Editorial

The subject of sexuality has been an area of concern for social science for many decades. It raises many interesting and probing questions. In Africa, there is much debate across the continent which has led in some cases to the passage of legislation to regulate specific expressions of sex and sexuality. While a few countries exhibit a fair degree of flexibility and tolerance, the majority of them have remained on a different plane in dealing with topics on sex and sexuality. The current issue of *The African Anthropologist* attempts to refocus on sex and sexuality. Several papers which discuss this topic are presented in this issue.

In his paper, 'Eating a ripe banana with its skin on: Health education campaigns against sexually transmitted diseases and HIV/AIDS in Mbozi District, Tanzania, 1980-2010', Musa Sadock explores the health education campaigns against Sexually Transmitted Diseases (STDs), including HIV/ AIDS in Mbozi district, Tanzania, from 1980 to 2010. He argues that the failure of the campaigns to prevent the spread of these diseases is in part due to the fact that the campaigns are foreign to the socio-economic and cultural contexts in which they were undertaken. Nonetheless, the campaigns have led to an increase of public awareness of STDs and shifts in sexual behaviour.

Ocholla and her colleagues delve into the topic of LGBT in the context of Kenya. Their paper is a collection of 'stories from the Kenyan LGB communities'. They argue that LGBT stories are unpopular since they are considered 'uncomfortable territory'. This paper covers stories of people in same-sex relationships against a backdrop of homophobia in Kenya. Homophobia is more common in older than younger individuals. People in same-sex relations go through difficult phases in their lives as they struggle to find acceptance and fulfilment. They have to challenge, explicitly or implicitly, the sexual hegemonies within the wider society, breaking away from either a heterosexual existence or finding a more balanced harmonious existence, where they could allow themselves to question and explore their sexualities, in relationships of their choice.

Historically, women have always been subjugated and oppressed by men in most cultures. In Nigeria, for example, this situation is due to the inequality in gender relations between men and women. Muoghalu's paper on rape and women's sexual health examines how patriarchy

interlocks with gender relations and inequality to deny many raped women justice. A feminist theory is used to explain rape, the societal reaction to rape and the health outcomes for the victims. The author concludes that many health problems suffered by women in Nigeria are a result of rape. The topic on reproductive health receives further attention from Akinyemi and colleagues. Nowhere is this subject more critical than in among the poor urban dwellers. Urban slum dwellers in Ibadan and Kaduma, Nigeria, aspire to have small families and healthy sexual and reproductive lives. However, they are constrained by religious and socio-cultural factors.

Finally, Odhiambo and colleagues examine the 'politics and economics of body image and sexuality in Africa'. In particular the paper asks and attempts to respond to the following questions: What happens with women or men who defy constructs of body image and sexuality? How does society adjust to individuals they consider deviant in its already defined and constructed political arena? In answering these questions the authors expose the 'lived realities' of persons who fail to conform to the expectations of the society, namely sexual and gender minorities. The paper presents some voices of those who have redefined body image politics and economics.

Together, the papers in this Volume should serve to keep the debate of sex and sexuality alive. We hope that they will invigorate research into the area of sex and sexuality as currently defined.

Editors

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'Eating a Ripe Banana with Its Skin On': Health Education Campaigns against STDs and HIV/AIDS in Mbozi District, Tanzania, 1980-2010

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Abstract

This historical study assesses health education campaigns against sexually transmitted diseases including HIV/AIDS in Mbozi District, Tanzania, between 1980 and 2010. Archival and oral data collected in Mbozi from 2008 to 2010 reveal that the campaigns have not had the intended impact of preventing the spread of the diseases. This is in part because the campaigns do not take into account the prevailing socio-economic and cultural contexts. Nevertheless, there is an increase of public awareness of sexually transmitted diseases and a slight change of sexual behaviour. Thus, to improve on the current campaigns, the stakeholders who are involved in intervention campaigns against sexually transmitted diseases should take into account the socio-economic and cultural environment.

Résumé

Cette étude historique évalue les campagnes de sensibilisation contre les maladies sexuellement transmissibles, notamment le VIH/ SIDA dans le District de Mbozi, en Tanzanie, entre 1980 et 2010. Les données d'archives et de sources orales recueillies à Mbozi de 2008 à 2010 révèlent que les campagnes n'ont pas eu l'impact escompté qui était de prévenir la propagation des maladies. Cela est en partie lié au fait que les campagnes ne prennent pas en compte les contextes socio-économiques et culturels existants. Néanmoins, on observe une conscience croissante du publique vis-à-vis des maladies sexuellement transmissibles et un léger changement de comportement sexuel. Ainsi, pour améliorer les campagnes en cours, les acteurs impliqués dans les campagnes de lutte contre les maladies sexuellement transmissibles devraient tenir compte de l'environnement socio-économique et culturel.

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Introduction

> Although government and Non-Governmental Organizations exhort us to use condoms during sexual intercourse, we do not normally use them because they reduce sexual pleasure. Instead, we like 'flesh for flesh' [referring to sex without a condom]. Using a condom is like eating a sweet with its wrappers on, or eating a ripe banana with its skin on (IDI Mwasomola, Tunduma, Mbozi).

As implied by the above quotation which was taken down in Mbozi District in 2010, governments and other organisations have faced challenges in their educational campaigns against sexually transmitted diseases (STDs) in Tanzania in particular, and in Africa as a whole. The challenges in question revolve around the absence of connection between the STD-related campaigns and the social reality reflected in sexual values and desires, and the economy. The campaigns have overemphasised the change of individual sexual behaviour, without considering the socio-economic and cultural factors which make individuals vulnerable to STDs. Thus, it is argued in this paper that health education campaigns against STDs, including HIV/AIDS, have largely been ineffective because their design did not take into account the local social realities. STDs, also known as sexually transmitted infections (STIs), incorporate a number of diseases which are transmitted through sexual contact. These include HIV/AIDS and a group of diseases, which traditionally have been referred to as Venereal Diseases. STDs are classified according to their major symptoms of genital ulceration and discharges. Hence there are Genital Discharge Syndromes which include chlamydia, trichomoniasis, gonorrhoea, bacterial vaginalis, yeast and candida albicans infections. In women chlamydia could infect the uterus thus resulting in a pelvic inflammatory disease (PID). There are also diseases which produce ulcers in the genitals which are referred to as genital ulcer diseases (GUD). Some examples of GUD include syphilis, chancroid, herps simplex, lymphogranuloma venerum (LGV) and Granuloma inguinale (Hunter 2003).

Health education campaigns involve the dissemination to the public of preventive information and knowledge on STDs. The knowledge includes the risk factors for the diseases and categories of people at high risk, available medical treatment, and the complications and consequences arising from non-treatment of the diseases (Darrow 1997: 88). The health education campaigns, however, face one major problem, namely that of a mismatch with social reality. Yet, little effort has been made in Tanzania in particular, and in Africa in general, to evaluate the campaigns against the diseases at regional, national or lo-

cal levels. Some pioneering evaluation efforts that have been made in post-colonial Africa have been synchronic, general and have focused on the change of people's sexual behaviour, especially on condom use among female sex workers, thus neglecting other social groups (as a document in Nguyen and Sama 2008; Barnett and Whiteside 2002). This paper assesses STD education campaigns across all social groups in Mbozi District for a period of nearly a quarter of a century. Specifically, it focuses on the following three questions: (i) What has been the trend of STDs in the District since the 1980s? (ii) How have educational campaigns been conducted in the district between 1980 and 2010? and (iii) What has been the outcome of the campaigns in terms of changing sexual behaviour of the residents of the District since the 1980s? From these questions we could learn lessons which could be applied in the current efforts to combat STDs, including HIV/AIDS.

The paper is guided by a bio-social perspective on disease (Nguyen and Sama 2008). This framework situates diseases and the people's responses to them within the socio-economic, cultural and political contexts of a society. Thus, this paper analyses the socio-economic and cultural environment of Tanzania generally, and Mbozi District specifically, with the aim of ascertaining whether these contexts have enhanced or hindered the health campaigns around STDs. By adopting this theoretical framework, the paper departs from the behavioural and psychological models, which as Whiteside and Barnet (2002) point out, have been predominant since the 1950s, and have focussed on individuals and the change of their sexual behaviour.

Methodology

This paper is based on archival research conducted at Mbeya Zonal Archives (MBZA), and in Mbozi District between 2008 and 2010. In the archives, I consulted documents such as STD registers and medical reports that provided information on the prevalence of STDs, and successes and problems associated with the campaigns. In addition to the above mentioned sources, I conducted interviews in Mbozi District with key informants who had specialised knowledge regarding STDs and health educational campaigns. These informants included medical doctors and the District Coordinator of STIs and HIV/AIDS Control Programme (DACC). The medical personnel informants furnished me with information on the successes and challenges of the campaigns. Besides these key informants, I selected a few people from the general public. These were randomly chosen, but I had to ensure gender and age representation. The general public supplied me with their assessment of

the campaigns. In conducting the interviews, interview guides were used. This being a qualitative historical study, I used a comparative historical approach for analysing the information. This approach entails comparing research findings from Mbozi with other findings elsewhere in Tanzania, Africa and other parts of the world. Ethical clearance for this research was granted by the Mbeya Medical Research and Ethics Committee.

Mbozi District

Mbozi District was created in 1964 and is one of the eight districts of Mbeya region in Tanzania. The district shares a border with the Republic of Zambia and Rukwa Region to the West, the Republic of Malawi and Ileje District to the South, and Mbeya Rural District to the north-east. It also extends north-westwards to Lake Rukwa where it borders on the Chunya District (see Appendices 1 and 2). Mbozi is generally a rural district, but with some large and rapidly expanding towns such as Vwawa, and Tunduma. The district is mainly inhabited by Bantu-speaking peoples, especially the Nyiha and Nyamwanga. These inhabitants are mainly agriculturalists.[1]

Mbozi District has the largest population in Mbeya region. In 1978 the population of the district was 233,418,[2] but ten years later it had increased to 330,282,[3] and in 2002, it was estimated to be 493,576.[4] The district's annual population growth rate is estimated to be 3.1 per cent, which is higher than the 2.9 per cent national average.[5] This high population growth is attributed to the high fertility rate and immigrants from other parts of the country.[6] The immigration and general people's movement into the district is facilitated by good transport networks. The district is crossed by a tarmac highway and the TAZARA railway both running from the port of Dar es Salaam in Tanzania to Kapiri Mposhi in Zambia.

Mbozi District has had high prevalence of STDs in Mbeya region; it is the second most affected by STDs, including HIV/AIDS in the Mbeya region. This high prevalence is partly attributed to a long history of intense social intercourse among people of diverse origins and cultures. Such interaction is thought to have been conducive for multiple partner sexual relations, hence the high prevalence of STDs. It is because of the high level of prevalence of STDs that I chose the district for the research on health education campaigns.

The prevalence of STDs in Mbozi Since the 1980s

Statistics and discourse on STDs show a high prevalence of STDs in the district since the advent of HIV/AIDS in the1980s. For example, the district

report of 2001 ranked STDs the sixth out of the top ten listed diseases afflicting out-patients over five years old.[7] Three years later another report noted that HIV/AIDS/STIs were among the five major health problems that caused high morbidity in the district; thus, the district accorded high priority for combating them.[8] The overall picture of HIV/AIDS shows that cases have been increasing since the diagnosis of the first case in the district in 1986. In 1998, 435 patients were tested for HIV with 311 (71.5 %) testing positive. In the same year 937 blood donors were tested for HIV with 130 (14 %) testing positive. One year later, in 1999, 616 patients were screened for HIV. Of these 384 (62.3 %) were positive while 232 (37.7 %) were negative. Among 602 blood donors who were tested 107 (17.8 %) were positive.[9] And five years later in 2003/4 HIV infection figures from antenatal clinics of Ruanda locality showed a higher prevalence of HIV than the Mbeya region's rate of 15.7 per cent. The Ruanda HIV rate was 0.2 per cent higher than the regional rate, while Igamba's rate was 5.2 per cent lower than the regional rate.[10]

An increase in respect of other STIs is also recorded. In 1997 a total of 692 STIs was recorded among the youth and adult out-patients. Of the total, 261 had GDS, 96 GUD, 173 syphilis, 30 PID, and 132 had other STIs.[11] Four years later another government hospital report noted 6,451 cases of GDS (3,336) and GUD (3,115) among in-patients.[12] Yet in 2004 out of a total of 5,353 expecting mothers who attended antenatal clinics and tested for syphilis, 491 had the disease.[13] Again in January 2005 the district recorded among the out-patients 3,441 cases of GDS, 3313 GUD and 1515 PID.[14] This high prevalence of STIs in the district has made it imperative to institute health education campaigns as one of the strategies for combating the diseases.

Health Education Campaigns in the Era of HIV/AIDS

The advent of HIV/AIDS has revived massive health education campaigns on STDs, which focus on changing individuals' sexual behaviour. The campaigns have been given impetus due to the high prevalence of HIV/AIDS, a lack of vaccine and effective cure of HIV/AIDS (Bonga 1999: 177). Furthermore, the campaigns against STDs have been intensified following a number of studies that have established the link between the high prevalence of HIV/AIDS and the high prevalence of other STDs[15] such as gonorrhoea and syphilis to mention but a few. Thus education is deemed to be essential for the behavioural change[16] needed for the control of the diseases. Yet the campaigns have registered only modest achievements in altering sexual behaviour as the following assessment indicates.

Among the achievements of the health education campaigns in Mbozi District had been not only the increase in the number of patients seeking medical treatment for STDs in various health facilities but also a slight change in sexual behaviour. The district, under the auspices of the District's HIV/AIDS Coordinator (DACC) conducted a number of seminars, peer education programmes, film shows, and drama as well as disseminating information through other media such as radio, billboards, pamphlets, etc.[17] An example of a billboard with messages aimed at the prevention of HIV/AIDS follows below.

Figure 1: A billboard on protection against HIV/AIDS, Mlowo Dispensary, Mbozi District, June 2010

Photo by Musa Sadock.
Translation: Sexual Indulgence has made me miserable. Take Care of your health, and your family (protect yourself from HIV/AIDS by ceasing casual sex, treating sexually transmitted diseases, being tested for HIV and using condoms).

Over the years the messages in the mass media as exemplified by the above billboard had emphasized that people should protect themselves from STDs by changing their sexual behaviour, by being monogamous, abstaining from pre-marital and or extra-marital sexual relations or using condoms. Detailed analysis of condom-use, and pre-marital or extra-marital relations in Mbozi District are provided in the coming sections of this paper. Campaigners promoting monogamy, abstinence and condom-use, often summarise their messages in a slogan, namely, ABC: A standing for Abstinence, B for Be faithful, and C for Condomise (see an example of an ABC message below).

Figure 2: Bill board on ABC, Mlowo Dispensanry in Mbozi District, June 2010

Photo by Musa Sadock.
Translation: Think before you decided. HIV/AIDS, mmh! Abstain, Be faithful to one sexual partner. If you fail use a condom.

Apart from insisting on monogamy and condom use, the campaigns have focussed on the treatment of STDs. Free testing and the treatment of STDs are offered. Such free medical services, alongside other campaigns against the diseases, have been possible through massive support from the Ministry of Health and donor countries, especially the USA through the United States Agency for International Development (USAID) and Germany via its organisation, the Deutsche Gesellschaft fur Technische Zusammenarbeit (GTZ).

The concerted efforts of the above-mentioned campaigns partly explain the slight decrease of the HIV/AIDS/STD prevalence in Mbeya region as a whole and Mbozi District in particular.[18] For example, in the 1990s and early 2000s HIV prevalence rates for Mbeya region generally and Mbozi District in particular declined. The rate for Mbeya region declined from 20 per cent in the early 1990s to 15 per cent in the late 1990s, while that of Mbozi District declined from 14 per cent in the 1990s to 11 per cent in the early 2000s (Jordan-Harder et al. 2000).

However, successes had been modest because of problems inherent in the campaigns. One such obstacle relates to the failure of the majority of the public to access information. Billboards and many other print media

were limited to urban areas; thus a great number of people living in the rural areas could not access the information, the exception was in few dispensaries where pamphlets were available and billboards erected.[19] Seminars and drama which could have offset this problem were limited to few rural areas due to a lack of funds.[20]

Even in towns, the messages were engraved in dilapidated visual media such as billboards. Given their condition, the media failed to attract a big audience as they lacked the criteria that would have pulled the public to the messages. Darrow (1997:89) lists the criteria as follows: first, the product (message) should appeal to the consumers, in this case the public; and second, the images shown must enlist excitement and interests to users.

The second problem was limited coverage of STD education to social groups. In general, the campaigns only targeted the youth, civil servants and sex workers.[21] Peer educators were at the forefront of campaigns directed towards sex workers and the youth. Between 1994 and 1995 intensive peer education program, dubbed 'Bar Workers Health Project' was conducted in the High Transmission Areas (HTA), that is, hotels, restaurants, bus-stops and bars along the railway line and road which run from the port of Dar es Salaam to Kapirimposhi (Zambia).[22] Other peer education programmes for sex workers and the youth were also conducted in Tunduma, a town at the border between Tanzania and Zambia. The programmes were run by an NGO called Action for Development Programme Mbozi (ADP-Mbozi).[23] Peer education was also conducted among pupils in primary schools. Yet, with the exception of primary school peer educators, concerns were raised about the lack of morality among some of the peer educators. One informant noted that 'some peer educators are as promiscuous as everybody, so much so that they have no moral authority to tell us about the need to change our sexual behaviours'.[24]

Third, the programmes did not cover all groups even in the same social category such as the youth. A case in point was the neglect of married youths and other couples in general. Despite the high prevalence of STDs, including HIV/AIDS among couples in Mbozi District,[25] there were no, with the exception of a few messages on billboards and other media, specific STD educational programmes to cater for couples. Yet, the ABC messages on billboards in Mbozi, in striking similarity with what Hughes and Malila[26] had found in other parts of Africa, were interpreted by adults and the married to be intended for unmarried youth and teenagers.[27]

The fourth problem was that the campaigns, to a large extent, ignored socio-economic conditions, especially poverty which put individuals at high risk of contracting the diseases or practising risky sexual behaviours that would lead to contracting the diseases. In Mbozi District, as in many other parts of Tanzania and Africa, poverty is inextricably linked with the spread of STDs (Iliffe 2006).[28] As one informant noted at Ndalambo township: 'Poverty forces some girls and women to engage in unsafe sexual relations with travellers in transit to and from Sumbawanga region. Consequently many of them get the diseases'.[29] This poverty in Ndalambo was not peculiar to that area, but also was widespread in other rural areas and towns found in the district, and had an effect similar to that of Ndalambo, that is of, forcing women and girls to engage in sex for money.[30] Realizing this link between the diseases and poverty, ADP-Mbozi started teaching entrepreneurship skills to the poor women and girls at Tunduma township aiming at improving their economic lot.[31] Additionally, small scale enterprises such as petty businesses were established for sex workers.[32] However, these kinds of initiatives had not been started in other parts of the district. The only resemblance of such projects, which were for orphans and people living with HIV/AIDS, existed in few wards of the district.[33] Moreover, the projects were too small to have a significant impact. Apart from poverty in urban areas, rural poverty especially of women forced them to engage in risky sexual practices. It was reported that some poor women engaged in risky sexual relations with men in order to get money for buying alcohol.[34] Thus, for these poor rural and urban women, the campaigns exhorting change of sexual behaviour were likely to fall on deaf ears.

The last obstacle is that there was a minimal change of risky sexual behaviour despite the campaigns. By stating this, it should, however, not be construed as denying the successes of the campaigns. Indeed, the campaigns led to the increase of public awareness and changes of risky sexual behaviour for some individuals.[35] Nevertheless, it is argued in this paper that the change of sexual behaviour in Mbozi District was not really so significant as indicated by the risky sexual behaviour such as multiple partner sexual relations among the married, unmarried and the general disregard of use of condoms.[36] The sections that follow elaborate on the issues.

Multiple partner sexual relations in Mbozi had multiple names and manifestations. The residents of the district referred to sexuality by different Swahili words: *kutembea ovyo ovyo* (having sexual relations with anyone), *uhuni* (sexual immorality) *starehe* (sexual indulgence) and *nyumba ndogo* ('small house' – denoting men`s extra-marital sexual relations).[37] In

Mbozi District, multiple partner sexual relations were manifested in extra- and pre-marital sexual relationships.

The multiple partner sexual relationships in the district were associated with many factors, one of which was the decline in traditional norms which did not sanction such behaviour. In colonial times, it was customary to penalise any man guilty of adultery and or transmitting an STD to her partner. Among the Nyiha, a man who transmitted the diseases to another man's wife had to pay two cattle to the offended man,[38] and for the Nyamwanga, the fine was one cow.[39] This traditional sanction, however, began to fade in the 1960s and 1970s, partly because of the application of national laws, the increased influence of Christianity and western education, and the arrival of immigrants in the district from other parts of Tanzania who had diverse cultures, and the decline of the role of chiefs.[40] Partly as result of the waning of traditional sanctions, multiple partner sexual relations increased.[41] One informant noted that 'despite HIV/AIDS, 'sexual revenge' was common'.[42] By sexual revenge he meant a situation whereby an offended man or woman also resorted to having sexual relations, more often without a condom, with the husband or wife of an offender[43] or any other partners. This infidelity, however, should not be construed as attesting to the sexual peculiarity of Mbozi residents, or denoting promiscuity that is unique to Africa. Adultery is common all over the world. As Susan Hunter observes:

> Men and women all over the world are adulterous; in 73 per cent of cultures worldwide married men and women report that they have had other partners while married. In the 1970s women began catching up with men, although in most cultures more men take on new partners than women.[44]

Premarital sexual relations are common as well. The youth of today, lamented another informant, enter into sexual relationships prior to marriage.[45] They say that they want to 'try it out' before they get married. Put simply, they equate pre-marital relationships to the testing of a car before one buys it. Indeed, they have a saying that 'you cannot buy a car before testing it'. The danger, however, associated with such relationships is that participants in the relationships never test for STDs before entering into the relationships. Another danger is that many of them 'try it out' on many sexual partners before they decide to get married. Thus, such behaviour increases the risk of getting and spreading STDs.[46] Like adultery, the youth behaviour of having multiple sexual partners before marriage is not peculiar to Mbozi District but universal. In 1996, one study in the US found a higher prevalence of STDs among the youth, which was partly caused by a higher rate of partner exchange.[47]

The afore-mentioned multiple partner sexual relations in the district persist despite the danger of contracting the diseases, especially HIV/ AIDS. When asked about this danger, the youths would compare the contracting of the disease to other risks happening in their daily lives. Indeed, the disease is likened to an 'accident', thus getting it depends on one's luck.[48] 'We have seen many examples of couples whereby one partner has HIV/ AIDS, while the other does not have it.' How can you explain, one informant queried, this difference in sero status, if not by sheer luck or lack of it?[49]

Regarding the availability and condom-use, in 2009 approximately 6000 condoms were distributed in the district through a project called Community Participation against HIV/AIDS (*Mwitikio wa Jamii Dhidi ya Ukimwi*). In addition to the project, many NGOs were active in the distribution of condoms in the district.[50] Despite the massive condom distribution, in general, condom use had remained low. For example, in 1996 a Demographic and Household Survey (DHS) in Mbeya region, where Mbozi District belongs, found out that only 25 per cent of the surveyed men used condoms during sexual relations.[51] Indeed, many informants during this study noted that a great number of Mbozi residents did not use condoms during sexual intercourse on the grounds that condoms diminished sexual satisfaction.[52] 'Using a condom, the youth argued, 'is like eating a sweet with its wrappers on, or eating a ripe banana with its skin on'.[53] This finding on non-use of condoms because of lack of sexual pleasure in Mbozi District echoes findings from other parts in Africa. Good examples of such findings include Watikin`s and Kamwendo`s in Malawi,[54] a state that borders Mbozi District.

Another reason for the low condom use in the district relates to the general social misconception about condoms.[55] It is widely believed in Mbozi that condoms are likely to slip off the penis and remain in the vagina during sexual encounters.[56] Similar to Callaham's findings in a neighbouring state of Zambia, the unpopularity of condom use in Mbozi also revolves around issues of trust, women's fecundity and masculinity.[57]

Conclusion

To a large extent, health education campaigns in Mbozi have failed to prevent the prevalence of STDs. This failure is partly because the campaigns have mainly emphasised that individuals need to change their sexual behaviour to the neglect of socio-economic and cultural contexts that impinge on the implementation of the campaigns, or drive individuals to risky sexual behaviours that lead to contracting STDs.

This being a brief historical survey of health campaigns against STDs; it leaves open many areas for further research. These areas may include a detailed study of peer education in schools and colleges, and local community participation in the campaigns. That said, we hope that this historical study may help stake-holders involved in interventions against the diseases to integrate socio-economic and cultural contexts in their strategies against the diseases. In other words, interventions against the diseases need to address the larger socio-economic and cultural issues prevailing in a particular society.

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3. District Medical Office (DMO) Mbozi District Council: Comprehensive Health Plan for the year 2002.
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5. The Tanzanian census (2002), and Mbozi Socio-economic Profile 2010.
6. Mbozi Socio-economic profile 2010.
7. DMO Mbozi District Council Comprehensive Health Plan for the year 2001, p. 5.
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9. Mbozi Designated District Hospital Annual Report for the year 1999, 30 May 2000 p. 18.
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11. Moravian Church in Tanzania: Mbozi District Designated Hospital Annual Report for the year 1997, 30 May 1998 p. 15.

12. DMO Mbozi District Council: Vwawa Government Hospital Annual Report for the year 2001.
13. DMO *Halimashauri ya Wilaya ya Mbozi, Idara ya Afya: Taarifa ya Mwaka 2004* (Mbozi District Council: Annual Medical Report for the year 2004).
14. DMO *Mwongozo wa Kutolea Taarifa za Huduma za Afya: Ofisi za Waganga Wakuu wa Mikoa: Wilaya ya Mbozi January 2005* (Guidelines of Regional Medical Officers on Reporting Health Matters: Mbozi District, January 2005).
15. Regional Medical Officer (RMO) – Mbeya, AIDS/ STD Control Program: Plan of Operation 1994-1998, Mbeya Region, January 1994, p. 8.
16. Ibid.
17. Interview with Dr E. Kyara, District HIV/AIDS Council Coordinator, at Vwawa Government Hosptital, 8 March 2010.
18. Ibid.
19. Author's observation during field work.
20. Interview with M. Kwai, a member of Mbozi Council HIV/AIDS Control Committee on 10 April 2010.
21. I use the term sex worker to refer to a woman or girl who engages in sex for sale within an urban context. The Swahili equivalent term is *Malaya.*
22. Kyara, interview.
23. Mwasomola, interview.
24. Interviews with A. Nzunda at Vwawa on 21 June 2010, J. Mwamlima at Vwawa on 18 June 2010, J. Mwasenga at Ndalambo on 3 June 2010.
25. Interview with Dr J.M. Mwamwezi at Mbozi Hospital on 29 April 2010.
26. S. Hughes and Ikanyeng Malila, 'Media and the African Context of the Social Construction of HIV/AIDS', in Kempe R. Hope sr., ed., op cit., p.114.
27. Interviews with P. Kidenya (RN) and M. Faustin (HIV/ AIDS Counsellor) at Mlowo Dispensary on 14 June 2010.
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29. Interview with Dr A. Syumbi at Ndalambo Health Centre on 3 May 2010.
30. Interview with J. Kasonso at Tunduma on 26 May 2010.
31. Mwasomola, interview.
32. Interviw with J. Mwakindu at Tunduma on 7 June 2010.
33. Kwai, interview.
34. Ibid.
35. D. A. Ross, et al., 'Biological and Behavioural Impact of an Adolescent Sexual Health Intervention in Tanzania: A Community-randomized Trial', *AIDS 21* (2007) p. 1947, Jordan-Harder, et al., op cit., p. 56.
36. A. Nzunda, interview.

37. Interviews with M. Mwakibinga at Mlowo on 14 June 2010, J.Mwakondu, at Tunduma on 7 June 2010, E. Mkuto at Kamsamba on 26 May 2010.
38. Interview with Chief Jackson Nzunda at Vwawa on 18 June 2010.
39. Interview with N. Mkoma (74 years old and custodian of Nyamwanga customs and traditions at the Sub-Chief Council-Ndalambo) on 3 June 2010.
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43. Ibid.
44. Hunter, op cit., p.196.
45. A. Nzunda, op cit.
46. Ibid.
47. Hunter, op cit., p. 154.
48. A. Nzunda, interview.
49. Interview with P. Nyondo at Mpanda village in Mbozi on 10 July 2010.
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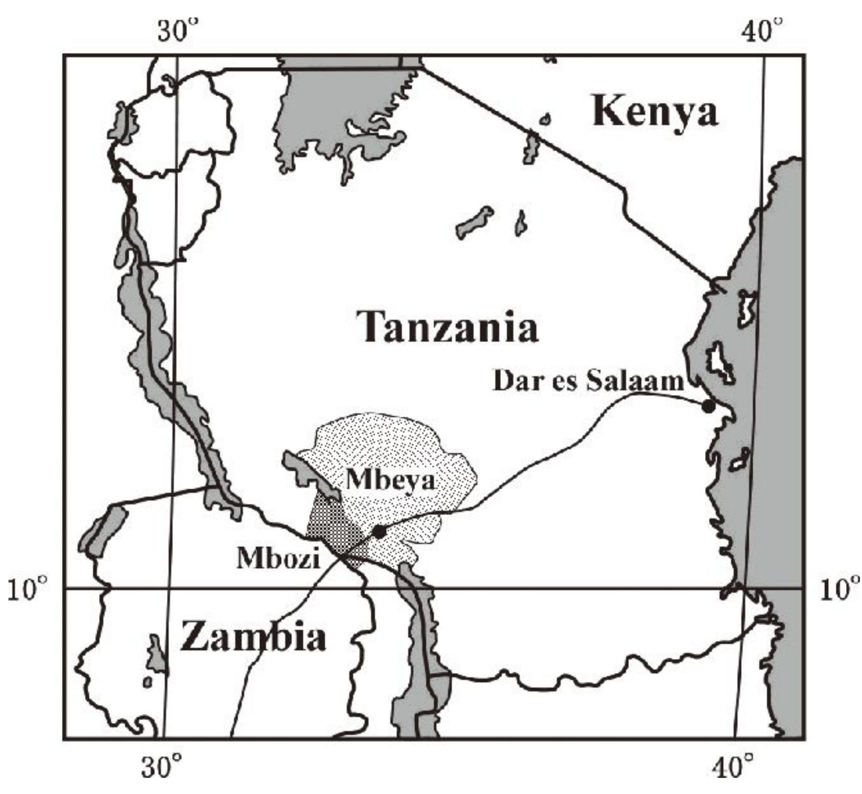
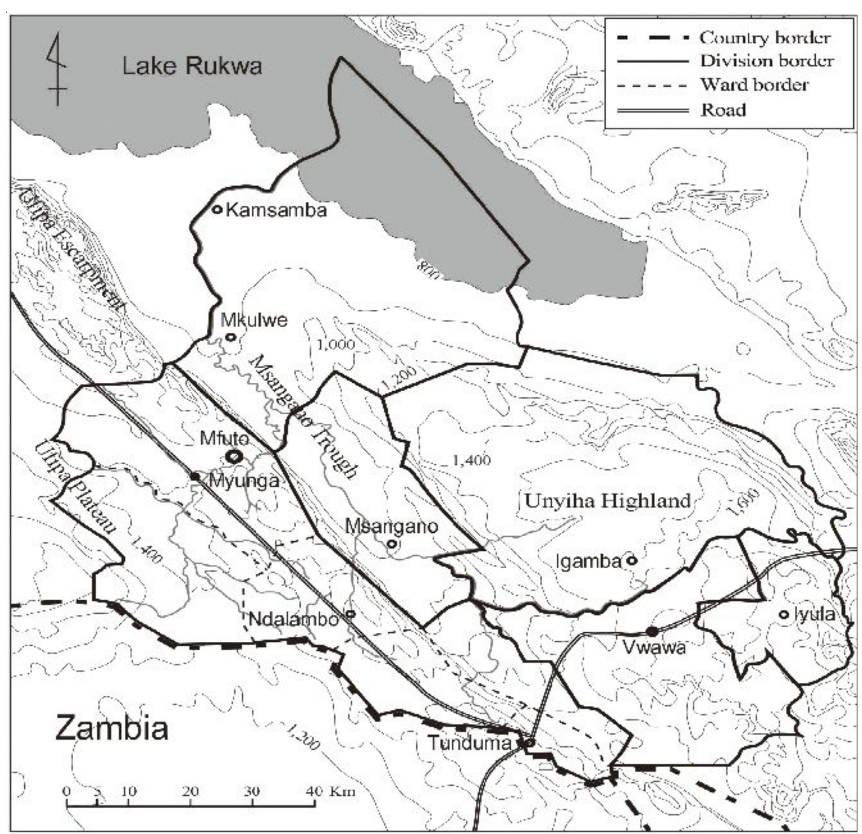
Appendices

Appendix 1: A Map of Tanzania Locating Mbeya Region and Mbozi District



Source: J. Itani, *African Study Monographs, Suppl. 34*, March 2007, p. 5.

Appendix 2: A Map of Mbozi District



Source: J. Itani *African Study Monographs, Suppl. 34*, March 2007, p. 59.

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LGBT Challenging and Reproducing Sexual Hegemonies: Stories from the Kenyan LGB Communities

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Abstract

LGBT studies in Kenya are unpopular since they are considered 'uncomfortable territory'. This paper covers stories of people in same-sex relationships against a backdrop of homophobia in Kenya. It is based on a study which explored same-sex practices in traditional Kenyan communities, homophobia and same-sex practising individuals. The methodology involved focus group discussions with 20 elders, and face-to-face questionnaires administered in eight towns through a random sampling of 605 people. Twelve same-sex practising people were selected through purposive sampling. They gave their stories with consent, and names were changed to maintain confidentiality. Research findings revealed that homophobia was more common in older than younger individuals. Same-sex practising people and gender minorities accounted for 22 per cent of the population subjected to questionnaires. From the same-sex practising stories, ten of which are featured here, it was found that the respondents had gone through difficult phases in their lives where they struggled to find acceptance and fulfilment. They had challenged explicitly or implicitly, the sexual hegemonies within the wider society breaking away from either a heterosexual existence or finding a more balanced harmonious existence, where they could allow themselves to question and explore their sexualities, in relationships of their choice.

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Résumé

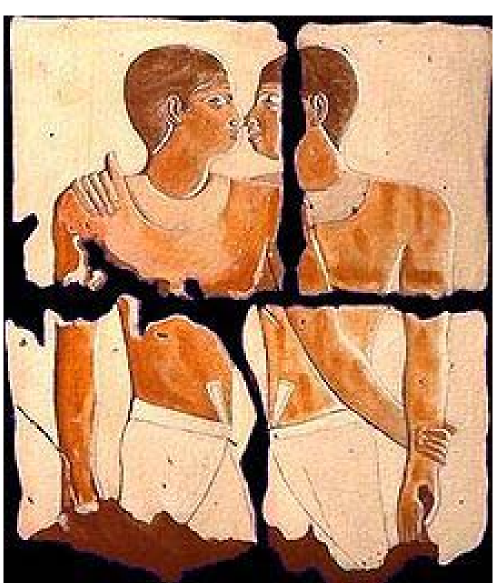
Les études relatives aux LGBT au Kenya sont impopulaires car elles sont considérées comme une « zone de non confort ». Ce papier met en exergue le vécu de personnes homosexuelles dans un contexte d'homophobie au Kenya. Il est fondé sur une étude qui a exploré les pratiques homosexuelles dans des communautés kenyanes traditionnelles, l'homophobie et les personnes homosexuelles. La méthodologie comportait des groupes de discussion avec 20 anciens et des questionnaires directement administrés dans huit villes selon un échantillonnage aléatoire regroupant 605 personnes. Douze personnes homosexuelles ont été sélectionnées par un échantillonnage raisonné. Elles ont consenti à raconter leurs histoires sous des noms d'emprunt afin de préserver l'anonymat. Les résultats de la recherche ont révélé que l'homophobie était plus fréquente chez les personnes les plus âgées que les plus jeunes. Les personnes homosexuelles et les minorités sexospécifiques représentaient 22 pour cent des enquêtés. Les récits des personnes homosexuelles, dont dix sont consignés ici, ont révélé que les répondants avaient connu des périodes d'adversité dans leurs vies, et où ils ont dû lutter pour forcer l'acceptation et le respect. Ces personnes avaient contesté explicitement ou implicitement, les hégémonies sexuelles au sein de la société au sens large, soit en rompant avec une vie hétérosexuelle ou en trouvant une existence harmonieuse plus équilibrée qui leur permet de remettre en question et d'explorer leur sexualité dans des relations de leur choix.

Background

Instances of same-sex relations in traditional societies in Kenya have been cited by several researchers. Murray and Roscoe (1998) wrote that about thirty Bantu societies provide for marriage between two women, including a dozen Kenyan ethnic groups. Among these were the Kisii, Nandi, Kamba, and Kikuyu. As these scholars point out, in other parts of Africa this was characteristic of status of women, such as royals or political leaders, but in East Africa, it ordinarily represented a surrogate female husband who replaced a male kinsman as jural 'father'. The wife may bear children for her husband, in whose clan line they then belong. In other cases, women marry women to achieve economic independence, and a bride price is paid. These autonomous female husbands are accepted as men in male economic roles. This dual-female marriage was economic, and illustrated the separation of sex and gender in African societies (Murray and Roscoe 1998). Murray and Roscoe (1998) also reported that women in Lesotho engaged in socially sanctioned 'long term, erotic relationships' called *motsoalle.* Evans-Pritchard recorded that male Azande warriors in the northern Congo routinely took on young male lovers between the ages of twelve and twenty, who helped with household tasks and participated in intercrural sex with their older husbands.

Khnumhotep and Niankhkhnum were ancient Egyptian royal servants. 'They shared the title of Overseer of the Manicurists in the Palace of King Niuserre during the Fifth Dynasty of Egyptian pharaohs, c. 2400 BCE, and are listed as 'royal confidants' in their joint tomb. Niankhkhnum means 'joined to life' and Khnumhotep means 'joined to the blessed state of the dead', and together the names can be translated as 'joined in life and joined in death' (see photograph below). They are believed by some to be the first recorded same-sex couple in history. The proposed homosexual nature of Khnumhotep and Niankhkhnum has been commented on by the popular press, and the idea seems to (partially) stem from the depictions of the two men standing nose to nose and embracing. Niankhkhnum's wife, depicted in a banquet scene, was almost completely erased in ancient times, and in other pictures Khnumhotep occupies the position usually designated for a wife' (Wikipedia, 2012).

Figure 1: Khnumhotep and Niankhkhnum



Source: http://en.wikipedia.org/wiki/Homosexuality (accessed 23-09-12)
Illustration from photograph © 1999 Greg Reeder

Boellstorff (2007) mentions same-sex desire and sexuality in Africa and how these have over time been interpreted by others. See also Aarmo (1997); Donham (1998); Morgan & Wieringa (2005) and Renaud (1997). Previous researchers (such as Latour, 1993 and Lykke & Braidotti, 1996)

have clearly separated analysis regarding biological sex, gender/gender roles, sex/sexuality and same-sex relations. Lykke (2010), however, states that 'gender/sex in its intersections with other power differentials and identity markers can pass not only as a "proper object" of study but that it need not have a fixed and essentialized understandings or definitions'. There has been a danger of oversimplifying ' "Gender" and "Sex" studies and making them reductionist' (Butler 1997). For instance, some researchers prefer to clearly separate 'Gender studies' and 'Gay and Lesbian' studies where the former are defined as a socio-cultural gender whilst the latter have to do with sex in the sense of sexuality. According to Butler, 'sexual practices and identities are gendered, and therefore, interesting for "Gender Studies"'. Likewise, '"Lesbian and Gay Studies" become unsustainable when they neglect the meanings of gendered subjectivities and sexed embodiments, and focus on sexuality only' (Butler 1997).

A critique of past studies, particularly studies on same-sex relations in traditional communities, is that they frequently seem to be simple explanations, usually 'objectively' given, as to why persons of the same sex or gender would enter into same-sex relationships. Butler (1990) speaks of the danger of the 'god-trick'. She mentions that 'researchers, politicians and citizens alike always think, act and speak *in media res*', i.e. from hindsight or whilst in the middle of a situation. Though people may try to remain objective, they are always fooled by the god-trick – i.e. the illusion of 'looking in' from the 'outside'. In actual fact, people, including researchers, often interpret objects of study through a coloured lens which consists of their own prejudices, cultural leanings, preferences or world views.

Hegemonic discourses present themselves in the rules, norms and values of societies. They are, however, not always accepted as 'God-given law'. People who identify as homosexual or same-sex loving have over several centuries defended their identities and in the past century established a movement, highly focused on questioning, redefining, deconstructing and reconstructing the hegemonic descriptions of their 'category' as described by Foucault (1978). Furthermore much of the contest against hegemonic discourses revolved around questioning the seemingly 'God-sanctioned' 'common good' that same-sex loving persons apparently did not fulfil, namely that of procreation (Lykke 2010; Bryld 2001; Bryld and Lykke 1982).

This paper focuses on stories of same-sex practising individuals and on the ways in which they have challenged and re-produced sexual hegemonies. It is part of a larger study, 'Uncomfortable Territories', which

explores the prevalence of same-sex relations in traditional communities, people's perceptions of same-sex practices and stories focusing on lived-experiences of same-sex practising individuals.

Methodology

An ethnographic investigation was undertaken in order to ascertain the existence of same-sex relations in traditional Kenyan society. The research team conducted focus group discussions with elderly men and women in every community. These elderly men and women were identified through purposive sampling. The researchers identified a focal point within the community, which acted as the entry to the community. The larger study involved 605 people who were subjected to face to face structured interviews with open and closed-ended questions. A stratified random sampling technique was used in order to ensure that the respondents were drawn from different age groups and sexes. Purposive sampling was used to identify twelve individuals in same-sex relations whose life stories are presented in this paper. The individuals were subjected to interviews as a way of exploring their life experiences and challenges.

The study was conducted in five major ethnic communities: Abagusii, Akamba, Maasai, Luo, and Mijikenda. The towns visited were Gede, Malindi, Mombasa, Nairobi, Makueni, Kisumu, Kajiado, and Kisii.

Findings

There were denials mostly from older respondents that same-sex practices had existed in traditional communities and many respondents lacked awareness of its existence (362 out of 605 or 59 %). Yet, as many were Christians, they also noted that homosexuality must have existed in the past because the Bible mentioned it. There were a few older respondents (over 50 years – 10 % of the sample population), however, who acknowledged the existence of same-sex practising people in the past. About 22 per cent of the sample population identified as gay, lesbian, bisexual or transgender. Against this backdrop of homophobic statements and a lack of knowledge we recorded twelve stories of LGB persons (Muchoki et al. 2010). Ten of these stories are featured here showing the struggles and triumphs experienced by the men and women. For ethical reasons, the names of those interviewed have been changed in order to protect them.

Stories from the same-sex community

Rebecca

Rebecca is Luo. She was born and grew up in Migori and has resided in Siaya, Kisumu and Nairobi. She is in her forties and says she has felt attracted to the same sex since she was very young. She grew up in a strict Seventh Day Adventist family. She says that she was attracted to her female primary teacher, admiring her very much whilst doing physical education in the playground. Rebecca is also quick to note that she has three other cousins, one of whom is transgender and two who are bisexual. Rebecca also says that she was attracted to boys too. In high school, she met girls similar to herself. Rebecca was an active choir member and sports woman. Later on, she married a man and had a beautiful daughter, but the marriage did not last, due to infidelity on the husband's part. Then she decided to focus on being happy and to follow her heart. She has since been in three long term relationships with women and does not intend to date men again. Recently someone told her family that she is a lesbian and Rebecca faced a lot of discrimination from her brothers and sister. They declined to talk to her, where previously they were warm and open. Her sister agreed for Rebecca's daughter to visit her, but not Rebecca. This caused a lot of tension between them. But slowly, Rebecca says that some of her family members are starting to accept her for who she is and some of her cousins even ask curious questions about what it means to be lesbian.

Irene

Irene is Kambaand was born in Kitui, and now resides in Nairobi. She is thirty years old and had a difficult beginning in Ukambani. She became an orphan whilst still very young and well wishers became her guardians and raised her. After many years of searching for people like herself, Irene managed to locate a local lesbian and gay organization and through it, the local lesbian community. Irene has been very actively involved in building up her skills as a young professional administrator and helping the LGBT community. She says that poverty, discrimination and both internal as well as external homophobia have made the lives of many gay, lesbian and transgender individuals very difficult. Some resort to alcohol and drugs and even petty theft just to make ends meet. Recently Irene recalls, she went to a local health centre for treatment and was abused and discriminated against once the nurses and doctors became aware that she identified as a lesbian. The reason they knew she was a lesbian was because of her insurance card which carries the name of a

prominent LGBT organization. During several visits she was asked by the doctor, 'Are you one of them? What kind of drugs do you take? Do you sleep with men? Do you have a girlfriend? How do you do it? Do you need counselling? Do you believe in God? Can I pray for you?' He also proceeded to tell Irene she should buy a Bible and should change her ways. Irene felt very uncomfortable during her visits to the health clinic and felt as though she would never be accepted for being who she is. Today Irene says she is in a stable relationship and always treats her girlfriends well. She also feels that she is making a valuable contribution to the larger society in her work with LGBT people.

Amanda

Amanda was born in Sweden, has Luo and Swedish heritage and resides in Nairobi. She is a human rights activist. Amanda is in her mid-thirties and has had feelings for girls since she was eight years old. She was very attracted to her best friend in those early years but even though she told her about her feelings, her friend did not understand the depth of those feelings until many years later. Amanda continued to feel deeply attracted to girls even in primary school but did not act on them. In Fourth Form of High School, she fell in love with a girl younger than herself and a deep friendship blossomed. However she says that she did not sleep with the girl. It was not until her early twenties that Amanda started dating men and though she loved them, she still felt attracted to women. She says that when her last boyfriend found out that she was bisexual, he grew so insecure that the relationship broke up. Amanda also felt that the men she dated were hoping for her to be the feminine-skirt-wearing, long-haired woman of their dreams, but that the image did not fit her own personal construct of herself. She was more comfortable with trousers and short hair. Furthermore she feels that relating emotionally with women is easier than with men, and the sex is great. Amanda describes herself as technically bisexual but a practising lesbian. This is because she knows that she is attracted to both women and men but feels more satisfied in relationships with women. Amanda has also had problems with the term 'lesbian', feeling that it did not sound right. If she could create another label for herself, she would.

Jane

Jane is Kikuyu, born in Kiambu and living in Nairobi. She is in her late twenties or early thirties. She says that she became an orphan very early in her life and had to move from one orphanage to another while she grew up in Nairobi. Jane was attracted to girls from early on, but every

time she showed any kind of affection to girls or tried to kiss them, she would be thrown out of the orphanage. Eventually she had a child with a man, and two other children followed. Jane is unemployed and because she never completed her education, she finds it very hard to find work. So she says she has turned to sex work, offering services to both men and women. However she is currently trying to make ends meet through manual labour. She says she feels deeply attracted to women.

Danicho

Danicho, a 27 year old Luo man, was born and resides in Kisumu. He says that he is not 'out' to his family about his sexual orientation. He has a boyfriend and he says that the larger LGBT community in Kisumu admires his relationship because it seems very strong and stable. He attributes this to good communication between the two of them. Danicho is a medical student and says that when ever his dad brings up the topic of marriage, he tells him that he wants to finish his studies and maybe even do his doctorate. His father apparently married at age 25. Fortunately his father is understanding, but Danicho still feels pressured by society into conforming and marrying, because many of his friends are married.

James

James is Kikuyu and was born in Mombasa, and now resides in Nairobi. He is in his thirties and grew up in Mombasa but later moved to Nairobi. He says he felt attracted to other guys from early on. He also has a cousin who is a lesbian. James has been working in the modelling industry, teaching models how to strut the catwalk and also had a boyfriend for a few years. He says that his boyfriend was very abusive to him, often hitting him and verbally insulting him. Eventually they broke up. James is now very active in highlighting the challenges faced by gay men, and he offers guidance and advice to people who are HIV positive.

Ngacha

Ngacha is Kikuyu and resides in Nairobi. He is in his forties and says that after he returned from further studies in the 1980s, he was earnestly searching for the LGBT community, only to be surprised to find many gay men hanging out around the public toilets in the central business district. He says the gay men met to socialize but some also formed very strong long term relationships. They came from as far as Garissa and other towns. Ngacha has been actively involved in the human rights arena, offering consultative advice and support on issues like HIV and general health of the LGBT community.

Larry

Larry is Luo, grew up in Nairobi. Larry is twenty-seven years and says that he grew up with his grandmother and uncle and family. He says that he too has always been attracted to men and boys as he was growing up. His sexual orientation was unfortunately exposed in the media and when his uncle found out, he was so angry, that he kicked Larry out of the house and withdrew financial support for his university degree. For a while Larry, says he depended on hand outs and support from his friends. Fortunately his grandmother never gave up on him and she eventually bridged the rift between him and his uncle. During some of his discussions with her on homosexuality, he says that his grandmother mentioned the name 'Nyalhana' (he is unsure of the exact word) which she said meant bisexual people or those who did not conform to any gender identity – who made advances to people of one sex and sometimes to the other sex.

Felicity

Felicity is Kisii. She used to live in Nairobi and over the years has been faced with numerous homophobic incidences. First she had a flower selling business but when clients found out that she was a lesbian, they shunned her, so she was forced to look for other work. She got a job teaching children at a school. One day her employer found out that she was a lesbian and fired her on the spot, claiming the children's parents would not allow her to teach. She also called her a sinner.

Then Felicity set up a business making bead craft work, employing some people to help her. She started to export the crafts two years ago. Business was hard and in 2009 she was attacked by a homophobic person in a disco in Nairobi. She was hit on her forehead and bled profusely. She ended up in hospital, received several stitches and had bleeding in and around her eye. Around this time, while she was in hospital, her crafts shop was broken into and she lost her materials and documents. The assault case went to court, but Felicity had to disguise herself so as to avoid the media attention. Her friend, who was witness to the attack, abandoned her for fear of the media attention and the security risk. She had been represented by a lawyer, whose services had been used by another gay man because of his willingness to work with LGBT people. It turned out that this lawyer had been deregistered, yet he had continued to offer services. He even demanded payment and at one point suggested to Felicity that she pay off the prosecutor so that he would be more interested in pushing her case in court. Felicity says that she refused to do this. Eventually she stopped engaging his services.

Finally she made one last attempt to try to get her business back on track and went to the US to sell her crafts. The accumulated trauma she had been carrying with her prevented her from doing much and she was stuck for a while without money, relying on hand outs from people. She sought asylum and does not want to return to Kenya until she has rebuilt her life.

Jody

In her early forties, Jody is Kikuyu. She lives in Nairobi, and runs an IT business. She says that the story of her exploration of her sexuality and sexual orientation is short and that she has not quite made up her mind about it. She says that she did not initially have feelings for women when she was growing up. She had always been a staunch Christian. However, when she returned from the US, she was pursued equally by several Kenyan women and men. She dated men at first but got tired of them. Eventually she started getting interested in the women and even found some of them attractive. Jody says after dating both men and women, she grew tired and was none the wiser about where her affiliations lay. She says she is bisexual but still not sure which side of the fence she will land with regards to sexuality and orientation. Jody would like to have children some day and so is still working on her 'baby project'.

Discussion

The stories above show similar patterns. The gay men or women often start feeling attracted to people of the same gender in their early years but are often afraid to act on them. Later in life some succumb to societal pressure to conform and date or marry persons of the opposite sex. This is reflected in other studies such as KNCHR (2012) and Beyrer et al., (2011) as quoted by Mbote (2011). Interestingly, the case stories above, however, show that most of the individuals have resisted this pressure. In the case of bisexual persons, the marriage may or may not be a result of force – sometimes out of love. Feelings of attraction to people of the same sex, however, still persist even during these heterosexual relationships. When the heterosexual relationships end these men or women may feel no real obligation or inclination to try again. Instead they move on to explore their more dominant attractions, i.e. to people of their own gender. In a sense they defy the predominant sexual hegemonies in their communities. More in-depth information on bisexuality may be found in Klein's 'The Bisexual Option' (Klein 1993).

Of interest is the case of Danicho who exerts his power to get his way. By telling his father, who may not have gone on to university level, that he must finish his undergraduate and even postgraduate studies, Danico

is taking advantage of the socio-cultural value of 'education' to counter his father's value of 'marriage'. Though a man, Danico's confidence may well be a reflection of a phenomenon in which education levels affect the age at which a young adult woman gets married (Jejeebhoy 1995). Being a strong man in his late twenties, with an advanced education gives him leverage over his father. Jody is interesting here in that she chooses not to make a decision about where her affiliations lie regarding sexuality or sexual identity. She keeps all her options open – marriage, children, and a satisfying sex life. Again this could also be a reflection of education, being a strong determinant for age of marriage and choices made in life (Jejeebhoy 1995).

Jane's story is special in the sense that she seems to have been open and free about her sexuality from very early in her life. She received numerous hard knocks from unkind and 'mis-educated' people at various stages in her life but must have found courage and perseverance from within herself to push on. Felicity, Rebecca and Irene too have overcome economic, physical and emotional hardships – realities for many LGB persons in Kenya (KNCHR 2012:94), but have persisted in finding same-sex partners throughout their lives. A life-long identity with ones sexual orientation has been found with several researchers (including Shere Hite 1976, 1981, 2004). Larry's story shows that an open discussion regarding non-hegemonic sexuality can take place between a grandmother and her grandson, and that acceptance can be found in the home even when one least expects it. Amanda's story exposes the insecurities that people feel when confronted with a phenomenon that negates normative sexual hegemonies. This is common amongst people who fear or hate homosexuals or bisexuals, dating back around 1200s during the life of Saint Thomas Aquinas.

Amanda's discomfort with wearing frilly feminine clothes and conforming to normative gender behaviour means that finding a partner will be determined by that individual's open-mindedness and ability to see beyond external appearances. James and Rebecca's stories show that sexually non-hegemonic persons can appear in numbers within extended families and may not be isolated cases. Still the development of sexual orientation is complex (Rosario et al. 2006). James's story also indicates that relationships between same-sex loving persons are as pre-disposed to the complexities of gender-based-violence as heterosexual relationships are. All stories, ranging from the youngest individuals to the oldest, Ngacha, show the intergenerational existence of same-sex loving persons who continuously challenge sexual hegemonies throughout their lives.

Conclusion

All the individuals have made positive contributions to society. By confronting homophobic speech, and actions from persons in their lives, these gay or bisexual men and women eventually build the courage to stand up for themselves. They explore same-sex relationships, with both negative and positive results. Ultimately, however, they work towards being in full control of their relationships and lives. The pursuit of happiness can be a painful one but has its rewards in the end.

This study recommends that in order for us to get a deeper understanding of the issues relating to same-sex relations in Kenya, it is important to carry out more studies into same-sex loving persons from the Abagusii, Maasai, Mijikenda communities. In addition, a further in-depth study on the lives and experiences of these and other individuals from the LGB community would expand the knowledge we currently have on same-sex relations. Lastly, more in-depth interviews of elderly persons over 60 years on sexuality in traditional communities would help us put same-sex relations in Kenya into a proper historical context.

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Rape and Women's Sexual Health in Nigeria: The Stark Realities of Being Female in a Patriarchal World

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Abstract

Historically, women have always been subjugated and oppressed by men in most cultures in Nigeria. This situation is due to the inequality in gender relations between men and women. Rape has always been with mankind throughout the world. However, in recent times, the incidence of rape has increased in Nigeria. The hegemonic patriarchal values and practices make it difficult for women who are raped to obtain justice. Perpetrators often go unpunished even if the victims have the courage to report the incident. The court acquits most of the rape offenders on account of the lack of evidence or because the victim has a 'questionable' character. Owing to this, rape victims suffer in silence due to the stigma and humiliation attached to the public acknowledgement of rape. This article examines how patriarchy interlocks with gender relations and inequality to deny justice to rape victims. The paper looks at the issues of gender and rape and their implications for the health of the victims. Feminist theory is used to explain rape, the societal reaction to it and the health outcomes for the victims. The paper concludes that many health problems suffered by women in Nigeria are as a result of rape. Public health practitioners should devise mechanisms of eliciting rape information from victims so as to effectively manage their health problems. The paper recommends the need for more practical ways of implementing laws on violence against women so that victims can obtain justice. Also, the role of women lawyers and other women's organizations should be reassessed.

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Résumé

Historiquement, les femmes ont toujours été asservies et opprimées par les hommes dans la plupart des cultures au Nigeria. Cette situation est due à l'inégalité dans les relations entre les hommes et les femmes. Le viol a toujours été une pratique courante dans l'histoire de l'humanité. Cependant, ces derniers temps, le nombre de viols a augmenté au Nigeria. En raison des valeurs et pratiques patriarcales hégémoniques, il est difficile pour les femmes violées d'obtenir justice. Les auteurs restent souvent impunis, même lorsque les victimes ont le courage de dénoncer l'incident. Les tribunaux acquittent la plupart des auteurs de viol faute de preuves ou parce que les victimes sont d'un caractère « douteux ». De ce fait, les victimes de viol souffrent en silence à cause de la stigmatisation et l'humiliation liées à la reconnaissance publique du viol. Ce papier examine les liens entre le patriarcat et les relations et l'inégalité basée sur le genre qui motivent le déni de justice aux victimes de viol. Cet article se penche sur les questions de genre et de viol et leurs conséquences sur la santé des victimes. Le viol, la réaction de la société à ce phénomène et les résultats en matière de santé pour les victimes sont analysés à la lumière de la théorie féministe. L'article conclut que de nombreux problèmes de santé dont souffrent les femmes au Nigeria sont le résultat d'un viol. Les praticiens de la santé publique devraient concevoir des mécanismes pour recueillir les informations nécessaires auprès des victimes de manière à gérer efficacement leurs problèmes de santé. L'article recommande la nécessité de trouver des moyens plus pratiques pour assurer l'application des lois sur la violence contre les femmes afin que justice soit rendue aux victimes. En outre, le rôle des femmes juristes et d'autres organisations féminines doit être réévalué.

Introduction

Rape has always been condemned by most societies around the world. It is usually associated with primitiveness and brutality and it is not seen as something that would be found among refined people. Most societies define rape as a criminal offence and those found guilty of rape are severely punished. Rape can be perpetrated by a man or a woman but in this paper I focus on the woman as the victim. Rape can be by a stranger or by someone who is very familiar such as a husband, brother, in-law or other relations.

Before I proceed, I will define the concept of rape. Rape is used interchangeably with sexual assault and sexual violence (Kilonzo et al., 2009). The World Health Organization defined sexual violence as any sexual act, attempt to obtain a sexual act, unwanted sexual comments and advances or acts to traffic or otherwise directed against a person's sexuality using coercion by any person regardless of their relationship to the

victim. In the same vein, Onyejekwe (2008) defined rape as one of the more pervasive forms of violence against women and a crime in which the assailant uses sex to inflict humiliation on the victim or exert power and control over the victim. The Declaration on the Elimination of Violence Against women adopted by the United Nations General Assembly in 1993 defines violence against women as any act of gender based violence that results in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (Onyejekwe 2008). Also, rape can be defined as sexual intercourse or other forms of sexual penetration by one person (the accused) with or against another person (the victim) without the consent of the victim (Peters and Olowa 2010).

In recent times, there has been an upsurge in cases of rape in Nigeria. In a study of causes and incidence of rape among middle aged and young adults in Lagos State, Nigeria, Peters and Olowa (2010) found that between 2001 and 2005, 10,079 rape cases were reported. The same study also indicated that only 18 per cent of rape cases in Nigeria are reported. A figure of 10,079 (which is assumed to be 18 %) within these few years, is an indication that rape is very rampant in Nigeria and constitutes a serious public health problem. In the same vein, Kilonzo et al., (2009) indicated that in the WHO multi-country study on women's health and violence against women, 15-59 per cent had at some time experienced sexual violence from intimate partners in Nigeria, Kenya, South Africa and other sub-Saharan African countries. According to Amnesty International (2007), rape by police and security forces is endemic in Nigeria as is the abject failure of the Nigerian authorities to bring perpetrators to justice. In their report, Amnesty international quoted a rape victim:

> There were three men, I have pains even today, they used my daughter too, she is 12 years old. They also raped my sister. Another man raped a woman who was four months pregnant and she lost the child. They were military men. Everyone in the village saw them, they didn't hide, they didn't care, I didn't tell the police because I fear them.

Rape continues to be experienced by Nigerian women and girls on a daily basis. According to Adesewo (2012), a 14-year old girl was raped by a 45 years old police officer in police station in Abuja. The girl reported that she was arrested along with another girl for fighting. When they got to the police station, the police officer took her to an uncompleted building and promised to secure her release if she agreed to have sex with him.

When she refused, the police officer threatened, rough-handled and forcefully had sex with her. This is one of the many rape incidents in Nigeria. In fact, it is as if the police and many other men see raping women as a fringe benefit and entitlement which may explain the impunity with which they rape women.

Rape has serious health consequences for the victims, including unwanted pregnancy, abortion due to unwanted pregnancy which can result in death, sexually transmitted infections including HIV, and psychological trauma which can extend to the rest of the person's life. According to Peters and Olowa (2010), rape has serious aftermath effects which include physical and psychological trauma, gynaecological problems such as sex trauma, urinary tract infection and sexually transmitted infections. As such, rape should be handled by the state with all seriousness. However, what obtains in many countries is that the society and the legal system make it very difficult for rape victims to obtain justice. Often victims are stigmatized and are considered a public disgrace to their families and significant others which may have serious implications for future relationships such as marriage. As a result of this, rape victims and their families are silent about their ordeal, thereby helping the rapist to escape from being punished.

Many Nigerian women who have been raped suffer in silence without reporting the incident to law enforcement agencies. Onyejekwe (2008) corroborates this and maintained that a culture of silence aggravates this problem partly from humiliation and intimidation of victims by the police as well as the embarrassment of public acknowledgement. In addition to this, being ostracized by those who consider rape as bringing dishonour to the woman's family and community worsens the situation (Hutton et al. 2006). Onyejekwe concludes that this culture of silence reinforces the stigma already attached to the victim rather than to the perpetrator, as the dominant perception is that women have provoked the abuser to attack. As such, victims are often unwilling to testify about their experiences. Apart from the physical aspect, some of the rape victims suffer mental health problems and trauma and other health hazards such as sexually transmitted infections including HIV/AIDS.

It is against this backdrop that this commentary examines rape and its health implications in relation to the influences of gender, cultural beliefs and practices, discrimination, women's low social status and how these affect women's sexual health, health generally and quality of life. The paper therefore unfolds with a discussion of the theoretical framework, the health implications of rape and ends with concluding remarks.

Before I delve into the various explanations of rape, it is important to explain the term patriarchy because of its central role in how and why women experience rape. Patriarchy is the term used to explain the societal beliefs, stereotypes, value systems and cultural practices which are embedded in the social system and which determine gender relations and influence the life chances, experiences of men and women. According to Trull (1997), patriarchy, male domination, discrimination and sexism have characterized every civilization. Interestingly, when gender interlocks with other patriarchal values and practices, it becomes a double burden. This is because under patriarchal values and practices, females are regarded as inferior human beings and are expected to be pure and gentle which means that experiencing rape renders the woman impure and she becomes an object of laughter, stigma and humiliation. The culprit can even taunt his victim openly.

There are other explanations of rape which include sociological or psychological theories. Some psychological theorists have maintained that stagnation of the Oedipal stage of development in males makes them prone to having sexual problems later in life, such as the failure to handle competitive relationships, thereby contributing to acts of rape (Peters and Olowa 2010). The sociological theory of rape posits that rape is an evolutionary strategy for certain males who lack the skill to obtain sex from females through non-violent means (Peters and Olowa 2010). Some sociologists believe that rape is an expression of gender inequality while some other sociologists attribute rape to sexual permissiveness within the society (McGrath 2009). Under such circumstances, if a woman refuses a man sex, he can go the extra mile to take it by force.

There have been many explanations for rape but this paper argues that rape represents a weapon of power and intimidation between the rapist and the victim and that this power-gender relation stems from the patriarchal views and practices which render women second class citizens. It also makes it possible for discriminatory acquittals of the rapist. It is important to point out here that gender has always been a factor with regard to the treatment of individuals and collectivities. In the explanation of the phenomenon of rape, feminist theory can be used to shed more light on how women's low social status and subordinate position interacts with patriarchal gender relations to make them victims of rape and makes it possible for the victim to be stigmatized instead of the offender.

Cornell's theory of gender and power (1987) is in line with the above position. This theory posits that the gender division of labour, gender

differentials in the way men and women are perceived, and the cultural placing men above women, all play a great role in the subjugation of women. These factors translate into women's poverty, powerlessness and low social status which in turn affect women's life chances and colour their experiences. This could explain why women suffer in silence because if they complain or report their rape experience, they may suffer the stigma and humiliation, and at the same time be blamed for their inadequacies because the societal general perception is that the victim must have provoked the rapist to attack, perhaps through her 'provocative' appearance (Onyejekwe 2008).

The theory insists that women's experiences should be viewed from the angle of power and dominance which the social structure awards men. This is usually at all levels of the social institutions; the family, economy, health and educational systems. Feminists agree that something is amiss in the treatment of women – what Betty Friedan (1963) memorably described as a problem without a name. Feminism is not only a set of beliefs but also a set of theoretical constructions about the nature of women's oppression and the part this oppression is played out within social reality more generally (Stanley and Wise 1983). Feminists believe that rape is an expression of male dominance over women as a result of society's long time sexual inequality. Therefore rape is used to intimidate women and keep them in their place. As such, it is an expression of power and dominance over women (McGrath 2009).

It is this issue of gender relations skewed against women and the fact that women are seen by society as people to be exploited that also makes it difficult for rape victims to obtain justice. In fact, the court requires the victim to prove her innocence and in the process it acquits most rapists. Onyejekwe (2008) corroborated this difficulty and said that rape is a crime notable for placing the woman on trial, particularly for cultural reasons. She is either charged as a false accuser, a gold digger, a frivolous or a scorned woman. Furthermore, describing the Nigerian situation, Amnesty international (2007) said that poorly defined criminal laws and weak law enforcement also create an environment where rape is committed with impunity. This inadequacy of the law interacts with societal norms and stereotypes to turn rape victims into accused persons. According to Imokuede (2007), Nigerian law defined rape as a forcible unlawful sexual intercourse without a woman's consent. The same law also made it mandatory that for a rapist to be convicted rape victims must prove beyond reasonable doubt that they were forced and to provide evidence of rape by showing, for example, semen. Onyejekwe (2008)

concludes that the failure of Nigerian government to investigate and punish those responsible for these grave abuses is a violation of the general principles of the human rights charter.

In the prosecution of gender based violence, juries put female victims on trial for their compliance with gender roles. Studies show that one of the predictors of conviction in rape cases is whether the female victim behaves appropriately (Tetlow 2009). In the process of examining the appropriateness of a women's behaviour, many rape cases end up in the acquittal of the rapists. In this way, the victim is turned into the accused. This discourages rape victims from seeking redress, thus perpetuating the culture of silence. The weakness of the prosecution laws in Nigeria was corroborated by Amnesty International (2007) when it asserted that the harsh reality is that if you are a woman or a girl in Nigeria who had suffered the experience of rape, your suffering is likely to be met with intimidation by the police, indifference from the state and knowledge that the perpetuator is unlikely to ever face justice. According to Amnesty International, there is a near total failure of the Nigerian state to protect women and girls from these terrible crimes. The Nigerian government has taken no meaningful action to translate its international legal obligations towards women and girls into national law, policy and practice. Looking at how patriarchy, the long history of gender discrimination, gender relations and women's low social status have played out to affect the outcome of proceedings of rape cases, one could not fail to see that inequality in gender relationships, power and oppression are key issues in rape against women.

The implications of rape for women's health

When people talk about implications of rape for the victim, people hardly ever refer to health implications for these victims. Many rape victims have acquired HIV/AIDS and other sexually transmitted infections which can result in infertility. Indeed Peters and Olowa (2010), have reported that rape results in trauma, sexually transmitted infections and potentially unwanted pregnancy which itself constitutes a traumatic experience. Also in order to save themselves from public embarrassment and ridicule, many rape victims who become pregnant through rape attempt abortion. This is in line with Kilonzo et al., (2009) in which they submitted that sexual violence can result in negative short and long term health outcomes including physical trauma such as vaginal fistula, HIV infection, and in places where abortion is restricted, unsafe abortions. It is important to note that unsafe abortion goes with health consequences such as infertility, psychological trauma or even death.

Moreover, rape leaves behind a big scar on the mind of the victim. Many rape victims suffer trauma and depression and these affect their education and work and may have implications for how other people treat them. Some rape victims can develop perpetual fear or hatred of men and may not want to have any intimate relationship with men, which is an indication that the sexual health of such person is affected. Kilonzo et al., (2009), observe that psychological trauma can have a negative effect on sexual behaviour and relationships, the ability to negotiate safer sex and an increased potential for drug abuse. Importantly mental health issues as a result of rape are not seen as crucial and this is why little has been mentioned about them. According to Kilonzo et al., (2009), there is poor documentation of long term sexual and reproductive and mental health outcomes of sexual violence. Interestingly, this mental health outcome is the most important aspect of the health of victims, because it is usually the aspect that lasts for a very long time and in some cases till the death of the victim.

Conclusion

From the foregoing, it is evident that victims of rape suffer from enormous health problems. Women experience rape not only from strangers but also from intimate partners and people known to them. The stigma associated with rape creates the culture of silence as many women and their families do not want to disclose their experience. The hegemonic patriarchal practices and values and weak legislation make it difficult rape victims to obtain justice. The paper concludes that many health problems suffered by women in Nigeria are as a result of rape. This is especially so in regards to mental health problems because suffering in silence has rendered many of them sick without people knowing what their real health problems are which makes them very difficult to solve. This means that there are many women who may have to live with the trauma throughout their life span – should be a source of worry for public health practice and practitioners in Nigeria.

In spite of the frustration and discouragement arising from the outcome of many rape cases, it is still important to fight on. On the part of government, there is the need for a more practical way of implementing laws on violence against women. Also, women lawyers, women organizations and other Non-Governmental Organizations should continue to empower women for them to be able to speak up and their assailants brought to book. That is the only way that this cancerous worm called rape can be eliminated or reduced to the barest minimum in Nigeria.

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Reproductive Health Aspirations and Unmet Needs in Urban Slums in Ibadan and Kaduna, Nigeria: A Qualitative Exploration

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Abstract

Reproductive health issues of urban slum dwellers are among the most challenging in Africa. Studies have generally examined this issue across the rural-urban dichotomy, without specific focus on urban slum dwellers. Many of these studies are also mostly quantitative. We utilize the qualitative approach to fathom the aspirations and challenges of urban dwellers in the domain of reproductive health. The results confirm that they aspire for smaller-sized families and healthy sexual and reproductive lives but are constrained by religious and socio-cultural factors. Idioms associated with their aspiration and experiences were well documented. There is the need to intervene in order to improve the sexual health of urban dwellers.

Résumé

La santé de la reproduction des habitants des bidonvilles sont parmi les problèmes les plus difficiles en Afrique. Des études ont été généralement menées sur cette question à travers la dichotomie

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rurale-urbaine, sans un accent particulier sur les habitants des bidonvilles. Plusieurs de ces études sont également la plupart du temps quantitatives. Nous utilisons l'approche qualitative pour comprendre les aspirations et les défis des citadins dans le domaine de la santé reproductive. Les résultats confirment qu'ils aspirent à des familles de plus petite taille et à une vie sexuelle et de reproduction plus saine mais sont limitées par des facteurs religieux et socio-culturels. Les idiomes associés à leurs aspirations et expériences ont été bien documentées. Il est nécessaire d'intervenir afin d'améliorer la santé sexuelle des citadins.

Introduction

Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination and violence (WHO 2002). Unfortunately, indicators from many developing countries particularly in sub-Sahara Africa suggest otherwise.

According to World Health Organization (WHO) Technical Consultation Definitions (2004), sexual health is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. Similarly, the World Association for Sexual Health (1999) suggested that human sexuality is constructed through interactions between the individual and wider society. These assertions provide the platform for the intellectual discourse on the understanding of sexual health of urban-slum dwellers as well as the distinctions between their sexual patterns and that of other urban dwellers. These distinctions are related to their social space and boundaries, language, opportunities, and challenges. Previous evidence on measurement of the unmet need for family planning has been purely quantitative (Ashford 2003; Becker, 1999; Bankole and Ezeh 1997; Westoff and Bankole 1996). Besides, the depths of understanding provided by previous numerical estimates and analysis considered urban dwellers as homogenous groups.

The theoretical underpinning to this analysis is guided by the environmental theories which posit that the attributes of larger social units such as neighbourhoods may have an influence on sexual behaviour, above and beyond the impact of factors impinging on a person from his/her immediate social context of family and friends (Leventhal & Brooks-Gunn 2000). The environmental factors may include civil and organizational elements as well as policy and economic issues (Careal 1997; Sweat 1995). Studies have found that sexual behavior may be influenced by neighbourhood variables including the overall level of

poverty and residential instability, and the prevalence of crime and aggressive behaviour (Hawkins et al. 1992). The depth of these constructs therefore, requires a thorough understanding of issues and the interconnectedness of these factors as they relate to sexual health in urban-slums. This is the gap identified in this article. The current analysis is therefore focused on assessing the sexual and reproductive health needs of urban slum dwellers, and also to examine the challenges at individual, household and community level attaining their sexual and reproductive needs. This is with a view to understanding languages associated with their aspirations, desire, unmet needs and sexual behaviour.

According to the UN-Habitat (2003, 2006) definition, an urban slum is a heavily populated urban area characterized by substandard housing and squalor. Beside these characteristics are issues of deprivation of basic social amenities and infrastructure. The living arrangement patterns in many urban slums are mostly considered as over-crowded and often unfavorable to healthy sexual living. These explain in part the high frequency of sexual anomalies and their consequences such as rape, early sexual initiation and high vulnerabilities to unwanted pregnancy and unsafe abortion associated with such living arrangements (Gary-Webb, Baptiste-Roberts et al., 2011; Jones, Sivarajasingam et al. 2011; Kabiru, Beguy et al. 2011; Greif 2012).

Compared to urban centres, evidence has shown that there are very poor sexual and reproductive health outcomes among women in urban slums. Studies have confirmed that women in urban slums have very little or no ability to communicate effectively on their sexual needs and to resist sexual demands (Bojko, Schensul et al. 2010). Also, men in urban slums have a higher likelihood to accompany socializing with alcohol use and there are very high tendencies to sexual risk taking (Singh, Schensul et al. 2010). Studies have also documented that social factors in urban slum areas influence to a large extent the sexual orientation and behaviour of youth (Adedimeji, Heard et al. 2008).

In Nigeria, the total fertility rate is estimated at 5.7 children per women, with over one-third reported as mistimed or unintended births (NDHS, 2008; Akinyemi et al. 2010). The unmet need for family planning is quite high with a very low prevalence of contraceptive use estimated at less than 15 percent. There are obvious rural/urban differentials across these outcomes, mostly in favour of urban residence and for those with higher social status, including education (Bankole et al. 2007; Akinyemi et al. 2010; Babalola and Fatusi 2009; Akinyemi and Felix 2011; Omideyi et al. 2011). However, such evidence is over-generalized and conceals some important aspects related to the typology of 'urban conglomeration'. A ma-

jor neglected group in research is the urban-slum dwellers. This group of people are mostly neglected and usually concealed as urban dwellers. Current evidence has shown that they are different in social configuration and exposure compared with other urban dwellers (NURHI 2012).

Methods

Study Setting and data

The study utilized a qualitative approach with data collected through the use of focus group discussions (FGD) in two towns (Ibadan and Kaduna) in Nigeria. The justification for the selection of these urban centres is the metropolitan nature of these areas and slum areas which fit into the study objectives. In Ibadan, Agbowo community was selected while Tudun Wada community was selected in Kaduna. The study was part of the Nigerian Urban Reproductive and Health Initiative (NURHI) study which was carried out in collaboration with the School of Public Health, Johns Hopkins University, and the Population and Reproductive Health Programme (PHRP) of the Obafemi Awolowo University, Ile Ife, Nigeria. The broad aim of the project is to understand the constraints for family planning utilization among the poor and middle class people in Nigeria.

Study participants

Recruitment of participants for the focus group discussions took place at the community and the health facility levels. Key-informants included both heads of facilities and traditional political structures in both communities. The community heads ('Baale' in Ibadan and 'Mai-ungwa' in Kaduna) were very useful in mobilizing participants at the community levels while the heads of the health facilities helped in recruiting eligible participants (especially females) at the facility levels. However, a systematic strategy was worked out such that all gatekeepers worked together to ensure that eligible participants were recruited. Based on the objectives of the study, only married and unmarried men between the age of 18 and the age of 49 years and married and unmarried women between the age of 18 and the age of 35 years (Users and Non-Users of Contraceptives) were included in this study. The participants were purposively selected to ensure that they met the age categories and were actually residing in the communities. Thus, a two stage procedure was used starting with pre-FGD questionnaire administered to community members. The questionnaire specified the criteria for the selection of the FGD participants. The participants who met the criteria for the study were then selected and invited for participation.

The FGD guide was translated into the local languages (Yoruba and Hausa) of the participants. The focus group discussions involved the use

of photo elicitation, vignette (story telling) and card ranking. The photo elicitation was done by presenting two families, one with six children and a pregnant wife in an unattractive environment while the second family had two children in a beautiful and attractive environment to elicit the views of the participants on advantages and disadvantages of large and small families. The vignette related the story of a woman faced with some decisions crucial to her sexual and reproductive health. The story was related in the relevant cultural context and it led to some questions that examined participants' attitude to vital reproductive health issues. The card ranking exercise involved a scenario where participants were asked to state their attitudes and perceptions of certain sexual and reproductive health indicators using three colours (red, yellow, and blue,) representing 'most risky', 'somewhat risky', and 'least risky' respectively. The sexual behaviours ranked by the participants include getting pregnant soon after having a baby, having six or more children, giving birth below 18 years, and abortion. Also, the contraceptives ranked include pills, injectibles, IntraUterine Device (IUD), fertility awareness, sterilisation and condoms. Sixteen FGDs were conducted (eight in each community) in the selected urban slums. The groups were younger married females (users and no-users of contraceptives) (two groups), older married females (users and no-users) (two groups), young unmarried females, older married males, young married males and young unmarried males. Each focus group comprised of participants ranging from between eight to twelve people.

Ethical considerations

The research instrument was approved and certified by an institutional review board at Johns Hopkins University, the Obafemi Awolowo University Ethical Board, and the State Ministry of Health of the Republic of Nigerian in Ibadan and Kaduna. Informed consent was obtained from all participants prior to the FGDs while the anonymity of the participants were guaranteed. All FGDs were audio-recorded and a note-taker was also present during the FGD sessions. Permission was obtained from the participants prior to audio-recording of the sessions. The recorded data were later transcribed verbatim using standard transcription techniques. All informed consent documents, audio recordings and transcripts were kept under lock and key at the study site.

Data Analysis

The analysis of the data was in two stages. A rapid analysis of the field notes was done first and this showed a clear pattern of the data and helped in developing themes and codes for the second phase of the

analysis. In the second phase of the analysis, data collected were transcribed and the transcripts were edited for accuracy. The transcripts were imported to the Atlas.ti software for qualitative analysis and themes were developed in line with the objectives of the study. Grounded theory approach was used to analyze the data. Hence, the data were coded for new categories until the level of saturation was reached. Analysis and presentation include content analysis with frequency counts of identified theme/codes, illustrative quotations as well as aggregated and disaggregated thematic and network mapping of family planning desires and challenges confronting the slum dwellers in family planning utilization.

Results

Sexual and Reproductive Health Desires among the Participants

The sexual desires of participants were assessed through indirect methods of the vignette and storytelling. Presented with two photographs – one depicting a large family and the other a small family – participants were asked to express their views on the two photographs. Table 1 presents the general description of the large and small family among the FGD participants. This is necessary in order to understand the participants' perception of large and small families which could eventually influence their fertility expectations and consequently their desire for family planning or otherwise. The figures in the cells (0 – 9) in the table refer to the number of quotations per coded theme per FGD. The large family was predominantly described in a negative way with 52 different quotations from the participants as against 11 quotations describing it as good and admirable. The participants described the large family as turning their family into a baby factory. In their words, some participants related:

> The large family was just producing kids anyhow without adequate spacing in between them. 'Won mbimo bi elede' (Yoruba language) i.e. they were just mass producing babies like pigs. [Older Married Woman, 32 years, Current User, Trading, Primary, Christian, Ibadan Agbowo]

> The second family (large family) does not seem to have the capacity to cater for the number of children they had. When the children are grown, you might see them in the motor parks selling pure water (water in small sachets), gala (Snacks) to trailer drivers. Though some may eventually go to school but they have to source for money themselves. The females among them may become house helps and have to depend on their benefactors to send them to school or learn a trade. [Young Married Woman, 24 years, Current User, Trading, Senior Secondary, Muslim, Ibadan Agbowo]

> The large family is just producing children one after the other. If they continue that way, it is going to be very tough for them because there is a need to be spacing children so that the mother can rest and even if she will be pregnant again, it should be later. [Older Married Woman, 32 years, Current User, Housewife, Quranic Education, Muslim, Tudun Wada, Kaduna]

> This family looks poor and they might yet be ignorant of the role that the large family size is playing in their poverty. They already have five kids, and the wife is already carrying the sixth child in her womb. I don't think they can be happy in such a situation. [Older Married Woman, 30 years, Non-User, Trader, Senior Secondary, Christian, Agbowo Ibadan]

On the other hand, the small family was predominantly described as good looking, well kept and enviable (65 reports). Among most of the FGD participants, it is believed that the small family would be happy with their condition (33 as against 6 reports) stating that they may not be happy with the number of the children they have, while the large family will not be happy with their condition (31 respondents as against for believing that there is joy in having many children). A participant noted:

> With a small family, your stress can be minimized and your life may be better off [A 32 year old woman in Kaduna]

The need to satisfy basic needs such as food and clothing will pre-occupy the large family and this will make the aspiration for a better future difficult for the children (62 reports) while the children from a small family have the potential for a better future since the family will be able to invest in their education and health (60 reports). Many participants therefore believed that the larger the family size, the more difficult it is for both parents and children to aspire for a better future and vice versa. There were 26 quotations supporting this view as against 11 expressing that the individuals' future is determined by God and not the factor of family size.

Although there is the desire for family planning across the entire group (61 quotations), there is also a high fertility desire among the participants across the different groups in the two slums selected for this study (28 quotations desiring an average of four children). Most of the participants rejected the Nigerian family planning logo which contains a family with one child as they argued that it is anti-cultural and that an average of four children should be displayed in the logo. Table 1 also reflects the unmet needs for family planning across the entire group in both locations for this study (34 quotations).

Table 1: Frequency of Selected Codes/Themes across the FGD Participants

Codes	Primary Documents																Totals
	Ibadan								Kaduna								
	Om	ofc	ofn	uf	um	yfc	yfn	ym	Om	ofc	ofn	uf	um	yfc	yfn	ym	
Largef-	0	2	3	1	5	4	2	5	5	5	4	5	2	3	3	3	52
Largef+	0	0	0	3	0	6	1	0	1	0	0	0	0	0	0	0	11
LFasp-	2	1	6	0	7	5	3	9	3	1	6	3	2	9	3	2	62
LFAsp+	1	2	2	2	0	5	0	0	1	0	0	2	0	0	1	0	16
SFAsp+	1	2	7	2	8	7	2	4	2	2	3	4	3	9	1	3	60
BothfAsp+	0	1	1	0	0	2	0	0	3	2	0	0	0	0	0	1	10
LargefH	0	1	0	1	0	0	1	0	0	1	0	0	0	0	0	0	4
LargefUh	0	0	3	1	3	2	1	2	2	4	2	3	1	3	1	3	31
Smallf-	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Smallf+	5	5	3	5	4	5	2	5	5	7	4	5	2	4	2	2	65
SmallfH	3	1	5	3	1	1	1	1	2	3	1	3	2	2	1	3	33
SmallfUh	0	0	2	0	0	4	0	0	0	0	0	0	0	0	0	0	6
BothfamH	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
Fsasp+	1	0	2	0	0	2	0	1	3	3	2	1	3	5	2	1	26
Fsasp-	0	2	0	2	0	0	2	0	0	3	0	1	0	0	0	1	11
Fertdesire	3	0	3	0	5	3	2	0	0	2	2	1	2	1	3	1	28
Fpdesire	0	2	2	2	6	4	3	1	7	3	5	3	5	7	5	6	61
Unmetneedforfp	3	2	1	2	1	0	1	9	1	3	2	2	0	1	1	5	34
Totals	**19**	**21**	**41**	**24**	**40**	**50**	**21**	**37**	**35**	**39**	**31**	**33**	**24**	**44**	**23**	**31**	**469**

Key: OM = Old married males, Ofc = Old Married females Current Users, ofn = Old Married females Non-Users Uf = Unmarried females, um = Unmarried males, yfc = Young Married females Users, yfn = Young Married females Non-Users, ym = Young Married males Largef-= Negative description of large family, Largef+= Positive description of large family, LFasp-= Large family aspiration for better future difficult, LFasp+= Large Family aspiration for better future could be achieved, LargefH=Large family will be happy, LargefUh= Large family will not be happy, BothfAsp+=Bothe families aspiration coul be easy to achieve, Smallf-= Negative description of small family, Smallf+= Positive description of small family, SmallfH= Small family will be happy, SmallfUh= Small family may not be happy, BothfamH= Both families will be happy, SFAsp+= Small family aspiration for better future would be easy, Fsasp+= there is relationship between family size and aspiration, FSasp-=there is no relationship between family size and aspiration, Fertdesire= Fertility desire, Fpdesire= family planning desire, Unmetneedforfp= Unmet needs for family planning, Fpdesire= Family Planning desire.

It is evident in this study that there were many participants who desired safe sex and sound reproductive health. They therefore desired family planning for child spacing for the sake of their education and health and that of the children in order to secure a bright future for the family, to satisfy their sexual urge and that of their husbands without being pregnant and to avoid past experiences of difficulties they encountered in pregnancy and child birth. The participants noted various problems associated with being pregnant soon after having a baby. They believed that the woman's health is not yet fully restored and a new pregnancy could affect the health of the mother, the unborn baby as well as the last baby.

Although there were divergent views among the FGD participants on having up to or more than six children and underage pregnancy, many participants were able to recognize the dangers associated with such acts. While there were 20 quotations supporting having six children or more, there were also 17 quotations condemning it. On the other hand, 22 quotations reflect the participants' rejection of underage pregnancy as against 15 quotations supporting it.

Fertility and Sexual Experiences of the Participants

Despite the participants overwhelming description of large families as not being attractive, their pattern of support for having six or more children, rejection of pregnancy soon after a delivery and intolerance of underage pregnancies, their personal experiences seem to contradict what they desire. It is evident in this study that many of the participants' current fertility and sexual behaviour were at variance with what they

describe as good and enviable life of the small family. Table 2 shows that quite a number of the participants were married before the age of 18 years. This is more pronounced among the participants from Kaduna than in Ibadan. Since women are culturally expected to begin procreation immediately after marriage in Nigerian culture, it is then evident that these categories of women have also experienced underage pregnancy. This is clearer in the young married women group, where the maximum age of the participants was 24 years and some of them already had 4 or more children at that age.

The number of children by the participants also shows that quite a number of them had large families especially, among the older married women groups where many of the participants had four or more children. It is also important to note that if the fertility trend among the young married women especially in Kaduna is sustained, the majority of them would also end up having large families. It can be deduced that with some of the participants having four or more children at the age of 24, some of them would have experienced short pregnancy intervals which the majority of them rejected and described as very risky for the health of the mother as well as the last baby and the unborn baby.

Unmet Need for Family Planning

The unmet need for family planning is the discrepancy between the expressed fertility desire and the use of contraceptives to limit or space births either due to non-availability or inaccessibility of any effective family planning method. The unmet need could also arise as a result of the poor quality of family planning services available, thereby leading to preventable failures of family planning methods. According to Casterline et al., (1997), women with unmet needs for family planning constitute a significant fraction of married women of reproductive age in developing countries. This position was reiterated almost a decade later by Bhattacharya et al., (2006), McCarraher et al., (2008) and McCarraher et al., (2006). Hence, the need also to understand the unmet need for family planning for the urban slums dwellers in this study.

Despite the high fertility desire expressed by some participants, there were still many slum dwellers in this study who desired to use family planning but were unable to do for various reasons. These include the proliferation of fake and expired pills, fake condoms and the lack of qualified medical workers who could administer appropriate family planning treatments. Some participants expressed themselves as follows:

> There is no original condom that common people can afford. The ones available are not good enough and HIV/AIDS virus can penetrate through the sub-standard ones especially when they break. Even

Table 2: Group Characteristics of FGD Married Women Participants

Location	Group	No. in Group	Age Range in Years	Ager at first Marriage		Education			No. of children	
				Less than 18	18 and above	Primary or Quranic	Post Primary	Secon-dary	3 or less	4 and above
Ibadan	**OO.M.W.C***	13	26 -35	None	All	2	9	2	7	6
	O.M.W.N**	9	30 - 35	None	All	1	7	1	9	0
	YY.M.W.C***	9	20-24	3	6	1	8	0	7	2
	Y.M.W.N******	8	21 - 24	1	7	2	3	3	8	0
Kaduna	**O.M.W.C**	9	25 - 35	8	1	9	0	0	4	5
	O.M.W.N	10	25 - 32	9	1	8	2	0	3	7
	Y.M.W.C	8	21 - 24	4	4	2	5	1	6	2
	Y.M.W.N	8	18 - 24	8	0	8	0	0	6	2

OO.M.W.C* = Older Married Women Current Users
O.M.W.N** = Older Married Women Non-Users
YY.M.W.C*** = Young Married Women Current Users
Y.M.W.N**** = Young Married Women Non-Users

> many homes have been scattered due to condom failure [Older Married Male, 35 years, Teacher, B.Ed, Christian, Agbowo, Ibadan.]

Another participant in the women group opined: 'I once used it (Injectibles) and yet got pregnant' [Older Married woman, 32 years, Current User, Trader, Primary, Christian, Agbowo Ibadan.]

In the light of these unmet needs for family planning, many of the slum dwellers confirmed that they were involved in many unreliable and often disappointing traditional methods and other practices they believed could prevent pregnancy. These included the use of salt solution, lemon, potash and other traditional concoctions to avert pregnancy.

Challenges Confronting the Urban Slums in Utilizing Family Planning

Challenges have the potentials of undermining the usefulness of a programme meant to provide solutions to a problem. It is therefore essential to examine the challenges confronting the proper utilization of a programme meant to improve health and living conditions of people as this could give an insight into appropriate steps that could be taken for proper implementation of such programmes for successful delivery of the mission mandates. In the light of this the FGD participants in this study were asked about the various challenges they face in the utilization of family planning methods using a vignette story of a woman, confronted with the decision of using family planning after two children.

Three main categories of challenges were identified. These challenges had negative effects on their willingness and ability to access family planning methods despite admitting their need for family planning. The challenges include those that were personal, the patriarchal structure of their households, as well as some cultural/religious beliefs in the societies. Some personal challenges include poverty and various misconceptions about family planning. Some participants believed that the ointments used to lubricate condoms could destroy a woman's womb leading to permanent infertility, ailments or death while others opined that if condoms should fall inside a woman's vagina during sex, it would need a surgical operation to remove it, which might lead to death. Similarly, there are beliefs that injectibles and pills contain chemicals that could damage a woman's womb causing permanent infertility, disease or death. Some participants stated:

> She may not have enough money and she knows the state of things in her home [Unmarried Female 20 years, student, Senior Secondary]

> She might also be scared that if she continues for a long time she might not be able to have another child again because there is the

> general belief that some family planning methods can spoil a woman's womb causing permanent infertility in some women. There are also side effects associated with pills which can cause the woman to stop using it. [Unmarried Female 16 years, Student, Senior Secondary, Muslim, Tudun Wada, Kaduna, Christian, Agbowo, Ibadan]

Also, some challenges in the household preventing women from utilizing family planning methods are largely related to the position of the husband as the head of the house and the need for the woman to obey his instructions, despite the fact that such instructions might not be for the good of the wife in some instances. The participants believe that 'he is the head of the family and whatever he says is final and there is nothing anybody can do'. This puts women who desire to use family planning in a difficult situation since any attempt to disobey the husbands' instructions and adopt family planning in order to protect themselves may result in maltreatment including physical violence. A participant affirmed that:

> A woman, after having three children, went to the hospital on her own to do family planning. Her husband was expecting her to conceive again but she didn't. Later, the husband discovered while having sex with her one day that she had been doing family planning without his consent. He was angry. He even beat her. He told her to go and remove it and she later gave birth to one more child. If she had told her husband, she would not have had to go through that kind of experience. [Older Married Woman Non-User, 35 years, Teacher, National Certificate of Education, Christian, Agbowo, Ibadan]

At the community level, cultural beliefs and religious orientation were found to be powerful in shaping participants decision to use family planning. Many participants believed that the use of family planning is a sin to God and must be avoided while there are those who also believe that if a woman through family planning prevents any of the children God has destined to come into the world through her, she will suffer the health consequences. Others also insisted that the need for a woman to have children of both sexes would prevent her from resorting to family planning because of the cultural demand for the sexes. Some participants noted:

> With the couple being 'Yorubas', from my own view, the husband will not agree because they have just two kids both of who are both girls! It's not done. [Young Married Male, 23 years, Trader, Senior Secondary, Muslim, Agbowo Ibadan]

> In Islam, having children is a form of wealth, just like riches is wealth; you are trying to have them. They believe that children are wealth,

> the more your children, the more your wealth. [Older Married Man, 28 years, Trader, Ordinary National Diploma, Muslim, Tudun Wada, Kaduna]

Discussion

This study has examined the sexual and reproductive health challenges of urban slum dwellers in two towns in Nigeria. There was generally a high understanding of the implications of unprotected sex, ill-timed births, high fertility, and other reproductive health concerns were expressed by the participants. Many of them understand and expressed the importance of a healthy sexual and reproductive lifestyle. They also expressed the health, economic and social implications of risky sexual relations. Despite this, the evidence observed underscores the wide discrepancy between their expressed understanding and their sexual behaviour. There is therefore an obvious concern for high levels of unmet needs among this group of people. In appraising their challenges in optimizing services that can help them to attain a healthy sexual lifestyle, there were concerns related to religion and personal beliefs, socio-cultural beliefs and factors as well as gender issues. Many of the participants are strongly of the view that the future is in the hands of God who ordains the number of children for individuals.

On the other hand, there are also many of these slums dwellers who desire to resort to family planning but have unmet needs. There is therefore the need for the Nigerian governments and development partners to strategize on how to eliminate the unmet needs for those who desire family planning. Such efforts will require the provision of quality family planning services among the urban slums as current conditions are deplorable, as shown in this study. The current situation of high fertility and low contraception has implications for maternal and child health in Nigeria (Walker et al. 2008). It will also require the provision of free, regular and quality condoms in all health facilities and public facilities in the slums for spacing and limiting births as well as combating the spread of Sexually Transmitted Infections among the slums dwellers in the country.

It is also evident in this study that many participants have a very poor knowledge of family planning with a lot of misconceptions about family planning. Although it is true that some family planning methods have side effects, these side effects may have been highly exaggerated by the participants, most of whom had never used them. There is therefore the need for serious and targeted family planning education for these people. This will improve their understanding and allay their fears about

family planning methods and will also allow them to make the choice of methods preferable to them.

The patriarchal family structure has also been found as a major barrier for women who desire family planning among the participants. Thus, many women could not resort to family planning due to the demands that they should obey their husbands. Women who went out of their way to use contraception without their husbands' consent are suspected of being promiscuous and are subjected to maltreatment in the family. This calls for conscious efforts to target men in urban slums in family planning education. This will improve women's freedom on their sexual and reproductive health needs and choices and encourage those who desire family planning to utilize it without any fear or molestation.

The cultural demand for male children among the slum dwellers in this study is also one of the challenges for family planning utilizations. Couples who have only female children are therefore not likely to be favourably disposed to family planning use while there are also various religious beliefs inhibiting the use of family planning methods. This calls for the inclusion of the traditional leaders and religious leaders who are the custodians of people's culture in family planning utilization in Nigerian urban slums. This has the potential of changing the people's perception and eventually enhancing their willingness to adopt family planning methods. It is therefore important to intensify campaigns that target fertility desire reduction among the urban slums in the light of the revelation in this study, which is in line with the findings of Magadi et al., (2003), Stephenson and Hennink (2004) and the African Union (2006).

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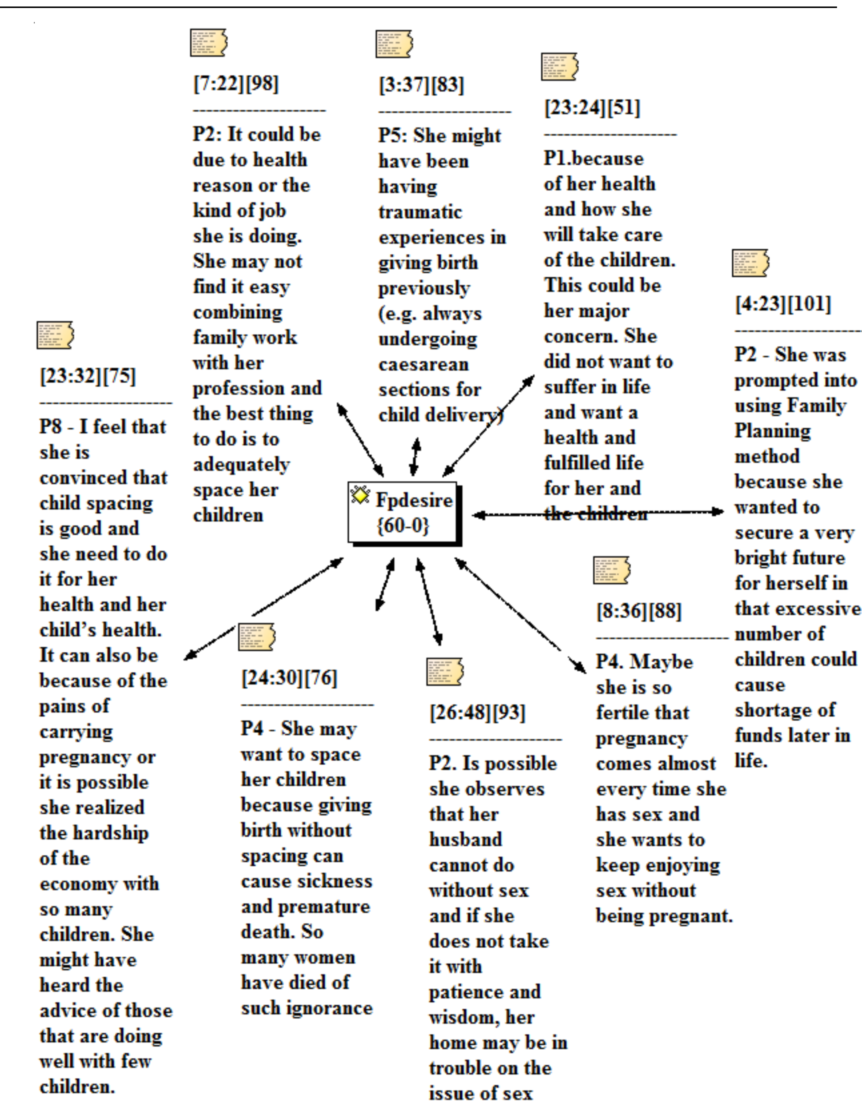
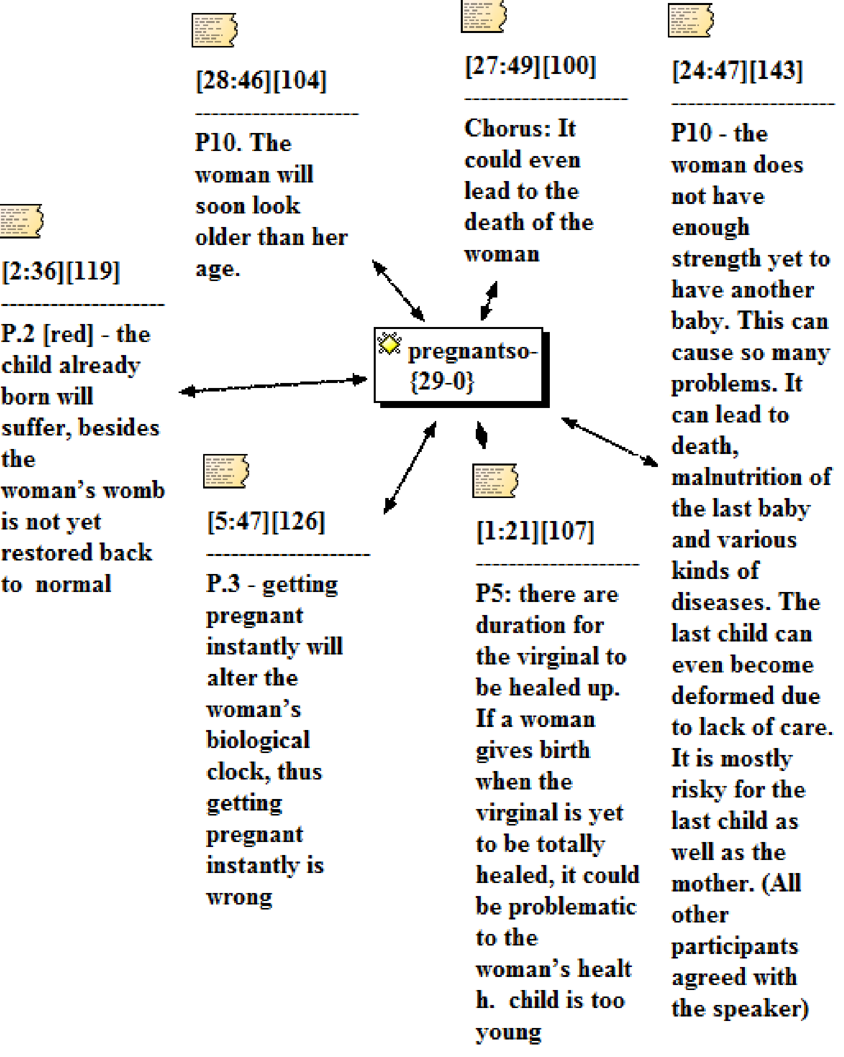
Appendices

Figure 1a: Pattern of Family Planning Desires



Key: Fpdesire= Family Planning desire

Figure 1b: Participants Rejection of Pregnant Soon after having a baby



Key: Pregnantso- = Against pregnant soon after having a baby

Figure 1c: Pattern of Supports for Having 6 children or more

Having 6 Children {1-2}

is part of

6childrengood {20-1}

is part of

6childrenbad {17-1}

[8:71][170]
P6. When the parent(s) die, the burial ceremony will be the talk of the town because there will be lots of people to plan for it

[27:47][99]
Others. Ah! Many people have more than six children around us and they don't have any problems

[1:30][112]
P2: Those with only one child are at very serious risks. Some spoil that child being the only child. Many children are good for old age.

[8:72][170]
P7. The Yorubas have an adage that says "a o m'o omo ti yio sinni"one is not sure of the child that will survive the parents. Anything can happen at anytime. For example, a couple with 3 children send all of them to go and spend the holiday with their cousins and while on the way, there was an accident that claimed the lives of the 3 children, who will bury the parents when they die?

[21:63][144]
P5. Some parents are rich such that even if they have 20 children they can take care of them comfortably.

[2:49][125]
P9: it is not good to keep the children in the womb, unborn

[5:61][130]
P.1 [red] - In present day Africa, Money is the main issue. So having excess children can lead to poverty

[23:55][132]
P2 - it will be difficult to educate all the children. Many of them will become taot and irresponsible. If you find out those who are political thugs today they will be children who come from large family. Have you ever heard that the child of highly placed people, even the politicians themselves are involved in political thurgery?

[1:31][112]
P5: Many children will hinder the parents from giving quality care and good education to the children. The children will always think that their parents are irresponsible for the inability to give them quality education.

[3:67][182]
P2 : It is somewhat risky. Too many children can affect the health of the mother and make her get quickly.

[8:69][170]
P4. I personally do not want more than two so that I can take care of them very well and give them the best education

Key: 6 children good = Supports having 6 or more children,
6 children bad = Against having up to 6 children

Figure 1d: Pattern of Supports for Underage Pregnancy

Underagepregnancy {1-2}

is part of

underagepreg- {22-1}

[23:48][121]
P6 - It brings complications during labour that could lead to loss of life or result in VVF.

[26:74][146]
P5. It is improper because, they can give birth to pre mature children even delivery will become a problem because she is not matured enough to marry

[8:63][168]
P1. Her pelvic girdle would not have expanded enough to be able to deliver safely and if she is operated on, as we all know, there is no guarantee that she will come out of it

[26:72][146]
P3. It could also lead to the birth of children with disorders.

[2:40][121]
P12 - such a girl would be in trouble. She may have to stop schooling

[2:39][121]
P6: it is dangerous because the young mother may lack the moral ability to nurture the child.

is part of

underagepreg+ {15-1}

[27:43][96]
P3. it is not risky if she has started menstrustaion.

[28:40][100]
P3. it is least risky because the girl can attend good ANC and get operated during delivery

[27:42][96]
P7. It is not risky at all because we have many live examples around us.

[8:64][168]
P6. In the olden days, most of those women don't get that old before they get married and start giving birth. And if you look at it, you will discover that most of them trained their children well and are now eating the fruits of their labour

[26:75][146]
P1. I don't think so because in my family we don't have any of such problems and we have a number of cases like that.

[28:43][101]
P4. Due to changes in maturity, girl can have children from age 14 without any complications

[24:50][150]
P8 - I don't think there is any problem. Many girls are marries before the age of 18 and have safe delivery

Key: Underagepreg+ = Supports underage pregnancy,
Underagepreg- = Against underage pregnancy

Figure 2: Traditional Methods Used to Prevent Pregnancy in Urban Slums

Traditional Fp {34-0}

[4:20][49]
P6 - Some people use a mixture of lemon orange and potash stone

[8:32][53]
P7. There is a way the lady will lie down to get rid of the guy's semen.

[21:30][49]
P3.By taking bitter traditional drinks and lemon drink.

[8:30][51]
P5. Some will use 7-up and mix it with "alabukun" (a drug used against stomach upset)

[2:19][51]
P2: salt +water + lemon orange

[22:47][104]
P9. Some women use laya while their husbands use guru to prevent pregnancy

[7:16][35]
Some use lime and salt. Some go to the toilet to pass excreta.

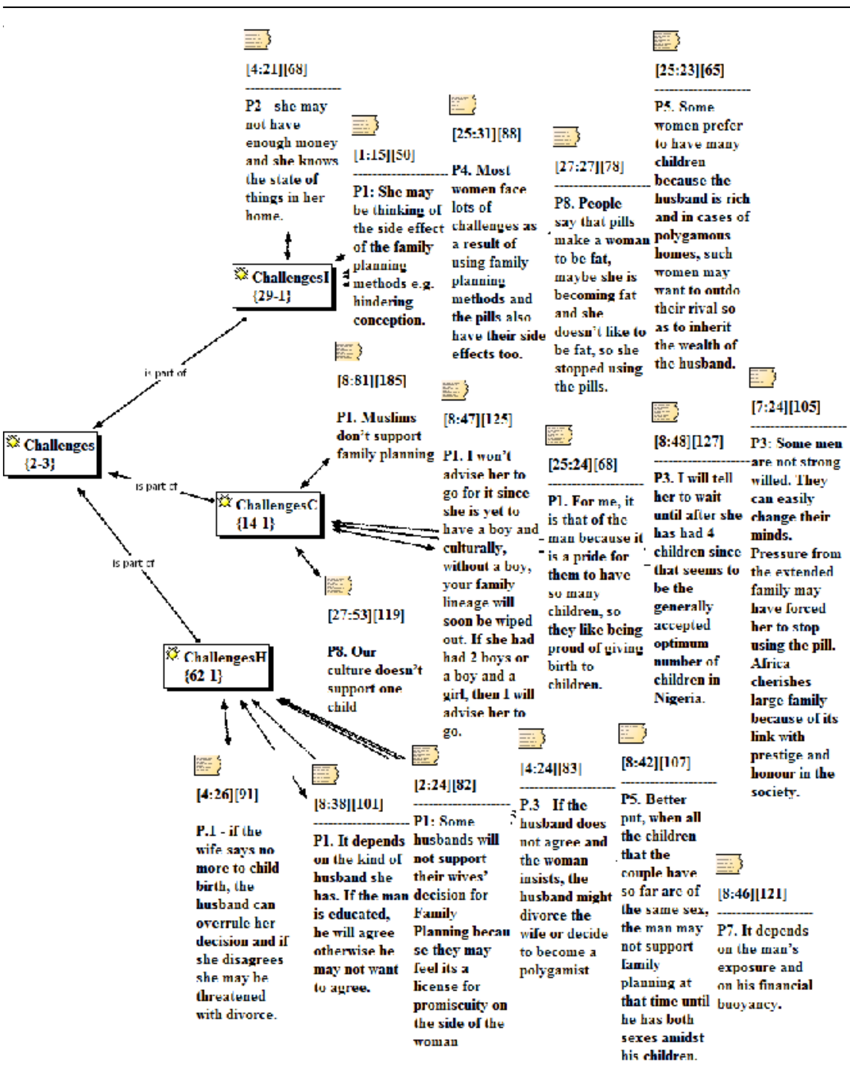
[28:22][53]
P5. Some people use salt, kanwa and bawon gyada

[28:23][54]
P10. Bula, Postinor, Kanwa ruran kwanta,

[28:24][55]
P8. Excessive intake of Benylin syrup

[2:18][50]
P6: Local/traditional ring

Figure 3: Challenges Confronting the Urban Slums in Family Planning Utilization



Key: ChallengesI = Individual/Personal Challenges,
ChallengesH= Challenges of their household structure,
ChallengesC= Challenges in their communities/societies

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The Politics and Economics of Body Image and Sexuality in Africa: Thoughts from a Path Less Travelled

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Abstract

Body image is internal and external. It is seen by ourselves and by others. Social body image constructs seem to be built on what is deemed to be beautiful within our cultural contexts, which in turn is perceived as valuable and in turn has higher social standing because everyone else looks up to it. The politics of body image is often a 'black and white' affair, without much room for manoeuvring. You are either the strong male or the weaker female. Together with the outward appearance, the sexualities of the bodies must also complement each other. But it is a semi-artificial construct which not all people can adhere to, much less attain, though they all try. What happens then with women or men who defy these constructs of body image and sexuality – who turn them on their head? How does the society adjust to these kinds of individuals in its already defined and constructed political arena? This article seeks to expose the lived realities of persons who fail to conform to the expectations of the society, namely sexual and gender minorities.

Résumé

L'image corporelle est à la fois interne et externe. Elle est perçue par nous-mêmes et par les autres. Les construits sociaux de l'image corporelle semblent trouver leur origine dans ce qui est considéré comme étant « le beau » dans nos contextes culturels, lequel beau à son tour est perçu comme étant gage de grande valeur et d'un statut social plus élevé, car suscitant l'admiration de tous. La politique de l'image corporelle est souvent une question de « noir et blanc », qui n'offre pas pour autant une franche marge de manœuvre. Soit l'on est homme, c'est-à-dire le sexe fort, ou femme, qualifiée de sexe faible.

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Conjugué à l'aspect extérieur, les sexualités des corps doivent également se compléter mutuellement. Mais il s'agit d'un construit semi-artificiel auquel tout le monde ne peut adhérer, et encore moins atteindre, mais auquel tout le monde essaie de parvenir. Qu'advient-il alors des femmes ou des hommes qui défient les construits de l'image corporelle et de la sexualité – ceux qui rament à contre-courant de ces normes ? Comment la société s'adapte-t-elle à ce genre d'individus dans son arène politique définie et construite d'avance ? Cet article vise à exposer les réalités vécues par les personnes qui ne parviennent pas à se conformer aux attentes de la société, à savoir les minorités sexuelles et de genre.

Introduction

Examples of sexual stereotypes are well articulated by Tamale (2011) as follows:

> He is a man therefore desires only female sexual partners; Human beings engage in sex for reproductive purposes only; He is gay therefore his life is exclusively defined by the sex act; and She is wearing a dress; therefore she must be a woman. These are examples in a long continuous list of everyday stereotypes.

How we perceive ourselves in relation to the world is the basis of body image. Planned Parenthood adapted Maureen Kelly's information in *My Body, My Rules* (1996), and agrees that internally it is the mental opinion of how we view our own physical appearance and how we think others see us. Externally, it is how others actually see us.

How we see ourselves is not necessarily the same way our body appears to others. Our sexuality encompasses many aspects of ourselves; it includes our bodies, our sexual reproductive organs, our biological sex, i.e., male or female, our gender, i.e., boy or girl, our identity, i.e., our comfort and feelings about our gender, and our sexual orientation, i.e., our romantic or sexual attractions towards another person (heterosexual, bisexual or homosexual). These and many other aspects of body image are explored extensively by Lykke (2010); Butler (1990, 1997) and Haraway (1991). Body image is therefore part of our sexuality. Body image is viewed in relation to values that are learnt or expected culturally and not necessarily innate (Lightstone, 2006). The question therefore becomes 'how does biology and culture affect gender and gender roles within a society?'

There are people who may act, feel, think or look different from the gender they were raised as. We have people whose reproductive organs are both male and female and we also have people who experience romantic or sexual feeling toward persons of the same sex. These are the people called gender minorities and sexual minorities respectively.

Whether they existed in Africa in the past is an issue for constant debate and is neither here nor there. Phillips (2001) asserts that 'Rejections of same-sex relations in African cultures can be explained by a preoccupation with procreation and the reproduction of kinship rather than the psychoanalytic notions of perversion and object choice which have often led to homophobia in Western societies' (as cited in Ben Anderson 2007:130). The reality is that they exist in Africa today. This existence comes at a price especially in a continent where family, culture, ethics and religion has a huge influence on our sexuality. Continued persecution and extreme hatred is something that sexual minorities and gender minorities experience constantly around the world and in particular in the African continent. It is important to try and understand why their existence elicits extreme emotions, and if it is even realistic to expect everybody to fit within the confines of what is considered 'normal' and what it means to co-exist in a society of tolerance and diversity.

To understand the politics of body image in Africa and why sexual and gender minorities are ostracized, we must understand patriarchy as a social system and its continued role in social constructions in the society. Patriarchy is a system that has supported men's domination and teaches that women are not as intelligent or as strong as men. This system and its beliefs is well and firmly rooted in the African culture, probably more than any other culture in the world. Therefore, what this means is when a child is born, it is socialized according to gender expectation and gender roles of that culture. Male children take on masculine roles and are taught to think and act in 'masculine ways', while the female children take on the feminine roles and are taught to act in feminine ways. Individuals are born sexed but not gendered. As Simone de Beauvoir (1949:295) wrote: 'One is not born, but rather becomes, a woman'.

In a social system of this nature, the roles are clear and defined with masculine roles seen as superior to the feminine roles. Since women are the ones who bear children, their role is expected to be more nurturing whilst the men's role then becomes one of providing for the family. This is what is considered 'normal' in a society. What happens to sexual minorities who clearly don't follow these constructs?

People on a Path Less Travelled

'Men who eroticize men instead of women engender a potential crisis in ruling ideas of true masculinity' Edwards (Ratele 2011). With male domination at the centre, it is no surprise that African culture that views women as subordinates would completely reject a man who would

otherwise be seen to have 'feminine traits', and frown on a woman who conveys masculine ways. In fact every time a discussion on homosexuality arises, you will hear someone asking 'who acts as the female in the relationship?', intimating that the female status is considered subordinate to the one who 'plays the role of the male'. It is also not surprising to see women themselves also looking down at the man who is perceived to be the 'woman' in a homosexual relationship. Interestingly, even in discussions on homosexual relations by homosexuals themselves, one often hears the question as to whether a person is a 'top' or a 'bottom'. This shows that political concepts of body image and social constructs cascade down to outlying communities which sub-consciously emulate male and female roles both in the bedroom and in the working sphere. Occasionally, however, one will find that a homosexual couple is 'versatile', i.e., that the individuals take turns to be the dominant or passive partner. Herein lies a domestic construct where tasks and responsibilities are also often shared equitably and equally. But less well understood, are the gender minorities – that is, transsexuals and transgender persons, whose relationships are even less well understood, let alone discussed.

In our traditions, male masculinities are put on a hierarchy from what is considered the ideal male behaviour such as leading, taking control, strength as being the best and what men should aspire to be, to the weak behaviours such as dependency, emotional, delicate described as behaving like a woman (referring to a man who did not meet the ideal male behaviour). Men who sleep around with many women are considered macho and are given praising words such as '*Ndume*' or '*jogoo*'. Raewyn Connell (1995:77) asserts the theory of hegemonic masculinity by saying that 'The term hegemony refers to the cultural dynamic by which a group claims and sustains a leading position in social life'). Patriarchal dynamics secure a general lead position for men over women, but they also marginalize all men that do not fulfil normative male attributes. In other words, all men are not equal, but subjected to hierarchies defined by race, class and other identity characteristics.

Often the roles of men are seen as protective and productive (where the product is of higher value than that of the woman). Women's roles are supposed to be nurturing and the products of their labour of lesser economic value. Yet in same-sex relations we often find gay men holding nurturing roles – such as raising children, whilst lesbian women may take turns to bring home the bacon. This therefore turns the social construct on its head and negates the commonly believed stereotypes of what a man and a woman should or shouldn't do.

Patriarchy firmly rooted in our African culture, conditions the mind of everyone, including the women to accept a subordinate role and even frown on their male counterpart who feels comfortable in that role that 'is considered to be for women'. We have had cases of men stripped naked and humiliated because they were found to be 'impersonating a woman' in their manner of dressing, walking or even behaviour. In contemporary Africa, we find that to some extent a woman who portrays masculine ways is looked at as moving up the scales and is tolerated, almost encouraged as long as she can combine the role by settling down eventually and having a husband to answer to. This is viewed the same in lesbian relationships. Lesbians are considered to have not met a 'real' man and that is why they would get involved in a lesbian relationship.

Then there is the debate about modes of dress. Here the discussion may take the following form: a lesbian couple may consist of a predominantly masculine woman and a more versatile or feminine woman. The masculine woman may not enjoy wearing feminine clothes, whilst the versatile woman does not mind it. In the mind of the masculine woman, her self-identity or body image construct orbits around a more 'male-ish' construct – one that she finds appealing and comfortable. She may also choose to keep her hair short, as the case may be. Should she be persuaded to wear more feminine clothes, she will need to adjust in her mind, her perception of her body image and how she is now perceived by others. With the new pseudo-body image, she may in turn feel pressured to follow the more socially accepted modes of feminine behaviour. For one construct supports the other – appearance and behaviour must be seen to be in harmony. After a little while of this pretence, the masculine woman may not find herself comfortable, and she quickly switches back to her usual mode of dress and mannerisms. For her, this fits her genuine inner definition and understanding of herself as well as her place in the world.

And what of transsexual or transgender persons? Here we have individuals who choose to be of the opposite gender, literally. This is where a biologically born man chooses to be a woman or a biological woman will, likewise, choose to be a man. Their wishes seem to go against all reason or logic of the present day disadvantageous implications of 'switching' gender. How else are we to understand a man – with all the trappings of living a good life – wanting to 'down-grade' to a woman? What difficulties and disadvantages await *her* in *her* new body and gender role? Why would a woman wish to have male genitalia whose full functionality is curtailed severely due to the fact that it is more aesthetic than operational? Perhaps those of us who feel well-adjusted to our gender

and biology will never fully understand what sacrifices gender minorities are willing to take and why.

The biggest loser in the politics and economics of the body image in the African setting has always been women. Our physical bodies have been the reason that our traditions founded on patriarchal values have given us a lower status and denied us full participation at all levels. The woman's body is imbedded in the very subject of morality and is therefore an object controlled by others. Real or imagined moral and legal regulation exists to restrict the expression of women's sexuality outside a marriage. A woman who sleeps around is branded a prostitute and labelled 'spoilt' (Human Rights Watch 2001). A label when scrutinized can be equated to a woman who is not controlled by men; if at the very least sexually.

Women who have sex with other women or are in a romantic relationship with other women are often seen as women who have lost direction and will have violence extended to them such as 'corrective rape' to force them to toe the line. They are ridiculed by their families for failure to settle down and have a family, labelled and more often than not denied safe spaces to socialize. According to Kapano Ratele, 'the main aim of such denunciation, assaults and vilification is not to exorcise society of same-sex desires but part of societal forces aimed at controlling all female sexuality and at subordinating female bodies and desires to men's commands' (Tamale 2011: 404).

A woman's body is given economic value depending on its use by others. If she bears several children, her body is valued as a machine that produces the future generation of a clan or society. If her body gives sexual pleasure – whether with elongated labia, infibulated and tightly sewn-up vagina and depending on whether she performs extra duties such as offering companionship, cleaning, cooking, advice or entertainment – her body will be valued accordingly. This further subjugation was noted by CEDAW (1994) as follows: 'The responsibilities that women bear and raise children affect their access to education, employment and other activities related to their personal development. They also impose inequitable burdens of work on women' (General Recommendation No. 21 of the CEDAW Committee, 13th session, 1994, para. 21).

Suppose a woman chooses to have fewer children or none at all. And supposing she chooses to use her brain and energies more in achieving other positive changes in society – because it is not necessarily a condition that all women must bear children in addition to being productive citizens, especially in the modern day. How then can she be viewed by society, her family and herself? The very fact that she has chosen not to

have children may be interpreted that she is lacking in some necessary feminine quality. But in actual fact she is reassessing her options, weighing her resources and the possibilities for the future – essentially becoming empowered and enlightened. This will have multiple implications for her home, her village, the society, its resource allocations and the economy.

Debate beyond Sexuality

These constructs come into play in every aspect of our lives. Men are expected to act in a certain way while women in another and if they do not conform to the roles set by the society, the society lashes out as a way to preserve the status quo.

> In countries without laws to protect sex workers, drug users and men who have sex with men, only a fraction of the population has access to prevention. Conversely, in countries with legal protection and the protection of human rights for these people, many more have access to services. As a result, there are fewer infections, less demand for antiretroviral treatment and fewer deaths. Not only is it unethical not to protect these groups; it makes no sense from a health perspective. It hurts all of us (Ban Ki-Moon, UN Secretary-General, August 2008(6).

Politically, governments in Africa will go as far as criminalizing certain acts to ensure that they continue to remain taboo, usually with devastating consequences. A case in point is by refusing to recognize the existence of 'men who have sex with men' (MSM). This group has until recently existed underground and was found to be amongst the 'most at risk population' in the fight against HIV/AIDS. This denial of MSM and associated stigma has discouraged African researchers from objectively evaluating homosexuality for fear that others would ridicule them and question their sexual orientation (Tapsoba, Moreau, Niang, and Niang 2004). This created a huge gap in the data available for the government to make the necessary concession in its service provision. A problem that was only going to continue if the government and the society refuses to acknowledge their existence and make provisions for them in the health policies. With the acknowledgement of MSM, what would naturally follow is the realization and acceptance of women who sleep with women or in more agreeable terms, 'women who love women' – for surely where there is a male form of a less understood phenomenon there must be a female version of the same. If the government then, were to begin understanding not only the sexual practices of these sexual minority groups, but also their socio-cultural and economic aspects, it might see the complexity of the interactions of bodies, images, social and economic functions that each individual brings to the political table and appreciate differences in varied persona.

Conclusion

As societies are becoming increasingly diverse, body image and social constructs may better be understood by studying minority or marginalized social communities and their interrelationships across other constructs. Negative stereotyping of the 'female' gender roles encouraged by the system of the day has been the biggest contributor in fostering intolerance within the society. Consciously challenging the stereotypes is the only way all body images and constructs may find a place in our society. We also need to realize their unique links to various behavioural, emotional, psychological and socio-cultural aspects.

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