

Eschatological Field Notes: Community Theatre, AIDS, and the Fate of Informant D. in Ilemera, Tanzania

*When you think that you've lost everything
You find out you can always lose a little more
I'm just going down the road feelin' bad
Tryin' to get to heaven before they close the door*

Bob Dylan, "Tryin' To Get To Heaven" (1997)

A MORBID IRONY

She gives me a long, tender handshake and says that we probably won't see each other next year. "Why?" I wonder. "I'll be dead by then," she replies and bursts out laughing. "God will have sent me an invitation to heaven." I hear myself voice something like, "Oh, no!" Along with a lame attempt to pitch her mood but my hesitant smile is pretty far from laughter. Shortly thereafter, I wish everyone at the community centre "Kwa Herini!" But the farewell rings hollow inside my helmet as I and my colleague Stephen Ndibalema roll down the hills of Ilemera on the motorbike.¹

Usually we talk eagerly after our village visits on the potholed dirt roads along Lake Victoria, but this time there is not much to say. All I can think of is the fate of young D, who at twenty something years is already a full-blown professional peer educator and action researcher. Certainly I noticed that she had slimmed since my last visit a couple of years ago, but it was as if her unselfish way of laying out the local context of AIDS, along with her enthusiastic appearance, made me look upon her as someone who could not possibly be dying. But that is the grim irony here: the ones who help others to survive are often also busy surviving – and dying.

This is said in an exceptional moment of the twenty-five year history of AIDS in Tanzania. Just a couple of years ago free antiretroviral (ARV) drugs were allocated to selected hospitals in Kagera and other regions. Some people I

meet, a few of whom are friends from previous trips, are actually alive solely due to ARV therapies funded by organisations like the William J. Clinton Foundation.² There can be no doubt about the importance of medical campaigns at the present time. However, it is equally important to point out that medical interventions will not alleviate the spread of HIV but rather mitigate the impact of AIDS for a certain amount of people, at least as long as programmes are externally funded. For poor people in lack of a varied diet, the ARVs can also be a daunting physical challenge. In a group interview (02/08/2006) with a People Living with HIV/AIDS (PLWHA) group in Kamachumu a few miles from Ilemera, a number of women claimed that they suffered so bad from the strong medicine on empty stomachs that the responsibility for their children ultimately kept them from quitting the therapy altogether. Such complications have brought together ARV campaigns with World Food Programme (WFP) interventions in some Tanzanian regions – although not in Kagera, which is a paradoxical region insofar as it generally has sufficient food supplies, but also the lowest per capita GDP in the country.³ And, not least, even in the best case scenario, according to leading epidemiologists, less than one third of AIDS sufferers can be reached by ARVs in the next ten years.⁴ Hence the necessity of sustaining the development of HIV prevention.

In this article I will not go into detail about biomedical versus socio-cultural responses to HIV/AIDS,⁵ but rather show how the sub-Saharan AIDS pandemic can be understood with (1) a few examples of community based performances (2) different research methodologies, and (3) informants in what will be called “backstage” performances. Combined these approaches uncover site-specific and yet complex epidemiological conditions. The objective is to justify why and how it is always necessary to involve social and cultural factors in any attempt to mitigate the epidemic – *even if* a cure could be produced and distributed.⁶ The reason for this is that the causal problems of AIDS existed before AIDS materialized and they may very well be around *even if* AIDS could be eradicated. No media or performance

conveys this more acutely and accurately than community based theatre, the most inclusive cultural practice on the continent due to its syncretistic, eclectic, and critical associations with ritual functions, communal meetings, vernacular story telling, old genres of Tanzanian performance as well as new interactive theatre and pedagogical methods and techniques from overseas.

A PERFORMANCE AND HALF A VILLAGE

There are many morbid ironies in Ilemera. In the performance I saw two years ago (12/03/2004), the doctor in the local dispensary played the cameo role of a man who dies from AIDS related diseases about five minutes into the action. This dramaturgical pattern is typical for theatre against AIDS in Kagera: people die at the outset of performances and the remainder turn into a struggle for surviving family members. Kagera is situated on the border with Uganda where the first accumulated mortalities were recorded in Africa 1982-83.⁷ Here, almost everybody has at least one family member who has passed away due to AIDS. In regions with less explosive epidemic experiences, such as Mtwara on the southern border with Mozambique where I conduct comparative studies, characters usually pass away towards the end of performances. The latter “tragical” dramaturgy lays emphasis on the preventive responses to AIDS, i.e. how to discontinue the spread of HIV, whereas the former poetics of death and survival draws attention to the impact of AIDS, i.e. how to cope with the suffering, care, and treatment of sick, widowed or orphaned people.

So the performance in Ilemera started with a man, depicted by the self-denying doctor, lying lifeless in a grove of pine trees under the vigil of his wife. Spectators from a nearby village sit scattered on the ground close to the action. The tense but silent scene soon erupts in a shriek as the wife meets the inevitable fate and turns into a widow. In accordance with the local custom a mourning period of forty days ensues. After that something controversial happens, arguably as dreadful as being bereft of a husband. It

starts with the arrival of the late husband's younger sister who confiscates all possessions of the household and it ends with the father in law, who claims the widow herself. The post-mortal property grabbing and wife inheritance are part of a traditional regimen in Kagera as well as many other patrilineal parts of Africa.⁸ AIDS widows do not just lose their spouses but also their belongings and belonging: their material and economic assets, quite likely their health due to the risk of having contracted the virus from their husbands, and their personal status since the other losses are tied in with a social stigma that makes it hard to pick up a new man and thus an economic guarantor.

Gender wise, it may, of course, also be the other way around. In one of her early songs, Saida Karoli, the most celebrated contemporary musical artist in Kagera, sings about a woman who wakes up in the middle of the night and goes to a bar called "Tisa Tisa" (also the title of the song). The husband, who is depicted as lazy and unable to satisfy her, is unaware of the nocturnal excursion. When she comes back, however, the husband wants to have sex and so he gets the virus that she has just acquired. He later dies and the woman goes to the capital Dar es Salaam and sells herself for money. She comes back beautiful and moneyed, but gossipmongers suspect that she has AIDS. The alluring wealth of the woman still makes men attracted to her and so they too get HIV. It all ends with the woman getting sick, along with everyone else. She dies and the rest will follow. The narrative of this song not only illustrates the contemporary epidemic impetus and distribution, but also previous 20th century STI epidemics in Kagera, especially concerning syphilis in the 1930s and 1950s.⁹

In the Ilemera performance, the confiscation sparks a reaction in the community that prompts the village chairman to summons a meeting using traditional drums. When gathered, the villagers are asked to help the widow and her children, which they do by donations of goats, maize and money. It is not spelled out, but everyone knows about the vicious circle of the

scenario: for a woman and mother the outcome of destitution is all too often prostitution, one of the leading causes of AIDS in Kagera. Prostitution should in this case be understood in a very wide sense of the word, namely a transaction between a man and a woman where one of them receives goods, money, food, or personal protection for sex. For abundant historical and political reasons transactional sex for poverty-stricken women ought to be understood as a means of survival rather than a moral or promiscuous act, as faith based organizations often have it.

What often happens with widows, D makes clear in an interview two years after the performance (03/08/2006), is that they dip into an emotional and physical depression since they fear that they are going to die themselves. After a while they realize, with retained vigour and sexual desires, that they must find a new way of making a living.¹⁰ At that critical juncture many leave their communities, where people presume they are infected, and head for the economically wealthier islands in Lake Victoria. If they are not HIV positive before reaching the islands, they almost certainly will get infected by the fishermen out there.¹¹ But the widows have reached a point where they have nothing left to lose, which is not to say that they are at a point of no return; after the long incubation with the dormant virus they eventually start weakening in opportunistic diseases and then usually return to their villages to die. They still have a year or two to live and may very well attract a few men before the fatal decline. This is the vicious epidemiological circle in and around Ilemera in the district of Muleba.

Donations can at best offer temporary solutions for widows. In the village meeting depicted in the performance, a Kagera Zone AIDS Control Programme (KZACP) representative offers the woman a more sustainable solution, namely by proposing to resolve the conflict between her and her sister in law by mediation. In so doing the assets are eventually returned to the house of the deceased. Since KZACP also happens to be the organizers of the theatrical event, their involvement in the fiction makes the plot meta-

theatrical – or, more precisely, performative. To at once depict and aspire to redress a cultural predicament that is widespread among the present spectators is to enact a perlocutionary speech act in the form of a promise that the audience is encouraged to act upon.¹² Without the anticipation of a feasible audience re-action, applied social theatre, at least in this case, would merely represent an ideal scenario for the organizers and, in the words of Kerr, “scapegoat the poor”.¹³

RUBBER AND RELIGION

The meta-staging, nonetheless, made me suspicious about the group’s sincerity and possible ulterior motives, not least because the main sponsor of KZACP is the Evangelical Lutheran Church of Tanzania (ELCT). Two things eventually relieved my scepticism; the first had to do with the course of action after the performance, the second with an intriguing renegotiation of church policies on condom use, at least by informant D.

The post-performance discussion in Ilemera went beyond the typical performer-spectator exchanges conducted by the joker and “spectators” in forum theatre. The common follow-up questions were indeed posed – “Are the events in the drama happening in your society?”; “What did you learn from the performance?”; “What can we do about these problems?” – but the 50-60 invited people, a significant part of a village, were divided into three groups that discussed the queries, presented the outcome of their talks and then ventured into a shared dialogue that lasted longer than the performance itself. The occasion ended with a fundraising for widows and orphans in the audience’s community – just as in the performance. This is something that takes place quite frequently in Africa but that few people are aware of in the North. Before the meeting was closed, the leader of the theatre group offered the villagers a standing invitation to free counselling at the KZACP office with regard to the widow dilemma, a very audacious appeal considering the resource consuming ordeal of such conflicts.

The second credible factor about the group had to do with their partial defiance of the mother organisation's policies on condoms. In Tanzania all major religious branches are discouraging people from using condoms. This goes against the National Policy on HIV/AIDS,¹⁴ which does not hinder the many politicians who give support to religiously authorized behaviour, i.e. sexual abstinence until marriage and subsequent faithfulness. The "C" in the ABC-model (Abstinence, Be Faithful, use Condoms) is something church-goers talk about outside their houses of worship, as one man told me at a World Vision meeting in Kyaka on the Ugandan border.¹⁵ His comment brought about an embarrassed laughter in the congregation that said much more than words.

When it comes to ideologically sensitive policy issues, attitudes often carry the significance of what is enunciated rather than the other way around. I recently talked about AIDS on a bus with a nurse from a Catholic hospital in the south-eastern region of Mtwara. She held no religious qualms, but on the issue of condoms she said: "Oh, *that's* a problem! I tell patients to use condoms when no one else can hear me." In contrast to her commonsensical stance most of her fellow believers prudently adhere to the papal commands of the Vatican. It is a matter of an attitudinal response to a principle, the opposite method, if you will, to conducting critical or scientifically valid studies. Should the Vatican lift its ban on condoms, people around the world would robotically do the same without any kind of reflective consideration and thus end the harm against countless people. As things are now, I can fully appreciate the passionate views of Reginald Mengi, former representative on the Tanzania Commission for AIDS (TACAIDS) and media tycoon, who criticised religious leaders' stance against condom use by associating it with the murder of believers who contracted AIDS from unprotected sex.¹⁶

The nurse on the bus worked close by to a Catholic stronghold that is one of my fieldwork sites, namely Mwena. Experiences from that place have confirmed my suspicions of how religious dogma not only allow but actively engage in *doing* harm.¹⁷ My first visit (2003-09-16) coincided with – or perhaps prompted – a village meeting where I found a religious convener inciting a crowd of about a hundred people and at one point shouted: “What do we think of condoms?” only to get the expected unanimous response: “Bad!”. A little later I was invited to speak to the congregation. Diplomatically I expressed a hope that all preventive and protective options are kept open for people without the financial means or social status necessary to make deliberate choices in critical situations.

The performance that followed by the youth group depicted a rather narrow scenario of HIV transmission. After having casual sex with untamed boys in town, a young woman develops vaginal ulcers which turn out to be an opportunistic infection related to AIDS. The woman’s parents first take her to a witch doctor, but his treatment does not hinder her from getting terminally ill. By the time she is taken to St. Benedict’s Hospital in Ndanda (a Catholic infirmary near Mwena), it is too late and she dies. The unusually long death scene and its ensuing grief bore signs of scare tactics, again with emphasis on the preventive side of AIDS in Mtwara rather than the impact dimension in Kagera. The message comes across as saying: “If you have casual sex, you will die”. The performance had an individual appeal with focus on moral liability rather than a communal appeal with room for deliberation.

After the performance, I, as usual, expressed a wish to conduct confidential gender divided focus group discussions with the women and men of the theatre group. For the first and only time in Tanzania, a community leader stepped in and hindered me and my colleague Margaret Malenga from holding talks.¹⁸ Instead, we held a rather diluted general discussion in the presence of the apprehensive religious police. At dusk, when the latter man left the performance site, the remaining youth keenly asked Margaret and I

about the reliability of condoms and other taboo laden issues. Again we kept a diplomatic tone and accentuated the need to keep all life saving options open for as many as possible. I also informed them that HIV tests are free at the district hospital Mkomaindo in Masasi town a few miles away as opposed to the Catholic St. Benedict's Hospital in Ndanda. It is scandalous that they had not been notified about this.

Three years later (2006-08-26), I conducted random interviews with villagers in Mwena. Both a woman churning maize in her home and people at a village pub serving home brewed alcohol said that they had not seen anything by the theatre group for a long time and that the AIDS epidemic seemed to have gotten worse in Mwena and its environs. Of course I cannot ascertain a link between the local epidemic state and the tightly controlled theatre group, but it seems clear that the Catholic stronghold of Mwena impedes fully developed preventive measures against the epidemic through, e.g. an iron grip around the young people's troupe. Statistically the villagers seem to be accurate: during my research project, Mtwara, the region with the lowest number of HIV testing in Tanzania, has surpassed the Kagera region in AIDS prevalence rates.

Back in Bukoba town in Kagera, a Catholic priest told me that he advises against condom use and advocates abstinence by force: "We have forbidden our members to have parties after six o'clock at night. If they disobey, we refuse to give them the sacrament in church." (I remember thinking, "Come on Father, who cares about reprisal if it comes down to having a good time *and* surviving a plague?" while pretending to be an objective researcher.) Notwithstanding the priest's rigid position, Bukoba town was full of stories in the summer of 2006 about late night parties at the Catholic Church on Bunena Beach on Lake Victoria, with drinking clergymen enjoying watching people stumbling down to the lake for a quick one. At the break of dawn, the beach beneath the church is cleansed in waves of condoms – thank God!

Unlike the Catholics, the Lutherans and the Muslims are slightly less dogmatic when it comes to banning contraceptives. A theatre troupe from Bukoba, which I have seen and travelled with a number of times, regularly dramatize scenarios with condoms in their performances, despite relying on the support of the Lutheran church.¹⁹ Coincidentally, the Ilemera group is supported by the same diocese. When I and Stephen addressed the question of condom use in our interview with the Ilemera group D. told the other present leaders in the community centre, with a surreptitious but emphatic aside: "It is very important to tell them about this!" She went on to say, without explicit backing from her colleagues, that, "one problem we have – and this is a big one – is that our sponsor is limiting our ability to talk about and distribute condoms." In the same breath she showed me a book circulated by a Lutheran publishing company that lays out the text on the ban of condoms and that they are meant to obey. Stephen later says that D. is a typical Abanyaiyangiro, an outspoken person from southern Muleba, as opposed to the more modest Bahamba of the northern part of the district.

On the topic of condoms, a scene comes to mind from a performance in the village of Birabo (09/08/2006) near Ilemera. A man has an appointment with counsellors about whether to take an HIV test and the possible outcome of a positive (i.e. bad) result. The advice is that he should then make sure to eat well and avoid having sex. He asks if it is acceptable to have sex with condoms, waving a rubber with his right hand. A counsellor replies that condoms only have partial protection and that abstinence from sex is preferable. The man then concludes the conversation by making one of the most intriguing social gestures I have seen in theatre against AIDS: the sign of the cross with the condom in his hand.

STATISTICS AND THE UNCERTAINTY OF EVERYDAY LIFE

My research on community theatre is about bringing together various approaches and methods and evaluating efficacious combinations of cultural

studies and practices for HIV preventive purposes. Statistics is an approach that may seem to be hopelessly remote from performance analysis, but is an inevitable mode of understanding AIDS and its preventive counteractions. Needless to say, my research methods are primarily qualitative in the form of, for instance, performance analysis, culture-historical studies, focus group discussions, and interviews.²⁰ However, the epidemiological dimension of quantitative data can be interpreted as a qualitative phenomenon if the focus is kept on people's attitude to and use of the information. It is largely due to statistics that previous notions about AIDS as a medical problem for particular risk groups were refuted; it was surveillance data that exposed AIDS as a generalized syndrome linking widespread societal causes and implications with living conditions for people in prime reproductive age groups, especially young female strata who are in fact overrepresented in all statistics by at least double figures.²¹ This also pertains to the site-specific epidemic in Ilemera, exemplified by recent statistics collected by home based care units in the ward where women significantly outnumber men in HIV/AIDS prevalence rates.²²

In Tanzania more than half of all AIDS cases are unknown, not only to epidemiologists but to the affected people themselves and their friends and family.²³ Few people go for a test and many live with the virus unknowingly, but there are also a lot of healthy people who lead their lives in fear of already being infected. Countless households live under a constant state of uncertainty and insecurity, leading to a defeatist or even fatalist attitude to AIDS as a personal and familial health concern. People pick up "statistical rumours" which may drastically exaggerate or understate current prevalence and incidence rates. It is interesting to compare different views of the epidemic in terms of what Giddens calls a "double hermeneutic", that is, the practical and discursive levels of expert knowledge and public knowledge respectively.²⁴

One implication of the double hermeneutics of epidemiological statistics is that something wrong can be true and something true can be nonsensical. I have met many people who think half the community is infected, or who think that traditional witchdoctors can heal affected persons, as well as people who doubt that AIDS exists at all. Most people live and protect themselves according to their social and economic ability; beyond that they appraise possibilities and risks according to their routine local knowledge and if that knowledge – in the form of, for instance, hearsay – is a misrepresentation of an epidemic reality then that misrepresentation becomes an epidemic reality, at least for those who share the stories. Rumours may, of course, also point to accurate epidemic trends (like in the previously discussed instance of Mwena). That is indeed the case in the Kagera region which at one point was the hardest stricken place in the world along with the Rakai region on the other side of the Ugandan border. Substantial declines in prevalence rates in the 1990s have been corroborated in recent research by Gideon Kwesigabo and this good news has apparently reached Ilemera and most other communities in the region.²⁵ When I asked about statistics, D maintained that one survey accounted for 9% of the Muleba district, of which 6% (in absolute numbers) belongs to the district's eighteen islands. Kwesigabo reported a prevalence rate for the Muleba rural district of 4,3% in 1999 (again, with almost twice as many infected females as males). Since then the district has unfortunately exhibited rising trends in HIV infections among young people and blood donors,²⁶ so D's account with a percentage in absolute numbers may very well be accurate.

Statistics can drain a lot of meaning from studies by its quantitative mode of appraisal, but can also give a lot of weight to “non-figurative” phenomena such as preventable mortality, gender injustice, and experiential uncertainty.

THE BACKSTAGE REALITY OF COMMUNITY THEATRE

In this article I started out by describing how a performance initiated a post-performance discussion that generated a donation for widows and orphans and an organized undertaking to legally liaise with oppressed women caught up in unjust survival games. This does not only have to do with mitigating the impact of AIDS but also preventing the spread of HIV. The theatre enacted the predicament of widowhood as a crucial symptom of the vicious epidemic circle related to patrilineal rule and its property confiscation, leading to destitution, which, in turn, entails prostitution, a leading cause in the dissemination of HIV in Kagera. In the post-performance discussion the villagers testified that the vicious circle indeed exists in their community and that they would take measures to protect widows – even with the help of KZACP counsellors if necessary. Besides this I conducted focus group discussions (FGDs) with the female and male members of the community centre, which verified the association of impoverishment and female prostitution. The FGDs also confirmed that the subsidising church discourages them from using condoms. This is, of course, a serious discrepancy in the work by the community group in Ilemera. The latter is one of the most advanced groups of action researchers I have come across in Africa, with outreach nurses, peer educators, coordinators, and counsellors. And yet the adverse stance against condoms can cancel out the possibilities to break the vicious circle of destitution/prostitution.

This is where D comes into the picture, a dissident who is ready to speak out against contradictory principles and practices in favour of epidemiologically, ethically and politically motivated actions, even in defiance of her financial and moral benefactor. It is highly likely that optimistic statistical data about declining incidence rates and prevalence trends encourage extension workers in communities to pursue what they consider to be efficient and true, in defiance of commands and dogmas.

Invaluable informants such as D make the “backstage performances” of interviews as revealing as the theatrical events.²⁷

Another informant who put his own leadership position at stake was a young man whom we interviewed in a community centre in Ijumbe (2006-08-04). He told us a story about the time when the governing political party Chama Cha Mapinduzi (CCM) suddenly discontinued their funding for the theatre group. The reason, he explained while anxiously looking over his shoulder repeatedly through the glassless window frames to see that no one in the village could hear him, was that a member of the rival party Chama Cha Demokrasia na Maendeleo (CHADEMA) took on a leadership role in the community centre. Democracy, even in one of Africa’s most stable nations, is quite restricted at community level, certainly institutionally although especially in informal situations involving ordinary people’s everyday life.

Informant D says that as a peer educator she has now abandoned choir singing and direct theatre that simply alerts people against the perils of AIDS. That is a very candid statement which most people in her position would not make since they constantly seek more funds for their projects. D, however, is predominantly interested in efficacy. As paradoxical as it may sound, abandoning theatre can be an achievement for state-of-the-art community based theatre. The latter course of action is about a broad action research methodology applying a variety of tactics rather than about styles or aesthetics. Community theatre, as it has developed in Africa and other parts of the world, is about intervening in places by calling attention to certain crises, mobilizing action prone groups of people, letting them identify ways through or out of their predicament by means of site-specific performative practices: local meeting forms, action research, lobbying, protests, seminars, home-based talks, therapeutic group activities, and so forth. Such practices can be more performative than theatrical, as it were, and do not necessarily take place in public but in private or backstage performances. Hence the objective of contemporary community theatre is

not to play theatre to communities, but to get as close as possible to a community's own discourses, practices, and human resources according to one or another scheme of efficacy. That may entail kicking away one's own ladder when cultural divergences are surmounted, projects launched and the ownership of programmes are handed over to groups on a sub-village level, through open-ended peer education training so that they can learn by doing on an independent basis. This is also how I sense the fate of informant D: she is seeking out others to hand over her own practical knowledge of living and dying.

¹ I had the privilege of working with Stephen Ndibalema, a teacher at The Fine and Performing Arts Department, University of Dar es Salaam, during my fieldworks in Kagera 2006. Stephen grew up in Kagera and is an artistic as well as academic expert on the region's performance traditions. In 2004 I worked with Priscus Kainunula, who works with the non-governmental organisation Humuuliza, one of the most important civil services for orphans in Kagera. When I visited Ilemera for the first time in 2003, John B. Joseph, program advisor for Swissaid in Muleba, accompanied me. All three are trilingual, fluent in the local language Ruhaya, the national language Kiswahili and English.

² In March 2003, the Clinton Foundation HIV/AIDS Initiative (CHAI) partnered with the Government of Tanzania, the Harvard AIDS Institute, and PharmAccess and worked with a multi-sectored team comprised of the Ministry of Health, the Tanzania Commission for AIDS, cabinet agencies, Muhimbili University, local NGOs and others to develop a business plan for providing comprehensive care and treatment to Tanzanians living with HIV/AIDS. However, it took a couple of years to allocate the medicine to many of the regional and district hospitals in Tanzania.

³ *Kagera Region: Socio-Economic Profile* (Dar es Salaam: National Bureau of Statistics (NBS)/Kagera Regional Commissioner's Office, August 2003), ix.

⁴ Stefan Hansson, *Control of HIV and other Sexually Transmitted Infections: Studies in Tanzania and Zambia* (Stockholm: diss. at Division of International Health, Karolinska Institutet, 2007), p. 75. This was also confirmed in an interview I conducted with Gideon Kwesigabo, Dean at Muhimbili University College of Health Sciences, Dar es Salaam (interview 29 May 2007).

⁵ For more on biomedical vs. socio-cultural prevention schemes, see my article "The Lives and Deaths of Zakia: How AIDS changed African Community Theatre and vice versa" in *Theatre Research International*, Vol. 32, No. 1, 2006, esp. pp. 86-91.

⁶ *Ibid.* I attempt to demonstrate how AIDS has brought societal crises and gender trouble onto the centre stage of African community theatre and thus reminded people of problems that indeed existed before the epidemic outbreak.

⁷ For a well documented account of the epidemic outbreak in Tanzania and Uganda, see John Iliffe's *The African AIDS Epidemic: A History* (Oxford: James Currey, 2006), chap. 4.

⁸ Vanessa von Struensee writes: "Although Tanzania's Law of Marriage Act, 1971, (LMA) recognizes marriage as a partnership and declares that any property

acquired during the existence of a marriage is joint matrimonial property, the LMA does not apply to inheritance and does not supersede customary law. Thus, the discriminatory rules continue to apply to succession matters to the detriment of widows. Worse still is the customary practice governed by Rule 62, of wife inheritance, where a widow is required to marry a male relative of her dead spouse. If she agrees, she can remain there as a wife, but with no claim or control over the land. Women succumb to widow inheritance under duress where the alternative is destitution.” (“Widows, AIDS, Health, and Human Rights in Africa”, <http://www.crisisstates.com/download/forum/HIV/901widowsaids.pdf>, pp. 25-26, 2005. Last visited in April 2007. This can be compared with the governmental legislation of the Married Women's Property Act in 1882 in the United Kingdom, under which married women had the same rights over their property as unmarried women and allowed a married woman to retain ownership of property which she might have received as a gift from a parent. In 1893 the act was broadened as married women were given full legal control of all the property of every kind which they owned at marriage or that they acquired after marriage either by inheritance or by their own earnings. Interestingly, Elin Diamond refers to the Married Women's Property Act in her analysis of Ibsen's Hedda Gabler, see “The Violence of ‘We’: Politicizing Identification” in Janelle G. Reinelt and Joseph R. Roach (eds.), *Critical Theory and Performance* (Ann Arbor: The University of Michigan Press, 1992), pp. 390-412.

⁹ Japhet Killewo, *Epidemiology towards the control of HIV infection in Tanzania with special reference to the Kagera region* (Umeå: Umeå University, Department of Epidemiology and Public Health, 1994).

¹⁰ Suicide is, of course, also an option and an often ventilated one. It is as if this fatalistic taboo is less unmentionable than the syndrome that causes it. To show a suicide attempt in performance is unusual, though. One exception took place in a performance by a theatre group in Bukoba town, where a disinherited widow tried to hang herself but gets saved by a neighbour at the last second. About a hundred noisy market place spectators quieted down in a moment, as if seeing something they had merely heard – or possibly thought – about before, if not experienced surreptitiously.

¹¹ The islands are notorious for their HIV/AIDS prevalence. In 1997, several years after the epidemic peaked in Uganda and Tanzania, a Lake Victoria fishing community was studied by Pickering and Okongo et.al., who found that “[i]ts men had on average one new sexual partner every twelve days” (quoted in Iliffe *The African AIDS Epidemic: A History*, p. 24, 165).

¹² See John L. Austin, John, *How to Do Things with Words* (Oxford: Oxford University Press, 1962).

¹³ David Kerr, *African Popular Theatre. From Pre-Colonial Times to the Present Day* (Nairobi: East African Educational Publishers, 1995), p. 160.

¹⁴ “There is overwhelming evidence about the efficacy and effectiveness of condoms when used correctly and consistently in the prevention of HIV transmission. Good quality condoms shall be produced and made easily available and affordable. The private sector shall be encouraged to produce and market good quality condoms so that they are easily accessible in urban and rural areas.” (*National Policy on HIV/AIDS* sec. 5.10, 2001)

¹⁵ It is a well known fact that all major faith based organisations in Tanzania – including not only Catholics but also Lutherans, Anglicans and Muslims – are officially opposed to the promotion, distribution and use of condoms. In a joint

statement at a convention in Dar es Salaam in 2002, seventy representatives from the major religions made it clear that they discourage their followers from using condoms due to the fact that all holy books are opposed to the use of condoms (Clerics' Condom Stand At Odds With National Policy in *UN Integrated Regional Information Networks - March 18, 2002*; <http://www.aegis.com/news/irin/2002/Ir020305.html>; last accessed 2007-08-15; cf. endnote 14 above).

¹⁶ "HIV/Aids Debate Hots Up" in *UN Integrated Regional Information Networks - August 20, 2002* (<http://www.aegis.com/news/IRIN/2002/IR020806.html>; last accessed 2007-08-15). Peter Nyanje writes in *The Guardian* (2002-07-31)

¹⁷ For further reading on the moral implications of allowing versus doing harm, see for instance Philippa Foot, "Morality, Action and Outcome," in Ted Honderich (ed.) *Morality and Objectivity* (London: Routledge and Kegan Paul, 1985), and Warren S. Quinn, "Actions, Intentions, and Consequences: The Doctrine of Doing and Allowing," in A. Norcross and B. Steinbock (eds.), *Killing and Letting Die*, 2nd. Ed. (New York: Fordham University Press, 1994). For more specific reading on how ideology comes in between national (South African) attitudes on AIDS and people's need for protection, see Catherine Campbell, *'Letting them Die': How HIV/AIDS programmes often fail* (Oxford: James Currey, 2003).

¹⁸ In the districts of Masasi and Mangaka of Mtwara region, Apart from Margaret Malenga (2003), I have worked with Andrew Hamisi (2003 and 2004), and Delphine Njewe (2006).

¹⁹ In a short television documentary about the Bukoba theatre troupe, that I was part of making, we made sure to foreground dramatic scenes involving condoms as well as an interview with the group leader Michael Kifungo about their defiance against their own sponsor when it comes to condom use. It was aired on CNN and MTV on World AIDS Day, December 1, 2004, as part of a series of short documentaries called "Staying Alive".

²⁰ I am using most of the research methods that Ann Bowling defines in health studies: "Qualitative research describes in words rather than numbers the qualities of social phenomena through observation (direct and unobtrusive or participative and reactive), unstructured interviews (or 'exploratory', 'in-depth', 'free-style' interviews, usually tape recorded and then transcribed before analysis), diary methods, life histories (biography), group interviews and focus group techniques, analysis of historical and contemporary records, documents and cultural products (e.g. media and literature)." (*Research Methods in Health: Investigating health and health services*, Maidenhead: Open University Press, 2004, p. 352.)

²¹ Statistical gender discrepancies are found in a number of reports in Tanzania (see "HIV/AIDS/STI Surveillance Report: January-October 2004", United Republic of Tanzania: Ministry of Health/National AIDS Control Programme, Report No. 19, October 2005) as well as in sub-Saharan Africa in general. ("Report on the Global AIDS Epidemic", Geneva: www.unaids.org, December 2006). Hence, women are more exposed to HIV and, in the words of a Ugandan representative at the 15th International AIDS Conference in Bangkok in 2004; it is statistically more dangerous to be a housewife than a soldier in Africa.

²² The statistics for 2006 reads as follows in the Ilemera ward, where the community centre in question deploys extension workers: Among 86 people living with HIV/AIDS (PLWHA) 13 were male and 73 female. These numbers – which are not scientifically validated but indicative of local incidence and prevalence trends – point to a greater willingness among females to seek or be recruited for medical

attention and also a great number of absent men in general. But the statistics are also indicative of the above mentioned gender discrepancies (see endnote 21).

²³ “HIV/AIDS/STI Surveillance Report: January-October 2004”, United Republic of Tanzania: Ministry of Health/National AIDS Control Programme, Report No. 19, October 2005), p. 2.

²⁴ Anthony Giddens, *The Constitution of Society: Outline of the Theory of Structuration* (Cambridge: Polity Press, 1984), p. 374.

²⁵ Gideon Kwesigabo, *Trends of HIV infection in the Kagera region of Tanzania 1987-2000* (Umeå University Medical Dissertations, New Series No 710, 2001).

²⁶ “HIV/AIDS/STI Surveillance Report: January-October 2004”, United Republic of Tanzania: Ministry of Health/National AIDS Control Programme, Report No. 19, October 2005), pp. 26-27.

²⁷ This reasoning is, of course, inspired by Erving Goffman's notion of and approach to social front and backstage performances in *The Presentation of Self in Everyday Life* (Garden City, NY: Doubleday, Anchor Books, 1959), see esp. p. 112.