mozambique.

Projects in Maramba demanded capital such as land and money that many poor HIV/AIDS affected people did not have. These projects ended up benefiting mainly government employees, rich peasants and JKT members. Mama Mu and other poor HIV affected people were interested in generating income through owning cattle. I wanted to know why she and other of my informants were not involved in any of the projects geared towards poverty alleviation in the country – (*Mkakati wa kuondoa umasikini Tanzania ‘MKUKUTA’* - as they were locally widely known and publicized) - especially the livestock keeping projects such as ‘Maramba Livestock Keepers Network (*Mtandao wa Vikundi vya Wafugaji Maramba* - MTAVIWAMA) and Maramba Dairy Farmers Cooperation (MADAFCO), considered successful by local standards. For the latter, the farmer had to buy a cow; with MTAVIWAMA – people were loaned a cow (which was locally known as ‘loan a cow and pay a cow’ (*kopa ngombe lipa ngombe*)). It was viewed as successful because the project operated throughout Tanga region and had been running since the late 80s. There was a ready market through a private company, which set up a buying point every day and cattle keepers were paid monthly. In addition, farmers benefited directly from drinking milk. It was seen as the ‘saviour of the poor’ (*mkombozi wa masikini*) programme. Her reply was a series of questions back to me:

I would love to keep cattle but where will I keep the cow Peter? How will I feed them every day? I was given a goat during the AIDS day celebrations last year to help me but I had to send it to my aunt at Mbuyukenda¹¹¹... I am not even sure it is still there.

I spoke to the leader of one of the two cow lending programmes. The leader corroborated Mama Mu’s statements. Interestingly, the denial was projected as ‘feeling sorry’ for poor HIV affected people because of their condition – cattle raising was viewed as burden to them. The leader of the group, Mr Mashaka explained:

Any prospective cattle keeper has to demonstrate that he or she can cater for the cow, that is, having an ample space to house the cow,¹¹² financial ability to feed it daily and treat it

¹¹¹ A village located five kilometers from Maramba.

when it falls sick... You must have strength to take care of a cow. Poor people with HIV we pity them (*tunawaonea huruma*) because of their condition we cannot give them a cow because we will be burdening them (*tutakuwa tunawatesa*).

Development programmes in the community demanded some initial asset, especially land, for the poor to benefit.¹¹² According to Scott Drimie (2002) ‘Access to land-based natural resources remains a vital component of rural livelihoods particularly as a safety net.... land tenure becomes increasingly important for the diverse livelihood strategies pursued by different households’ (Scott Drimie 2002: 15). Because poor HIV affected families were both landless and sick, they were not considered. As a result these projects, too, became appropriated by the few with capital such as government employees (in the education and health sectors) and especially soldiers. Unlike Mama Mu, John Majamba kept two cows he received from MTAVIWAMA in 2006 and two hybrid goats as presents from an international NGO, the same kind of goat and from the same source as Mama Mu, who had to send it to a relative in a distant village. John’s livestock were zero grazed in a piece of land he bought in the village and were daily fed by hired labour. From his projects, minibuses, houses, and government pension, he could afford to send two of his daughters to boarding schools in the Kilimanjaro region and also maintain his houses. As Mutangadura notes, although HIV/AIDS impacts both sexes it is not neutral and worsens ‘existing gender based-differences’ in accessing ‘key resources such as land, credit’ and ‘agricultural services and technology’ (Mutangadura 2005: 6; also Haddad et al 2002).

In asserting the importance of land for development of the poor while projects leave them marginalized, Pottier (1999) notes that ‘developments in land use and claims rather suggest that the politically weak, a category containing most women and their dependants, stand to lose from such contestations. This illustrates how vital important access to land continues to be from a food security perspective, and calls for a historically informed discussion of women’s relationship to land’ (Pottier, 1999: 56). Kathleen de Walt underlines that pro poor projects targeting nutrition improvement need to consider nutrition the central aspect of their planning and implementation:

¹¹² Cattle kept for dairy purposes were mostly zero grazed because projects encouraged keeping hybrid cows that had to be fed inside.

¹¹³ I was informed by a number of people that a few rich farmers collude with corrupt project operators and use the names of poor peasants to access additional cows on the pretext that they will pass on the benefits to these poor families.

For agricultural research and development to have a positive impact on the food consumption and nutrition of the rural poor, policymakers must make improving nutritional status an explicit goal from the start of program planning and implementation. Once policymakers have identified improved nutritional status as an explicit policy goal (rather than as a by-product of attaining other goals), they must develop strategies to address food consumption issues directly for groups with identified resource constraints and opportunities, within the policy environment of specific countries and regions. (De Walt 1991: 127)

To improve agricultural productivity in HIV infected women, Mutangadura (2005) proposes simple, appropriate technologies including ‘intercropping to reduce weeding time, promoting use of high yielding crop varieties which are not labour intensive such as potatoes.’ (Mutangadura 2005: 10). This, however, presupposes that all rural women have access to farmland, but the case of Maramba has shown this is not so. Poor HIV infected people, who are the most socially weak, must struggle with off-farm activities to obtain income, employing means that are damaging to their fragile health. The farming arrangement in Maramba between the JKT and the community members, challenges the role of the government in assuring food security and good nutrition to its people.

In this chapter I have argued that existing ownership patterns of land in Maramba challenges the capacity of households of people living with HIV to cope with the disease. The land issues I describe exacerbate their poverty. One has to examine land distribution patterns, and access of the very poor to it, to understand hunger among people with HIV. Likewise, without a careful assessment of the extent of accessibility and availability of food at the household and individual level, and how these are distributed, the extent to which people cope with disease and food security is blurred. The HIV/AIDS affected household of the poor in Maramba fail to ‘cope’ with the burden of having to wait for rainy seasons to farm one type of crop. Even though their physical health may have improved because of taking ART, for the poor, daily survival remained a complex task. They have to struggle in off-farm activities where they compete with those not directly affected by the disease. The limited income from off-farm activities means poor families neglect their eating patterns, jeopardizing not only the health of the sick individual but also that of family members. The poor affected by HIV in a time when ART is available, consider themselves as part and parcel of the working household. However, an unfavourable social and economic environment in the village forces them to work beyond their health capabilities.

CHAPTER FIVE

AMBIGUITY IN UNCERTAINTY: ANTIRETROVIRAL TREATMENT AND LIVELIHOODS OF THE POOR

Antiretroviral therapies...can be extremely invasive: their powerful effect may extend life but it can also shatter the person's 'lifeworld' and force a redefinition of the self, of one's possibilities and priorities, thus greatly influencing drug consumption and adherence to treatment. (Alcano 2009: 119).

This chapter considers the impact of antiretroviral treatment for people with HIV in the face of the uncertainty of life in Maramba. I show how ART impinges on Maramba people's conceptualization of health and wellbeing, and how people with HIV negotiate its access and use. Van der Geest and Hardon (2006) contend that as medicines become widely available, their social and cultural effects should be taken into account as local meanings of health and wellbeing deeply influence the outcome of medicine use beyond their immediate properties. While ART has brought many people around the globe 'back from the dead' (Russell et al 2007; Roura et al 2009iii), the experiences of HIV affected people in Maramba portray a dynamic struggle as they try to adhere to 'these valuable things' (Van der Geest and Hardon 2006: 5; cf. Apparadurai 1986).

While the viewpoints of the rural poor on antiretroviral treatment expressed here overlap with other research in this field, I hope to make a contribution to at least four discussions. The first concerns local people's conceptualizations of ARVs and their role in HIV/AIDS treatment as they become available for the first time in their community. In line with Rayna Rapp, I argue that biomedical language on the effectiveness of ART is appropriated in a 'terrain that is always already structured by prior social and cultural commitments' (Rapp 1999: 315), and that specific labels and meanings attached to the disease come to be understood locally (Kleinman 1980; Good 1994; also Santos et al 2005). Secondly, I consider how uncertainty about the future among people who are yet to enter treatment is handled in the face of the known benefits of

ART. (Whyte 1997; Human 2009; Meinert et al 2009). The third theme examines the perceptions and experiences of people who are on ART as they struggle with their expense. The last theme focuses on of death in light of the wider perceptions that ART elongates life.

A backdrop to ART roll out in Maramba

My field work in Maramba coincided with major progress with the roll out of ARVs in Tanzania, generally, and Maramba in particular. The government began to provide free antiretroviral treatment via major public health facilities in December 2004 (MOH/NACP 2005; Egger et al 2005). From 2005 to mid 2007, the ‘therapeutic clients’ (Meinert et al 2009) from Maramba commuted to Muheza district hospital (popularly known as Teule) to obtain ARVs. Muheza had modern equipment where of CD4¹¹⁴ counts, viral load¹¹⁵ and weight could be measured. Opportunistic infections could be treated and medicine collected.

At first, people used the Maramba health facility vehicles, which carried up to ten people, for the commute. But as numbers increased they had to travel by bus. Patients recalled the journey to Muheza as ‘catastrophic’ (*balaa*) or ‘punishment’ (*adhabu*), and complained about the time spent at Muheza and the money for transportation and food while attending the clinic. Hamisi Hamidu’s account exemplifies the experiences of the majority of the patients who had to travel to Muheza to receive treatment:

It was like a punishment (*adhabu*)...you had to be ready by 5 in the morning because the trip was far. It took an hour and a half because of the road. Sometimes during rainy seasons we had to stay back. The driver drove so fast to be there early as everyone from the district went to Teule. The roads were so rough and the trip bumpy, both ways we reach our destination too sick, some of us were very already sick...at Teule we had to spend the whole day at the CTC, food was a big problems there. We had to spend the whole day there because the hospital transport, and even the bus (when we became many) only returned to Maramba at five in the evening...it was *balaa*.¹¹⁶

¹¹⁴ Also known as T-cell count, CD4 count is used to measure the strength of the immune system. This measure is used primarily to monitor disease progression and to guide treatment. During my field work the measure used to initiate PLHIV on treatment was when patient's CD4 cell counts were ≤ 200 (MoH/NACP 2005)

¹¹⁵ ‘Viral load’ is used to measure the severity of a viral infection in HIV patients, and is calculated by estimating the amount of virus in an involved body fluid.

¹¹⁶ There were reports of token money for transportation and food from an international organization, but availability was reportedly erratic.

Unlike those who were too poor to afford their own transport, the better off, such as the JKT, had their own transport and utilized the better equipped Tanga regional hospital in the city. Their treatment package was provided by the government and they did not mix with non JKT patients. Some soldiers paid for treatment before it became free in 2005. A local group of 28 led by John Majamba decided to raise the transport problem with local authorities so that treatment could be delivered to Maramba. The local treatment centre at Muheza hospital also instituted plans to deliver drugs to Maramba.

Following this shift, the District Hospital directed all patients from Maramba ward, who were still getting their drugs at the district and regional hospitals, to relocate to Maramba's health facility. A total of 164 patients were relocated to Maramba clinic, in addition to the 153 people already attending the CTC. In total there were 317 attending the clinic, with 139 on treatment. The shifting of patients did not, however, go hand in hand with structural and human resource changes.¹¹⁷ Plans for the Maramba health facility to have its own care and treatment centre (CTC) were initiated, with a separate building undergoing major renovations from the beginning of 2008. By the time I left the field in March 2009, patients were still sharing the old building¹¹⁸ with other patients, causing congestion and delays. Hamisi explains: 'Although we did shift there are still some problems, even though the facility is there I have to be there before they open because there are many people...if I delay a little I may not leave until two in the afternoon or three.'¹¹⁹

While shifts were taking place at the health systems level, at the community level the arrival of the drugs at the health facility generated gossip. When I arrived in Maramba, although there were HIV/AIDS campaigns, they focused on prevention and testing.¹²⁰ Apart from official radio

¹¹⁷ The staff complement was not increased to match the sudden move of patients to the facility. A health official informed me that manpower competence was not assessed, and the space was insufficient. According to 2007 Maramba health facility data, total attendance of outpatients and in-patients was 33,794 and the number of clinical officers was 3. The doctor/patient ratio was 3 to 43 per day, besides the number of HIV patients.

¹¹⁸ According to a clinical officer at Maramba there were contractual breaches, including poor quality renovations which had to be rectified by the contractor.

¹¹⁹ Although drugs were now delivered to Maramba, major tests such as CD4 counts, viral loads and liver function, still had to be sent to Muheza for diagnosis. The patient had to return and collect her results on another set date.

¹²⁰ Most of these campaigns in the community took place during major national holidays such as Independence (Uhuru) Day, AIDS day. On such days HIV testing stands were open throughout the night.

campaigns, people in Maramba came to know about the availability of ARVs through seeing people going for treatment.

‘When you eat those drugs they make you really fat’: Community understandings of ART¹²¹

According to Kleinman people use locally suited explanatory models to ‘manage’ and ‘label’ certain illnesses (Kleinman 1980: 77), and in Maramba ARVs became laden with different meanings and interpretations. On Tuesdays and Fridays as I walked towards the clinic in the centre of Maramba I could see scores of people walking and others on bicycles. Casual observers and intentional onlookers quickly assumed that those who attended clinic days were all HIV positive and taking treatment. People would casually point and say ‘he (or she) has it’ (*anao* - implying s/he is HIV positive). Even during non clinic days people would identify a person who was seen attending the clinic with the phrase ‘he (or she) is at the care and treatment centre’ (*yuko kwenye kitengo*), but which actually implied he or she is HIV positive and on ARVs.¹²² Being seen at the clinic affirmed what Whyte and colleagues argue about the effects of taking medicines as having ‘social and performative effects’, by which people ‘confirm sickness’ (Whyte et al 2002: 15).

Ambiguity arose in the conceptualization of the therapeutic effects and benefits of ART among HIV positive people. The conception of ART as treatment was often conflated with local shared knowledge and terminologies on the understanding of the functions of drugs in the human body. When the question ‘what do you know about “AIDS treatment” (*matibabu ya UKIMWI*)?’ was posed, it was always met with resistance. As a local hamlet leader, Bosingwa Hamida (46) replied, ‘What I know is that there is no AIDS treatment but drugs to prolong life.’ This resistance arose in part because in the local Swahili language the noun *matibabu* implied to cure:

To treat (*kutibu*) is to be given a drug (*dawa*), which it cures (*ponya*). There are two things about treatment, for example I have a cow, I gave it drugs and it did not *ponya* so I looked for another drug. With AIDS someone is treated for AIDS, does not get cured but

¹²¹ The responses reported here come mostly from a long series of in depth interviews and group conversations I conducted with 60 people of the ‘general public’ (for analysis purposes I designate this identity to informants who were neither patients nor health workers), and also from participation in formal and informal gatherings with different persons in the early months of my arrival in the community. The interviews focused on the general public’s perceptions of HIV/AIDS and its treatment in the community.

¹²² These labels contrast with others that were recorded before the advent of ART. Such labels associated HIV infected people with death and dying (Nyblade et al 2003; Kisinza 2002).

'add days to live' (*wanaongeza siku za kuishi*); that is not treatment because that person is not cured. AIDS has no treatment. God sent it so when you get it you must die. If you give a cow a drug and he does not get cured, that is not a good *dawa*.

The Swahili meaning of the verb treat (*tiba*) is translated to mean 'cure' (see TUKI 2001). This is significant because while the English meaning is explicit for both *relieving* and *curing*, the Swahili meaning emphasizes curing. The responses that ART were not 'treatment' were also conceptualized in relation to the popular understanding of AIDS as incurable, which was long understood before the availability of ART. 'It did not used to be like this, they were getting thin, they had diarrhoea and did not leave the bed, "they were dying but now they live"' (*walikua wanakufa sasa wanaishi*), asserted a young male trader. Symptoms like weight loss were noticed, as before the availability of ART, physical symptoms were an important indicator of HIV status (also Ezekiel et al 2009: 962). The few who explained treatment in medical language, while employing local terms, spoke of virus (*wadudu*) or being made drunk (*lewa*), by the drugs. 'That is why the drugs have to be taken until they die...they do not treat but simply make the virus sleep or *lewa*, if they stop for one day, they wake up and start killing "immunity"' (*kinga*), asserted Jimmy, a home based care (HBC) provider. A popular sentiment repeated to me was that ARVs were seen as drugs that were meant either to 'push or extend days' (*sogeza siku*), 'add days' (*ongeza siku*) or 'prolong life' (*refusha maisha*). They were often described as 'life drugs' (*dawa za maisha*).¹²³ The tendency to deny the incurability of AIDS also contrasted with the mention of the efficacy of drugs to cure diseases such as malaria and diarrhoea, which were common in the area.

In Maramba, respondents' views and understanding of the treatment did not relate to its chemical effect of inhibiting the ability of retroviruses (such as HIV) to multiply, but rather what they saw happening to the bodily appearance of the person once they initiated treatment (also Santos et al 2005). The perceived ability of the drugs to change the body was conflated with food. During interviews ARVs were regularly labelled 'fattening drugs' (*dawa za kunenepesha*), after being 'eaten' (*kula*). A retired soldier living in the community explained to me that, 'These ARVs they

¹²³ Despite this reference, the language of local AIDS campaigns was ambiguous. While campaigns to encourage people emphasized the availability of lifelong treatments, prevention campaigns labelled HIV/AIDS potentially deadly. For example, one campaign I noted during AIDS day was 'if you do not wear a condom you will die'. Similarly, local churches and the many mosques preached AIDS death slogans in the community. This may explain the dilemma respondents had in conceptualizing persons on ART as sick or not.

eat and they even get bellies' (*wanakula wanapata vitambi kabisa*)... they 'make people with HIV fat' (also Ezekiel et al 2009: Roura et al 2009iii: Watt et al 2009). In Maramba *kula* was also used to describe having sex.¹²⁴ Interestingly, the description is also gender laden as only the man 'eats' the woman and not the other way round.

Generally 'being healthy' (*kuwa na afya*) was synonymous with being fat (also Ezekiel 2009). People would praise each other for putting on weight as this was related to eating well, which also signified an increase in wealth. Weight gain also symbolized success in life. For men, having a potbelly (*kitambi*) was symbolic of earning a good income, and of status and wealth in the coastal communities of Tanzania (Leseth 2003), other African countries (Bayart 1993) and the globe at large (de Garine and Pollock 1995).

According to Van der Geest and Hardon (2006), medicines, as things, carry symbolic meaning (cf. Apparadurai 1986). They go on to assert that antiretrovirals also acquire meanings when they enter people's lives 'far beyond their material (chemical) properties' (Van der Geest and Hardon 2006: 1). The fact that people who took the drugs gained weight meant that the drugs were perceived positively. Comments such as, 'the drugs have accepted him' (*dawa zimemkubali*) or 'they loved him' (*zimempenda*) were directed to those whose appearances were perceived as having changed positively. One day as I was about to attend a local AIDS group, the woman accompanying me commented on the appearance of a member named Jonathan (37). While still at a distance she said, 'I see the drugs have loved him so much he has even surpassed his original shape...do these drugs simply prolong life or they also cure?' The drugs' positive outcome were contrasted with the statement 'Drugs have rejected her' (*dawa zimemkataa*) for people perceived to be HIV positive and emaciated. Antiretrovirals were thus perceived to have the power to transform a person's illness into a socially defined status of wellness (Van der Geest and Hardon 2006). Whyte and colleagues (2002) affirm that 'people do make empirical observations, and they are concerned when a treatment does not work' (Whyte et al 2002: 35). In Maramba, when a person was emaciated and perceived to be positive, people questioned their status, as this statement from a conversation with one woman shopkeeper in her 30s asserts: 'When you eat those drugs you must change and look nice.'

¹²⁴ Similar connotations have been recorded from Southern Africa (see Wojcicki 2002)

Scholars have recently documented how ART has challenged HIV related stigma through masking people's illnesses, 'thus making HIV less salient to their public identity' (Green 2009: 70). In Maramba however, there were forms of stigmatizing attitudes towards ART and people who enrolled. A popular discourse was that without the drugs they could tell the symptoms of those who were dying and therefore avoid them. Thus they judged that those who took ART were given the chance to spread it intentionally because the bodies become fat, and so were not easily recognized as infected. A view from a 43 year old woman and a local tea seller, sum up this view:

Those who eat drugs (*hao wanao kula dawa*) the drugs help them become fat and they seduce (*tongoza*). ...They come with their big bellies, can you say no? He tells you he does not have the virus and convinces you by giving you 2,000 shillings, you will agree with him...If they give drugs to make people fat they are hurting us - they come with the money and as you see we are poor and hungry and need money, we accept them. If I were a leader I would not give people the drugs because they enhance sex, we know people here who are positive but still sleep with others

Similar findings and arguments have been raised by Roura and colleagues (2009iii) in their recent qualitative study in north eastern Tanzania. They argue that while the drugs have contributed to a reduction in self-stigma there was an alarming increase of blaming attitudes towards people on treatment, hence affecting ARV uptake (Roura et al 2009ii). Whether these claims are true or not, the words from the woman above unmask power relations between women and men when it comes to sexual negotiations in the community. However, such claims seem not to impact on the uptake of ART in Maramba as Roura et al have claimed, a subject I discuss below.

'Treatment gap': Biomedical demands and patient's dilemmas

While the community perceived the effects of ART on the body in more or less positive terms, my observing people who had not yet started treatment, and those who were already on treatment, revealed interesting dynamics. Although most of the people who constituted my core sample were on ART, for a while I was able to observe through Flora's household how the drugs

were admired but at the same time created ambiguous notions of ART protocols.¹²⁵ Jo Wreford designates this stage the ‘treatment gap’. This is the period between diagnosis of positive HIV status and before entering treatment (Wreford 2008: 74-75).

After being diagnosed as HIV positive, people like Flora attended the clinic every three months. During this period their health was monitored through measuring their viral load and CD4 T-cells which are responsible for the immune system that protects the body from new infections. If detected with less than 200 CD4 count, they are able to start treatment. Although they may or may not experience themselves as being sick, if they acquire opportunistic infections such as malaria they are also treated. A nurse counsellor at the Maramba health facility informed me that, ‘We normally tell them these drugs are *kali* (strong) so they should not “jump into them”’ (*kuzifakamia*). She added, ‘We encourage them to make sure that their CD4 remains high...by eating well and performing “less tiring activities”’ (*kazi nyepesi*). To become a disciple (*kuwa mfuasi*) of these drugs is not a joke...it is a life commitment. We in fact, put a lot of emphasis on making sure that they try as far as possible not to let their CD4 drop (*zisishuke*), we and are happy if they succeed with this.’ They were also told to rest a lot, perform exercises, have protected sex, and most important eat enough and follow a balanced diet. In other words, these are the procedures patients are told to follow so their CD4 counts do not drop, so that they do not have to start treatment (a life commitment) because if they consent and decide to start the treatment they are, in one way or the other, ‘on their own.’

Despite warnings from the doctors, Flora continued to work to make ends meet. In my many discussions with Flora's daughter Mary, she wondered why Flora was not being put on ARVs. On a day when Flora was hospitalized for diarrhoea Mary wondered:

Why do they ‘make her suffer’ (*mtesa*)? Why should they not put her on ARVs like other people? ...their lives and bodies (*miili*) have become better ...It is the only treatment to make her better so that she can live longer, look at how she is weak and sick every time...many people look nice and healthy and do their work....if she is better I will go back to my business work in Dar es Salaam.

¹²⁵ Although in this section I am discussing only one case, there were two other cases of more or less the same nature but which I could not follow closely. The family of one patient decided to take their relative, who lived in a different district, to a health facility in the city. According to Mr. Abdul, the local health officer, many patients have demanded to be put on treatment despite their CD4 counts being above the required level. For this reason they have lost many patients who decided either not to come or returned too late, and some died.

From Mary's remarks the period Flora had to wait for her CD4 to drop was not in line with what was happening to her body. It created uncertainty; not knowing when Flora was supposed to enter treatment or, in her own words, how long her mother had to 'suffer'.

At the health facility the procedure of entering treatment was different from what Mary's household perceived as Flora's immediate need of ART. The importance of CD4 count was appropriated differently. Using the term called 'biological citizenship' to expound on how diagnostic technologies impact on social relations, expectations and human predicaments, Rose and Novas write that:

Such persons use those languages, and the types of calculations to which they are attached to make judgements as to how they could or should act, the kinds of things they fear, and the kinds of lives for which they hope. (Rose and Novas 2005: 446)

Understanding of medical directives regarding ART was appropriated and reflected upon in relation to the time from when the individual was found to be HIV positive and the efforts family members had put since she was hospitalized with HIV/AIDS related illnesses. Flora's younger sister, Hawa (40) who lived in Dar es Salaam, had cared for Flora when she was first diagnosed with HIV in 2006. When we met, she also wanted to know why the doctors were delaying her sister's treatment:

The reason we brought her back here from Dar es Salaam is because we wanted her to start taking drugs while at home... But until today she has not started, they say that *kinga ziko juu* (her CD4s are up). As you can see her condition she is continuously losing weight and strength.

The family associated Flora's weak condition with working too much and eating too little food. Given the publicity around ART they believed putting her on ART would eventually improve her health. One day I explained to Mary the medical requirements and the measures involved but she seemed not to fully comprehend. 'I have heard mum say but...So, if you are telling me, that she is sick, those CD4 are high she cannot get the drugs, but if you look at her its different¹²⁶... what if she falls sick everyday and they are still high? What is the use then of ARV? What if she dies because of being sick when those CD4 are up?' Speaking of CD4 measurements, Meinert and colleagues (2009) wonder whether 'the measuring is necessary and important for good quality of

¹²⁶ I had a long discussion with family members of patients about their understandings of CD4. Most, like Mary, wished to conceptualize the measurements, the increase and decrease, not in terms of numbers but bodily appearances of their patients, and whether or not she was ill with other diseases like malaria or fever.

care' (2009: 196). Thus, not putting Flora on treatment while her appearance communicated otherwise, created uncertainty about the direction of her life and about her future. The major uncertainty was about death, before she could be put on ARVs, but also about how long she would suffer and endure repeated illness and emaciation while she had family responsibilities.

One day Flora received her CD4 count results, which had taken more than the usual time to be returned to her, apparently because the measuring machines had not been working.¹²⁷ 'They have told me that my CD4 are going down...the doctor reprimanded me a lot for not looking after myselfthey told me if I continue like this they will put me on ART...'. This suggests that ART was seen as both punishment and possibility; an ambiguity that lies at the heart of responses to ART in the region. Flora's CD4 cells had plummeted, from 373 in June 2008 to 255 by December 2008. Asking how she felt about this advice from the doctors she told me, 'I try hard, as you know me and our situation here in the house, but what can I do? Insufficient food is the only thing that is killing me; you know the kinds of food we eat here'.¹²⁸

Whereas biomedical protocols are aimed to give structure to the performance of medical practice, Oliver Human (2009) contends that sometimes following standardised procedures may end up costing one's life in poorly resourced health systems. He adds that because hospitals follow protocols they cannot be held responsible; responsibility is shifted from the protocols to the human body (Human 2009). When patients like Flora are told to maintain their CD4 count not to go below 200 it is their own responsibility to make sure they follow procedures by staying healthy by eating well. So when they fail or die the medical protocols cannot be blamed for any shortcomings.¹²⁹

While talking to Flora one day, as she weaved her *kiungo*, I noticed that she was particularly insistent in wanting to start treatment despite the clinic's advice. As I probed more she said, 'As you can see my body, I am so thin, I do not have energy enough to work and earn enough to eat, if I start drugs I will be better...I need to work, even my clothes do not fit me nice and well.' I

¹²⁷ Patients' CD4 counts were taken every month but for a period between August and December 2008 the machines located in Muheza were not working. Patients could not receive their test results.

¹²⁸ Flora was referring to the experiences of foods in the household I detailed in Chapter Four..

¹²⁹ Emerging evidence from clinical studies have begun to recommend the initiation of ART when CD4 counts are above 200 due to excessive mortality of patients who are put on treatment at the current threshold of ≤ 200 (Walensky et al 2009; Marazzi et al 2008).

asked her how well, and she said ‘This is not my body, these clothes are supposed to be tight, not loose like this, if you had seen me before this problem I was big’. Flora’s aspirations for ARVs did go beyond wanting to regain her strength so she could return to work. The importance of looking nice according to societal definitions of being healthy was emphasized. When discussing HIV positive people’s experience in Uganda, which reflect Flora’s experiences, Meinert and colleagues stress that rather than reflecting critically on their faulty immune systems, patients seem to use the numbers to rethink their social worlds (c.f. Meinert et al 2009).

Flora’s case can be compared to that of Maimuna (21), whom I met at the Maramba ART clinic. She lived with her parents since her husband died two years before. She had been monitoring her health by visiting the clinic. But later she started developing skin rashes and losing weight. At the clinic she was given amoxycillin tablets for treatment and septrin tablets for prevention, but the rashes persisted. Apart from the need to get better, her entering treatment was more to avoid potential stigma: ‘Where I live people talk a lot, my parents know that I am positive, I had to tell them but I cannot let people know. I cannot stand being pointed fingers at. It is better to be positive in the urban area because everyone has their own business, but in the village, everyone minds your business.’ She added that her body changes communicated a different message and was worried if not put on ART quickly people would discover her problem. However, the CD4 were not down enough to have her enrolled. ‘My skin has changed, I look very old now, I have to wear hijab all the time to cover myself. People are asking why I cover myself while I never used to do so.’ Although she left the community before I could follow up her case, unlike Roura et al’s argument above, Maimuna wanted to be on ART mostly to mask the disease and avoid potential stigma.

Flora was enrolled in adherence classes¹³⁰ for three consecutive days in January 2009. Her daughter, Mary, accompanied her to the classes as her treatment supporter. Flora speaks of the adherence sessions, ‘I was given rules of taking drugs... I was also showed the drugs and how to take them. If I do not follow the rules I may get sick or the drugs will fail to work ... I was told to eat good food and they have told me not to work.’ I added, ‘But only during the first few months

¹³⁰ Before starting to take ARVs, patients whose CD4 count have dropped below 250, are given orientation on how to use the drugs for a period of three days. The orientation is also given to a caregiver.

when you start treatment?’ She replied in the affirmative, paused and added again ... ‘But for how long can I not work? Whose food will I eat?’ (*Nitakula cha nani?*).

CD4 counts and weight symbolize doors through which to access ART, but they may become constrained. As Rayna Rapp (1999) writes, ‘the discourses and practices of biomedicine and technology are played out on a complex cultural ground’. Although the households of Flora and Maimuna appropriated both the medical terms and language, they also questioned its requirements while mirroring their own immediate needs. For both Flora and Maimuna, the known benefits of ARVs were desired at a time when biomedical measurements did not permit it. The biomedical protocol was contradictory to what Flora and her household believed necessary. According to Byron Good, medical technologies are like ‘symbolic forms’ and they become a symbolically mediated mode of apprehending and acting on the world (Good 1994: 87). It is safe to suggest that Flora perceived ART as ‘food’ to restore her body image and strength so that she can return to her role of an effective producer in the household. In their household, food has been difficult to obtain and Flora was one of their main providers. Also the fact that she was directed not to work hard was synonymous with telling her not to seek income, badly needed for the household survival. In other words, although the family was aware of the CD4 counts before taking ART and how health officers at the CTC emphasized maintaining them, they struggled to comprehend that in light of Flora’s status. Unlike the findings of Meinert and colleagues (2009) in Uganda, where patients preferred the results of CD4 count because “‘knowing one’s kilos” was not a common way of following bodily changes’ (Meinert 2009: 197), Flora and her family found knowing her CD4 count to be disempowering and contradictory to their own evaluations of her wellbeing.

Uncertainty in chronicity: Negotiating treatment and livelihoods by PLHIV in Maramba

I now turn to the experiences and perceptions of people on treatment. According to Green (2009), in the post HAART era ‘the emphasis has shifted to the problems associated with living rather than dying with HIV’ (Green 2009: 63). My discussion in this chapter does not argue that ARVs do not work, but demonstrates that HIV positive people in Maramba went through

complexities in their lives.¹³¹ For people on treatment, major sources of uncertainty revolved around side effects (locally known as *madhara ya pembeni*) caused by the drugs and unpredictable opportunistic infections (*magonjwa nyemelezi*). This discourse contrasted strongly with the positive language of the general public and aspirations of people who had yet to enter treatment, such as Flora. Although the HIV affected persons in my core sample accepted the drugs' ability to prolong their lives, there was a deep resentment about taking medicines and about the unpredictable illnesses and side effects, amidst their poor diet. For example, one of the reasons Anita preferred to farm less was due to illness and getting tired after taking the drugs, which she attributed also to not eating properly:

These drugs have helped us but they make us suffer to say the truth. Sometimes you are worried (*unakuwa na wasi wasi*) when I will be well or if time to die has arrived (*safari imewadia*)...the problem is with these when fevers catch you. When you wake up you are happy if you are well, but if it (fever) continues you start wondering what to do, but then 'you give yourself hope' (*unajipa matumaini*) that you are taking ARVsometimes I also think being worried brings sickness, but how can you stop worrying? People see you and they tell you, I am lucky because I have taken drugs and I am better. But nobody knows what goes inside my body or inside my house. Although my life may depend on these drugs its myself who knows how I suffer...at the facility they tell you to make sure you take drugs everyday so that my CD4 do not drop, but they do not provide me food...we were given food but it was quickly finished.¹³² The truth is that, yes, we still live but it is not like the past, being sick is still there (*kuugua kuko pale pale*)...Some days I wake up so angry, I see that I do not have food in the house, yet I am supposed to take these drugs, sometimes I do not...although I will feel bad but not like when I take in an empty stomach.. I feel like I am going to die.

Anita's statement reveals that although taking treatment has enabled longer life, to her it does not mean life has returned to normal as scholars have argued (Roura et al 2009iii; Watt et al 2009), with patients reporting 'feeling increasingly comfortable with their status'. Being on ARVs for people with HIV meant taking new identities carrying their own price tags. For Anita, life did not become 'normal'. She asserted that since starting drugs she has been 'suffering', and her new

¹³¹ The discourse around HIV/AIDS in Tanzania, to my knowledge, did not embrace the heated stance about its very existence, as was the case in South Africa. All the people I spoke to acknowledged that HIV/AIDS was real. However, as I will discuss further, a few loosely believed HIV and its associated symptoms correlated to a disease that existed many years ago, and may have resurfaced, an observation which Mshana and colleagues also made in north eastern Tanzania (Mshana, Plummer et al 2006).

¹³² HIV/AIDS patients starting ART were some time before I arrived in Maramba given food parcels by WFP at the clinic in Muheza, parcels to last them only for six months after commencing ART. However, all the patients complained that the food was insufficient as they had to share with other family members.

life, her new identity, contrasted with her previous life because of her constant worry about her wellbeing. Indeed, as Brashers and colleagues argue, although patients have revived their lives, this revival entails a life new life of sickness and uncertainty (Brashers 1999). Similarly, Russell et al., drawing from their experience of patients taking ARVs in Uganda, argue that, ‘for PLWH a euphoric return from near death to new life can be quashed by the struggle for work and lack of money and food’. (2007: 345). For Anita, in the face of food problems she had to skip drugs and also felt uncertain of her future. Taking treatment for some people with HIV is not an act in itself, it is connected to their already complex lives of constant struggle in an environment with limited opportunities for the poor caused by historical and structural factors. This is reflected when Anita contrasts the biomedical requirements to the situation in her house; ‘but nobody knows what goes inside my body or my house’.

Uncertainty, caused by the unpredictability of the onset of symptoms of opportunistic infections, and of side effects, was also illustrated in people’s reflection on their struggles to farm, and wondering about their circles of support. In biomedical terms, side effects are the results of a drug or other therapy in addition to, or in extension of, the desired therapeutic effect. ‘The term more often refers to pharmacologic results of therapy unrelated to the usual objective ... The term usually, but not necessarily, connotes an undesirable effect’, notes Stedman (1982: 1284). Biomedicine defines side effects exclusively in biophysical terms disregarding cultural and social factors (Whyte et al 2002; Etkin 1992). Etkin argues that in some cultural situations ‘what is deemed a side effect is embraced... as a requisite part of a process in which the early outcomes indicate that therapy is under way’, (Etkin 1992: 102). However, she adds that, ‘in biomedicine side effects are typically understood to occur during the course of therapy or shortly thereafter’ (Etkin 1992: 101). However, it is the long term effect of the drugs people struggle to endure.

One day Mama Mu called me to assist her with food. I found her lying on the *sufi* mattress I had helped her to obtain.¹³³ And because the ceiling of her room was high and she did not have a bed, the mosquito net could not be properly attached. Malaria is the leading disease in the area and without protection it could result in death, especially for people with compromised immunity. Her immediate circle of support were her neighbors, young boys whom she described as *wahuni*

¹³³ When I first met her she slept with her two grandchildren on a mattress a neighbor who traveled loaned her. Before, she was sleeping on a mat. When the neighbor returned she had to give it back.

(outcasts) but who also had compassion for her situation and exchanged mostly foodstuffs and services¹³⁴ with her. In her soft but lamenting voice she told me:

These drugs *zilituamsha tulipokua tumelala*¹³⁵ but these *homa* 's (fevers) they come all the time. Yesterday I was very fine when I came to sleep but when I woke up I feel this heavy fever on me...these boys are good to me but since they left yesterday they have not returned, they would have helped me with something (food) to push until tomorrow, I was planning to go to the farm and now because of this I am stuck and I had to call you, I am always worried...But what can we do? (*tutafanyeje?*) We just have to take the drugs even if I do not want to.

I asked Mama Mu if I could help her to get to the health facility but she refused, saying the fever she had did not require a visit to the hospital. Mama Mu distinguished between three kinds of fever, one that may be caused by malaria, the other that may be caused by the strength of the drug, and the last may be due to hunger. They all made her tired, but she cautioned that if it was caused by the drugs, she would carry on, and only go to hospital if the symptoms were severe:

...sometimes the drugs will make me tired, I can feel it because I will feel a little dizzy (*kizunguzungu*), I can rest for a while and I will be fine later. Today I woke up and felt the same dizziness, but it has somehow persisted for a while. It feels like mixed with normal fever (*homa ya kawaida*), I do not even know...I will not rush to the hospital, besides they will end up giving me just Panadol! But I am sure I will be fine, I just need to eat first...maybe it's because I am thinking too much, if the fever is too much then I will go to the hospital. Forgive me for troubling you but these drugs are no joke, they are very strong and sometimes they behave strangely in my body....I do not know when these problems will end.

The words of Mama Mu illustrate that in the course of an unpredictable illness the difficulty was to differentiate between symptoms that were caused by the drugs, or fever and malaria, caused by opportunistic infections, which in turn determined the course of action. These symptoms were mapped in relation to important needs that patients had to fill as required by treatment protocols, which included a proper diet. She felt that her immediate need was to obtain food before seeking

¹³⁴ Since she was the oldest woman among the other renters she would cook and share her meals with the young unmarried men. When they managed to bring food they will ask her to cook for them and ate together. Most had casual jobs, such as carrying luggage, felling trees, small scale mining, they were not always around when I visited.

¹³⁵ Literally meaning that ARVs 'revived us when we were asleep' but the implied meaning is the drugs 'we were dying and resuscitated us'. In the United States the effect is commonly referred to as the Lazarus syndrome' named after the a biblical character Lazarus who was revived from the dead by Jesus [Brashers et al 1999)

other solutions. The experience of Mama Mu and others can be compared inversely to Scheper-Hughes' account of the favelas in northwestern Brazil where hunger was medicalized and treated with tranquilizers (1992). In Maramba, in the face of scant food shortages, the ARVs as a medicalization process, itself caused hunger (also Kalafanos 2010: 365).

Because the demands of medical treatment were not often met, people on treatment became more uncertain about their lives and questioned the direction of their prolonged lives in light of these demands, in most cases without foreseeable solutions. Some scholars have argued that in such situations people suffering from chronic illness need to be taught how to 'cope' with uncertainty (Mishel 1997; Brashers et al 1999), and uncertainty should be accepted as a fact of life (Mishel 1999: 272). However, as I discussed in the previous chapter, patients who are poor are faced with a multitude of problems that may directly affect the onset of symptoms. Additionally, they have already been living with the uncertainty that food insecurity creates; they are deeply familiar with uncertainty, which their ill-health exacerbates. Having little to eat suggests that a patient may fall ill due to reduced immunity caused by hunger and, in extreme cases, malnutrition.

Christina had been intermittently ill for a while. She had repeated malarias and a continually painful and swollen leg, from the knee to the foot,¹³⁶ which she had to endure to complete important household tasks. Her sister, with whom she shared the same plot, was doing fine. Both Christina and her elder sister were HIV positive. One day I arrived at their house with Jimmy as part of a local ART adherence program.¹³⁷ Flora was sick but refused to go to the hospital. As I spoke to Gisela, she seemed worried about her sister's deteriorating condition. In her explanations she conflated biomedical language with her life experiences in trying to understand the direction of her sister's life as well as her own:

I do not know why she is always sick and her CD4 dropping, we eat the same food and take the same pills, she also sleeps under a mosquito net, but I have been better. She works and I also work, her leg problem is not going away ever since she started taking ART, it is worsening. Every day when I wake up I wonder what will happen next. It does not mean I do not get fevers, I do, but it seems the drugs are not working in her body. But

¹³⁶ Known effective solutions for lipodistrophy (the redistribution of body fat to different parts of the body) includes surgery. But this is for patients who have money

¹³⁷ I participated in a HBC care program run by a local church for six months and observed their activities. It was operated by care providers visiting patients at homes, distributing pills and ensuring patients took their ARVs, among others. These programmes run in the whole ward of Maramba and beyond.

she started treatment before me, she should be better...if drugs help to increase CD4, and by now her body must have get used to her. We were told the drugs only trouble someone during the first six months but it has been more than almost three years...

According to Brashers et al (1998) prolonged survival with ARVs may mean high levels of uncertainty for longer spans of time for HIV-infected persons; ART itself is 'a chronic and pervasive source of psychological distress for persons living with HIV.' As a stressor in itself, uncertainty has been described to negatively impact on immune functioning (Kiecolt-Glaser and Glaser, 1988; Jemmott and Locke, 1984). Christina's refusal to go to the health facility for treatment was compounded by the fact that services and treatment at the clinic was not good. Patients felt it was better to stay home rather than make a trip to the facility knowing they will get poor treatment, a fact Mama Mu also complained about. If treatment for a remedy was known, people would visit a drug shop rather than go to the clinics, thereby creating more chance of misdiagnosis. However, for most patients with limited funds, it was difficult to get important drugs, even though the policy required HIV positive people be treated free of charge. This proved very stressful for people at home and who were sick with opportunistic infections. Patients went as far as questioning the effectiveness of ARVs as they still got sick. Christina wondered why she had repeated fevers despite taking malaria prophylaxis:

I know that these ARVs are supposed to increase immunity, and when you get other diseases you can treat them and you will be fine. But I have done that many times but my CD4s still are not going up. Does this mean ARVs do not work in my body anymore or what? When I go to the hospital they prescribe me the same pills...I will go when I feel like.

Because Christina and Gisela were both on treatment an explanation was sought for why Christina was more often intermittently ill than her sister. How much Flora felt she could work always raised a heated debate because of her repeated ailments. The clinic directives to work little and rest much, directives that one is also required to follow before entering treatment, are hard for Christina to follow, as well as those on treatment in my sample. For these people, the efficacy of ART was tied to a belief that the drugs will enable them to return to work. However, the extent to which working is required, and how one could balance that without affecting their bodies was not easy to determine.

As part of the HBC adherence programmes, every Tuesday we distributed septrins¹³⁸ and painkillers. We also collected people's views of their experiences of taking ARVs. On one particular day, Gisela became impatient: 'We are tired of taking the drugs (septrins) you bring every day. Tell your bosses that we want food, we cannot take drugs in empty stomach.' Often patients threatened to quit the programme if their concerns were not addressed. The leaders asked us to convey that food is being looked into and continue to distribute septrins. I felt uncomfortable whenever we had to conduct these visits knowing we could not fulfill even basic needs. Jimmy, the home-based care provider, suspected that to give patients empty promises about food was covering up for the organization leaders who received money for the drugs we distributed because, he argued: 'there is no one who would distribute free foods and drugs to poor people every day.' While the government is praised for bringing treatment closer to the poor there were specific constraints for people in the margins of successful programmes (cf. Biehl 2007; Kalafanos 2010). Thus, in accordance with Russell and colleagues, 'ART can treat one's vulnerability, HIV, but it cannot address the failure of the maize crop due to drought, hunger, rising debt levels and the limited availability of credit.' (Russell et al 2007: 345). The cries of the poor illuminate just how biomedical issues are only part of their larger problems.

In August 2008, long after the programme had ended, I visited Christina. Gisela had gone to collect money from people who owed her. Flora was still having intermittent infections, especially malaria. After talking to her, as I was preparing to leave, she stopped me and asked, 'Tell me something', as if something bothered her, then looked down and paused before asking me again, 'and now is it not known when the *dawa* will be found?' She was neither the first nor the second person with HIV to have asked me this question. Despite not mentioning what kind of *dawa*, I knew what she was implying. 'Drugs to completely cure?' (*Dawa za kutibu kabisa?*) I let her know I understood what she meant. 'Completely', she repeated my words emphatically. She added, 'If they could be discovered so that we can do away with this contract (*tukaachana na huu mkataba*) of drinking drugs everyday... it is very difficult.'

¹³⁸ Septrin is a brand name for a combination of antibiotics called co-trimoxazole. This is the main drug used to treat and prevent PCP (*Pneumocystis carinii* pneumonia) a potentially fatal illness which used to be the leading cause of death in AIDS patients. HIV positive people are said to be at risk of PCP when their CD4 cell count falls below 200. At this point, doctors recommend that they start HIV treatment to lower their viral load and increase CD4 cell count. See www.aidsmap.com

She continued:

With this poverty you do not know what will strike you next...but it is God's plan for sure, if he will give ability the experts to discover it, it's God's decision to make, we just have to sit down and look to God because they have failed, we just have to look up to God. She paused, sometimes, when I look at them 'I hold my soul firmly, I 'take a grip on myself' I swallow them' (*nafunga roho sana, najikaza nanywa*).

Christina's words suggest she is bound to a 'contract' that is too complex for her to adhere to, and would break it if there were alternatives. The words further suggest that people with HIV, although aware that ARVs are helpful, felt they were walking a tightrope through fear of new opportunistic infections and side effects, especially when they know they have not fulfilled medical requirements that demand the body be maintained according to particular standards if they are to lengthen their lives. Due to the free provision of medicines, when the patient does not respond well, he or she is often termed 'non-compliant' (Trostle 1988: 1305).

Like Christina, Shabano wanted to know if he would see his son finish secondary school, 'If I could know how long I could survive, I would like to see my son finish school and stand on his own and manage the house then I will be happy.' Uncertainty linked to HIV status of mothers and their children, has been documented (see Regan-Kubinski and Sharts-Hopko 1995; Mishel 1999). Brashers and colleagues (1999) were perhaps right when they argued 'While new discoveries about the disease and exciting antiretroviral therapies hold the promise of improved survival, ambiguity about the durability of treatment response and ultimate survival contribute to the level of uncertainty' (Brashers et al 1999: 201).

'This numbness is too much': numbness as punishment

I visited Hamisi Hamidu one day and found him by the entrance of his father's house lying on his back on a mat on the floor, his legs up against the wall. Although I was at the entrance he did not recognize me until I spoke. Due to ARVs he has almost lost his ability to see clearly, with the problem worsening. I asked him why the odd pose. 'It is these feet, the drugs we take cause it, and they get numb (*ganzi*) everyday.' I asked if he had taken any medicine. He brought me a small container containing the Amitriptyline pills he had finished taking; tablets for

neuropathy.¹³⁹ They did not work and other prescribed tablets were also ineffective. ‘The problem with this *ganzi*, it was better if it was the normal ones without pain, but these they pain a lot, *asikuambie mtu*,¹⁴⁰ feels like I am being cut and pierced.’

I sometimes feel like taking a little alcohol so that I can at least sleep for the night...they punish me a lot. These are the pains that wake me up at the middle of the night. I cannot say I am used to them, during the day and night I always wonder how I am going to persevere the next day with these pains...The thing with these pains is when I walk for a while or if I am busy doing something, like cleaning the chicken house, that is when I can little forget about the pain. But the worst part is if I keep myself busy during the day the pain at night also increases. So, it’s like I am being punished at night (*naadhibiwa usiku*) for not experiencing the pain during the day.¹⁴¹

In scientific literature numbness has been noted as a serious side effect for people on ART. It is known as peripheral neuropathy, a feeling of numbness or bad pins and needles in fingers, toes, hands or feet (Simpson and Tagliati 1995; Geffen 2010: 42). On the seriousness of neuropathy Davis and colleagues (Davis 2004) write, ‘Although many AIDS-related conditions have decreased with the development of antiretroviral therapies, peripheral neuropathy continues to be a significant problem, and may be on the rise since many antiretrovirals may cause or exacerbate neuropathy.’ A recent study found that numbness was associated with disclosure problems and stigma, and interfered with daily living such as dressing, bathing, grooming, eating and mobility (Ownby and Dune 2007) while Meyer-Rosberg et al (2001) reported it to cause difficulty in concentration, lack of energy, lack of sleep, daytime drowsiness and reduced employment (also Harden and Cohen 2003). In Maramba, patients who were taking ARVs experienced more or less similar problems. My discussion here details how poor people experience these pains as impacting on their lives. Numbness imprisoned them, restricting their movements. As Hamisi explains, ‘I have to stay inside the house all the time, I just stay in the village ‘like a prisoner’

¹³⁹ A term used to describe the damage to the nervous system. Here I use it to describe the effects caused by the toxicity of ARVs.

¹⁴⁰ A literal translation will be “no one should tell you”, however, the implied meaning would be something like “No one can argue against, I am the one who knows/feels best” a Swahili phrase used to emphasize a point in argument that should be taken as valid by the narrator.

¹⁴¹ In his own experiences of taking ART and neuropathy, the South African journalist Adam Levin (2005) provides almost similar descriptions. For him feet pains were a “nightmare” “fierce 24/7”, could not do anything, lying on his back was the “most merciful position” (2004: 41-42). Being better off he could afford the high dose of morphine but alternated to the expensive MST or Dihydrocodeine, but still did not totally relieve the pain.

(*kama mfungwa*). I cannot enjoy myself like going out to take a walk comfortably.’ Because of the numbness and not seeing properly one day Hamisi stumbled and broke his left arm. This created a feeling of uncertainty about the future, ‘I do not know what will happen next, I am going blind, I cannot feel my feet and now I have broken my arm!’ John Msemwa, a factory worker living with HIV, also spoke of *ganzi*, saying that the numbness made him become ‘a human being without feet’ (*binadamu asiye na miguu*). Illustrating the numbness as the main suffering over and above taking the drugs, he said:

Feet pain is suffering (*mateso*) for sure...I do not have feet because I cannot feel my feet anymore (he explains while touching his legs) you see, there is nothing here, muscles strains me a lot (*mishipa inakakamaa*) and I sometimes even fail to move, it’s *mateso* (he repeats emphatically). I almost lost my job because I could never get out of the house for days... One day I was riding my bicycle from the clinic and by time I reached home I did not have my slippers with me! I had lost them along the way even without me knowing. I am now forced to wear shoes all the time, I and with this heat I got fungus even without knowing. Whenever I complain to the doctors they prescribe me the same pills but they did not help. The pills are even worse because after their strength finishes the pain increases twice... ‘It is too aggravating’ (*inakera sana*) because I cannot walk comfortably anymore.

For John, his foot pains were one of the reasons he had to disclose his status to his employer at the sisal factory where he worked. His job required him to stand the whole day while he inserted bits of sisal fibre into the machines to manufacture ropes:

I said to myself if I kept quiet I will continue to suffer, my boss agreed and I am given time to rest more often. I am also allowed to sit and stand whenever I feel like. When the pain is too much I send my brother-in-law to report that I cannot make it. I feel lucky too, because this is the only main problem I face with these drugs apart from having periodic fevers.

Anita, Mama Mu, Gisela and Christina, all said how pain in their feet limited their farming activities over and above other side effects and infections. Most work required them to walk either to farm or to follow up on debtors, as was the case for Gisela. Numbness and pains in her hands and feet was among the reasons Mama Mu did not farm as much as she wanted, despite her illness. She said she had to force herself to focus on her work if she was to perform well:

If I planned that I will go to farm tomorrow, sometimes at night I pray the numbness to go away...If I simply say to myself I will not go because of these pains I will not eat...but at times, eeish! It’s too much; no matter how I force myself to concentrate and go to farm sometimes I fail. There was a day I reached the farm and decided to return home

immediately...these drugs have given me weight but with a price...I also cannot hear properly these days.

While numbness and other side effects may affect many people with HIV despite their socio-economic level, its impacts were more severe for those who already occupied the lower socio-economic strata. Failed solutions by the state to address the suffering caused by illness, without being able to solve the repercussions of taking ARVs forced people to look for alternatives, a theme I turn to below.

‘If ARV is not a cure, I can try others’: Seeking alternatives in uncertainty

According to the anthropologist and sangoma, Jo Wreford (2008), a probable reason for patients seeking traditional medicine after discovering they were infected with HIV was denial. People constructed something like a witchcraft scenario to provide an explanation (Wreford 2008: 211-212). The rejection of their HIV status could be explained in part by their trying to avoid the stigma that accompanies disclosure (Wreford 2008; Ashforth 1996; Ashforth 2005).

However, all of the participants in this study who sought traditional medicine had already enrolled on ART. People taking traditional medicine are viewed as problematic by the clinic. They are seen to be digging their own grave, similarly to what Rose and Novas have called ‘those [...] who refuse to identify themselves with [the] responsible community of biological citizens’ (Rose and Novas 2005: 451). In the language of citizenship scholarship, they were rejecting ‘scientific truths’ (cf. Geffen 2010). I would argue that rather than rejecting scientific truth – after all, all my informants not yet on ARTs desired to be, as we have seen – people were seeking to widen their life chances and to ameliorate their everyday suffering. Interestingly they had also publicly disclosed. They included, Shabano, Anita, Hamisi, Grace and Mama Mu. They sought the help of traditional healers despite a strong warning against mixing the two from the clinic.¹⁴²

The wide use of traditional medicine in the area was no accident. Traditional healing in Tanga region has been widely practiced and documented (Feierman 1990; Feierman 1985; McMillen

¹⁴² There were many complaints from health workers at Maramba health facility that generally people would visit healers before coming to the health facility

2004; Makundi et al 2006, Brehony et al 2006). Local healers working with medical doctors in Tanga city have successfully been using traditional herbal remedies to treat symptoms of opportunistic infections in AIDS patients since 1992, long before medical treatments were available in the country (McMillen 2006; Scheinman 1992; Scheinman 2002). According to local estimates¹⁴³ there were more than 60 traditional healers in Maramba A and B villages alone.¹⁴⁴ Most employ divination and spirit possession to establish diagnosis and identify appropriate treatment. They focused mainly on addressing problems related to court cases (*kesi*), witchcraft or sorcery (*uchawi*), spirits (*majini*) and performing exorcisms (*ku-punga mashetani*). Healers identified themselves with three main strands *wa kitabu* (literally – ‘of the book’ those who use the Koran), those who mix spirits and herbs to treat, and those who used herbs alone (also McMillen 2006; Gessler et al 1995).

Early in my fieldwork, patients denied using traditional remedies, but later patients opened up and spoke of alternative medicines.¹⁴⁵ Within my sample patients embraced alternative treatment as a way of alleviating suffering from opportunistic infections and the side effects of ARVs.

I visited Hamisi one evening. He was seated with a young man named Farouk (38) who he later told me was a traditional healer. Farouk prescribed about half a litre of brown water with what looked like a tree branch inside for Hamisi (see Figure 2). He also gave him some black powder folded in a piece of old Arabian newspaper. I had an exchange with Hamisi when he revealed a long pattern of traditional practices he has been using ever since he began using ART.

HA: This is a traditional herb, the healer gave me it helps to treat HIV and also it helps to treat opportunistic infections.

PM: Do you use it together with ART

HA: Yes I do

PM: Why?

¹⁴³ Healers in the area have registered themselves, a move partly stemming from government demands. To obtain the number present, but perhaps unregistered, I spoke to six prominent healers who provided me with estimates.

¹⁴⁴ The estimated healer ratio to population in Tanzania is 1:350 while that of medical doctors is 1:200,000. Using same estimates it implies the healer ratio for Maramba is 1:210 and that of biomedical doctors is 1:3155. Scheinman estimates healers ratio at 1:146 for Tanga rural as a whole (Scheinman 2002)

¹⁴⁵ Tanga AIDS Working Group (TAWG), station at the regional hospital in Tanga city, conducted collaborative workshops with healers and biomedicine, some of which I attended. Healers were taught to use hygiene, how to keep records, refer to hospital patients who had symptoms of AIDS, and were told never to claim to cure HIV/AIDS.

HA: These are all medicines and the healer (*mganga*) said there is no problem to use when I take ART...ART goes to fight the virus, this treats other diseases and also increases white cells, and helps ART, but I also want to get cured (*kuponywa*)

PM: But the clinic does not want you to mix treatment.

HA: They just say it but I have been mixing and did not get a problem....if there was a problem I would have died already that is why I continue to use... taking these drugs (ARVs) everyday is a burden (*mzigo*), I take them but all these pains in the feet, and I cannot see properly...at the end I may end up blind...you know there is cure for AIDS from healers?

PM: I do not know, tell me about it.

HA: I had a relative driving cars to Congo and there was a healer who treated him and he was completely cured [he goes inside and brings me what looked like a pointed tube and started demonstrating to me - see plates below]. I had a little of it but it finished and the healer went to take more herbs but has not returned. I suck some of these and insert it in the rectum for a day.¹⁴⁶

Plate 5: Hamisi's alternative



¹⁴⁶ Geffen reports a similar kind of remedy called Ozone which was inserted using similar methods when visiting 'quacks' in South Africa, although he argues it was never found to be effective (Geffen 2010)

Plate 6: Hamisi's combination therapy



Taking ART together with traditional medicine is as good as being non-compliant, as Whyte and colleagues aptly put it. It 'is often the outcome of scepticism about the doctor and his medicines' (Whyte et al 2002: 67). My findings differ. I have noted that people with HIV sought medical attention and wished to be on ART. Although patients believed ART did in fact lengthen their lives, the uncertainty of new infections and side effects, fed their doubt and they sought alternative treatments and embrace promises of cure. This is not scepticism about biomedicine per se, as much as an attempt to broaden the base of healing.

In Uganda Whyte describes the social and cultural processes in health seeking behaviour as sources of answers to uncertainty experienced through sickness: 'People try medicines, rituals, and the services of experts in their attempts to alleviate the problem and limit uncertainty...uncertainty and response are linked to broader social and moral concerns that shape and are shaped by them' (Whyte 1997). Speaking of intimate concerns, Hamisi once confronted me with a very personal problem. The drugs had made him impotent and he wanted me to bring him a drug that the doctor had prescribed for him. He had tried traditional medicine before but they delayed his erection and needed a quicker remedy. 'I know we have been told not to have

sex but when this woman comes I look stupid in front of her if when I fail to get an erection. I do not want her to know I have this problem as she will not respect me anymore'. Questions of respect, masculinity, sexual potency and illness are bound together in ways that challenge simplistic ideas about treatment.

Patients in Maramba seem to hold that treatment with ARVs was like any treatment with traditional remedies. Some, after a few years of taking ART, believed it also had its limitations and costs in terms of side effects and opportunistic infections some of which could not be completely addressed by biomedical treatments. Alternatives were sought in order to reduce, and possibly eradicate their suffering in the face of death. The combination of modern and traditional remedies was not because patients did not want to disclose. As Ashforth (2005) puts it, apart from ameliorating suffering, traditional healers have been part of their lives for a long time and are therefore well trusted to address both the physical and social aspects of diseases. Possibly, Jo Wreford was accurate when she asserted that seeking healers is more than denial or stigma because 'what is at stake here is the question of personal agency in the face of a death bringing illness' (Wreford: 2008: 212-213).¹⁴⁷

HIV/AIDS and death: local ambiguity and uncertainty on the effectiveness of ART

Christina died on the night of the 18th of January 2009 while she was being transported to the regional hospital after her condition suddenly worsened. The local facility registered that she died from malaria. The doctors reported that she was also diarrhoeic, with abdominal pain and vomiting. At the time of death her CD4 count levels were 26.

Although she was known to be HIV positive, her death was considered to be sudden and perceived as unexpected. During her funeral the crying women's repeated utterances revolved around questioning her untimely death and the fact that she had left behind three children. 'Who will look after the children,' one woman cried; 'Children without their mother they are nobody, *nani kama mama*' (who like a mother?) remarked another. Some voices questioned God, why

¹⁴⁷Somi and colleagues recorded the proportion of patients who remained alive in six cohorts around the country between May and October 2005 who were followed up for 24 months at six, twelve and twenty four months and found out that in the overall the survival rate was 53% (Somi et al 2009). Reasons given for the deaths were systemic such as workload of few health workers, drug stock out, recording problems. Patients factors were named as erratic visits and seeking services from different facilities.

she had to die while she was still young, ‘Why did you take her away now?’ Other mourners recalled her good deeds when she was alive. ‘You worked very hard for your family why did you have to die now?’ One woman asked. During the funeral sermon outside the house, and because there was no man (father figure) in the house, the pastor from the Catholic Church with which Christina was affiliated gave the only speech, as representative of the family. Christina was portrayed as a hardworking and loving mother. The pastor ended with a popular religious phrase spoken during most funerals, ‘*Kazi ya mungu haina makosa*’ (The work of God is not wrong).

From my sample of 30 people living with HIV, seven died tragically. Five of them were on ART. Their deaths generated much talk and questions, particularly in relation to their medication. These debates varied and were highly ambiguous and contradictory. The talk was heated when four deaths happened in the span of two months - between December 2008 and January 2009 - two months before I left the field site. Their medical information indicated that all had been on ART treatment with advanced symptoms of the disease, and had responded positively. There had been deaths of people on ART before¹⁴⁸ but the successive nature of these four deaths invigorated debates around the efficacy of ART. A common feature of all four deaths was their suddenness; they had not been bedridden for a long time. These debates revolved around whether these drugs really work to *refusha maisha* or not, and if they did, questions and answers about why some people taking the drugs died and others did not were hotly argued. People in Maramba chose to appropriate biomedical knowledge combined with their own local experiences to question why people died in spite of being on ART. These debates were framed from different angles predominantly biomedical and socioeconomic, as well as in moral terms, but highly conflated. Local ethnographic studies and reviews of people’s perceptions of HIV/AIDS related deaths have been confined to the pre-ART period with these deaths perceived mainly in discourses of socioeconomic and moral terms (Dilger 2008; Dilger 2007; Becker and Geissler 2007; Smith 2004; Setel 1999).

¹⁴⁸ According to the Maramba health facility, deaths are rarely recorded in the facility because the critically ill are referred to Muheza district hospital. When deaths occur at home, families do not come to report. Deaths at home are required to be reported and documented at the village government office, but this was not done.

For example, one of the reasons Christina's death was unexpected and therefore questioned was because on the day she died she had woken up and performed her duties as normal. Gisela recalled, 'She even went to the farm and dug some cassava.' It was after returning from the farm that she was reported as saying she was not feeling well. However, she was not taken seriously because she had been intermittently ill for a while but not so seriously. 'I did not think it was going to be that serious, as you know Christina has been sick at times but she perseveres and never complained much...in the evening she complained that she had bad pains in her stomach, I thought they were normal but that night she complained '*sana*' (too much).' Gisela's complaint about the sudden death of her sister is contrasted with the old perception of HIV/AIDS patients who died after being bedridden for a number of days. In our conversation malaria was downplayed as the cause; more weight was given to her lifestyle that went against the rules of taking ARVs. Gisela suggested that Christina's death emanated from working 'too much on the farm,' one of the forbiddens of the clinic rules, which may have affected the drop of her CD4 count. Although she also said that lack of food was a problem in the house, she wondered about it as she ate the same food as Christina. 'I know food was a problem but what I ate she also ate...so I am not sure.' The belief that her death was God's wish and that the time for her to leave had come, was invoked at the end. As Gisela put it, 'She suffered very much. God has decided to put her to rest.'

Mama Mu perceived the death of Flora similarly to Gisela. Although she acknowledged that she herself worked on the farm, what harmed Flora was her *hoteli* work. 'We were told not to do work in fire for a long time,' but she continued, and added, 'I also farmed but I do not do too much....but I do not know, I am think I am also lucky.' She, like Gisela at the end also emphasized that God, 'wanted her more than us...if your days have arrived you cannot stop God from taking you. When my safari comes, I will also go.' At the end, God and religion was used to explain things, as Becker and Geissler further assert, 'countering simplified notions of causal effects of AIDS on religion (or vice versa), the diversity of interpretations and practices inserts the epidemic into wider, and more open, frames of reference' (Becker and Geissler 2007: 1). The influence of Christianity and Islam in Maramba was strong and people followed their faith seriously. In line with Becker and Geissler, 'People rely on shared religious practice and personal

faith in order to conceptualise, explain and thereby to act upon the epidemic' (Becker and Geissler 2007: 2).

The sudden death of Mr. Johnson Njovu (76), a former sisal labourer who migrated from Zambia in the 50s, further demonstrated the ambiguity of the debates about death of HIV sufferers. Again these debates were framed around adherence. He was among the first generation of people to start on free antiretrovirals in 2005. I had known Mr. Johnson from his participation in the local AIDS group where he never missed a meeting or failed to show up for the garden work of his group at the local health facility premises. I was even closer to his son Samuel (39) who was a local hamlet leader and an active member of a local church, which I also attended. I conversed with Samuel days after the burial and his views on his father's death while on treatment were very mixed:

I do not really know how these drugs work, of all the people who ate drugs in the community I knew, the person who I believed will not live this long was my father. I will not lie to you, Johnson used to drink alcohol while on drugs. Although he did not tell me I knew it because we lived in the same house and I used to provide him money...At least if he was drinking *bia* (beer - industrially made), but he was taking *mnazi* (palm wine). I know rule number one is not to take alcohol when taking these drugs. Although I knew the alcohol may cause him problems I did not expect he was going to die that day...since he started taking the drugs he has never been hospitalized for a day...even on the night he passed away he had been spending the whole day talking to and visited people. He even attended a funeral of a friend in Maramba A. It was as if he was saying goodbye to people (*alikua anaaga kila mtu*).

Unlike Gisela, Samuel's confusion was not because his father worked so hard but the fact that his father, broke one of the rules, that of drinking alcohol. Taking alcohol with any kind of drug in the community was considered fatal. He had lived on ARVs 'for a long while' and had gotten accustomed to it. Although Samuel seemed to question the type of alcohol his father was taking, when asked about it he responded that *beer* had more status, 'beer *imepimwa* (has been tested), not like these local brew.'

Essentially, local people found avenues to explain and justify the causes of deaths when conventional explanations seemed insufficient. The next case resembles the situation of the Njovus and Christina but contrasts with the extent of survival. It involved a young woman named Mariam Maimu (31). I had come to know Mariam through her mother, Agnes Maimu (54), who was a neighbour of my host. Mariam had arrived in the community in a dire condition and was

immediately put on ARVs. She weighed only 35 kilograms when she started treatment. After only four months her weight remarkably rose to 65 kilograms. When I visited the house before her death, Mariam was always inside reading her bible and had recently become born again because of the miracles of the drugs she once told me. This was confirmed by her mother. 'It's God's miracles (*ni miujiza ya Mungu*) I am alive today, if you had seen me when I came,' her mother interrupted as she was sorting rice, 'that one we could carry her on a basket when she was brought.' Although she had not regained enough strength she was looking forward to returning to her work as a restaurant operator at a town called Horohoro at the border with Kenya. She suddenly died one night in January 2008. Her mother, although acknowledging the death of her daughter as fate and God's wishes, did not, however, comprehend how ART worked on her daughter's body, as other people on ART were still alive. She did not understand the medical language of CD4 counts and weight, and had followed all the treatment rules and provided food to ensure her daughter's survival:

They told me her CD4 were low that is why she died, but I used to feed her very much and she never missed a meal, all those treatment they gave us she took them. What I did not understand is she responded very well, she gained weight too, she was not really sick anymore, she was getting better...I never thought she would die so soon...there are other people I have seen they do not look better like my daughter did but they are still alive... I took care of my daughter well feeding her, she even gained weight...I do not know... Gods work cannot be wrong (*kazi ya mungu haina makosa*).

Notions of wellness in the community as discussed earlier are premised on a body which is 'healthy' in terms of looking good and increased weight. Equally, Mariam's mother claimed to follow the rules of treatment such as providing food to her late daughter, which her daughter responded well to by gaining weight. In Maramba people closely observe each other's behaviour. Agnes had seen many people in the community who misbehaved while taking treatment. She could compare their behaviours with that of her daughter, which was confusing. For Agnes, the fact that CD4 could be low and the weight normal, yet death occurred did not make much sense.

People's conceptualization and perception of these deaths can best be illustrated by an exchange I had with Jimmy, Juma (also a local HBC provider) and Samson, a local fish trader, on our way back from Christina's burial. Jimmy was strongly convinced that the drugs, 'had an expiry date in the body of a patient (*zina mwisho wake wa kufanya kazi mwilini*)...because if you catch the disease you must die, not matter what.' I asked him what he meant and he said that, 'The drugs

cannot work forever, they stay with you and after some time they stop working (*zinaacha kufanya kazi*) and if the patient then catches a small disease like malaria they die...just like Christina, Johnson and Mariam, they die.’ I was surprised by Jimmy’s views given the fact that he had attended training on HIV/AIDS, and he was also one of the community HIV/AIDS educators. However, Samson argued along religious lines that people who caught AIDS during the early days were doomed to die so the deaths were inevitable. ‘We were told in church one who gets AIDS must die...these drugs are nothing.’ But his view was weakened by the fact that if it was so, ‘why were drugs working? Do you want to tell us it is Gods decision or Satan?’ Juma questioned. Towards the end of our debate there was general consensus that if a person on ART ate well, treated opportunistic diseases on time, did not have sex, and could access nutritional supplements, there was a great chance he or she would survive longer. But it was unclear for how long one could live. Nevertheless, this view was immediately opposed by Juma who questioned, ‘If that was the case how could Mr. Kilokola die? He was the pharmacist at Muheza district hospital, he had all the drugs at his disposal, even those micronutrient supplements (*virutubisho*), he had a salary, but still he died.’ There was a pause after Juma’s compelling evidence. ‘Maybe he was having too much sex?’ Samson claimed, albeit in jokingly. However, Juma’s ‘evidence’ seemed to debunk the earlier reached consensus about eating well and following treatment rules and all of a sudden they all changed their arguments and seemed to concur with Jimmy’s view that maybe it was true the drugs indeed had an expiring date when in the body. Jimmy added ‘The difference with the past is that now you do not have to suffer in bed for a long time.’

Jimmy’s conclusion seemed to have a powerful effect and ended the debate, shifting the discussion from people’s behaviours of following drug regimen to the drugs themselves. In this sense the drugs were reified and conceptualized as having their own power when inside the body. This conclusion was reached from his ‘evidence’ of sudden deaths. While on one hand people appropriated medical knowledge and used medical measurements as defining the lifeline towards death. as argued by Meinart and colleagues (Meinart et al 2009), people in Maramba analyzed the effectiveness of treatment by considering the effect the same drug had on different users. This is not to say they chose completely to ignore medical explanations but it seems, for them, the biomedical language does not provide definitive answers in explaining the longevity which

seem to be promised by taking ART, hence creating a space for debating exactly how long one could survive.

The notion of the inevitability of death of HIV positive people was also heavily informed by a discourse on immorality; those infected had sinned and therefore death was their punishment. When compared to other diseases, HIV/AIDS has been singled out because people perceive it as a disease sent by God to punish those who sin and practice immoral behaviours (cf. Dilger 2007; Becker 2007: 16). Accordingly, people claimed the death of people with HIV were inevitable because of breaking God's laws (*sheria za Mungu*), explained to me as fornication (*zinaa*), as defined in Islamic teachings, and adultery (*uasherati*) in Christianity. In discussing HIV/AIDS with a local Christian pastor, he concluded that 'Death is payment for sinning (*mshahara wa dhambi ni mauti*)'. ART was thus perceived as being unable to stop one from dying because implicitly it was interfering with God's directives. Others did not necessarily identify their views within religious frameworks but were bounded within a broader context of suffering, which included non-religious perspectives. Such claims included that HIV infection was the outcome of the moral breakdown of society (*kuvunjika kwa maadili ya jamii*), and thus death was payment (*malipo*) for breaking those moral norms (cf. Dilger 2007: 68; 2008; 2009: also Setel 1999).

This chapter has argued that despite the many benefits of ART, it also served to create many uncertainties about future livelihoods in the face of socioeconomic constraints and limited opportunities. People on treatment struggle to find a balance between taking treatment everyday and living with the uncertainty of side effects, opportunistic infections and even death. Unlike the citizenship scholarship, people in Maramba did not demand ART driven or motivated by 'human rights' (Nguyen 2005; Robins 2004); rather clients saw ARVs as part of a solution to their health among mountains of other social and economic problems. This critique reminds that even though, ironically, treatment with ARVs has returned most poor people back from the dead, the long term feasibility of such programmes remains questionable if the broader social and economic structures that brought about the suffering and poverty prevail.

CHAPTER SIX

‘HATUNA NDUGU HAPA MARAMBA’¹⁴⁹: HIV/AIDS AND FAMILY CARE

It was a misty Monday morning in March 2009 when I read a message on my mobile phone from one of my informants, John Msemwa (37), who was living with HIV. He asked me to visit him immediately. I had received many calls from other informants but never from John. He and I met him almost every week, so I sensed something was not right. I quickly dressed and sped on my motorcycle across the sisal fields to where he lived and worked, in a sisal factory. We had become close friends beyond my research role and like my other informants we were all sad that I was about to leave. As the wind blew against my face causing my eyes to tear up, thoughts ran through my head about what might have befallen John. Was he forced to quit his job at the sisal estate because of his repeated illnesses, I asked myself. I found him seated on the veranda of his room, his right elbow on his right thigh and his palm on his right cheek. He looked deep in thought and it seemed he could almost not recognize the sound of my motorbike as I arrived. He apologized for calling me so early, saying he knew we might not meet again soon and wanted to talk to me about something important to him:

I could not sleep at night. I needed to talk to you before you leave. You know me very well by now and I know you can help me once you finish your studies. As you know my sister is a labourer too, she assisted me before I took these drugs, but anything can happen. She is very poor and old, and diabetic as you know, to look after me again. I cannot return home to Mbeya, there is no home there as both our parents died, she is my only relative I have now. You are going to South Africa (*Afrika Kusini*) I hear they have ‘developed’ (*wameendelea*). Try to find me ‘well wishers’ (*wahisani*) to assist me with aid of any kind so at least I can build a house and start a small business in Maramba, so that I can stop working in this estate before it is too late. I feel like working in the factory is deteriorating my health.

¹⁴⁹ ‘We do not have any relatives here in Maramba’

John Msemwa's concern represents most of my informant's dilemmas when it came to seeking care; most did not have people close to them in Maramba and of institutionalized support structures were absent. The importance of social relations, especially the extended family, in supporting individuals and households impacted by HIV/AIDS in African countries is well documented by Ankrah (1993), Barnett and Whiteside (2006) and Besley (2005). Extended family networks and the African clan system in particular, have been considered important in addressing care and support as a way of relieving pressure from health systems in the face of HIV/AIDS. This chapter highlights family support structures in relation to their historical antecedents. I show that the colonial and postcolonial policies of social and economic differentiation created and sustained labour migration which significantly affected social relations of care and support in communities. While access to ARVs may delay illness and death, family networks of those who were affected by HIV/AIDS in Maramba were already decimated by historical processes as expounded in Chapter Three. As a result, existing family networks were complex, creating uneven experiences of care, with some families containing weak and others strong support structures. These structures determined and influenced decisions of where to seek care, and were informed by individual, household and broader community circumstances. Following the sociologist Sungeetha Madhavan, this chapter also contends that there is a need to see the impact of the disease on networks of support as 'an additional destabilizing mechanism to an already fragile system' of support to HIV/AIDS affected households. (2004: 1452).

This chapter aims to contribute to current debates on the extent to which community safety nets are able to absorb the impacts caused by HIV/AIDS. Different concepts have been employed to explain the capacity of social relations to support those in need of care. The term 'safety nets' has been conceptualized as 'measures employed by people to protect themselves from the worst effects of poverty' (Foster 2007: 54). Foster distinguishes between 'formal' safety nets provided mostly by government and non-governmental organs and 'informal' ones, such as the extended family together with communities. Others have employed the term 'social capital' – comprising social networks of mutual trust and reciprocity within communities and institutions (Welsh and Pringle 2001). From social capital, Mark Belsey formulates the notion of 'family capital' with dimensions such as relationships and the family network, and family resources – knowledge, skills and material resources (Belsey 2005: 17). On the other hand, Mtika utilizes the term 'social

immunity', designating it as 'the ability of a collective of people, specifically the extended family, to mitigate the impact of an affliction' (Mtika 2001: 178). Throughout this chapter I will use these concepts. In particular, I distinguish between immediate family members (family capital), and other community members, or people who are not directly related, especially by blood, to the HIV positive person and his or her household members.

Policy in Tanzania still emphasizes the need for patients to be cared for at home by their family, who should be supported by home based care entities. But as indicated in the previous chapters, HBC support in Maramba was limited to the provision of medicines, leaving the economic burden of support to families. What follows attempts to answer the question of how the extended family networks of HIV positive patients provided care to affected household members, particularly the patient, in Maramba.

'Our parents started their life here'¹⁵⁰: the plight of migrant families

In my core sample of nine informants, of the six women, five were heads of their households with no surviving parents or grandparents in the community. This included the households of Gisela, Christina, Mama Mu, Neema and Flora (see Appendix 2). Their predecessors were mostly migrants to Maramba who worked in the plantation economy during the colonial period. They differed only in terms of the generation that arrived and place of origin, a pattern common in the community. For Gisela and Christina, both their parents migrated to Tanga in the 50s from present day Burundi, and only settled in Maramba in the 70s, after working on different estates in Tanga region. Christina and Gisela were thus second generation immigrants, and their children, still young, the third. Neema's grandparents migrated to Tanga from southern Tanzania and bore four daughters, only one of whom was still alive, but she had long ago migrated to Kenya as a young girl in pursuit of economic opportunities and had never returned. On the other hand, Mama Mu migrated to Maramba from her home village of Daluni, a small village 20 kilometres from Maramba, to live with her husband who was also a former migrant, and later became a small miner. Flora's parents were also labourers who migrated from West Usambara; likewise they did not maintain ties with their homelands. After arrival in Maramba, these households and many others did not possess networks on either their paternal or maternal sides. The income from

¹⁵⁰ A common phrase in Swahili, '*wazazi wetu walianzia maisha hapa*'. It implies a new start with the independence that comes with earning an income, normally following leaving family home, or moving to a new house or a job.

their labour was more or less their only support in place of extended networks. Where they could they engaged in small business and subsistence farming, as described in previous chapters. An outstanding feature across my entire core sample is that in households where a male was HIV positive there was usually a woman living in the house to care for him. In the houses where the woman was HIV positive, there was not ordinarily a man to take care of them.¹⁵¹

In his insightful review *AIDS and the Family: Policy Options for a Crisis in Family Capital*, Mark Belsey highlights three main aspects of family structure following the impact of HIV/AIDS. They include, family networks, family childcare arrangements (Belsey 2005: 12) and household dynamics. For Belsey, the notion of the extended family arises because ‘family networks extend beyond the common household or compound’ (Belsey 2005: 14; also Spiegel and Mehlwana 1997). These consist of formal and informal responsibilities beyond a common household through kinship, tribal and other related groupings such as clans. The extended family consists of networks at two levels, horizontal and vertical, or they can be both. Horizontally, they are seen in terms of siblings and cousins, while vertically, in terms of parents, offspring, uncles, aunts, nieces, nephews, and other relatives (ibid.). As generalized as this can be, Belsey cautions that although there are no agreed family network indicators, ‘at a minimum the network is likely to include family members such as grandparents, parents, children, and the siblings of those in each generational category’ (2005: 18). He argues that to understand the capacity of family networks to provide support, the availability of parents and siblings who are alive is an important indicator. (2005: 14).

The household of Gisela and Christina illustrate this well. While John Msemwa migrated alone to work as a labourer in the sisal estates, Christina and Gisela were both born on the estate. When they were growing up they were likely to become farm workers before completing their primary education. This is clear from Gisela's account:

Our parents came here and we were born here. There used to be other people from Burundi but many have died poor and others left to other estates. Some have died and we continue with life...we cannot return to Burundi. You cannot desire to return to a place

¹⁵¹ There was only one household where a man stayed alone in a sisal estate house. However, his sister lived next door, at times assisting him with cooking. This trend is not unique to Maramba. In a study on ‘household size and composition in the developing world in the 1990s,’ by Bongaarts, spouses were likely to be present in almost all male headed households, while it happened in only ten percent of all female-headed households (Bogaarts 2001).

you do not know anyone. I am sure we have our relatives there but our parents never took us there, it was very expensive...When we were growing up we helped out with farm work sometimes and became labourers until now. There was no money and the factory did not pay much. After our parents died there was not so much work. I was the eldest and took care of the rest. I decided to try some business selling things at the house. But because we have been here for a while Christina could get a job in the estate and even our younger sister. Our younger brother helped me with my business. It has always been us helping each other.

When Christina first became sick she lived in an estate house with her three children, two of whom she bore with a man who later moved to another plantation and left her with the children.¹⁵² She said she became too poor to afford the costs of medication when she developed HIV/AIDs related illnesses given her meagre daily wage. 'Back then we were paid 1,500 shillings per day. I stopped working and so I was not paid. The little savings I had I spent on drugs to self medicate and other hospital costs before I discovered what was troubling me was this problem (HIV/AIDS). By then I had no savings left... I also had to feed my children and the money I had was not enough.'

Christina sold almost all her assets when she was bedridden before starting taking ARVs. This suggests that initial efforts to care for herself were with little or no support from immediate family members (also Haddad and Zeller, 1996). After she could not work any longer she had to give up the sisal estate house to a person who could work. Christina's household dissolved (cf. Barnett and Whiteside 2002; Urassa et al 2001).¹⁵³ The dissolution of households because of HIV/AIDS had also occurred with Mama Mu, Neema and Flora, all of whom initially had their own houses and small assets such as beds, a mattress and cooking utensils. All were sold to pay their medical expenses before they started taking ART. As Mama Mu explains, 'I had my own home, I had a house, although it was made from mud I had to sell everything, even my bed, and move into this rented room. I had to start life again with taking drugs but I do not know if I will ever have my own home again with this poverty.'

¹⁵² The man was married to another woman in his own home and would move in with Christina during farming seasons. She said he may have died as there was never any communication after he left.

¹⁵³ In HIV/AIDS literature the scenario of household dissolution appears when an adult member dies and the remaining family members are compelled to join other households; in most cases they are divided between relatives or community members for support.

According to Foster, community safety nets do not collapse but tend to accommodate increased demand by reducing benefits (Foster 2007: 60). In other words, he suggests that in times of hardship, community members (relatives and other non-kin people) will assist each other, forgoing other needs to assist the affected household. However, he does not say how much support from other members in the community is enough to prevent households from collapsing. The dissolution of these women's households signifies the lack of care and support from both formal and informal safety nets in the community. The fact that the households of people with HIV dissolved after they fell sick implies that safety nets were not working properly. Moving out of one's household seems rather to signify that the members are struggling and failing to survive normally (c.f. Rugalema 2000).

Unlike Mama Mu, who did not possess an immediate relative with whom she could move in, Christina moved in, with her three children, to the house of her sister, Gisela, who had succeeded in doing business and running a small shop and who had built a house in the village.¹⁵⁴ The choice to move into her sister's house was compelled also by the fact that people living with HIV/AIDS are stigmatized and Christina could not disclose her status to people other than her immediate family (sisters, children and a brother), the only relatives she had. HIV positive people and their families 'fear rejection by those outside the household owing to perceived stigma associated with the disease' (Belsey 2005: 36; cf. Lloyd 1988). Christina explained further:

If it was not for my sisters, I do not know how I would have survived. With this disease you cannot tell people you have AIDS, who would want to take care of a sick person with this kind of life? Life here without an income is not life...my children would have suffered a lot....who can you go to ask for help in this Maramba? No one, because everyone is looking for money. Those who will well care for you with this problem (referring to her HIV+ status) is only your blood relative. A non-related person (*mtu tu wa kawaida*) or a distant relative cannot assist you, if you have one, we do not.

¹⁵⁴ Gisela had in the late 80s moved from working in sisal to working in a shop owned by a local man, where she developed skills to start her own shop at home. During my fieldwork the shop was operating in huge deficit after she used almost all of its capital to treat herself when she also fell sick with AIDS in 2006.

Table 14: Mama Mu's care and support sources

Name	Name	Relation	Forms of care and Support
Mama Mu	Mama Mu	Self	Food provision; cooking
	Mu	Son	Periodic food parcels; emotional support
	Issa	Grandson	Farming; collecting firewood
	Zamia	Sister's daughter	Cooking; collecting firewood; farming

Table 15: Christina's care and support sources

Name	Name	Relation	Forms of care Support
Christina Lugolugo	Christina	Self	Food provision; caring for children
	Deny	Son	Assist in hospital visits; farm work
	Gisela	Sister	Providing shelter; accompanying during hospital visits; collecting ARVs; bathing; cooking; emotional support-encouragement; funeral arrangements
	Sifa	Daughter	Cooking; buying medicine; assisting with bathing and feeding when bedridden
	Chris	Brother	Periodic foods parcels; funeral arrangements
	HBC		Home visitation and drug distribution
	Church		Spiritual support: prayers ; funeral arrangements

Christina's experiences suggest that care is accommodated more within the family than the community, a situation I found among all my study participants. As shown in tables 14 and 15 above, in the households of Mama Mu, Gisela and Christina care was provided by immediate family. When in Gisela's household, she was accompanied by her sister when collecting drugs. During my visits, when Christina was intermittently ill Gisela would collect her medicines for her. Since food was a big problem in their house they would sometimes receive small parcels from their brother. Mama Mu monitored her own health. Although she was helped by her sister when she was bedridden, her assets were used to pay the medical costs even after starting treatment with ARVs.

Similar conclusions on the role of family and HIV/AIDS have been reached in studies conducted in Mwanza region, north western Tanzania (Nnko et al 2000) and northern Tanzania, Arusha region (Evans 2005). Christina's emphasizing relatedness in terms of blood was also acknowledged by her sister Gisela who was listening close by during the interview. Blood relationships were very important in receiving support from a family member during difficult times, a situation Ringsted (2004) also found in her study in neighbouring Muheza district.

Conversing with Christina before she died, she told me that it was their responsibility to ensure that their family grows, so that they can help each other in the future. Her statements indicate that she aspired towards a better life which nonetheless she imagined mirroring her own, and she believed in kinship as the basis of support in times of crises:

Our family is very small, our children should bear many children so that the family can grow big and assist one another. Nowadays there is hardship everywhere, whenever it's time to harvest, people start stealing produce from the farm, if our family was big enough some would go and guard the crops until we harvest....we do not have any relatives here (other) than our children. When we become many you are assured some will become successful in life and might help us, that is why I emphasize my children to go to school and not to play and fall pregnant...I tell them everyday life of being a labourer is not life, they should not become like us.

Within the geography of kinship, someone termed a 'true relative' (*ndugu wa kweli*) could provide social and economic support. It did not mean that the person's status of being a relative, for example by blood, was relinquished. A common phrase used to illustrate a non-worthy relative was 'a relative just by name' (*ndugu jina*). When I asked Mama Mu whether she received any support from relatives, she first said she had relatives but they could not help her because they were far away and also very poor. She also suggested that people who offer care and support become fictive kin. 'You are my relative' she said, 'you always come to visit me and sometimes help me out. Those who do not do that are not true relatives, just by name.'¹⁵⁵ To quote Spiegel and Mehlawana, people 'impute kinship ties onto reciprocal relationships' (Spiegel and Mehlawana 1997: 40). With few kinship ties in a community, people enter into relationships that might help materially and economically. Such relationships become unsustainable if transfer of material assistance always goes in one direction (ibid: 40). Given that people with chronic illness in situations of poverty such as that in Maramba always needed assistance, as detailed in the previous chapters, sustaining reciprocal relationships with both kin and non-kin in the community became difficult.

The capacity of Gisela's family capital was tested after Christina died. Where the extended family was larger, children would be distributed among the clan in the community or to distant

¹⁵⁵ This referencing of a relative as one who provides was very common among my informants when referring to someone who might have assisted them in some way.

relatives, as described by others (Ankrah 1993; Foster 1997), but this was not the case with Gisela's household. All Christina's three children were left for Gisela to look after, she herself struggling with her HIV positive status and a treatment regime, unsteady source of income and periodic AIDS-related illnesses. This was because they were staying in her house in which there was some space, unlike the situation of her younger sister who was also a labourer and living with a migrant in an estate owned house. She did not have uncles or aunts to send the children to. I met Gisela after Christina was buried and she complained that she could not support them as much as their mother tried to, because she was alone. Although their younger brother had agreed to support them with food he had not been providing much because he had his own family to look after. 'Their mother loved them so much and worked hard for them, and themselves are not used to work hard even after returning from school, they wait for food that I cannot fully provide. Sometimes they come and look at me and ask for food, I also have to feed myself you know...my brother.' Thus it remains an underlying question of whether the experience of assuming this role by Gisela will affect Gisela's own health and the children's social and economic development.

The role of the African clan, as argued by Ankrah (1993), contrasts sharply with many families that I observed in Maramba. Ankrah firmly contends that the extended family will always manage in desperate situations to support HIV affected households, including the child-headed households, as these must be linked to the larger clan and are supported economically and socially. Ankrah views the clan broadly, quoting Fortes as 'a set of locally united lineages, each of which is linked with all or most others by ties of clanship, which act together in the service of certain common interests indicated by the bond of exogamy, by reciprocal rights'. (Fortes 1945, cited in Ankrah 1993: 8). Ankrah adds to the definition:

The clan is the major principle around which the African Kinship groupings are organized. It is a social unit with a common ancestor and a common totem. Clans have survived through the centuries, are found almost ubiquitously across sub-Saharan Africa, are still recognized, and thus help to explain the strong consciousness of kinship and lineage that still remain a dominant mindset among African people (Ankrah 1993: 8).

The definition of Ankrah fits well with clanship roles in the region I come from, where I am still well connected to my great grandfather's lineage and my grandfather's brothers and sisters' families. In Kilimanjaro region, migration and colonial policies did not significantly affect the

structures of the families (Stahl 1964). This broad application of the clan follows Mdhavan's (2004) caution that experiences in Africa are highly context specific in nature. The histories of Mama Mu, Gisela, Christina, Anita, and Flora's household family structures in Maramba were shaped in advance by the social and the economic history of their parents, which affected the availability and strength of kinship networks they would have in the future to support them in times of chronic illness such as AIDS.

Returning patients and extended networks

It was common for people to migrate, as a survival mechanism, back to Maramba when plans in their new destination did not succeed, or even when they did succeed. However, those who returned successful were in the minority.¹⁵⁶ It was also common to see and hear people being returned home to their families after falling ill with AIDS. These migrants returned to be cared for by those relatives who remained in the community after their support structures had failed; some totally collapsed, and their households dissolved. The family structures that returning patients encountered determined the nature of care and support they received. Since some parents who were original migrants to Maramba had already died, relatives will return to empty homes or to their closest siblings. Most poor migrants returned to already strained family networks that had been affected by structural processes of poverty and were struggling to survive. Returning migrants were thus viewed as adding strain to already fractured families.

Within my broad sample of 30 people, eight were returning patients.¹⁵⁷ The story of the Mukangara's household best illustrates this predicament. In October 2008, I was introduced to the Mukangara household by a HBC provider who specifically took me there to meet an HIV positive person named Mathias Mtunguja (42), who was bedridden. On entering the house, I encountered two other ill adults, Mr Mula Mukangara (56), a retired JKT soldier who was the head of the household, who was bedridden with TB. He was married to Mathias's sister, Betty (48). There was also Arnold Mtunguja (49), the brother of Mathias and Betty, who was also very

¹⁵⁶ Many people considered Maramba difficult to survive in without a viable source of income. Those few who succeeded and had parents in the community will return to build a house for them and leave immediately after.. When their parents died, most likely the house would be sold. There were also many stories around witchcraft, with migrants believing people in the area did not want to see others prosper, and may be hurt if they stayed in the community. Stories of people who were killed through witchcraft after they became wealthy were well circulated.

¹⁵⁷ In my sample of nine households, three included returning patients. They included, Shabano, Mathias and Neema.

sick with anaemia, heart and kidney problems. He was also emaciated; his stomach was distended and stiff like a person with kwashiorkor, although he could walk unassisted, unlike Mula and Mathias. Rumours circulated that they were all HIV positive. Mathias and Arnold had recently both returned to Maramba after their own households dissolved due to their sickness. Mathias had been living and working in a neighbouring sisal plantation as a labourer since the year 2000, following the revival of the estate. He had also worked as a miner in different parts of the country, but mostly in Tanga. He stayed with a woman who left him after he fell sick. They did not have any children. On the other hand, Arnold, who had not been home since 1983, returned from Arusha where he had worked as a car mechanic and a part time small miner and had a wife and three children. He had been sick for almost a year and could no longer support his wife as he became financially bankrupt through treating himself.

Both Mathias and Arnold's situation could be viewed as a representation of the limited benefits of a migrant labour economy. Their departure from Maramba and ultimate return also echoes historical processes of migration that the colonial economy had set up but had not changed or improved in the post-colonial times. Upon returning to where they were born, they were both engulfed by another dilemma. The home of their parents was no longer in existence as both had died. The complexity of their dilemma could best be explained by situating the historical background of their family (Mtakuja family) as Betty narrated:

Our late father, originated from Lushoto (West Usambara). He came here in the 50s where he met our mother, whose parents also moved here in their times. We were born five children. He worked as a clerk in different sisal plantations in Tanga and then moved to settle in Maramba in 1964-65. He worked first as a clerk in a logging company here in these Mtai Mountains, before joining Maramba estate (now JKT) in 1972....I went to Lushoto once, we were born here and Maramba has been our home, we do not even communicate with where my father came from. During his time working in these companies, he lost ties with home, we do not even know where our uncles and aunts are, some have died, others are in different parts of the country. If you ask me about our family and our home I will tell you that my family is my sisters and my brothers, maybe, the family of my late young sister, but she was married in another family, we are not very close with them after she died, only greetings maybe, not more than that.

Following the economic crisis of the 1970s and the handover of the Maramba estate to JKT in 1983, people like Mr Mtunguja were left jobless and landless.¹⁵⁸ This made their father (and other villagers) unable to properly fend for his family. None of his children were able to support him financially because, ‘we were very young, even Arnold decided to leave in 1983 to look for green pastures elsewhere... I got married and the others were very young,’ said Betty.¹⁵⁹ Since the Shambaa were patrilocal, strong bonds to the maternal kin were eventually weakened.¹⁶⁰ Betty married Mr Mula in 1987. Mr Mula became an important source of support when Betty’s parents fell sick. ‘When our father was paralysed in 1989 my husband and I were staying in the army camp. Because I was the oldest girl I was responsible for taking drugs to him and making sure he was alright...my husband assisted with many costs when our father was sick.’¹⁶¹

Despite receiving support from their daughter, their father had to sell his land in Maramba B village to support himself and his wife, ‘It was bad luck they both died – our father died in 1990 and mother in 1993.’ Betty added. The only plot and house left to them was disputed in court by a neighbour and the children were eventually left landless.¹⁶² With the death of their father and mother the family of the Mtunguja was almost non-existent. Non-existent because in a patrilocal society the males carry the name of the lineage, and without Arnold and Mathias, a household of *Kwa Mtunguja* (Mtunguja’s place) as it would have normally been referred to, had ended. Since Mathias and Arnold only knew where they were born, that is Maramba, the house they arrived at had few relational connections. They did not have other extended family of uncles or aunts, relatives from the paternal side or maternal side. Thus when they returned, they arrived at the house of their sister’s husband, Mr. Mula Mukangara. In addition to Mathias and Arnold, Betty

¹⁵⁸ He was one of the leaders in the land crisis between JKT and the villagers I report on in Chapter Three.

According to Betty the farms in the estates were his sole and important source of income after he lost his job in the JKT farms following the economic crisis. When the JKT took over the farms it destroyed their important source of food and income as they had planted many and different permanent crops.

¹⁵⁹ I encountered a number of households in the community some of whose members emigrated following the crisis and JKT takeover of farms. In my sample of 30 households, 6 had a member who was forced to emigrate.

¹⁶⁰ The in-laws of Mr. Mtunguja also migrated to Maramba to their mother; they too did not have an extensive family network.

¹⁶¹ The importance of having a salaried man in Maramba has been highlighted in Chapter Three. Although the soldiers were looked on as oppressors, exploiters and HIV/AIDS carriers, their social utility to the in-laws to whom the daughters were married was sometimes appreciated.

¹⁶² Apparently the father had traded with these neighbours’ parents but the children were not involved, and when they opened a case they lost. Betty believed there was foul play involved.

and Mukangara had two children of their own. They lived with three other children from Betty's younger sister, Stacey (39), who worked as a barmaid in Tanga city.¹⁶³

Given the above background, the household of Mukangara had difficulty incorporating extended family who were former migrants in Maramba. I could say that the household I encountered contained four different but symbolic households at the same time, if I consider both Mathias and Mukangara as representatives of their own dissolved domiciles. The three children of Stacey represented a household of their own. The situation in Mukangara's house can be compared in a number of ways to that of Gisela, and even that of Mama Mu. All were products of historical migration patterns and possessed limited extended networks from their paternal and maternal sides in the community. The arrival of Mathias and Arnold to receive care from their sister Betty only served to complicate the care and support she could provide to Mr. Mula Mukangara, whom himself had lost touch with his clan since he did not return home to Dodoma region after he retired from JKT. The strain of care was further compounded by the insufficient income earned by the members of the household.¹⁶⁴

Networks and sources of care in Mukangara's household

The limitations of extended networks and of community safety nets were made clear in the process of caring for the three patients. The siblings had to ensure that their sick family members were taken care of despite limited resources. Like it was for Christina, Gisela, and Neema, only the family members were responsible for the day to day caring of the patients. Betty assisted with Stacey's daughters, who slept in the same room as Betty's mother and Betty's only child (See Table 16 below).¹⁶⁵

¹⁶³ Betty took in the children in 1999, They were Asha (15), Asimwe (11) and Mercy (8). Asha went to secondary school and the other two, to primary school. Stacey sends a month's worth of food (rice, cooking oil and maize) to the house for her children because the cost of living with them in the city was too high.

¹⁶⁴ The only source of income was his small pension of 300,000 Shillings (USD 200) every six months, combined with two dairy cows, which had to be looked after by paid labour.

¹⁶⁵ Betty had another three children from previous relationships.

Table 16: Mathias's care and support sources

Name	Name	Relation	Forms of Support
Mathias Mtunguja	Betty	Sister	Bathing; dressing wounds; cooking; food provision; feeding; funeral arrangements
	Stacey	Sister	Medical bills (drugs purchase, making hospital arrangements, hospital visits); feeding and bathing; funeral arrangements
	Asha	Cousin	Cooking; shopping for food; cleaning the house
	Asimwe	Cousin	Cooking; shopping for food; cleaning the house
	Samuel	Uncle	Drugs purchase; hospital arrangements; funeral arrangements
	Teule hospital		Transportation of Mathias's body

In the mornings, the children cleaned the home and surrounds, lit the fire, and helped their aunt to boil milk for all the 'patients'. 'I give them each in their ward number one, two, and three,' (we laughed as she pointed to the rooms - imitating a hospital setting). After that she made sure the children were bathed and ready for school by preparing tea for everyone before they left. She also prepared evening and afternoon meals with the children's help. Betty was also responsible for bathing and toileting Mula and Mathias. Betty bathed Mathias as there was no able male member in the household to do so. Betty also worked on their three acres of land leased at the estate plot and had to divide her time between caring for her husband and brothers as well as ensuring the household has enough food. Her efforts tired her; she had to struggle on her own despite the fact that they were surrounded by neighbours on all fronts. I asked Betty why she did not ask for assistance from them and her answer suggested the limits of seeking care from community members other than her family; 'You cannot go and trouble people with your problems, they also have their own problems, and it's not civilized (*ustaarabu*).' Her answer further implied that the notion that the community will rise to assist households affected by HIV/AIDS (Ankrah 1993; Foster 2007) is not always the case.

Mathias' situation began to deteriorate and as I became close to the family we often discussed ways to take him to the hospital since he needed an operation to drain the pus out of his chest. In conversations with household members, the importance of proximate relatives who could assist

with funds for Mathias's medical costs was well debated. There was Samuel Njovu¹⁶⁶, the son of Johnson Njovu, who was also HIV positive and who was then still alive. He was considered the better-off relative of the Mtungujas. However, he informed me he was not in a position to assist. 'My father is also sick, so is my mother, recently my sister from my mother's side came home with her two daughters, I also have to feed them, I also have my wife and my children, they all look up for me to care for them.'

A similar scenario has been reported in Uganda by Seeley and colleagues (1993) where people reported that they were busy with their own responsibilities. In poor communities in Kenya (Amuyunzu and Eyeh, 2005), as in Maramba, people cited their own poverty as hindering their ability to assist others. The authors also found that neighbours were more likely to assist with major ailments¹⁶⁷ than minor illnesses because they saw minor illness as too common to merit community intervention. Mtika (2001) argues from Malawi that when the HIV/AIDS epidemic reaches the point where other households also suffer it 'it makes illness and death so extensive that ties in the extended family networks get fractured, social capital endowments become unfavourable, reciprocity and redistribution are undermined, social immunity is weakened, and food security gets compromised' (2001: 185).

However, unlike the situation in Malawi or Uganda, where affected households could speak of extensive family networks, this was rare in Maramba and in the households I observed. Relatives had to be searched out desperately. For relatives who lived far away, some degree of contact had to already have been established for people in Maramba to consider asking for support. 'Knowing' a relative, even if they were blood related, was not to enough to impose responsibilities on them. For example, Arnold mentioned their uncle who lived in Iringa region, southern Tanzania, who was a police traffic officer, might offer support. But Stacey and her sister dismissed the idea because it was not considered civilized: 'You cannot just show up to people you do not know and have not met and expect them to assist you it a civilized behaviour at all.' Failing to obtain support from the few relatives in the community, all of whom were from the maternal side of their late mother, and poor, a decision was made to approach an aunt on their

¹⁶⁶ I introduced Samuel in the previous chapter, Samuel's mother was the aunt of Mathias's late mother.

¹⁶⁷ Since the authors used only focused group discussions they were not able to gauge the extent of support offered during major illnesses.

late mother's side and ask her to sell a piece of land, one of the important assets in the community, to pay Arnold's medical costs. However, she refused on the grounds that nothing will be left for her family, and besides they used it to farm for food for their own consumption.

The above search reveals the dynamics of support when other community members are also suffering. It suggests that while networks might be there it matters if the networks are also in a good position, especially, economically, and willing to assist. In fact this was the main feature throughout my informant's struggles for support. Indeed provocative ideas provided by Foster (1997) in situations like these, by suggesting relatives recognize their roles are in their own way static: 'It may be possible to work with communities to strengthen mechanisms which encourage erring relatives to fulfil traditional family responsibilities' (1997: 395). In the words of Madhavan (2004), such ideas tend to view the extended family adapting positively in all circumstances without recognizing that 'responsibilities change over time in response to crises, as do the people responsible for providing care' (Madhavan 2004: 1451). Increasingly, patients had no options but to hope for whatever might happen to them. The situation in Mukangara's household made Arnold regret his life, and he contemplated leaving to go to distant relatives. 'I feel really sorry for my younger sisters. I and Mathias were supposed to support them and not the other way round... that is why I want you to give me fare so that I leave. You know it is different with us men because we have stronger hearts. I told Stacey not to think of me but Mathias because he is in bad shape, I am better - my quest is to give relief to my sisters (Betty and Stacey) who have to think about three people at a time.¹⁶⁸' His blaming himself for failing to do anything was like a reflection of the failure of decisions that were made in the past in response to state of affairs that engulfed Maramba. In other words, his predicament can be looked at as a condemnation of the processes that made him leave and become poor at the first place.

I decided to join hands with Stacey in making sure Mathias attended hospital. In addition to money trouble there was the lack of physical support needed for nursing. Someone had to visit him and take him food, also bathe him and wash his clothes. That caregiver would need to be fed. It cost 6,000 Shillings (4.6USD) for a return bus fare to Muheza hospital, almost three times

¹⁶⁸ At one point Arnold wanted to bring his wife and three children, who were still in Arusha, to Maramba because they were evicted from the room they stayed in for failing to pay rent. However, Mr. Mula Mukangara refused on the grounds that there was no room for them to stay in the house which already accommodated seven people.

a day's wage for a sisal labourer.¹⁶⁹ Stacey lived in Tanga city; she was closer to the hospital and became responsible for visiting Mathias and her fare was cheaper at 2,000 Shillings. But Mathias took days to get attended to as so many tests had to be performed. This unexpected extension took a high toll on Stacey who was caught between her work and supporting Mathias:

They have cut a hole on his side ribs and are draining out the pus and it will take seven days! After those seven days I am taking him home *yasije yakaniharibikie*¹⁷⁰ I am all alone and I have work to do. They have told me to choose if I want to assist my brother or work. I want to talk to the doctors so that they can discharge him early. I cannot do this anymore because I will lose my job. I suggested if they can allow him to come back home but they telling me the injections will have to go through his drip. I told Mathias I cannot spoil my employment because he is not the only person who needs care and food because he is sick, even the able (meaning her children) also need that. I am the only one who is well (financially and mobile) I should care for those who are sick and those who are well too... If I just have to care for you Mathias I will hurt those who are well too and my employment will falter then how would I care for you, or where will I get bus fare to come and visit you?

Stacey faced a dilemma, as did I. When she said she cared for those who are sick and well she meant because she was salaried she had to provide for both her children and pay hospital bills for the sick members, on top of visiting Mathias at the hospital. I was depressed because I felt I may have contributed to her predicament by insisting Mathias attend the hospital. I did not anticipate that his being hospitalized was actually more of a burden to the sisters than if he was at home. I contributed the fare for Betty and she managed to visit Mathias. But on the next day she was called home by her husband because the cow's caretaker had suddenly left and their three cows did not have a feeder. He also needed her support.¹⁷¹ We managed to get the son, named Ankal (28), of Betty's late sister, who was in Maramba for vacation, to attend to Mathias, but he too could not stay longer at the hospital as he had to return to college. Feeling the pressure to support Mathias, Stacey once lamented:

Sometimes I wish could leave this region and stay very far away from all these burdens of my family...I have never enjoyed life but caring for my sick relatives...maybe God is trying to tell me something...It is not that I am refusing, he is my relative although I have lost money so that he gets better!

¹⁶⁹ A daily wage was 2,500Shillings.

¹⁷⁰ Difficult to translate, but implies she was afraid if Mathias died it would be costly to transport his body.

¹⁷¹ By the time Mathias was hospitalized, Mula was paralyzed in both legs. This obliged Betty to spend most of her time at the house

The inability of the family to adequately provide for Mathias' needs suggests two complex scenarios regarding the limits of the extended family. Because of the gendered nature of migration it is women who are left to perform these roles. While men are advantaged vis a vis mobility, women bear the brunt of the migration processes, remaining in the community most of the time. Also, the multi-tasking women perform destabilizes other sections of the household. Care is not limited to simply feeding and bathing in resource limited settings. Betty juggled visits to Mathias in Teule hospital, nursing her bedridden husband and providing food for the cow.

The second scenario involves the complexity of the health system in the rural areas. While getting a referral implies moving to better services, in Maramba it sometimes translates to increased poverty and debt for the affected family. Since news of referrals was often sudden, family members are often not financially prepared when the news arrives.¹⁷² Comments from a local health clinician about patient and family referral experiences, affirms the fears of the costs of taking care of Mathias that Stacey was afraid of:

They do not like being referred, even if there was free transport. I would say out of ten, five will not accept being referred. It is costly for many families as they sometimes eat one meal a day. If they travel to hospital in town it means they jeopardize their food security. There is also the cost of travelling to town and feeding the patient at the hospital, they rather have a patient stay here because it is close to visit. Also, they say in town they also have to buy medicines like here. Worse is that they are afraid if the patient dies, because it is very expensive to transport a dead body. They sometimes beg us not to refer the patient or they become afraid to bring the patient in fear of being given a referral.

External safety nets that have been suggested to assist poor households include the operation of home based care (HBC) services (Foster 2007; Belsey 2005),¹⁷³ which were available in the community. However, HBC providers could in no way provide sufficiently for the needs of patients like Mathias and Arnold whose health needs were beyond their capacity. The most the HBC could provide was visitations and recommending that the patient go to the hospital when their health deteriorated.

¹⁷² There was a time a man put his house and the land on it, to obtain 100,000 Shillings (USD 76) from Jimmy after he was told his son was anaemic and needed blood in Tanga regional hospital. The money promised was to be returned with a ten percent interest. I noticed this to be an inducing way of getting loans otherwise it would have been impossible to obtain such an amount in the community; it was more than a month's of a sisal labourer's income. I was often approached to assist in such scenarios.

¹⁷³ A study on HBC in Tanzania found out that HBC was twenty five percent less expensive for adults and twenty one percent less for children (Danziger 1994).

Social safety nets with holes: Support networks and bereavement

The limited nature of ‘safety nets’ and family capital were more pronounced concerning funeral arrangements and the subsequent post-burial meeting of the family of Mathias who died in January 2009 at a referral hospital in Kilimanjaro region where he was taken for an operation for pulmonary bronchitis. In communities in other parts of the country and in Kenya, people form support groups such as burial societies for events like these and sometimes charged fees (Dercon et al 2005; Narayan and Pritchett 1999, Nyambetha et al 2001). In Maramba these were nonexistent.¹⁷⁴ Further, in many communities in Tanzania it was normally the responsibility of the head (mostly male) of the lineage to take charge of the mortuary arrangements (Feireman 1978; also Fortes 1945: 187). In traditional Shambaa culture, kinship obligations require that the paternal side of the family take control of all funeral proceedings. In the case of Mathias' death, it was ironic that it was Stacey who had to attend to these. She obtained a loan through a friend in town and even travelled to Kilimanjaro to collect Mathias' body. While she was accompanied by Samuel, she carried most of the costs, obtaining a loan to pay for transporting Mathias' body from the morgue.¹⁷⁵ Stacey repeatedly lamented her role, one that would in other circumstances be performed by men:

I am doing everything on my own, I do not have any major help, the things that are supposed to be done by men they are all left to me because I earn this small income. All my brothers are sick, the one (Tim) who is better is very poor to assist. With all these costs it's like my life is going backwards than forward. After the funeral I do not know how I will repay these debts!

In the literature, support networks have been noted to work better when community members die than when members are ill (Seeley et al 1992; Lund and Fafchamps 1997; Phillips 2002). Coming together signifies shared values and norms in recognition of the loss of a person and the need to help the bereaved family with funeral arrangements. Death reminds one of one's mortality, “and that they would hate to be left alone if they lost one of their household members (Amayunzu and Ezech 2005: 103; also Phillips 2002). In Maramba participation in funerals was considered important to ensure continued social cohesion. The phrase, ‘Today it's you, tomorrow

¹⁷⁴ I noted only JKT had a procedure to transport their employees once they died for free, to their homelands.

¹⁷⁵ Similarly when Christina died there was no a male lineage leader to stand for the family. The church leaders assisted by their brother took the lead in this regard.

it's me' (*leo kwako, kesho kwangu*) was commonly used as a reminder of the need to support one another in time of crisis such as death.

While these safety nets perform certain roles associated with funeral procedures, in Maramba at least, they were insufficient for the most crucial aspects of modern funerals, those requiring cash for paying hospital bills, transporting the body, feeding the mourners, buying the coffin and its accessories, transporting the body to the gravesite, and digging the grave. At funerals that I attended in Maramba, responsibility fell on the family of the deceased. Community members assisted mainly in hands on activities such as cooking, serving food to mourners, and grieving with family members, but did not contribute to the direct costs of funeral arrangements.¹⁷⁶ Due to such costs it was common for relatives to hope that their loved ones would not die in distance hospitals or villages, so that they did not incur the high costs of transportation. Stacey's lamentation above also signals the fact that the few available men could not meet the funeral costs because they did not command viable income to meet their culturally assigned duties.

In communities where extended kinship systems are in place, clan and family members attend post-burial meetings to discuss matters related to the deceased, in most cases the paternal side heading the meeting. At the meeting after Mathias' funeral the weakness of family support became even more apparent (see Appendix 3). The participation itself echoed the limited extended family networks as it mirrored the absence of relatives from the Mtunguja side. There were 15, mostly middle aged, women seated on mats covered with *khanga*, together with five elder men sitting on the chairs provided. The number of relatives reflected the imbalance between matrilineal and patrilineal sides related to Mathias in Maramba. Apart from Mathias's siblings Stacey, Betty and Arnold, the rest were from his distant maternal side.¹⁷⁷

¹⁷⁶ Community members who visited the funeral voluntarily contributed through giving money and writing their names in notebooks that were placed in a tent. One notebook was for family members and the other for visitors. This was also evident with the deaths of Christina and Johnson.

¹⁷⁷ Mathias' after burial meeting composition was similar to both Mr. Johnson Njovu and Christina's funeral, who both had limited extended family networks.

The meeting, led by Samuel and which lasted for about an hour, was mainly concerned with Stacey's costs. She had incurred a cost of 470,000 Shillings (331 USD).¹⁷⁸ The total contributions from relatives, reflected the notebook provided during the funeral, amounted to 4,450 Shillings (3.5 USD) while that from community members was 7,760 Shillings (6 USD), though I estimated more than 200 people attended the funeral. The local Church contributed 10,000 Shillings (8 USD).¹⁷⁹ Samuel, who did the calculations, complained about the small amount from family but thereafter charismatically pleaded with the attending members to pledge support to cover the debt. Relatives were asked to at least come up with 10,000 shillings after a month:

I know this family of Mtunguja is very small in number. But this burden is ours all as relatives. This may happen to you too in the future. So let's join hands to relieve the debt for our sister. We know we have our own problems but let's be kind to assist...besides, let's form an association so that such problems when they occur we can easily solveas you all know we also have other two patients who are sick, but will not discuss today, we have this issue of Mathias' funeral first to take care off.

There was little response from the grieving family members. The idea of forming an association was appealing but the suggested costs for covering Mathias funeral were not. Several people said they would try to come up with the money but Samuel had to push them individually to commit to the payments. Samuel then promised to visit the house of each of those who attended to collect the money. After a month and a half I followed up with Samuel to hear his progress and he told me he did not even bother. 'I know these people, they do not have a steady income, you saw for yourself the contributions from the notebook, do you think they will even bother after the funeral is over? I did not think so.' The debts from Mathias' funeral expenses were automatically left to Stacey to shoulder. It also implied the family, Stacey and Betty specifically, will continuously have to shoulder expenses for their brother Arnold, and Betty's husband, Mula, who both urgently needed medical attention. Both died a few months later, partly due to insufficient funds to send them to the hospital.

According to Belsey, in the process of addressing care to HIV/AIDS affected households , 'one critical ingredient for effective coping appears to be a dependable family network that extends

¹⁷⁸ The per capita income per person per year in Tanzania for that year was 326.0 USD (United Nations Statistics Division 2008).

¹⁷⁹ Church participation was ironic. The choir that grieved with the household by singing through the night for three days was fed, as were the pastors who had performed the mass, which cost more than 50,000 Shillings (39 USD).

beyond the immediate family household and serves a substantial reservoir of family capital' (Belsey 2005: 7). Further, the definition of the family offered by Ankrah (1993) and Foster (2007) is in line with the above stipulation (Belsey 2005). They go as far as to emphasize two crucial aspects, also implied in other research, namely that the family is permanent and it is committed to economic and social support.¹⁸⁰ But as my case studies have shown a situation that differs from this definition. In the case of Mathias, Arnold, Mula and indeed, that of Christina's households extended networks were needed to shoulder support. Despite the insufficiency of extended networks, willingness to provide care from the available networks was there, but the capacity of the members was inadequate. This illustrates how poor families with inadequate networks nearby struggled to provide care in the face of limited income.

While forms of support external to the family are important, such support needs to be analyzed in relation to the suffering involved as well as the capacity and quality of the support. This is not to say that community safety nets do not exist at all, but evaluating the extent to which these forms of support are able to address the impact of HIV/AIDS is crucial. As the cases above show, support of long term diseases such as HIV/AIDS wears down a family's capacity, since care is a long process and requires substantial amounts of money to ensure essential goods such as food for the household, and for the individual to be taken to the hospital for treatment.

Exiting Maramba: failed family capital networks

I have argued so far that the limited nature of family capital in affected households constrains their ability to care for the ill, despite the availability of ART. Also as I have shown in Chapter Four, some patients were providers in their households before they became bedridden. Many struggled to remain healthy and to maintain the wellbeing of their families for whom they felt responsible. This led to family conflict, affecting the quality of intra-household relationships (cf. Belsey 2005). While others, like the household of Christina and Mathias, confront their situation to the best of their ability, others in desperation choose to leave the community to seek better care and support elsewhere.¹⁸¹ The stories of Shabano and Neema's households below, illustrate well the complex nature of what it means to live in a community where structural limitations

¹⁸⁰ Neither Ankrah and Foster dispute the fact that HIV/AIDS has put pressure on extended family networks, but contend that these institutions will always bounce back and cope with such pressures.

¹⁸¹ In my sample of 30 households, five people left the community for almost the same reasons discussed here.

have affected the extended network supposedly ready to offer care and support in times of sickness.

Shabano returned¹⁸² to Maramba after he was forced to retire due to HIV related illnesses in 2003. His wife had died in April 2002 and his daughter in 2004. Unlike other people with HIV who returned to the community bedridden, Shabano returned well¹⁸³ and wealthy, and continued in his role of provider for the extended family. Because he had retirement funds from his previous employers he decided to open up businesses to start a new life and bought a house from a retiring JKT soldier. He lived with his son Rahim (12) and his sister Anti (62), who supported him, mostly by cooking and washing his clothes. He also lived with two children of his late brother (who had died from AIDS related illnesses), Salum (16) and Mamy (15), and one of Anti's children, Lily (14). Being an electrical engineering specialist, his skills were of little use in Maramba. He opened a guest house and had a car which he used as a taxi in Tanga city and left his relatives to run it. With the business he established in Maramba he was able to frequently travel to Dar es Salaam to obtain the best drugs.¹⁸⁴ However, he was not trained in business skills and neither were his poor relatives who ran his guest house and his taxi. The taxi was involved in a serious accident and could not be repaired. With much of his funds spent on drugs and supporting his relatives as well as running an unsuccessful business, he quickly by 2006 he had to consider his options carefully. He considered himself lucky because that was when free treatment became available and he no longer had to buy drugs. Although his businesses failed, extended family members still looked up to him because he earned hard cash from the house he bought, though still meagre. His house constantly had relatives who came and stayed for a while and then departed.¹⁸⁵ He had to cater for their food while they stayed with him and for their fare when they left.

While network studies have shown that the immediacy of kin relationships (Malia et al 2005) and proximity of networks are related to positive health outcomes (Seeman and Berkman 1988;

¹⁸² Like Arnold, Shabano had left Maramba in 1983, at the time of JKT's arrival and taking over of the farms. Like Arnold's father, Shabano's parents were employees and benefited from the plantations before JKT took over, a period when SAPs were being implemented in the country.

¹⁸³ He started taking ART in 2002 long before they were made free.

¹⁸⁴ People speculated he was taking ART he says, when he returned, but because they were not known by then he lived normally by travelling to Dar es Salaam to buy them.

¹⁸⁵ I lived less than twenty metres from his house and we conversed almost every day whenever I was in the field.

Wellman and Wortley 1990), such did not apply to Shabano's health predicament as time went by. The burden of providing economic support for his extended family took its toll and constrained plans for himself and for his son. He often referred to them as opportunists and 'poor', that they did not assist him. It led to weakened ties with his parents and some of his siblings, although he felt obliged to assist them whenever they visited. He went as far as to suggest that he wished he had not bought the house in Maramba, 'When I die my son will not get what is rightful his...these relatives they are just waiting for me to die so that they can sell everything and divide among themselves'.¹⁸⁶ Our conversations revealed high levels of anxiety caused by longstanding tensions with his father to whom he had sent money to build a house for himself and the family only to return and discover he appropriated all the money for his own use. He attributed his economic loss to having to spend his pension, which could have augmented his living expenses, on buying a house. While I was there, they rarely spoke unless there was a family dispute to address.¹⁸⁷

Although Mama Mu referred to uncaring relatives as 'relatives by name', Shabano talked of the extended family as a burden and a threat to his wellbeing. Shabano's referencing his extended network as a burden was a reflection of his role as the head and as provider. This reiterates the fact pointed out in Chapters Four and Five that some HIV positive people in my sample, such as Flora, were important pillars of economic support for their families. What differs seemed to be the extent of support and the level of dependency in relation to other household members. There is a complicated understanding of care and support between a bedridden HIV/AIDS patient and one who is on treatment and well, creating uneven experiences of care in households.

Shabano's dilemma could be conceptualized as an outcome of having an extended network, but which is neither capable nor supportive. This formulation contrasts with the notion that extended networks or clans in rural areas are useful for families affected by HIV/AIDS. Although he returned home to live with his relatives, for him, they became 'too much'. He once lamented, 'It was better if I had my own place and stayed with my own family alone, my relatives have

¹⁸⁶ This was a common scenario in Maramba. I witnessed more than five cases of relatives taking each other to court over inheritance, mostly involving houses. One man murdered his brother over a single room mud house.

¹⁸⁷ At times Shabano seemed to implicitly to acknowledge that hardships in the community may have forced his father not to build his house, though he claimed he used to send money for him to use.

become a burden to me, I cannot support them any more...nowadays even my food is not good and enough, I have to feed all these people, my money is not enough.' Apart from the burden he felt from his relatives, he had also lived and worked for more than 15 years in a nuclear family in Kigoma, and had become accustomed to it. He was used to having a salary that offered security for him and guaranteed his children's education. Now he lived in an extended network where he was the only provider, and, as Spiegel and Mchlwana (1997) argue, relationships with material wealth going in one direction are clearly unsustainable. Mtika (2001) puts it aptly speaking of reciprocity in AIDS affected communities: 'The threat of AIDS to household food security lies in its impact on social immunity, the collective resistance against problems. Social immunity is rooted in social capital endowments, the reciprocity and redistribution opportunities embedded in networks of interpersonal ties' (2001: 185). In Shabano's case, and indeed that of Christina, Gisela and their relatives, the quality intra-family relationships coupled with the financial capacity of their relatives jeopardized any meaningful potential support that could have been provided, no matter how small.

The return to Maramba with no job and having to support members of his poor extended family financially, more than just his wife and two children as before, culminated in terrible stress for Shabano. Despite being 'home', he continued to view Maramba as not conducive to his wellbeing:

In this village life is very difficult...I do not have someone to truly assist me, my eating is becoming a problem, even my CD4 have dropped, from 654 and now they are 345! Although I have food problems now they expect me to still take money out of my pocket to pay someone to farm and feed me and them...I am a good electrical technician, if I can get a job anywhere I can work...but not here in Maramba, what can I do here with my skills?... I cannot farm with my condition and capital is a problem.

Shabano never considered his extended family as a viable support to feed him as he watched his food intake decline every day. He also did not think that they would be able to take care of his son Rahim after he died. He gave his two cows into the care of one of his brothers, but one of them died because of poor care.

Once he made a trip to his former place of employment in Dar es Salaam to follow up on his retirement. There he discovered that former colleagues were receiving better services from ARV

clinics, which seemed to him to be well funded compared to the one he was attending. 'In Maramba we are being denying many things. My friends, whenever they take drugs they are also given food supplements pills, multivitamins to boost their immune and supplement their food intake...we are really deprived in the villages', he insisted.

Shabano was unaware of the different national and global ART programmes that support clinics countrywide, and with the different packages involved.¹⁸⁸ But certainly he could reflect on the discrepancy of services between his urban colleagues and those in Maramba. In Maramba very few people on ART knew about the importance of and need for nutritional supplements (apart from food). Shabano's curiosity about these valuable supplements for those on ART, seemed to invigorate his desire to leave the community.

Towards the end of 2008, Shabano revealed casually that he was considering moving with his son to his in-laws in Mwanza region, where he had not been since 2003, and had little communicated with ever since. I considered his decision with interest. Later I asked him why he thought the in-laws would consider allowing him to stay with them when he had cut ties with them. His answer suggested that he had thought it out well. Besides anything else it suggested a decision made out of desperation to avoid destitution:

They are wealthy, my mother in law liked me very much because I used to bring them presents from work...I know they will accept me because I have the only memory of their daughter, my son Rahim, his grandmother loved him so much, they will let me stay with them...it is better to go there than die poor here in Maramba. They are good people.

His son Rahim seemed to have become the focal point of his worry about support and care structures that his family in Maramba did not offer. He had to choose himself and his child over them. The role of the clan, as Ankrah (1993) argues, will not always be able to provide care to its members in times of distress. I once asked Shabano about his sisters and the children of his relatives who he was looking after 'I also have my son to look after, they have their life I have mine, I tried to support but I cannot live where I know I may end up dying soon', Shabano explained. He left in May 2009.

¹⁸⁸ In Tanzania, various international organizations are responsible for providing technical support to HIV/AIDS centres and these are divided according to region (see GFTAM 2003).

Specific contexts determine the nature of extended family support mechanisms as the case of Shabano has shown. Unlike Arnold, who was prevented from going to his uncle in Iringa because he had lost contact, Shabano could not look to his uncles in the community because they were poor. Instead, he chose his in-laws who did not reside in the community. Following Belsey (2005), while family networks represent the foundation of family capital, the extent to which the resources of family networks may be drawn upon is determined by factors such as perceptions of familial obligations as well as the quality of intra-family relationships (Belsey 2005:18- 20). I would add that, the ability of families to provide care is also a crucial factor. Shabano could at least think of old networks and rekindle them, unlike John Msemwa, Mama and others, who had no alternative but to live in hopes of any assistance that might come to them.

Shabano's experience and decision to leave Maramba could be compared to that of Neema Mbuti. As discussed in Chapter Three, Neema's household had also been struggling to obtain food for her. Her network was also very limited, living with her aged grandmother who was the only descendant left after her husband died many years before.¹⁸⁹ Even the meagre remittances her brother sent were not satisfactory for the rest of the nine family members living in the two bedroom mud and grass thatched house. Neema decided to leave Maramba with her three children, and went to live with her father who stayed in Pwani region 300 kms. from Maramba. Her father had remarried after he separated from Neema's mother¹⁹⁰ (who died in 1994). He had agreed to take Neema now that he had a new job and could take care of her. She said, 'If I continue to stay here I will end up dying from hunger and my children will suffer, they do not even have their father. My father stays close to Kibaha hospital, it is a town and there are good services and they get a lot of food aid my father tells me. When I get better I will come and maybe take grandmother to come and live with us, this is not a place to stay if you do not have a job.'

Neema did not decide to leave because her relatives were burdened by her, or because of poor relations with them, but more because of limited opportunities to support herself, her children and other members of the household. The cases I observed in Maramba show that relationships

¹⁸⁹ They had come to Maramba to work as labourers in the 1950s (I introduce Neema's household in Chapter Four and detail in Appendix 2).

¹⁹⁰ The step-mother had refused to stay with Neema when she had full blown AIDS in 2004.

that are useful to ensure the propagation of the household, especially ensuring food availability, do still matter.

The nature of care in Maramba can be compared to what Oleke, Blystad, and Rekdal (2005) found in their ethnographic account of what they term 'crisis fostering' for orphans in northern Uganda. The authors show how 'purposeful' voluntary exchange of non-orphaned children that was practiced in the past is now dominated by 'crisis' fostering of orphans. The authors do not attribute this to the effects of AIDS directly but link their findings to historical events that affected the area over the past 30 years, when armed conflict, uprooting of the local pastoral and cotton-based economy - and the effects of SAPs - 'produced dramatic economic marginalization with highly disturbing consequences for orphans and their caretakers'. More than 50 percent of households were no longer found to be headed by a resourced paternal kin 'in a manner deemed culturally appropriate' by the patrilineal dominated Langi society (Oleke, Blystad and Rekdal 2005).

I once spoke with a respected traditional healer in the community, Mr. Sadui Abdullah (aged 82) about his experiences with Maramba's past and present relations of support; he argued that in the past, especially during the Ujamaa period, community members had the energy to help one another regardless of how they were related, but that seemed not to exist anymore:

Nowadays there is even a saying, 'a person is money' (*mtu pesa*), or 'money talks' (*pesa inaongea*), they also say, 'money is loved, not people' (*hapendwi mtu, pesa tu*), things have changed. In the past you could come in this village and stay at anyone's house, and even if you did not have fare to go where you want, your host gave you. Life has become difficult to do that. Everyone is crying hardships (*shida*), who will assist you then? The rains have also run away, they used to fall three times in a year and so you were assured of food. Life nowadays in this village you have to struggle a lot to survive.

It may not be possible to corroborate the statements of Mr. Sadui regarding the exact nature of the historical forms of care and support in the community. But as I have shown, current circumstances surrounding the decisions on allocating roles of care and where to seek support, were influenced by individual household and family networks relations, but structured by the historical and existing larger socioeconomic context. Seeley and colleagues (1993) provide a succinct conclusion to the discussion about the capacity of the extended family networks during

a time of HIV/AIDS infection. They warn, 'Blanket statements about the role of the extended family in Africa as a safety net need to be questioned and assumptions that the extended family will be ready and able to assist sick members, treated with caution' (Seeley et al. 1993: 122).

In this chapter I have argued that the existing support family structures among poor PLHIV in Maramba cannot be properly understood if not fundamentally placed within their broad social cultural and economic context, which transcends the immediate impact of the HIV/AIDS crisis. These processes have placed not only households of the affected in critical situations, but also the unaffected ones, complicating reciprocity practices of care and support between households. A common phenomenon among the families I observed was the difficult decision making processes about where to seek assistance which was not readily available in the community since care was considered the responsibility of the immediate family, to begin with. Although having an extended family is important in times of stress through illness, not all extended members were capable of addressing the needs of the sick and their household members. Factors such as intra-familial relations and ties between members play a crucial role in determining care. Most important for the situation in Maramba was the quality of care that members could provide. Care to people affected with AIDS demanded more than just emotional support, but also physical and financial inputs to feed the household and the person on treatment. Given the precarious nature of income generating opportunities, this was an ongoing problem. The few relatives that were there were too poor to lend their support, even when willing, in life and death. While some patients were compelled to return to seek care from family networks in Maramba, only to meet with limited care networks, others were forced by particular circumstances, mainly poverty, to leave the community to seek care and support elsewhere. This chapter concludes that, while family and extended networks are crucial in assisting HIV/AIDS households, experiences are uneven.

CHAPTER SEVEN

CONCLUSION

My study has sought to research and understand the experience of care and support among people with HIV/AIDS in a rural community in northeastern Tanzania. In the introduction I raised questions about the adaptability and functioning of poor households affected by HIV/AIDS, with ART available, in an area which has undergone a long process of historical, social and economic domination.

I carried out the study in line with the long tradition in the social sciences and, in particular, anthropological approaches to HIV/AIDS in sub-Saharan Africa. My ethnographic encounter occurred at a time when significant developments in HIV/AIDS treatment had taken place in the world and when antiretroviral treatment was made available to the poor due to large campaigns by human rights groups and ‘therapeutic citizens’ in different parts of the African continent (Nguyen 2005; Robins 2004; Geffen 2010). Precisely three years after these drugs became available without charge in Tanzania I embarked on my fieldwork in the most affected community in Muheza district, Tanga region. Anthropological studies on ART experiences among poor groups in Tanzania are scant or totally unavailable. While health facility based studies on ART adherence are important to ensure the correct uptake of drugs and adherence of people to programmes (Ware et al 2009; Mshana et al 2006ii; Roura et al 2009i), existing anthropological endeavors on the same have been primarily to conceptualize how the drugs constitute different meanings to patients and community members (Ezekiel et al 2009; Meinert et al 2009). I have argued that ARVs are a lifetime medication and experiences of patients go beyond taking medications to incorporate how they sustain their livelihoods, which are equally if not more important than taking the drugs.

In Chapter Three, to demonstrate how the historical context of land alienation in Maramba has profoundly shaped people’s food security and their ability to care for one another in states of sickness, I had to take a long view by engaging with the origins of food security and early experiences of HIV/AIDS in the community. I started by showing how prior to the 18th century

the indigenous Shambaa could sustain themselves with food and support one another in times of illness. The major structural changes took place with the introduction of a colonial economy whereby tracts of lands were alienated in the area and a labour intensive economy that emphasized the production of cash crops rather than food was put in place. The labour imported to work in the plantations were compelled to settle in surrounding villages for various factors; most did not return to their homelands and became part of the local population. This population increase was not accompanied by an abundance of arable land for food production. However, postcolonial agriculture policies did little to alter the colonial economy. The Ujamaa villagization policy disrupted the settled local economies, further disrupting food producing capacity and social security networks. This disruption became severe for local people when the global economic crisis hit the country in the 70s, affecting the plantation economy on which the locals almost entirely depended for income. Villagers became even more susceptible to oppression and marginalization when the government handed over the surrounding colonial plantations to government entities such as the JKT. The arrival of JKT coupled with the economic crisis destroyed villagers' systems of food production and instituted a farming system that was not in line with villagers' needs. Further, new relations born out of the control of farms placed villagers in a position of heightened vulnerability to HIV transmission.

Following the historical processes and structural conditions affecting food insecurity and HIV/AIDS, in Chapter Four I described the contemporary position of Maramba's food insecurity among those who have HIV/AIDS. I argued that the land tenure arrangements between ordinary Maramba villagers, rich peasants and JKT members, and families affected by HIV, served only to undermine the production capacities of those who were poor and sick. As a consequence poor households affected by HIV/AIDS were struggling rather than coping with food problems to maintain their livelihoods. This was evidenced by four main interrelated components. Firstly, the production of food for the period 2008 in the households of people living with HIV/AIDS was lower when compared to other households that were not affected. Secondly, as a result poor HIV affected households had to employ famine survival strategies while having to compete with other households with no sick members in an environment with limited opportunities, undermining their income but also affecting their already fragile bodies. Thirdly, to survive for the day with low income, HIV/AIDS affected households had to curtail their food intake and also repeatedly

consume food types affecting their nutritional intake. The importance of owning land to ensure food and income security was demonstrated by the existing 'pro poor' projects such as dairy farming which, however, exclude the poor sick because they do not own land. As I was in the process of completing my thesis (January 2011), I received news from Maramba that the JKT administration decided to stop all villagers from cultivating in the JKT space indefinitely. This decision will definitely have serious ramifications on the livelihoods of many people and remains to be seen how people will survive.

I then shifted the focus on treatment in Maramba. The availability of treatment using ARVs has led to a decrease in deaths but has not otherwise positively changed the lives of the poor in Maramba. Unlike the recent research about HIV/AIDS in Tanzania that has argued for the return to 'normalcy' for people taking ART (Roura et al 2009ⁱⁱⁱ; Watt et al 2009), my thesis has shown that HIV affected people on treatment in Maramba enter a new life of uncertainty, precariousness, fear and instability in the face of wide and constraining social and economic factors prevailing in the community. Rather than simply looking at people's perceptions of the drugs they take, I have related their drug use to their everyday experiences. Because of public campaigns on the clinical benefits of ART in Tanzania, the drugs have acquired a positive meaning among those who had yet to enter treatment and who, I have argued, desired the drugs as they imagined they would fulfill certain societal notions about wellness. People with HIV/AIDS saw ARVs as part of a solution to their health problems among a number of many other social and economic problems. I have shown how food security in affected households limited people's capacity for hard work. The study shows that work was their main resource, amidst limited support structures. ARTs come with complications, especially in terms of side effects and opportunistic infections which limit the ability of people to engage in productive activities. These constraints compelled some in Maramba to skip doses and to seek alternatives, especially traditional medicines, although strongly argued against by the clinics. When my informants on treatment died, their deaths led to debates filled with uncertainty and without clear conclusions on the effectiveness of ART.

In the absence of modern social security systems the African extended family has been the cornerstone in the provision of care in times of distress especially in times of food insecurity and

illness (Ankrah 1993; Foster 2007). In this study I have argued that the capacity of the extended family network to offer support to its members affected by HIV/AIDS needs to be properly contextualized by considering the antecedents of its setting in order for home based care to be effective in spite of the availability of treatment that prolongs life. The existing structures of families in Maramba were a product of long historical processes of migration with original clan settings which were affected notably by the need for labour and the postcolonial Ujamaa and structural adjustment policies. These processes led to a limited number of family members that could provide support to affected households in times of sickness and death. Some families were only left with siblings after their parents migrated to Maramba. A notable feature of Maramba as a migrant community has been the phenomenon of female headed households. Moreover, I have shown that due to the limited opportunities for gaining income, which itself was caused by historical structural constraints, it was the poor households that suffered the most. Widespread poverty among other villagers further compounded the ability of 'social safety nets' in the community to act as support mechanisms to the poor affected households. Out of desperation some people were forced by these circumstances in the community to emigrate and seek support elsewhere. It remains to be seen if such strategies will be sustainable over time, and this would be established by undertaking further ethnographic research.

In this thesis I have argued that while treatment with ARVs has been able to prolong life, in the long run, the provision of ART alone will become increasingly complex if food insecurity persists and family structures of support are absent. People who depend on their work without other means of support require economic support to sustain their livelihoods especially when the broader social and economic structures that brought about their suffering and poverty remain. For ART programmes to succeed there is an urgent need to combine them with social and economic initiatives that are contextualized and that address the needs of the targeted population to rebuild their livelihoods in the long run.

APPENDICES

APPENDIX 1: Ethics and inequality

My research required me to reflect on the ethics of observing vulnerable people living with HIV under conditions of extreme poverty. The process of selecting participants for such a sensitive project led me to seek rapport with medical personnel, shopkeepers, traditional healers, home based care workers, people living with HIV/AIDS, as well as local officials and people who lived close by to me, before selecting individuals for this study. I made sure to balance my research by participating with a sizeable number of participants within their households and in the village of Maramba, which gave shape to their everyday lives. My engagement with those who were sick compelled me to extend my observations beyond core individuals and to form relationships with people who were closest to them, including family members, neighbours and professional caregivers.

Anthropology rests on the ability of the anthropologist to suspend broad assumptions that might limit the scope of enquiry about diverse human experience. My assumption about Maramba before entering the field was that the state would provide care and support for people living with HIV/AIDS. I thought there would have been a sufficient infrastructure to cope with the pandemic. However, I discovered that I had arrived in a place where people were mostly poor and struggling to meet their daily needs, while living with a chronic and highly stigmatized illness, with little or no support. By living in the community I was able observe in action the struggles associated with care and economic insecurity.

During the conception of my study I carefully considered my role as a researcher. I hoped to extend my research in some way that might improve the health benefits of the people in Maramba. But the extent of the support could not be easily anticipated until I had arrived in the field and started meeting people. While my primary task was to conduct in depth ethnographic fieldwork, I found myself questioning this role in the face of dire and urgent need on the part of my research participants. Indeed, the most complex aspect of my ethnographic experience in Maramba was to address my role which was often construed as that of a sponsor (*mfadhili*), who was there to address social, economic and health predicaments, rather than that of an academic

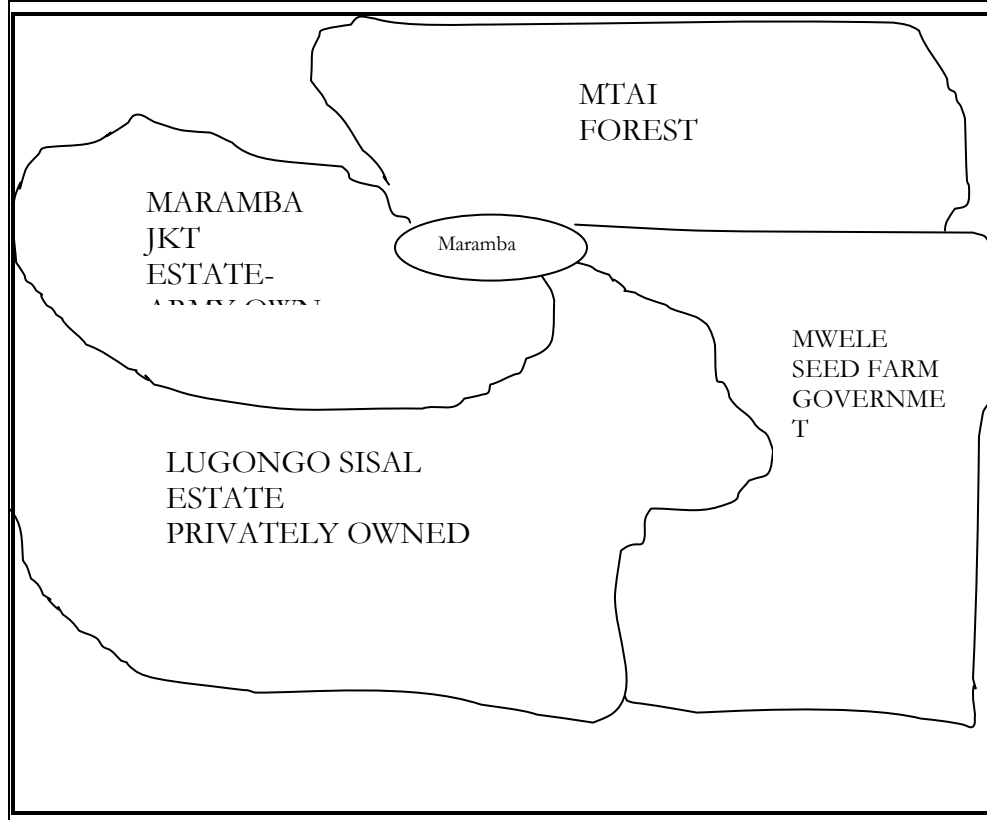
researcher. The fact is that what my participants really needed was someone who could solve their problems, which were in essence socially, morally, but to a larger extent, materially based.

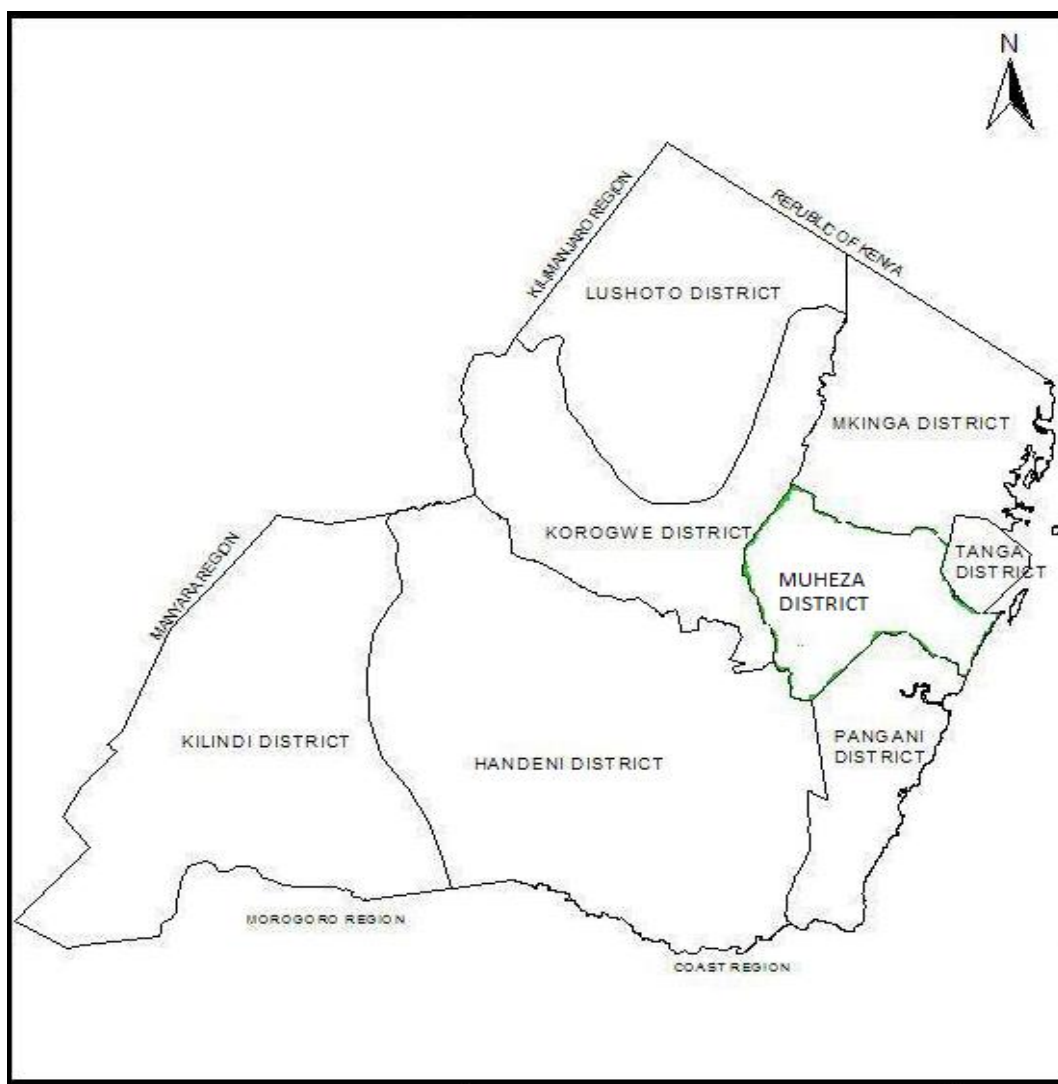
Participants needed money to buy adequate food to support their treatment regimes. They needed fare for transportation when they were referred to hospitals outside Maramba. They needed money to buy medicine when the village health centre did not provide them without cost. People required money to purchase food to feed their family members, and they needed money to take their children to school. Most of my informants would have barely managed these costs even if they were not ill, with illness compounding an already insecure economic situation. What forms of support a graduate student like myself with a limited budget could render, was limited. In the end it was my daily company and empathy that rendered the research both ethical, necessary and with transformative potential.

To limit any harm that could have been caused by unrealistic expectations, I reminded my participants of my academic role and its potential benefits to the general public when such information might be taken up by policy makers. At the same time I extended considerable support, where I could. I only came to understand that they understood my intention towards the end of my fieldwork, as I was about to leave, when my research participants wished me the best for the rest of my studies, and invited me to return to say hello when I finished.

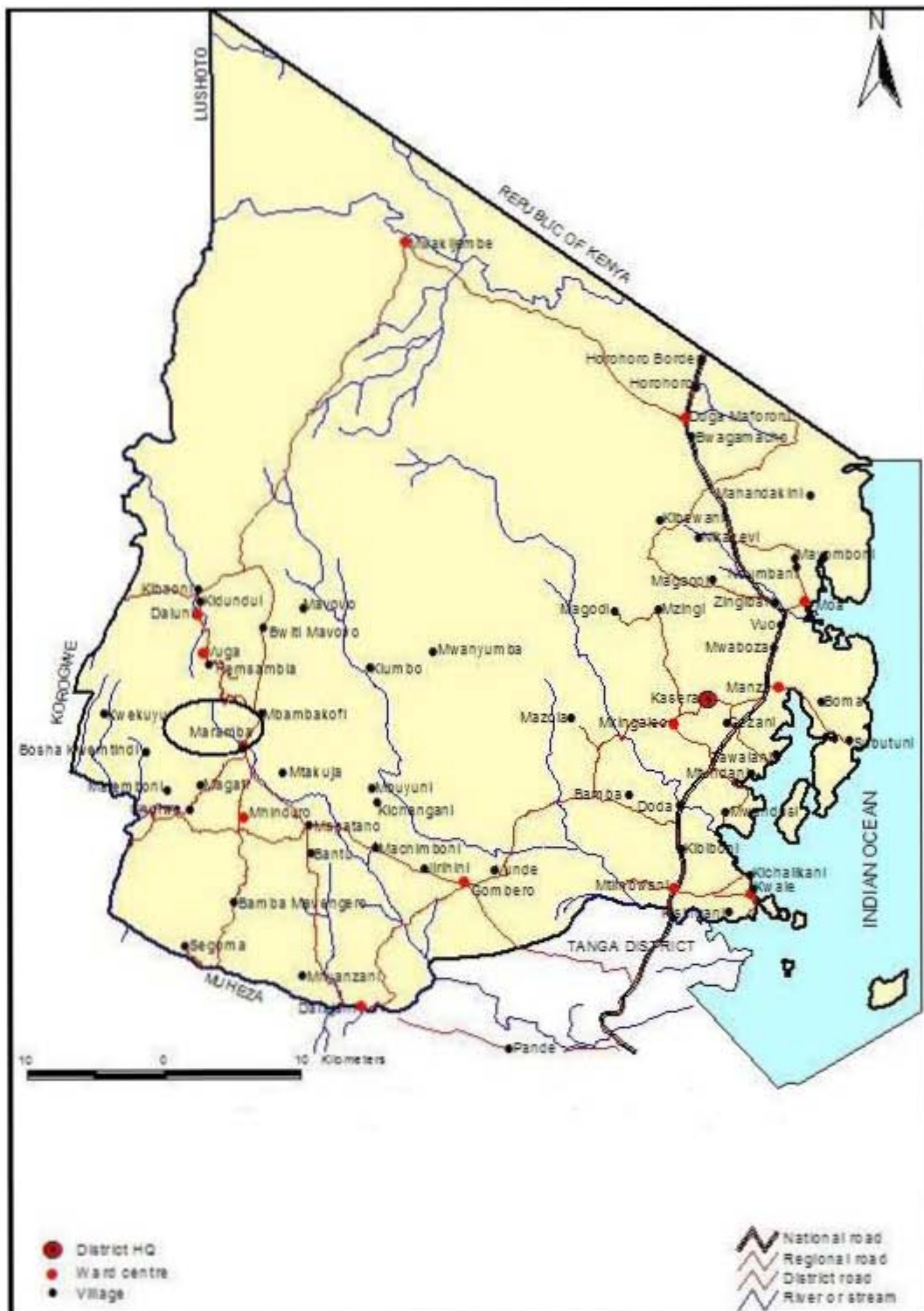
APPENDIX 2: MAPS

A SKETCH OF MARAMBA VILLAGE AND SURROUNDING ESTATES





Tanga Region Map



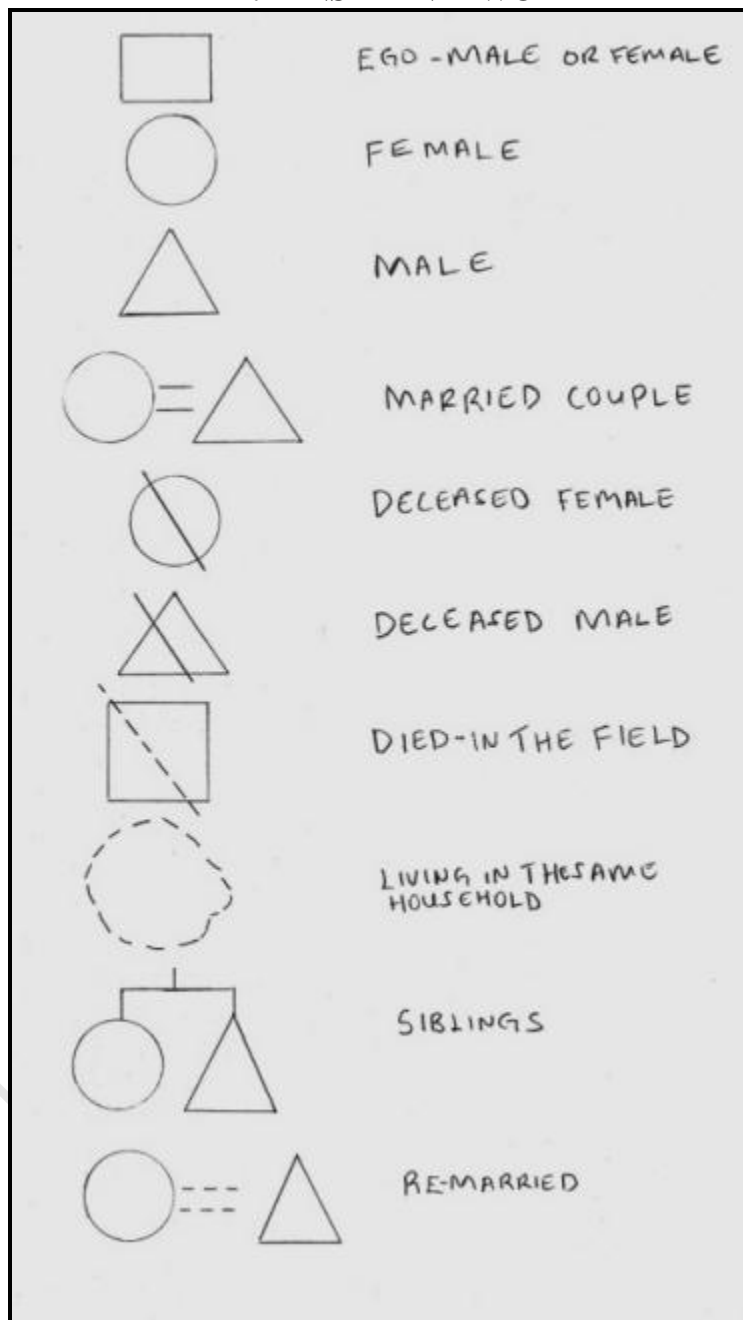
Mkinga District Map



Map of Tanzania showing Tanga region

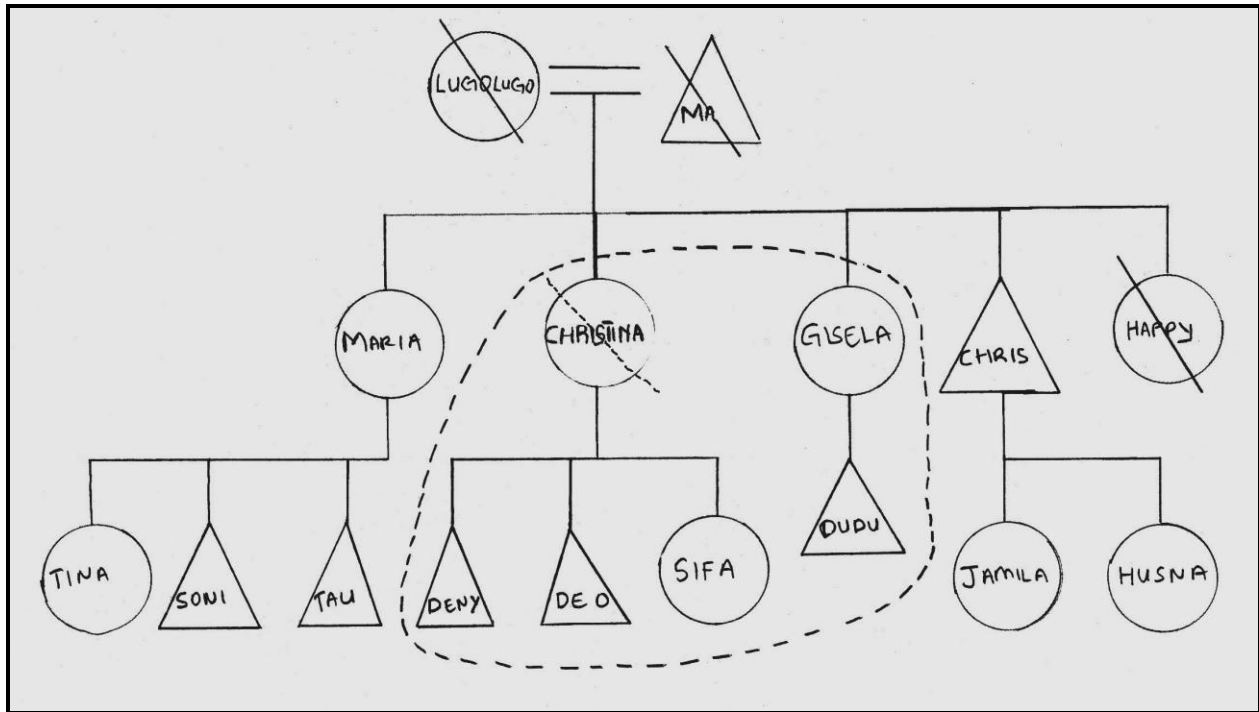
APPENDIX 3: CASE STUDIES

KEY: KINSHIP NETWORK



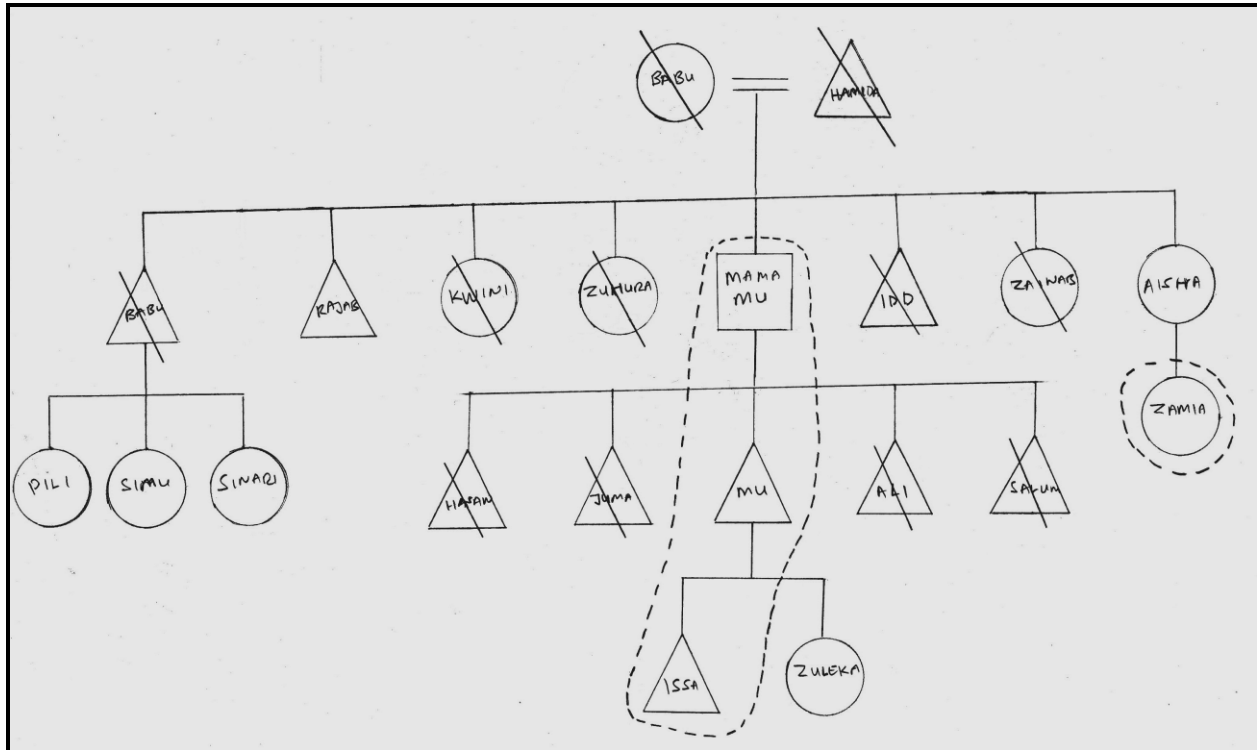
Christina and Gisela Lugolugo's household

Kinship network chart



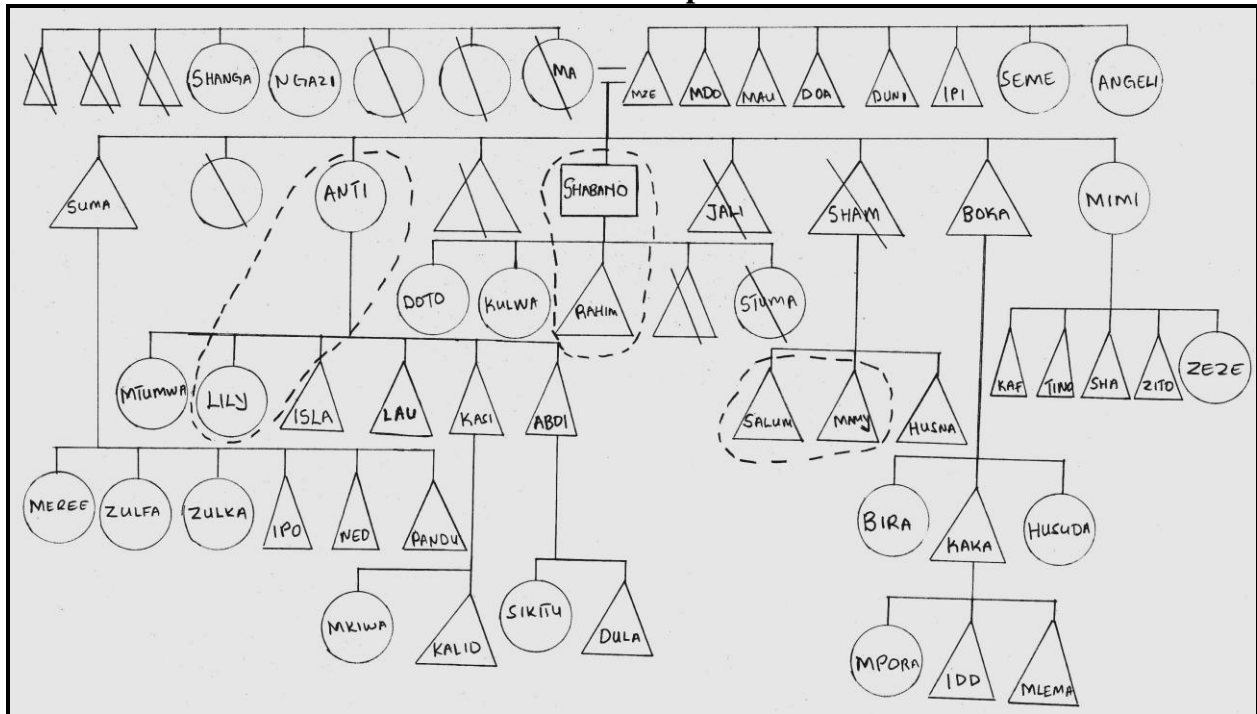
Mama Mu's Household

Mama Mu kinship network chart



Shabano Mstaafu

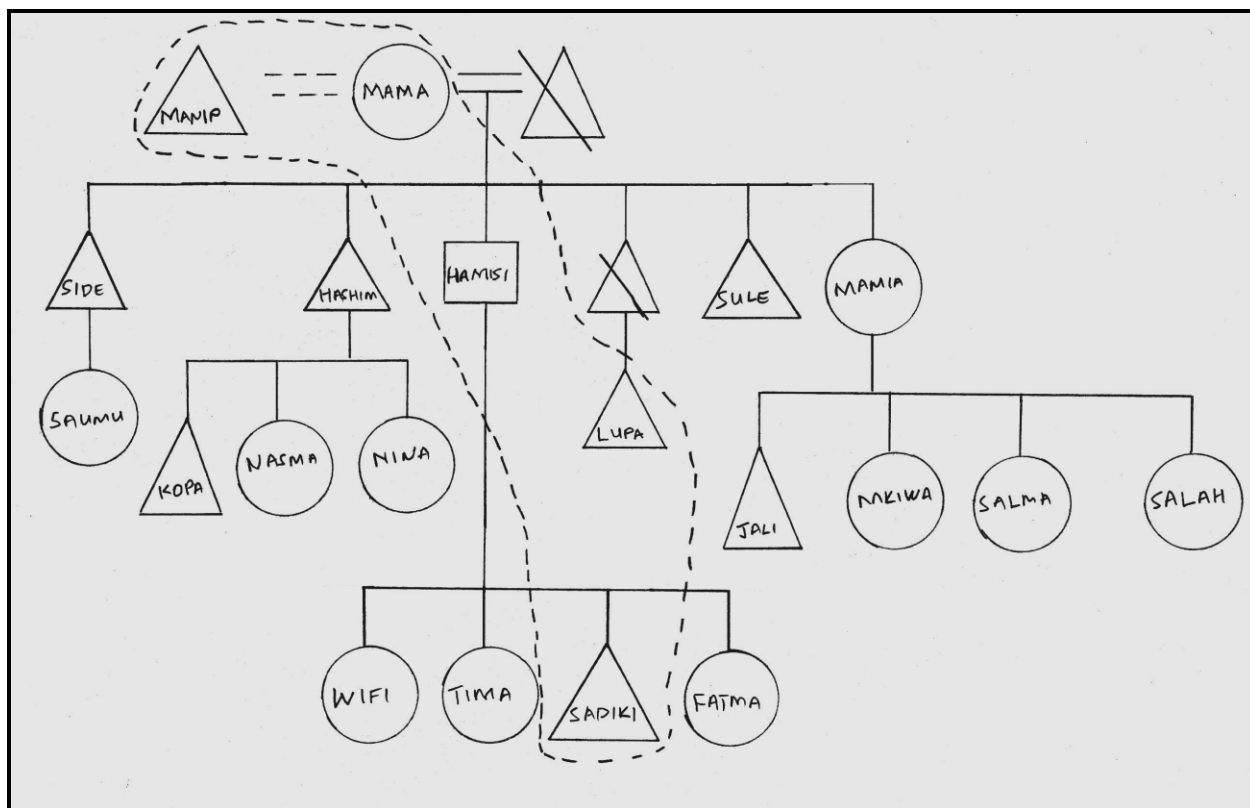
Shabano Mstaafu kinship network chart



Among all the people in my sample, Shabano Mstaafu (50) had the largest network of kin in the community. All the paternal uncles lived in Maramba. Most of them were peasants, although some, Ipi (54), Duni (65), and including his father Mze Mstaafu (87), were employed in the plantation economy before and after independence. Following the economic crisis that hit Tanga in the s70s and 80s, their sources of income collapsed.

Towards the end of my fieldwork he frequently complained about his ability to provide himself with enough food while taking treatment, and at the same time support his family.

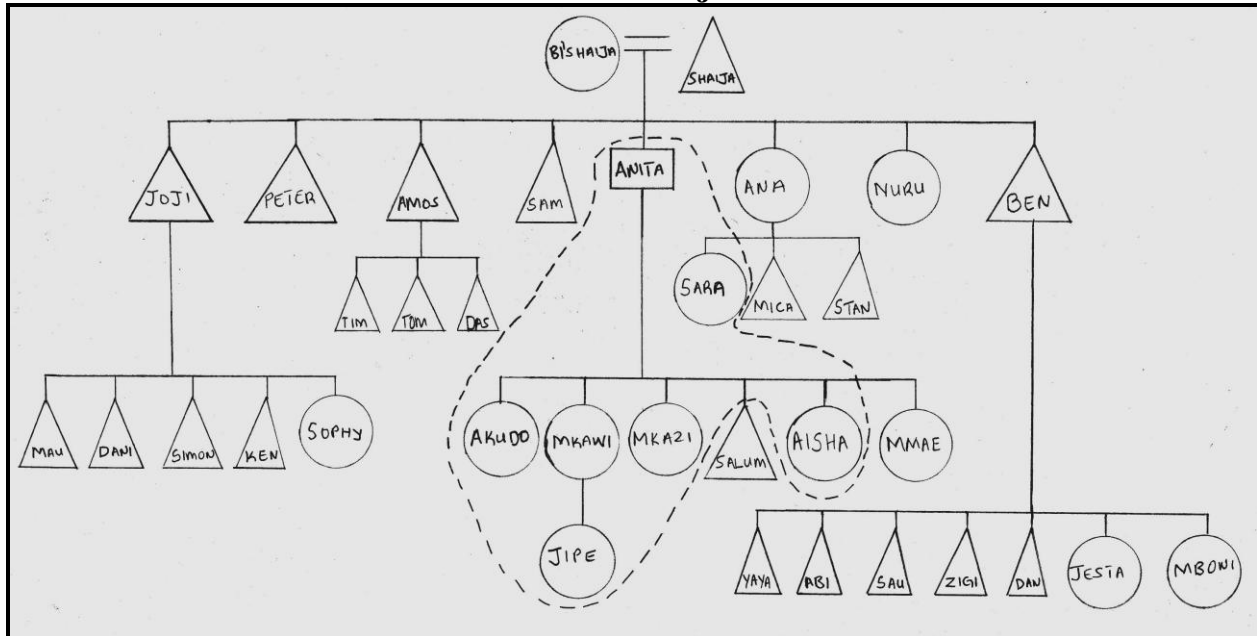
Hamisi Hamidu's Household



Hamisi Hamidu (46) is the son of the late Mr Hamidu of the Al-Habis tribe, who migrated to Tanga in the 40s, from Muscat, Oman. His father was among many people of Arabian descent who came to Tanganyika during the colonial period as traders. Before settling in Maramba, Mr Hamidu opened shops in Mjesani sisal estate and operated several trucks that were hired by the estates to move sisal and other goods. Hamisi and his brothers worked in the shops, and with the trucks. Hamisi fell ill in 2003. He had repeated fevers and tried to self medicate with paracetamol. At the local health facility he was treated for malaria. But he became no better:

I slept inside for three days. My body was so heavy I could not even lift my arm. I was given amoxycillin but it did not help. We were staying with our step father who assisted me to the hospital at Muheza where I was hospitalized for two weeks. After a little while I started getting boils. They were so big and they were everywhere, in my back, my arms and legs. Between 2003 and 2004 I was still getting fevers and I started coughing without stopping. I was found with TB and commenced a TB dose until 2005 when I completed it. I thought I was alright but I was still feeling sick with fevers. I called my mother and asked him what might be wrong with me? We visited a healer but his medicine did not help. Whatever I ate I vomited. My skin started to change and looked like an old man. Even when I went to the toilet my faeces were very strange and very dirty! I told my mother I think this might be it (AIDS). I was taken to Tanga hospital where I was tested positive. I returned home and told my mother that my blood is not good. She cried a lot with tears.

Anita Shaija



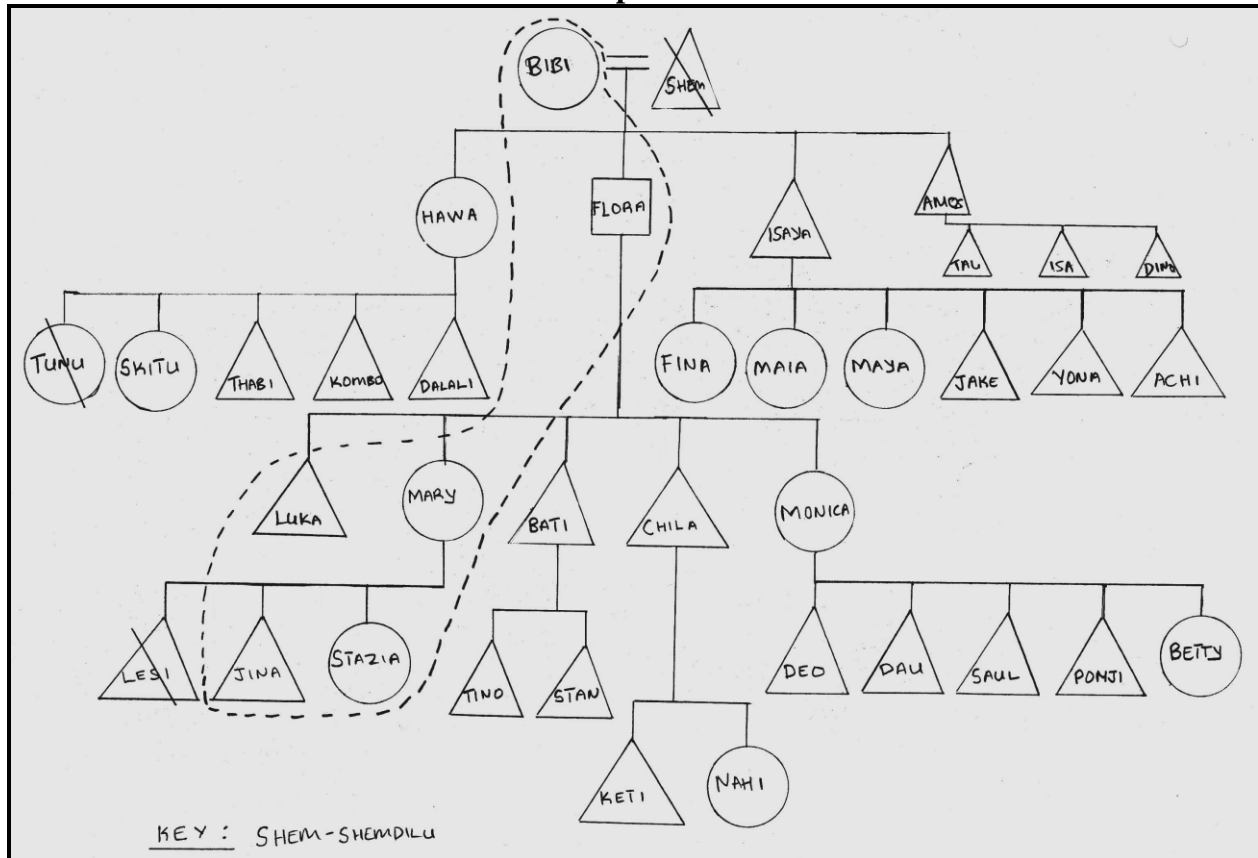
Anita was born in 1965, the seventh in her family. She had her first child before finishing primary school in 1977. She started ART in 2006, weighing only 35kgs with a CD4 count of 77 cells. During my fieldwork, although her CD4 was high, at 722 cells, she was sick intermittently, mostly with malaria. For a time she joined an Anglican church run HBC group where she earned 10,000 shillings (7.7 USD), but the income was short lived following embezzlement by church leaders and the programme's closure in May 2008. Her children helped with cooking and washing, but she was responsible for providing food. She struggled to keep up their acre plot in the JKT. Her partner rarely assisted as he was responsible for children from previous marriages.



Anita and family members

Flora Shemdilu

Flora's kinship network chart



I met Flora Shemdilu (49) in March 2008. She had lived most of her life in Maramba. Flora lived with her mother Bibi, her two children, Mary (32) and Luka (14), together with Mary's two children, Jina (6) and Stazia (2). Flora was one of the few people I was able to observe before and after starting on treatment. She first started feeling ill in 2006. Before falling sick Flora worked most of her life as a small restaurant worker selling food to plantation labourers in the neighbouring Lugongo sisal estate, a job she learned from her mother:

I was employed in a restaurant owned by an Arab in Lugongo. I spent most of my time in the kitchen cooking chapattis, buns and tea, from 5am in the morning. By noon my job was done. I started coughing a lot but I thought it was because of the smoke in the kitchen every day because we used firewood. But it got worse as I could not sleep well at night and had repeated fevers. I had to stop working and slept all day while coughing. I had become small like a stick and could not even move my neck; people were saying I was already finished. Everything I ate I vomited. I was taken to Tanga hospital where I was discovered with TB. I had lost a lot of weight. The doctor there suggested I test for HIV. I accepted. When the doctor came he asked me if I can persevere before telling me the results, I told him to just tell me, if you won't it will not change

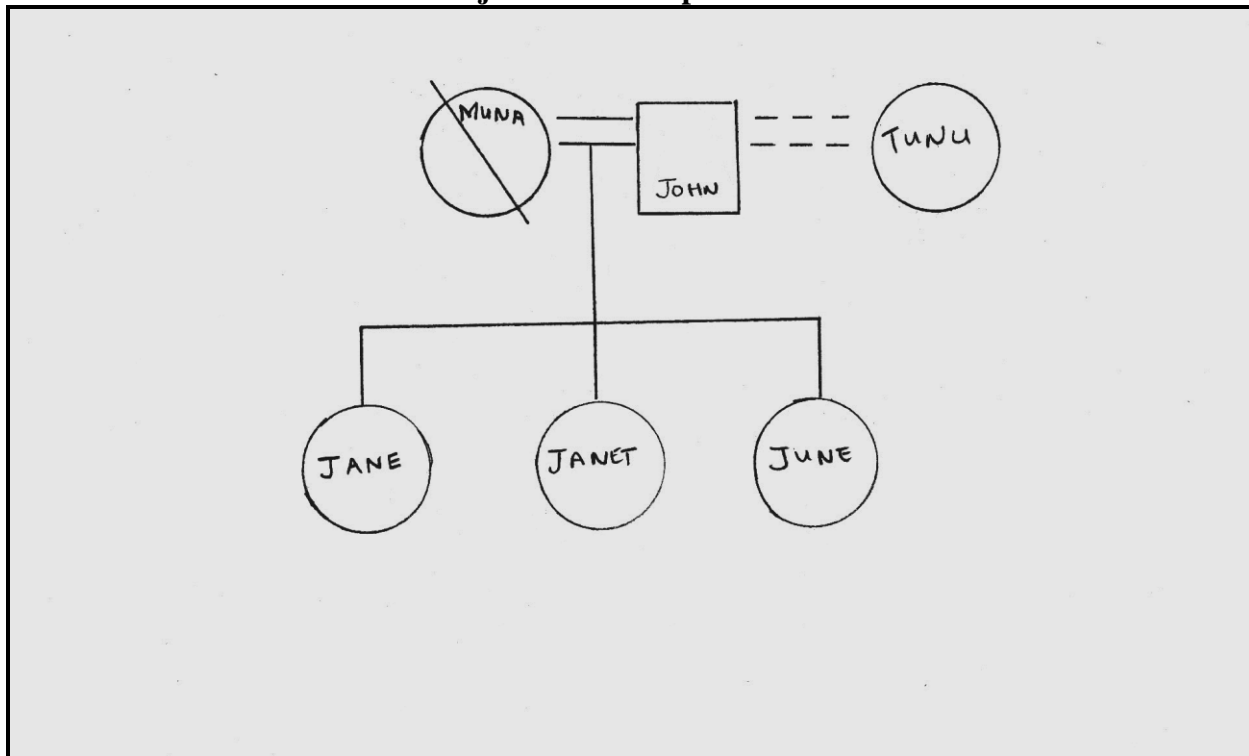
anything. And he told me that nimeathirika (I was positive) I said to myself I am already infected, I cried.



Members of Flora's household making *viungo*

John Majamba

John Majamba's kinship network chart



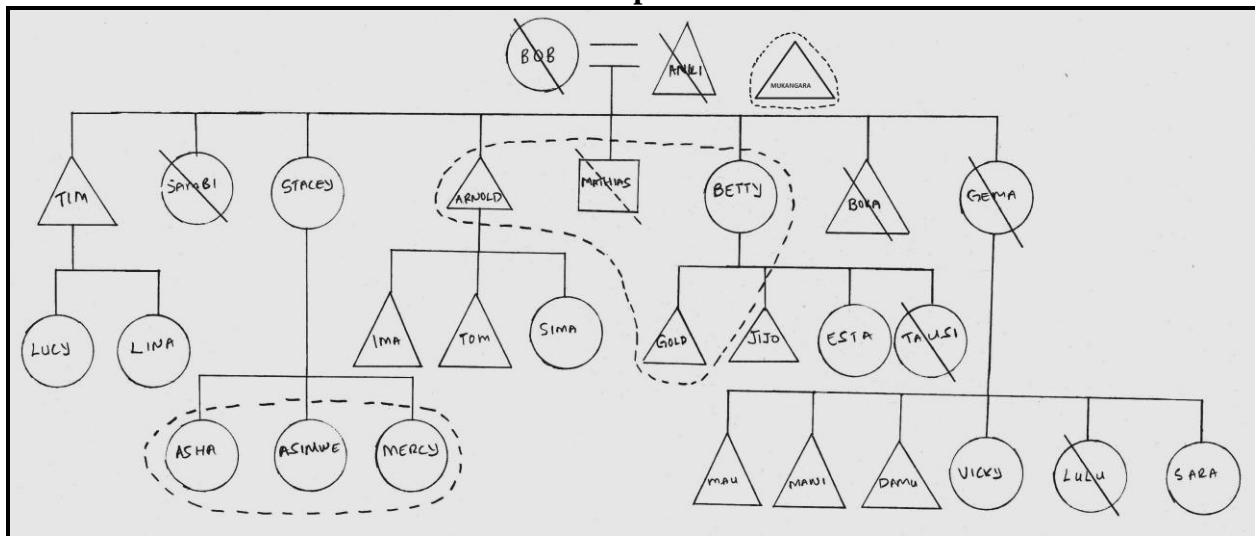
John Majamba (45) retired as a JKT officer in 2004 after he discovered he was HIV positive. He married Tunu (32) in 2006 after his wife Tunu, passed away in 2003 from HIV/AIDS related illnesses. He discovered he was positive when his wife started getting sick back in 2002, although he said he was first in denial:

When she fell sick I wondered what was troubling her. She had already tested but she did not tell me because she believed I will be mad at her. She got TB but the doctors said it was too strong for her. She died even without finishing the dose. When I was in the army our health was regularly checked. The doctor recommended I check my health too. But I already knew I must have been infected and it took me almost six months to go and test. I decided to test in town and I was found positive....I decided that with the disease the army will not be good place for me. I said to myself, why can't I just retire and use my retirement income to build my life positively and bring up my children so that even if I die they will not hangaika (wander)? So I retired... I called my children and told them they should not worry and concentrate on their schooling and not become like me.

He was among the few people who had publicly disclosed their status and decided to live a positive life. Because he had money he started purchasing ARVs long before they became free through the public system. He commuted by bus every week to Muheza hospital, 50 kilometres from Maramba. When the drugs became free and available in the community health facility, it relieved him the burden and could thus focus on his income generating activities.

Mathias Mtunguja

Mathias's kinship network chart

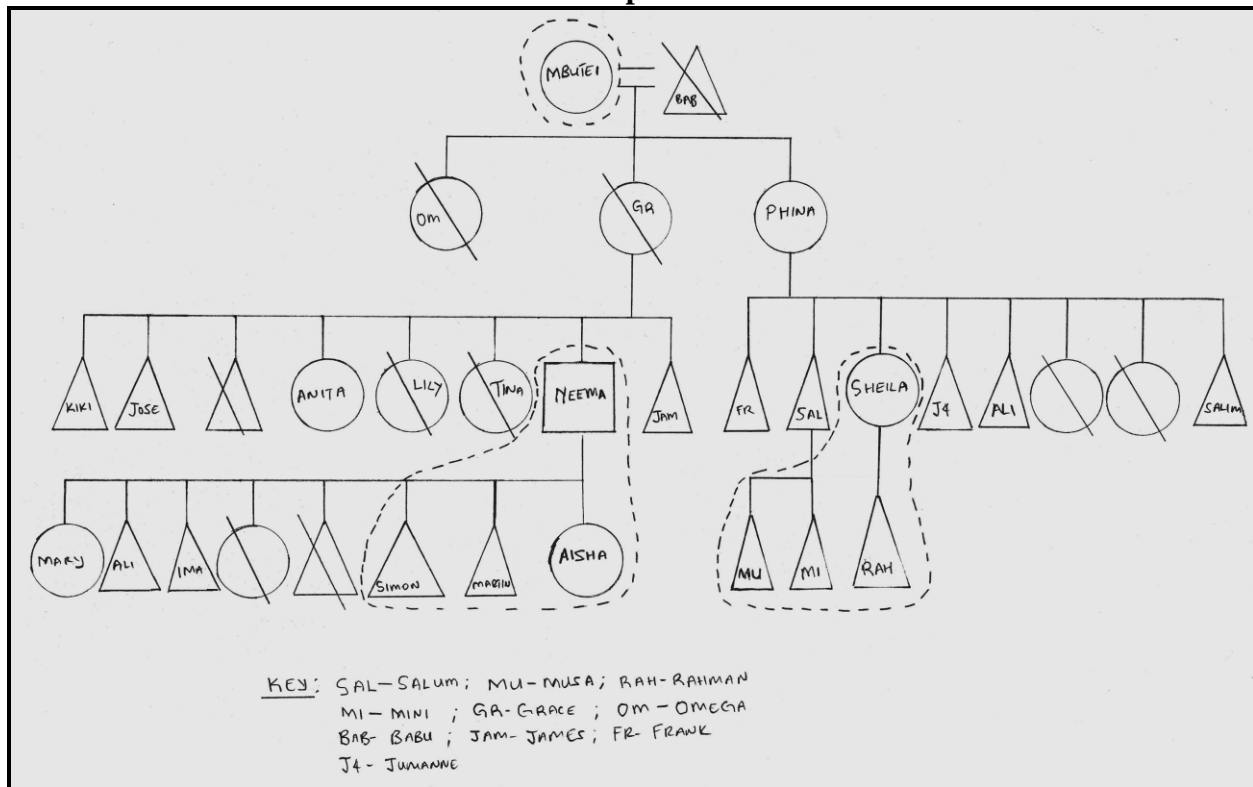


Mathias arrived back in Maramba in 2006. He was working as a farm labourer in a sisal estate. When I first met Mathias he stayed in a one-windowed room that contained kitchen utensils, blocks, old chairs, hay for the cow, old building materials and two ducks. The room was used as a store before his arrival. His condition was painful to watch. Entering his room I was hit by a heavy odour of rotten wounds. But I would later learn Mathias had no wounds on his outer body, they were inside and the smell was coming through his respiratory system when he coughed. There was a five litre plastic container cut in half in which he spat out the heavy pus every time he coughed. The smell was made worse by the heat generated from the ceiling-less corrugated-iron roof. I was told he used to be bigger than me, but now he had protruding cheek bones, his hands were bony, and I could count his ribs from a distance. He probably weighed less than 40 kilos. Nevertheless, he was talkative, though he spoke with great difficulty, intercepted with coughing and spitting pus:

I started feeling bad in March 2005. I was coughing a lot but I ignored it...I did not like the idea of going to the hospital that is why I ended up like this. Going to the hospital cost money, I would need to board a bus and stay there, who would look at me? Our work as a labourer we do not get much. What we get it goes to food mostly, how would I have afforded the drugs and other services? After my situation got bad I had to return to my sister here, although I felt bad because I knew I was coming to burden her. If it was not for my fellow labourers to forcefully advice me to come home I think I would have been dead by now. I did not even have money to come here so I walked slowly in the roads, it took me almost twelve hours to get here...at the hospital they put me on a TB dose which I completed, but my chest is still bad. I was told I needed an operation first before I start ARVs.

Neema Barongo

Neema's kinship network chart



I first met Neema Barongo (38) in December 2007. She appeared healthy and probably weighed almost 70 kilograms. Neema was the second patient I was introduced to by a home based provider named called George Hassan. At first it was difficult for me to imagine that ten people lived in the two roomed house made from mud and sticks, until she elaborated how the sleeping arrangements worked out. She slept on the bed in one room together with her daughter, Aisha (13), who was in standard seven. Simon (12) and Martin (7) slept on the floor on a rugged mattress about 4ft square. They shared this rug with Musa (6). Musa and Mini (5) were children of Sheila's brother, Salum (36), a bus driver working in Dar es Salaam City, whose wife, Tatu (26), was caring for them and living in the same house. The other room accommodated Mbutei (79), Sheila, Rahman (1), Tatu, and Mini (5). Sheila and her toddler, together with Mbutei, slept on the bed and the rest on a makeshift mat placed on the floor. The house did not have a living room neither a dining area. The small five metre square space in front of the house was used for such purposes.

In Neema's business, she travelled mostly between Tanga and Kilimanjaro selling fish while engaging in farming during the rainy seasons. She said it was during the peak of her fish business that she started feeling sick:

I remember it was in 1991 when I started feeling pain in my chest. Whatever load I carried on the head the chest also pained. I self medicated for almost a year. Sometimes I felt better and after a while the pain returned...I did not fall very ill again until sometime in 2001. I had met a man who hailed from Mkomazi, in Kilimanjaro region. We did fish business together, we had a child in 2002 but he died the same year....Himself also died in 2003, I think he died from HIV but with TB because he coughed a lot, and his cough was very dry. I also came to have that kind of cough that is why I know so. He never went to test...I stayed with my in-laws for six months after his death.

My health deteriorated very fast I went to the health facility and they told me I had typhoid. I took a dose for two weeks and the coughing returned. A friend of mine we did business together and whose husband died from this disease asked me if I had tested and I told her I had not. She advised me to do the test and I was found positive. I did not have enough money to feed myself and my in laws did not like me so much so I returned to Maramba in 2004. When Mbutei saw me she cried so much because I had lost so much weight...if you ask people here they will tell you how big I was, probably twice my current size...

APPENDIX 4: PLATES



Graveyards in the middle of houses and footpaths



Copra (coconut trees) planted in village plots by a progressive farmer



Mathias's funeral

APPENDIX 5: BASIC REQUIRED NUTRITION FOR PLHIV

Energy	Body building foods	Protective foods	Extra energy foods
<i>Staples:</i> Mainly carbohydrates and fibre (i.e. sugars, starches), tubers	Protein, minerals and vitamins: legumes and animal products	Minerals, vitamins and fiber	Not in a particular group but providing energy and taste
<i>Cereals:</i> maize, millet, rice, wheat, sorghum, millet, green banana, <i>Tubers and roots:</i> cassava, arrow root, taro, potato, yams, plantains, and sweet potato	<i>Legumes:</i> beans and peas, pigeon peas, cowpeas, nuts, groundnuts, lentils, <i>Animal products:</i> beef, chicken, pork, cheese, eggs, milk and insects	<i>Dark, leafy, green and orange vegetables:</i> Such as sweet potato, cassava and pumpkin leaves, spinach, cabbage, collard greens, carrots, pumpkin and pumpkin flowers, amaranth, okra and other local wild vegetables <i>Fruits:</i> such as guavas, oranges, baobabs, mangos, passion fruit, papayas, bananas, tomatoes, avocados, pawpaws, pineapples, jackfruit and wild fruits.	<i>Oils and fats:</i> such as ghee, butter, sunflower oil and palm oil <i>Sugars:</i> Honey and sugar cane

Source: (FANTA/AED 2004; RCQHC/FANTA 2008)

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