

Grandmothers Called Out of The Challenges for African

BY NJOKI N. WANE AND EDNA KAVUMA

Le syndrome d'immunodéficience humaine a tué plus de 13 millions d'adultes et plus de trois millions d'enfants à ce jour dans le monde. Cet article interroge l'érosion des normes culturelles, les pratiques et les valeurs qui historiquement ont soutenu le tissu social des communautés africaines. Les auteures considèrent aussi le rôle changeant des grands-mères dans la famille africaine alors que les fils et les filles meurent du sida.

Family life has never been under greater stress. (Muganda and Wachira 7B)

Men should act responsibly about their children, especially those whose mothers are HIV positive. They should not abandon their children; they should not leave these women to struggle on their own and especially when they are dying. These cases are on the rise and more campaigns to target this problem are required. (Kavuma July 20, 2000)

Acquired Human Immunodeficiency Syndrome (AIDS) has killed almost 13 million adults and more than three million children worldwide to date (Aspaas; Webb). This disease has robbed many African families of some of their youngest and most talented members and has reached pandemic proportions in sub-Saharan Africa, where it is spread primarily by heterosexual¹ contact. With merciless ease, AIDS has claimed 11.5 million lives throughout Africa in the last decade, a quarter of them children (Webb). Without effective implementation of sustained treatment,

support, and disease prevention policies, African women, particularly grandmothers, will bear the burden of the crippling effects of AIDS, as they will have to provide financial and emotional support for their orphaned grandchildren.

We write this article as African-Canadian women living in Canada but interested in the AIDS crisis in Africa. Wane, an educator and African feminist scholar, interested in issues of indigeneity and development, ponders whether the answer to AIDS could be lying within social norms of both the pre-colonial

and contemporary African societies. Kavuma, a fourth year pre-medical student, would like to work with, and among, African women and search for a cure for AIDS, in addition to searching for ways to halt the rapid spread of HIV.

The article is based on AIDS research supervised by Wane and on journal entries made by Kavuma² during her medical anthropology internship at AIDS clinics in two capital cities—Windhoek, Namibia and Kampala, Uganda. The experiences reflected in the journal entries in Namibia and Uganda provide first-hand information on what is currently happening at the grassroots level. Edna Kavuma visited local AIDS governmental organizations (GO) and non-governmental organizations (NGO) working to combat AIDS and interviewed several employees from the different organizations and clinics. She paid attention to interactions between clients and care providers, to client's reactions, and to the services available for HIV/AIDS patients. She also recorded the ways in which women in Uganda are creating awareness about AIDS through dramatization and networking. These entries make women's work on AIDS visible. This article concludes by posing the question: how can local communities and African governments, in conjunction with the international community, including Canada, develop strategies that are culturally and socially appropriate for dealing with AIDS in Africa?

This article interrogates the erosion of cultural norms, practices, and values that historically sustained the social fabric of African communities, and it considers the changing role of grandmothers in the African family as sons and daughters succumb to AIDS. However, it is important to point out from the outset that we do not wish to romanticize the situation in Africa and do acknowledge that pre-colonial societies were characterized by various forms of violence. As a result, the discussion on AIDS needs to be interrogated both from a historical and contemporary context as Amina Mama eloquently states:

It is my view that the prevalence of so many pernicious forms of gendered violence demands both historical and contemporary analysis. By deepening our understanding of violence against women during the epoch of imperialism, we will be better able to comprehend and so to counteract the multiple forms of violence meted out against women in postcolonial African states today. Imperialism is the major trope

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Retirement

Women Facing AIDS Today

of this analysis because it is the common historical force that makes it possible to consider an area as large and diverse as the African continent as having general features that transcend the boundaries of nation, culture and geography. (47)

Mama captures the essence of many African feminists who are interrogating and reconceptualizing issues of violence by the situating the discussion in a historical and social context. Mama goes on to show that the link between gendered violence in pre-colonial Africa, the brutalization, degradation, and domestication of African women through colonialism and neo-colonial African nationalist regimes, has continued the trajectories of contempt and disempowerment of women of their colonial white masters. She is emphatic that we should not lose sight of the fact that Africa as a collective:

[B]eing conquered by the colonizing powers; being culturally and materially subjected to a nineteenth-century European racial hierarchy and its gender politics; being indoctrinated into all-male European administrative systems, and the insidious paternalism of the new religious and educational systems ... has persistently affected all aspects of social, cultural, political, and economic life in postcolonial African states. (47)

When we therefore conceptualize violence that African women have gone through during this era of AIDS, it is important to pay attention to the historical as well as the contemporary underpinnings of violence. Many times when we think of the word "violent" or "violence," the image of cars and buildings being blown up, or one person hurting another, comes to mind. These images fall within the very static and rigid definition offered by *Webster's Encyclopedic Dictionary* where violence is defined as "a use of physical force so as to damage or injure" (1099). This definition does not encompass the way in which violence extends beyond mere physical force. Such a definition does not allow the psyche-violence that traditional, colonial social structures or institutions may have perpetrated on an individual's emotional, spiritual, and psychological well being to be taken seriously. However, it is beyond the scope of this article to rupture the "institutions" of violence in Africa. The focus of our article is to examine the

challenges that African women are facing in this era of AIDS.

We situate our discussion in an anti-colonial feminist discursive framework in order to theorize how colonialism destroyed African cultural norms by introducing an educational system that was not supportive of indigenous education. This anti-colonial feminist discursive framework enables us to explore the challenges and ways of resistance of indigenous people and in this particular instance, of African women. It is an interrogation of the configurations of power embedded in knowledge production (Dei).

Anti-coloniality is a social theory that interrogates power relations inherent in the interrelations of subordinate, colonized groups/societies to dominant, colonialist societies or cultures. It is the writing and speaking about the experiences of slavery, migration, suppression colonialism, neo-colonialism, and resistance (Dei; Ashcroft, Griffiths and Tiffin). This framework in particular challenges the institutional powers and imperial structures that have prevented many African government from realizing the importance of dismantling colonial structures left behind by colonizers after the attainment of political independence, and it evokes alternative paradigms of education, development, or social growth. The frameworks, referred to as the rewriting of history and the negating of images, have created "alternative paradigms" and theories that continue to depict indigenous knowledges and skills as unsuitable for formal discourses. A feminist analysis provides the lens from which we can examine the discourse of traditional norms from a woman's standpoint and, at the same time, acknowledge the flaw embedded in feminism theorizing (Lazreg).

Post-colonial and anti-colonial theorists urge Africans to end the crisis by providing an education to her people by revamping their economies and getting rid of their corrupt political leaders. It is therefore our anticipation that once the various crises (political, social, economic,) are arrested, the battle against AIDS will be half won. In addition, we

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need to keep in mind that African's women's oppressive conditions are complex and multifaceted. Molaria Ogundipe-Leslie refers to this complexity the "sixth mountain" on an African woman's back.

But what is the specific condition of the women in Africa? ... One might say that the African women has six mountains on her back: one is oppression from outside (colonialism and neo-colonialism), the second is from traditional structures, feudal, slave-based, communal etc., the third is her backwardness (neo-colonialism); the fourth is man; the fifth is her color, her race; and the sixth is herself. (28)

The six mountains signify 500 years of assault, battery, and mastery of various kinds dating back to the fourteenth century with the arrival of Vasco da Gama. This is compounded by structures and attitudes inherited from indigenous history and sociological realities. The traditional past is, for the most part, evident in the physical control of a woman's body and its products. For example, this is specifically true in relation to the practice of genital mutilation. This practice has no place in today's society and wherever it is practiced, it should be stopped (Ogundipe-Leslie). It is dangerous not only because a girl can bleed to death, but because the use unsterilized surgical instruments can also result in the spread of HIV.

African³ Family Households Threatened

For the African family, the steady replacement of extended family networks by a nuclear family, the emergence of female-headed households, and families headed by children as a result of the impact of HIV/AIDS, present challenges that were unimaginable barely two decades ago. The traditional African wisdom that a child belongs to the community is under threat. Why is the African family system being threatened?

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For most people, it is usually through the family that children acquire cultural values and norms. In the past, African children were taught social, economic, and political roles as well as their individual rights and social obligations. Traditional methods of instruction were oral narratives, including myths, fables, legends, riddles, lullabies, and proverbs. Mothers, in fact, used lullabies as a means of instruction. According to Kenyatta, the whole history and tradition of the family and clan were embodied in these lullabies; by singing them daily, the children could assimilate this early teaching without strain.

Various rites of passage were the final "institutions" of learning. In Kenya, for example, the piercing of the ears for both boys and girls marked the passage from childhood to adolescence. Before this, boys and girls were under their mother's care. After the ritual of ear piercing, the boys were placed under the guidance of their fathers, while the girls were left with their mothers to learn through role-playing, imitation, and observation. The family set-up with its traditional teachings and rites of passage prevented promiscuity and premarital sex. Men and women were made aware of the dangers of premarital and extramarital sex. For special types of education, such as sex education, children, now considered young adults, were taken away and provided with intensive instruction on morals, appropriate sexual behaviour, sexual taboos, and so on. Sex education is no longer a private affair as indicated by Kavuma's journal entries after her visit to Sexually Transmitted Diseases (STD) Clinic in Matatu⁴ hospital where she had an interview with Dr. Maria.

Visited the STD clinic in the Matatu Hospital. The entrance to the clinic is through the emergency ward waiting area. From where I was seated, it was quite clear that few people felt comfortable going through the entrance to the AIDS clinic because each client who enters the clinic had to be scrutinized and interrogated. This location may keep many patients away. Dr. Maria is the only physician who visits the clinic once a week from 9:00am to 1:00p.m. According to her: "I cannot afford to spend more time here because I have other hospital responsibilities." I noted that Dr. Maria is about seven months pregnant and seemed to zip through patient examinations very fast... I noted that she did not bother to ask her clients' permission for me to be in the examination room. She had a translator because she did not speak the local dialects fluently. (July 18, 2000)

During the pre-colonial period, a person who had a sexually transmitted disease would not have been subjected to kind of diagnosis and treatment that is being provided today. Counseling and treatment would have been provided by a herbalist and within the confines of their homes. In our contemporary times, we do not have community set-up to deal with sensitive issues such as sexually transmitted diseases. And as Kavuma notes in her journal, the public location of the clinic may prevent many would-be clients from seeking help. Furthermore, the person designated to advise or treat those who are sick is not from the community. Often, she/he cannot communicate in their language but has to go through a translator. This dilemma is not specific to one location, but is found in many of the clinics in Namibia.

When Kavuma visited the Ministry of Health and the Social Sciences Blood Donor Clinic, she met with Ms Baraza, the HIV Counselor/Psychotherapist responsible

for counseling blood donor who have tested HIV positive. Ms Baraza confirmed the insensitivity of the counseling model she was using when she said:

I find that the western counseling method is very different from the Namibian style. There is a need for culturally sensitive counseling model ... but I guess there is no one to counsel these people. I have to use the method I know and that is the western model. (July 20, 2000)

Kavuma's journal entries indirectly highlight the erosion of the social fabric that used to be in place to deal with sensitive issues of the community. Is it because there is no one to counsel these people, or that the cultural resources have been depleted because of the adaptation of socio-economic and political models that cannot sustain African societies?

The introduction of colonial/missionary education in Africa marked the beginning of the erosion of African values and norms. The imposed education served to segregate and promote division between genders. Boys were provided with vocational education that prepared them to work as blue-collar workers. Girls were given education that would enable them to be "good" wives. They were taught domestic science or basic hygiene. The children were taken away from their homes and placed in either boarding schools or day schools (Nathani; Wane). This was completely contrary to the indigenous methods of education in which education is a simultaneous process of learning to deal with everything in life. We do not want to romanticize the indigenous African education, but faced with a crisis such as AIDS, it is important to look at the mistakes that have been made and search for answers in pre-colonial, colonial, and neo-colonial eras.

Needless to say, African cultures and societies would have evolved even if there had been no colonization. However, the changes brought about by colonizers disrupted the traditional functioning of many African societies and made it much easier for people to engage in behaviour that would have been unthinkable in traditional African societies. Individuals exposed to western education, with its emphasis on individualism and freedom of expression, for example, are much more open to premarital or extramarital sex.

Today, the traditional African family has been fragmented under the pressure of social and economic transformation brought on by urbanization and by a shift away from subsistence agriculture. As a result, many rural families are currently headed by females as husbands migrate to the cities in search of jobs, a trend that started with the coming of the colonizer. The result is that spouses live away from each other. Consequently, the AIDS epidemic is never far from a rural woman who has never left her home village. AIDS, contracted by the a man while separated from his wife, creeps into her life during her husband's occasional visits. The disease becomes the

uninvited silent guest who gradually takes control of a woman's ability to provide for her family. The outcome is that the economically active men and women are taken away from their families by the long arm of death, generating a merciless increase in the number of orphans, widows, and widowers.

The Causes of the Rapid Spread of HIV/AIDS

A number of reasons have been advanced to explain the rapid spread of HIV/AIDS in Africa: denial, sexual taboo, shame, ignorance, and insufficient government effort to come to terms with the disease and its devastating results. However, we strongly believe that the breakdown of traditional structures through colonial education paved the way for the spread of AIDS. The issue of the erosion of cultures in relation to AIDS has not been taken up, and we firmly believe some research in this area is long overdue. For instance, with the breakdown of many traditional structures, there are no avenues to dialogue or vent the frustration that is caused by HIV and subsequent deaths through AIDS. Many African communities continue to deny the existence of the disease, primarily because it is a disease associated with intimacy. It is not in the African culture to discuss issues of sex openly. In addition, people deny its existence and dangers because the name AIDS means shame—a curse has befallen a family or a community (Rivers). No one wants to be identified with an inexplicable occurrence or a curse. In traditional African settings, communities had ways of getting rid of a curse through ritual cleansing (Arewa). As a consequence of cultural erosion, this social infrastructure is no longer in existence. In many communities, people suspected to be carriers of HIV/AIDS are socially ostracized and geographically isolated.

During the traditional rites of passage mentioned earlier, young women and men were provided with sex education. However, since the collapse of traditional educational institutions, very little has been done to introduce other ways of teaching young unmarried adults about the dangers of engaging in any form of sexual contact. Children leave their homes without any preparation at all. The end result is teen pregnancies and/or exposure to all kinds of sexually transmitted diseases.

Early research on AIDS in Africa considered the context in bio-anthropological terms, seeking out deviance within African sexuality to provide a quick and simple explanation for the heterosexual spread of the disease on the continent. The dangers inherent in this armchair

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anthropology, with its racist undertones, have been well documented. For instance, the reports of AIDS cases in Zaire were worded in ways that reinforced cultural and gender stereotypes of assumed black, female sexual immorality (Webb). Many western researchers on AIDS in Africa sought to overlook the cultural vacuums in pursuit of the universal, and in doing so created an increasingly disputed narration of the real. Many theories are still being put forward regarding the influence of culture-specific sexual practices and various traditional activities which might increase the incidence of HIV transmission (Webb).

The spread of HIV in Africa varies from region to region. The variation in rates of HIV infection reflect socio-economic and cultural differences. Differences in behaviour, prevalence of sexually transmitted infections, levels of malnutrition, access to health care, and viral subtypes may explain this variation. The phenomena of migrant workers and the development of road networks, for example, have been analyzed for their role in spreading HIV. Most males migrate to plantations, mines, or cities and travel along transportation routes in search of work. For instance, for countries such as Uganda, Namibia, Kenya the spread of AIDS was linked to the highway transport system. The behavioral pattern combined with the transport access acted as a conduit for AIDS—men, who were truckers and drivers, engaged in illicit and unprotected sex with commercial sex workers along the way (Aspaas). As a result, instead of remaining localized, HIV spread with the traveling men (Obbo cited in Aspaas). It should be noted however that, the spread of HIV in Africa is not due to loose morals. As highlighted earlier, HIV may be spread through sharing of needles or through mother-child-transmission. It is interesting to note that in some cases clients who visited the clinics were not sure how they had contracted the disease. When Kavuma met with the staff from one of the clinics in Uganda, they felt that it was necessary to be open about the disease and to be aware that they, too, can be vulnerable. This is vividly captured in Kavuma's journal:

When I met with the Center Director, volunteers in the reception, lab technicians, and counselors. I remember asking them why AIDS was such a problem. The lab technician said: "people need to change their behaviour and they need to get away from the mentality that "it won't happen to me." When asked whether it would help if women insisted on condoms, he commented: "it is a difficult concept to initiate in Uganda, because of cultural norms and beliefs. It is also important for people to know that handling a person who is HIV positive when they have an open wound could lead to contracting of AIDS—I do not know whether many people know of this. I think it is better to have AIDS prevention campaigns targeting men since they have a dominant role in a society. The campaign should stress the use of condoms by

men as part of the solution to the problem. (August 4, 2000)

In most African societies, many African women are dependent on their male counterparts for economic stability (despite the fact that women do all the farm work). These women hesitate to suggest condom use for fear of jeopardizing male support (Mtuleni). Webb noted,

Within marriages or semi-permanent relationships, initiating the use of condoms may be extremely difficult. Many females ... state[d] that if they requested their partner to use a condom, they would implicitly be accusing the men of infidelity, or admitting it themselves. This barrier regarding trust prevents the topic being discussed openly, even though many women tacitly accept the likelihood of their (often absent) partners having other sexual partners. (154)

Africans cannot go back to where they were before colonialism. However, an assessment of the disintegration of social structures and the need for new governance made up of culturally-appropriate guidelines would provide new directions. Africans need to sit back and take stock of what has happened, not to lay blame on the colonizer but to establish new ground rules for regulating their societies. These ground rules could be established by borrowing from African traditions and what currently constitutes an African culture, which is a combination of many cultures.

A Critical Reflective Analysis

African people are educating themselves and their communities. Although there are differences in dealing with the AIDS epidemic in Namibia and Uganda, it is clear that the communities have been mobilized. As noted on July 20, 2000 by Kavuma in her journal:

When I asked Mr. Kwataniro an official from the NGO Living with AIDS about the strategies for AIDS prevention, he said: "The center has initiated AIDS awareness programs in Namibia by targeting the gatekeepers of the community. These are mainly the chiefs, religious leaders or elders who are well respected. Without the 'blessing' of these key community leaders it would be difficulties for people to listen to us. This is because locals look up to the elders and may not trust outsiders." Mr. Kwataniro informed me that he speaks on radio shows about AIDS issues and holds debates on the radio throughout the week. He also informed me that he organized workshops on the following topics: 1) Sex in the Light: This addressed the issue of sexual activity in darkness. Kwataniro noted that this leaves women at a disadvantage since they cannot tell whether or not their

partner is wearing a condom. Kwataniro felt that this empowers women and encourages foreplay so that a woman can take part in administering the condom and give her a chance at negotiating condom use... 2) Home-based workshops: Kwataniro explained: "These workshops train volunteers and community health workers to assist AIDS patients in their homes. Most of the trainees are family members of the patients and this works well to de-stigmatize AIDS patients in their home environment." 3) Counseling services: According to Kwataniro, these services work closely with the Matatu Hospital STD Clinic to advise and provide emotional support for AIDS clients.

However, Uganda seems to be more successful in preventing the spread of AIDS, and most of the credit goes to Ugandan women. They have organized informal groups to deal with the issue, and receive support for their efforts from both the NGOs and the government. Persons with AIDS (PWA), especially women, travel throughout the country performing dramatizations and engaging in activities for people with AIDS. Women talk to each other and, when they get a chance, listen to radio advertisements in order to educate themselves. Women's support groups frequently visit Ugandan communities to talk about AIDS and mother-to-child transmission. When Kavuma met with the officials from Wamwoyo Hospital on August 10, 2000, she noted:

Dr. Damaris explained: "Society for AIDS Care (SAC) works on advocacy, capacity building, training and networking with women throughout Africa. SAC works closely with UNICEF, WHO, UNFPA, UNAIDS, Uganda Child Rights, Uganda AIDS Commission, and various other NGOs that deal with AIDS issues in Uganda. The chapter in Uganda has over 600 members in total. Uganda was able to break the silence on AIDS. President Yoweri Museveni and his wife have been committed to reducing the spread of AIDS in Uganda. ...NGOs work specifically to prioritize the needs of AIDS orphans and work closely with family or guardians to ensure that there are sufficient funds, food and clothing for the children.

Kavuma noted that this is lacking in Namibia. The Namibian government implemented an AIDS policy in 1999, despite their public commitment to do so since the early 1990s. President Sam Nujoma launched (or announced) the policy. In Namibia, however, there is a lack of effective integration between the NGOs, local communities, and government because of insufficient resources.

In contrast, Uganda's government has been consistent in its response to the epidemic since 1982, when the first AIDS case was reported, by promoting public awareness and instituting preventative programs. During the same period, Uganda introduced a multi-sectorial approach to



Rochelle Rubinstein, "Multiply," Linocut on Photograph, 6" x 4." 2001

the concept of AIDS. There is also evidence of cooperation and collaboration between the NGOs, local communities, and the government in implementing AIDS-prevention programs as noted by Kavuma in a journal entry dated August 15, 2000 recording her meeting with the officials from Wamwoyo Hospital in Uganda.

Counseling Session: All persons who visit the center for an HIV test are provided group and individual counseling. In the group session there was a lot of stress on ABCD [A-Abstinence, B-Be faithful, C-Condom Use, D-Death] of HIV. During individual sessions clients confirmed they had an HIV test before, but wanted to check their HIV status. Two of the women had been tested before and had been positive. One of the women had lost her husband through AIDS. The two male clients had been tested in the past three to five years and had tested negative. Of the two males, one had a wife who was eight months pregnant. All of the women, although they had one steady spouse, had abstained from sexual behavior for the last two years. After this individual session, each client was sent to the lab for the blood test.

Group discussion: While waiting for the test results the counselor spoke to the clients in groups again about the methods of preventing HIV/AIDS transmission. She elaborated on abstinence and demonstrated condom use by both men and women. However, the women in the group seemed very reluctant to use it and said it looked too big and too complicated. The counselor offered the male condoms to all who thought they needed it but did not offer the female condom.

Intermission: While the clients waited for their results, it was interesting to listen to their conversations and observe their reactions. Most of them talked about the importance of knowing their HIV status. One client mentioned that she would like to know how to be healthy and lead a good life even if she is HIV positive. Another said she would like to be able to prepare for the future of her children and relatives. None of the clients spoke of the fear of stigmatization or isolation.

Individual Session: Out of the six clients, three were positive. All three became members of the Post-Test Club (PTC) which is a support group for people living with AIDS. When the counselor offered them male condoms all of them declined saying they did not need them since they planned to abstain from sex. One man who had indicated that his wife was eight months pregnant said that he did not intend to inform her until delivery of their unborn child.

From these entries, it is quite clear that the Ugandan government is trying to deal with issue by providing educational sessions as well as facilities for HIV tests. In addition the NGOs have also taken an active role in trying to compact the spread of HIV and to provide support for people with AIDS as noted by Kavuma on August 15, 2000:

The Aids Support Organization (ASO) was initiated in 1986 to form a support organization for people with AIDS. It has seven centres and provides pre/post-test counseling, home-based care, food provisions, social and educational support for AIDS patients. It takes care of over 12,000 orphans and can afford to pay school fees for only 300. ASO also implements income generation opportunities for people with AIDS and their families. ASO trains community volunteers to go out in villages and rural areas to sensitize the public about AIDS issues.

Without parental guidance and with the inability to maintain basic life skills at a young age, the girl child becomes extremely vulnerable to exploitative forces.

It is however, important to note that each of these two governments

had recognized the need to deal with AIDS issues and that it was imperative for them to acknowledge that AIDS would affect every segment of society if people were not mobilized through collective efforts. Of late, both governments have established review teams in order to evaluate the outcomes of their efforts and action for the greater benefits of the community. It is evident that there is a great need for NGOs and the communities to work collaboratively in both countries. However, the involvement of NGOs, government, and local communities in these two countries differs tremendously.

While both countries provide medical and counseling services, they still continue to struggle because of lack of resources. This has prevented both Namibia and Uganda from being at the cutting edge of medical advancements and being able to provide proper treatments for their AIDS patients. For instance, in Namibia clinical services are very strained, as demonstrated by Dr. Maria who has to work late into her pregnancy. Uganda's situation is better, as is evident in the services available for AIDS patients throughout the towns.

Mother-to-Child Transmission

Mother-to-child transmission of the AIDS virus has contributed to over 90 per cent of HIV infection in children (Hofnie, Haihambo, and Nuembo) and represents the second most common mode of infection. Transmission of the disease can take place in three ways: via the placenta, during passage down the birth canal, or through breastfeeding (Msellati *et al.*; Giaquinto). Lack of knowledge about AIDS and its transmission has become a growing concern, as most mothers are not aware of the risks or of preventative or treatment opportunities.

It is projected that 42 million children will be orphaned by the year 2010 (Muganda and Wachira). Robinah Babirye of World Vision Uganda, argues that 12.1 million orphans of sub-Saharan Africa have been forced to grow up too soon. Without parental love and guidance and with the inability to maintain basic life skills at a young age, the girl child becomes extremely vulnerable to exploitative forces. In her efforts to survive, she is susceptible to prostitution, the "sugar daddy syndrome," or early marriage. And if she has AIDS, she is faced with discrimination in foster homes, where she is treated as an outsider.

Redefining the Role of the Extended Family

The AIDS epidemic is forcing a redefinition of the role of the extended family, particularly that of grandmothers. In the past, their role was holistic in nature; they occupied a very central place in the life of a child. They did not have to work to support their grandchildren. With the outbreak of AIDS, this role has been changed to that of sole supporters of orphaned grandchildren. Family-support networks have become depleted with the loss of adult

working family members. For instance, Muthoni, a 60-year-old woman, felt that she did not have the strength or the energy to struggle to support her grandchildren. She loved these children, and she had performed her role as teacher of the traditions with diligence. She wanted to continue with this role of educating her grandchildren. However, her role changed with the deaths of both her daughter and her son-in-law. Two years ago, Muthoni's daughter brought her three children because she and her husband were too sick to look after them. Since then, the two parents have died. Looking back to her young days, Muthoni feels society's morals have disappeared with the acquisition of western education:

How did my daughter contract such a deadly disease? Today, I cannot go to the market on a regular basis as I used to. I thought by educating my children I had invested for my retirement. Look at me. Three young children to look after on my own. I have few resources left having sold the only family land to buy medicine for my daughter and her husband. It is too painful for me to talk about it. (Muganda and Wachira 7B)

Grandmothers have come to represent the best of the extended family. In the natural order of things, it has always been assumed that when couples raise their children they are investing in their own future, as the roles will be reversed in their old age. The AIDS crisis has changed all that. The Kenya national AIDS and STD control program, for example, reports that there are nearly one million children orphaned by HIV/AIDS. It is estimated that almost 50 per cent of children whose parents have died of AIDS in Kenya live in households headed by grandparents. In one third of these cases, a single grandparent raises the children. The grandparent's role as caregiver is no longer temporary, as 70 per cent of grandparents who become guardians can expect to be saddled with the responsibility of raising children until they reach adulthood.

Suggestions and Recommendations

The Canadian International Development Agency (CIDA), the Canadian Public Health Association (CPHA), and the University of Manitoba have teamed up to fight AIDS in Africa with 55 million dollars. Such initiatives were made in order to support community efforts to fight the HIV/AIDS pandemic in Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia, Kenya, and Zimbabwe (Walsh).

We would strongly suggest that these activities continue in addition to setting up centres in Africa in collaboration with local communities, NGOs, and the government. There are centres in Toronto that have demonstrated the possibility of instituting provision of services for AIDS patients. When Casey House, for example, was first opened in 1985, it was one of the few hospices for

people living with AIDS in Canada (Archbold). Today, this centre provides palliative and supportive care to in-house and home-care residents, working with the fundamental goal of meeting the needs of each client and his or her family until the last day. In African what is needed is financial resources to support AIDS families and to fund research. The humanitarian recognition of the need for full medical treatment of the patient and also for the emotional care of family members provides a breath of hope and peace.

Conclusion

Although there is no immediate solution to the dilemma facing African women and AIDS, we believe that greater awareness created among rural African women can lead to a change in behaviour that will reduce HIV and the increasing burden of care for those left behind on elderly women, the grandmothers. Kavuma's journal entries show that women are prepared to deal with the problem once it is identified. Studies of rural communities in Uganda targeted for AIDS information programs have shown that women who had heard of AIDS are more likely to feel less threatened by the disease (Kilian). Awareness was increased through various health centres that show videos about the disease to patients in waiting rooms. Lagarde concluded those women, for example, who attended the health centre for maternity purposes had an opportunity to receive information on the devastating results of AIDS and on how to protect themselves from being victims of the deadly disease.

HIV/AIDS is an epidemic to be eliminated, although the battle may be long and exhaustive. Overcoming the low social status and empowering African women requires a concerted and consistent effort from African communities and governments. Senegal is one of the few countries in Africa that has implemented rapid initiatives of AIDS prevention programs to combat the disease. The legalization of prostitution or female sex workers in Senegal has allowed for periodical testing, counseling, and monitoring of the disease (Meda).

Canada's ongoing efforts in community-based research, such as those studies conducted in Namibia and Uganda, are essential in combating AIDS at the grassroots level. Providing funds only for AIDS' NGOs and African governments is not sufficient. Any effective long-term solution requires an understanding of, and needs to take into account, how cultural norms may influence the spread of the virus. Without this knowledge, any support Africa may receive from the western world will be at best a band-

**70 per cent
of grandparents
who become
guardians
can expect to
be saddled with
the responsibility
of raising
children until
they reach
adulthood.**

aid solution that will not have a positive, lasting impact in the fight against AIDS.

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¹Several methods have been identified as ways in which HIV/AIDS is spread. These are through heterosexual intercourse, man-to-man sexual intercourse, the sharing of injection needles among their users, and mother-infant transmission.

²In the summer of 2000 Edna visited AIDS clinics in Namibia and Uganda. Her primary interest was to familiarize herself with the AIDS situation in Africa; her goals are to raise awareness and to mobilize resources on how to make AIDS treatment more accessible and affordable, especially by women.

³Africa is not a homogeneous society. Africa does not have a monoculture, therefore the AIDS situation differs from country to country.

⁴We have used pseudonyms for hospitals and personnel for confidentiality purposes.

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MICHELINE MERCIER

Tu remonteras la rivière,
le calme de ses flots laissera miroiter
les rayons du soleil de son réveil
à son coucher.
Elle s’allongera sans fin
jusqu’au bout de ta vie.

A son image
Tu te sentiras envahie d’un
sommeil profond. Grouillante d’un
esprit créatif, tu sommeilleras
en tes rêves, heureuse de tes choix.
Et malgré l’orage, même
si la tempête fait rage, portant
le flambeau de l’honneur, ton courage
ramènera le calme.

Micheline Mercier est mère et grand-mère.

SIGNA A. DAUM SHANKS

I Remember your Arms (October 1999)

turning turning turning hundreds of jar tops
over hundreds of rubber seals
to protect all the pickles and beets that fed us
throughout the next winter

shaking a broom furiously while you yelled at
raccoons
that would stop for a moment, with a look of
understanding
of what you were saying,
and then continue to non-chalantly rip singles
off the homestead house’s roof
just before they’d grab some corn and wash
the husks for lunch

zipping up my winter coat as high as it will
go up my neck
after telling me to take it off, put on the ski
pants and then put it back on because
It’s January on the prairies, not January in
Hawaii!

Now I will also remember your arms
half their regular size
wrinkled from the sudden and unwelcome
weight loss
trying to wiggle out of an i.v.
going even further to grasp the mask over
your face that works the respirator
and then facing imprisonment by the rude
nurse who straps them down
as if they belong to a person who should be
strait-jacketed

I am left to wonder whether these actions are
signs
you wish to be left alone to let happen
whatever will naturally ensue
or that you long to show the world you still
have the energy
to turn turn turn
to shake
to zip

*Signa A. Daum Shanks, originally from Saskatoon, is currently
pursuing a graduate degree in law at the University of Toronto.*