AIDS AS A LONG WAVE DISASTER

by

Tony Barnett and Piers Blaikie, School of Development Studies
University of East Anglia, Norwich, NR4 7TJ.
Tel: 0603.56161, Ext. 2336.

ABSTRACT

This paper focusses on the AIDS pandemic in Uganda, which can be viewed in terms of disaster theory, although it differs in some important ways from disasters which occur as discrete events, and those which have precedents. The special chacteristics of the AIDS pandemic as a disaster have far-reaching implications for the way in which society makes responses to it. A period of social experimentation is necessary, where readjustments to repeated and growing number of deaths are made, and where past experience is seen as an increasingly unreliable guide to what action to take in the future. Changes in the explanation of the disease and in expectations of life's fulfilment in the face of AIDS take place. Coping with the direct impact (illness and death to the individual and her/his family) can be seen as adaptive and experimental behaviour in the face of a slowly unfolding and unprecedented disaster. A methodology is outlined to analyse the differential socio-economic impact of AIDS on households with different access to resources, and on regions with varying patterns of labour demand in agriculture.

Keywords. AIDS, disaster, coping, farming system, access, adaptive behaviour.

Introduction

This paper first analyses the AIDS pandemic in Uganda in terms of theories and recognised causes and patterns of a disaster, and compares it with other disasters. Then a discussion follows on the ways in which people explain the disease - after all, the most effective way in which people can protect themselves against the disease relies on a scientifically sound explanation of how the disease is contracted. Then the way in which the disease is

TABLE 1: RAKAI DISTRICT; SEROPREVALENCE BY AGE AND GENDER (PERCENTAGES)

Age Group	Men	Women
10 - 14	0.0	5.0
15 - 19	5.0	30.5
20 - 24	25.0	42.0
25 - 29	35.0	31.0
30 - 34	30.0	22.0
35 - 39	15.0	22.0
40 - 44	20.0	20.0
45 - 49	19.0	15.0
50 - 54	5.0	14.0
55 - 59	0.0	9.0
> 60	0.0	0.5

Source: Musagara, M., Musgrave, S., Biryahwaho, B., Serwadda, D., Wawar, M., Konde-Lule, J., Berkley, S., and Okware, S., "Seroprevalence of HIV-1 in Rakai District, Uganda, Poster 010 IICOAACA.

The above data give some indication of the present and likely future magnitude of the pandemic, and justify, on the criterion of scale alone, calling it a disaster of major proportions.

AIDS as a disaster and how people cope

> "We use the term coping as a general term to include defense mechanisms, active ways of solving problems and methods for handling stress..." [1]

> "Households make pre-emptive decisions following a drought in an attempt to mitigate the somewhat predictable effects of a severe (food) shortage or market distortions perhaps six months distant.
>
> Most response strategies to actual or potential food shortage are in fact extensions of practices conducted in some measure during a normal year. The vast majority are *in situ* and can be broadly classified as self-help." [2]

The literature on coping mechanisms in the face of disasters is very large. Two rather different ideal types can be

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[1] *L.M. Murphy and A.B. Moriarty, **Vulnerability, Coping and Growth**, Yale University Press, New Haven and London, 1976.*

[2] *M. Watts, "Coping with the market: uncertainty and food security among Hausa peasants", in **Coping with uncertainty in food supply**, I. de Garine and G.A. Harrison, Clarendon, Oxford, 1988.*

perceived to have affected their hopes and expectations of life are reviewed. How does the disease confront people's expectations and hopes? If there are conflicts between those of different people, whose are sacrificed, and whose survive? Finally, the paper discusses ways in which individuals, households, families, and communities cope with the illness when it strikes them and close relatives or neighbours. Lastly, a framework for analysing the ways in which the economic and social structuring of access to resources affects the capability of different individuals and households to adapt and cope with the impact of the disease is presented.

The Aids pandemic in Uganda is beset with problems of inaccurate and incomplete data and sensationalist reportage in the national and international press. However, there are more respectable data available, and cautious estimates can now be made about the present and future demographic impact of the disease. The AIDS Control Programme (ACP) has recently estimated that 1.3 million of the total population of c.17 million are sero-positive, and that the number of AIDS cases doubles every six months (WorldAids, 1991, No.14). The longer term demographic predictions are open to large margins of error, but a recent population prediction shown to the Ugandan president suggested that the impact of AIDS could reduce the growth of population from 37 million in the year 2,010 to 20 million.

Present data on sero-positivity and mortality are patchy, but indicative of the fact that in certain areas, the pandemic has already caused exceptional demographic change. The SCF Orphans Study has indicated that in some parishes in Rakai District in the western Lake Victoria area, in excess of two thousand parents (of identified orphans, with one or both parents dead) have died of the disease from 1977 to date from a present day population of about 30,000. Obviously, these statistics have to be used with a good deal of caution, since clinical diagnosi of the cause of death was not made for all these parents. A sero-survey of Rakai District undertaken in 1989 by ACP and Columbia University indicated the following very high rates

distinguished, although in reality they overlap. The first is a priori risk aversion strategies. These involve pe-emptive actions to minimise the probabilities that the disaster event will occur in the first place. Examples include production strategies of "risk-averse" farmers and pastoralists. Multiple cropping, inter-cropping, multiple enterprise livelihoods, grain storage and building up cattle numbers in well-watered years are some examples. There are also reproduction strategies in the face of high infant mortality, whreeby a large number of births improves the chances of a minimum labour force and living children to look after parents in their old age (even though they will mostly not survive long enough to enjoy it). In all cases adverse conditions are expected and planned for.
The other type of coping mechanism is ex post strategies. These are the most common and well-noted and take many forms in different economies and cultures. The majority have evolved in response to risky physical environments, particularly to drought. They are often sequenced, and are identified with different stages of a disaster as it unfolds, with increasingly radical and desperate measures being brought into play, as the situation worsens (Corbett, 1988). They also follow a sequence in terms of the level at which people are involved. Within the household, a reduction of consumption of staples, sale of livestock or gold and the collection and consumption of famine foods are some examples. At a higher level, the seeking of wage employment, borrowing grain from relatives, or mobilising networks of obligations and rights from patrons and relatives may occur . Regional, national and international levels may also become involved in terms of public works and "food-for-work" programmes, price controls on staple foods, and the distribution of food.

However, AIDS differs in some crucial respects from the types of disasters, mentioned above. The first is that the AIDS pandemic does not take the form of a discrete event, with recognisable stages and responses. This is so for three main reasons. Firstly,a priori strategies for preventing the disease requires an accurate medical explanation and effective changes of sexual practice. For a variety of reasons, the perceptions, explanations and changes in practice are not in place, as the next section will explain. Secondly, coping with the main dowstream effects (illness and death) involves well-established coping mechanisms upon each individual death. It is only when the scale of deaths gradually becomes apparent that 'coping at the margin' is seen to be inadequate. In other words, the scale is unprecedented, but in terms of the whole community or region, rather than the household or family, in which one or even two deaths may occur in quick succession in "normal" times. (There are cases of seven or more AIDS deaths occuring in the same family, but this is not common). This realisation that the pandemic is unprecedented is now clearly widespread in most parts of Uganda, and especially in Rakai and Masaka Districts, in which fieldwork for this project was carried out.Thirdly, AIDS can be described as a "long wave" disaster. It does not seem to the affected society to be a discrete event, with recognisable trigger events, which can be used to mobilise action, such as an earhquake or the devastating floods in southern Bangladesh in the last week.Even a drought and the subsequent famine that it may trigged both have recognisable onsets.

The implications of AIDS being a long wave disaster are that the different stages of coping tend to become attenuated and delayed. The first stage involved the recognition and explanation of the disease, which is discussed in the next sections. Without the benefit of medical information being disseminated to the public by mass media, or widespread public meetings until well into the pandemic, the only overt symptoms are an unusually widespread syndrome from which people are suffering followed by death. By the time these are recognised, of course sufficiently high HIV+ prevalance rates to cause exceptional demographic change in the future are widely established, and the scale of the disaster has in the meantime enormously increased. Depending upon the rate of infection and the mean period between infection and the onset of recognisable symptoms of ARC, it is estimated that, for every one person with these symptoms, there may be in the region of ten more who are already HIV+, (although this estimate must remain no more than a guess due to the lack of data on the epidemiology of AIDS in Uganda, and the knowledge on sexual practice on which it is based). Thus the raw material, the evidence, on which explanation of the disaster is made, takes at least five years to appear before the first stage of coping with the disease can begin (that of recognition and scientific explanation of how the disease is contracted).

Secondly, once people are recognised to be suffering and dying from the disease, the ways of coping are familiar, since death and illness have established responses, as in all societies. Thus, existing coping mechanisms to deal with illness and subsequent death are mobilised. It is only when an unusual number of deaths are suffered, all accompanied with the same syndrome that existing mechanisms start to be seen to be inadequate. The whole sequencing of responses from experiencing deaths, through to explanations and readjustment to societal hopes of fulfilment and ambitions, and coping with the direct impact of illness and death, are driven by the spatial and temporal growth of the epidemic. In some parishes of Rakai District over 2000 parents have died from a total population of about 30,000, and the arrangements made for care of the sick, support for close relatives, funerals, orphans and so on clearly cannot follow established patterns. In nearby parishes, where mortality is very much lower, existing coping mechanisms will show less signs of stress. However, adaptations can only be made on the basis of experience, not by prior planning based upon the absorbtion of televised or otherwise published scientific warnings. Unlike some other disasters, such as famine or floods, a priori coping mechanisms and experimentation cannot easily be brought to bear, other than a change in sexual practice. In the case of famine, stockpiling of food and other short term risk-averting strategies can be followed before the symptoms make themselves felt.

Crises, "abnormality" and coping

2.1 Crisis, "abnormality" and coping

Crisis events occur form time to time in people's lives and in

the lives of whole communities and societies. Such events call for the mobilisation of resources to cope with their impact. When people know an event will occur because it has happened in the/past, they develop ways of coping with it in advance. Such coping strategies depend on the assumption that:

a) the event itself is socially perceived and recognised as following a familiar pattern, and

b) the decision environment (consisting of the social, economic and natural environments) will not have changed. Thus it is assumed that people and the natural environment will behave in familiar ways.

The assumptions upon which people make their decisions therefore rest upon the knowledge that, sooner or later, a particular event will occur and thus represents a risk concerning which people have some stored subjective estimate and experience of how to cope. For example births, deaths and marriages will occur for all households, and likewise droughts or floods may cause widespread loss some time in the future for those living in a physically hazardous environment. On the other hand, people do not like conditions of uncertainty where there are no known and familiar ways of coping with a particular event such as explicit systems of rights and obligations, providing safety nets and support groups. Thus the unprecedented or unknown event creates a situation of uncertainty.

In situations where communities and households are increasingly affected by illness and death (such as in the AIDS pandemic), the balance is perceived over time to move from the known to the unknown. At the margin, another single death may seem like any other, and of course, most societies have well established mechanisms to cope with a death. But when large numbers die, and are perceived to do so as a result of unprecedented causes, established coping mechanisms may begin to show signs of stress. In such circumstances, expectations derived from past experience increasingly become a poor guide to the solution of management problems in the present: coping becomes difficult. The circumstances of everyday life become increasingly uncertain and therefore stressful and puzzling. Confronted by such uncertainty in the decision environment, it is to be expected that a range of 'experiments' will be undertaken by households and communities as their experience of the new situation increases. Such 'experiments' can be seen as attempts to reverse the balance between the known and the unknown in a search for normalisation. In sudden disasters, such as earthquakes, where established coping mechanisms are inadequate this period of experimentation may be brief. As we have indicated above in the case of a disease such as AIDS, where the nature and epidemiology of the disease means that the onset of 'abnormality' is very gradual, but where the rapidity of spread increases as a critical mass of HIV+ people is reached, the period of transition and experimentation may be expected to be quite long and delayed. The duration of the crisis, whether long or short, will provide advantages and disadvantages from the perspective of developing coping mechanisms whether these are local mechanisms (for example new ways of caring for orphans) or society-wide policies (for

example developing a health budget which takes into account large numbers of AIDS sufferers).

If coping is to be possible, and if people are to manage a crisis, then the existence of a crisis must be socially recognised. In other words, a household or community must explicitly define the situation as one which is 'abnormal, and which is not manageable by recognised coping strategies. The recognition of 'abnormality' is a first step in recognising uncertainty about how people and the environment will behave in the future, and that normal coping mechanisms are becoming inadequate. For example, the establishment of the WHO GPA at the international level, and of TASO at the national level, may be seen as just such a recognition. In addition, the perceptions expressed by villagers in the most affected areas, show how this abnormality is recognised at the level of the local community.

In an affected household, illness or death of one member may be accepted as 'normal', but subsequent illness and deaths which follow an unprecedented pattern will force recognition that an 'abnormal' situation has developed. In an affected community, this transition may occur because a large number of households is affected, or because people from outside the community define the situation as unprecedented, or both of these things may happen at the same time. In the case of Rakai district in Uganda, many households have been forced to recognise that there is a crisis. People are beginning to think about new ways of managing what is now defined as a novel situation. In some parishes, for example, there have been calls for special bye-laws to control prostitutes and infected men. Clearly, this is an example of experimentation and new forms of action.

The entire district has been defined as being in crisis by external observers such as the media and through the activities of researchers and medical teams. However, the transition to recognising an unprecedented crisis by the local people themselves in Rakai District varies from place to place, and this variation is principally driven by epidemiological factors. For example, it is still at an early stage in the north and west of the district particularly away from trading centres and roads. There remain communities and households which do not perceive the situation as being unusual, and "abnormality" is confined to "others" in other places. Here, a process of denial of the abnormal and unprecedented is evident. In addition, the entire district has been defined as being in crisis through press reports and the activities of researchers and medical teams.

Explaining AIDS in Buganda

Individuals and communities must develop explanations and understandings of the disease if they are to cope with its impact. This section describes how individuals explain and try to make sense of the experience of living in communities where there is widespread illness and death.

From a rational perspective, the most effective way of coping with the pandemic is to change sexual behaviour and also to avoid other possible sources of contamination such as infected hypodermic syringes or implements used in ritual scarification. In order to do this it is necessary to have an accurate explanation of how the disease is transmitted. Information has to be translated into knowledge and then into action (principally in this area involving a change to safe sex). However, this is not an adequate account how real people actually deal with these risks.

In reality most of us all cope with hazards and risks by a combination of rational and non-rational responses. This is not to suggest that we act "irrationally", but there is a considerable difference between "non-rationality" and "irrationality. Broadly speaking, the distinction is as follows. Rational behaviour is behaviour which has a clear goal and where resources are used efficiently in order to achieve that goal. One of the resources is adequate information and knowledge about the hazard and about the risks attaching to that hazard. The claims of scientific explanations as in some sense true and superior to other forms of explanation rest on the belief that experimental evidence provides an adequate account of the main factors in a causal chain which leads to the appearance of a particular phenomenon. The scientific explanation of AIDS rests on establishing a chain of causality between the symptoms of illness and the ways in which the virus compromises the human immune system. Rational response to this knowledge involves breaking this chain of causality at some point - within the body or between bodies. When people do not act in accord with this line of reasoning, it is not necessarily the case that they are acting irrationally - denying the validity of the scientifically established chain of causality. They may be acting in relation to another explanation, one based on different assumptions as to the nature of the causal chain. These assumptions may use the language of "chance", "luck", "witchcraft", "sorcery", "sin", "morality" or "punishment for moral misdemeanour"[3], but they are

[3]See for example Richard Davenport-Hines, **Sex, Death and Punishment: attitudes to sex and sexuality in Britain since the Renaissance**, Collins, London, 1990, for an account of the way in which sexually transmitted diseases have been treated as a moral rather than a medical issue in Britain, and Max Gluckman's famous essay, in **Custom and Conflict in Africa**, which shows how malaria can be treated as an issue of witchcraft, or the work of Maryinez Lyons on sleeping sickness which shows how that disease was used in the context of colonial government as a rationale for relocation of population. Megan Vaughan's paper "Syphilis in Colonial East Africa: the social construction of an epidemic", in Ranger, T. and Slack, P., **Epidemics and Ideas: Essays on the Historical Perception of Pestilence**, Past and Present Publications, Cambridge University Press, Cambridge, 1991, provides another interesting case study of the ways in which the languages of medicine, morality and colonial administration can be mixed together and can result in the production of policies which in the end do not deal with "medical" problems but with the social and political prejudices of the powerful.

not "irrational" so long as the assumptions (however misinformed they may appear) are used as the basis for future action and the logic of those actions flows from the assumptions. All that can be said of these other forms of explanation, and for that matter also of scientific rationality, is that they have a "bounded rationality", they take into account certain limited knowledge and information in entering the decision process, or give weight to some information or knowledge which an observer would weight differently. Some of this difference in weighting may derive from "custom", "superstition", "belief" or "values". In these circumstances, some may label this a "non-rational" basis for the ways in which people act. However, although the basis for action may be "non-rational" in this sense, it is most certainly not "irrational". This term suggests that a person is acting contrary to the information or knowledge which they have. All this means that the users of this label "non-rational" cannot understand why another person or group gave greater weight to one piece of information and less weight to another, and that they (the users) would have reacted differently. In what follows, it will become clear that in Uganda as elsewhere, people are responding rationally to the AIDS epidemic in terms of their own world view and experience.

The first thing to be said is that there are quite wide variations in the level of awareness of the causes of the disease between different regions of Uganda and through time. One of the earliest outbreaks of the disease was experienced in the smuggling ports on the western shore of Lake Victoria. Those traders involved in smuggling began to fall sick and die in 1980-81 (source: fieldwork 1989). The dominant local explanation at that time was that the traders had been involved in a major swindle of Tanzanian traders, and that the latter, coming from the district of Bukoba (well known for its powerful witches - in particular the Haya and Ziba people), had bewitched the Rakai traders and caused them to die. The fact that the traders wives were not long in following them to the grave was seen as confirming the potency of Bukoba witchcraft. However another trader not involved in the original swindle also died together with his wife. About this time public health education was reaching schoolteachers and local leaders. An alternative explanation was required, and the message of the health educators was assimilated but without completely displacing the existing explanation. Today it is possible to find a range of syncretic explanations. It is still common to hear a composite explanation in which the scientific and witchcraft explanations are merged, suggesting that while the infection can be picked up during sexual intercourse, there is always a chance that it will not occur, even if the other person is known to be infected. Thus the language of "chance" and probability is introduced into the chain of causality and it is said that this "chance" can be influenced by witchcraft, which if malignly exercised, can cause the infection to pass during that particular sexual encounter. There are a number of other variants such as the belief of some men that if they pay women for sexual intercourse, they propitiate one of the lesser gods, who, if not properly placated, are well known for activating the infection. Here the languages of science, witchcraft, religion and the market are intertwined. Such an intermingling of theories of causality reflect the ways

in which individuals deal with a hazardous environment by drawing down different parts of the culturally available vocabulary so as to enable them to continue to behave in ways which are "normal". Such a process of creating a rational framework for daily life fits in with the attempt to construct normality in an abnormal and novel situation such as we have suggested exists today in Buganda. It is a way for individuals to hold onto past normality as the decision environment changes. However, the process is not uniform. Gender, age and locality will all influence the particular combination of explanations which individuals and groups will draw upon in order to explain and to cope.

In the areas of highest infection, the medical explanation is widely held by the majority of the population, and particularly by older schoolchildren. This explanation includes identification of the virus as bukuwa (a small insect), which is passed between partners during sexual intercouse. It was also noticeable that in areas which had not experienced high mortality from AIDS, such as in Kabula sub-county in north eastern Rakai District and in Kigesi District, hundreds of kilometres away near the border with Rwanda, explanations of AIDS as the result of witchcraft continue to prevail.

Even in those parts of south eastern Rakai District which have experienced the highest mortality, there is much evidence, at least from men, of continuing risky behaviour together with its attendant rationalisations. Two quotations from a couple of men frequenting a bar in the study area, illustrate this. "If indeed AIDS exists and is caught from sex, I will be the example" (meaning 'the exception to the rule'). "People were never meant to be like timber and live forever" (meaning 'we all have to die sometime'). It is interesting that it is men who adopt these types of orientation. There are a number of reasons for this. Firstly,in Buganda society, as in many others, male identity is closely tied up with sexual conquest and with fecundity. Secondly,there appears to be little in the way of male solidarity, and there is a history of the past thirty years which has placed a premium on individual competition and survival, success in these endeavours being symbolised at least in part by sexual conquest. For these reasons, it is all the more necessary for men to keep escape hatches open so that they can continue to act as they have in the past. Studies of male attitudes and sexual behaviour in north America and Europe are little different in this respect.

In contrast, women see the existence of the disease as a threat to themselves and their children, but one against which there is little defence given their subjection to men. Amongst women, one of the most distressing experiences, and a threat with which they have to live, is the birth of an infected child. Its suffering is a continual reminder to the mother of the consequences of her past actions, and an indication of what will certainly be in store for her too. There is enough experience of HIV positive children who "are born coughing" in the worst affected areas for it to be a major motive for changing sexual behaviour- if, of course, women can avoid unwanted sex. It is certainly among women that most discussion is heard of the need to change sexual

behaviour.

Two further examples show how people do not act on the medical and experiential knowledge of the infection and of the chances of catching it. The first is the belief that the act of marriage itself makes the partners immune from infection. This has probably come about because both the Catholic and Anglican Church as well as Muslim leaders have urged marriage and "zero grazing". Although adherence to this advice may reduce future risk of infection from sexual intercourse outside marriage, it does not of course guarantee the sero-negative status of the partners at the time of marriage nor the prevention of inter-spouse infection afterwards. The second example is the belief that a pregnant and seemingly healthy woman cannot be HIV-positive. In addition, the idea that female beauty is a protection against AIDS infection is prevalent among men, and this is mentioned by adolescent schoolchildren in their essays which were analysed as part of thiis project, but not reported in this paper.

Even if an accurate explanation of the disease and of the risks involved is believed, the current rates of seropositivity make even occasional sexual intercourse highly risky in the centres of infection. Therefore occasional bouts of celibacy which may be brought on by the experience of a suffering child or the death of acquaintances may not be effective. The effect of advice by the AIDS Control Programme to "Love Carefully" is likely to be ignored unless it implies the use of condoms without exception. Since these are unavailable anywhere outside Kampala and the biggest provincial towns, and since until very recently the Government of Uganda has been ambivalent in its attitude to condoms, the advice, even if taken, in unlikely to be effective.

There are a number of other strategies which are perceived to reduce the risk of infection. For example, men tend to seek much younger sexual partners and wives in the belief that these women will not be infected. The result of this practice can be seen in the proportion of very young women who are now seropositive and in the differences in numbers of AIDS cases and rates of seropositivity as between men and women. Other men seek brides outside Rakai and Masaka Districts altogether. In some cases husbands and wives whose spouses have died of AIDS migrated, seeking a new partner elsewhere, and leaving behind them the stigma of being the spouse of an AIDS victim and of living in a notorious area. These actions of course contribute to the spread of the disease to other areas.

The change of sexual behaviour to "zero grazing" (faithful marriage) is being advised by the churches and Muslim leaders but most religious institutions have resisted the slogan "Love Carefully" since it seemed to condone promiscuous behaviour. There is, in any case, no evidence that large numbers of people heed either counsel. The only reliable evidence would be a comparison of rates of seropositivity at short (for example, annual) intervals. The rates of seropositivity in Rakai District from the study by Musgrave and his collaborators[1], only indicate

[1] Musgrave, S. et. al. op. cit.

that "zero grazing" has probably not been widely practised over the past five years or so.

There is evidence in the communities in Rakai that there is social pressure to control circumstances which might facilitate casual sex. Rural Resistance Commitees (RRCs) have introduced bye-laws banning discos, and the levels of casual sex at bars and hotels in trading centres appear to have been greatly reduced. Certainly, in the course of our research when we stayed at small hotels and visited bars in places such as Kyotera, Kalisizo and Lyantonde, they were not the hives of activity which they reportedly were even five years ago. Transmission also occurs at weddings and funerals, and some RRCs have attempted to ban alcohol and to reschedule these events to daylight hours so as to discourage sexual encounters. There is also new legislation at the national level. which has raised the age of consent from 14 to 18 years, made homosexuality and prostituion illegal, and made the rape of a child less than 14 years a crime punishable by death (World Aids, 14: March 1991,3). Whether these responses will accelerate a change of sexual practice remmains to be seen, but a useful indicator is the rationality and knowledge of the sexually active population itself, particularly those adolescents who are about to start sexual activities, and are, for the most part, still sero-negative.

Expectations and crisis in Buganda.

In the previous section the perceptions and explanations of AIDS in Buganda society have been examined. Here, the ways in which AIDS is perceived to affect people's expectations of life are discussed. In any culture people can be assumed to have a hierarchy of expectations, which may be threatened by a crisis, and force a re-ordering of these expectations. The highest expectation might be self-respect and a sense of worth created by the giving and receiving affection. Another, lower in the hierarchy may be an acceptable stanard of living now and in the future, while lower ones still may be a minimum food intake, basic shelter and survival in the short term. Any crisis forces a person to re-appraise these, perhaps to re-arrange them, and to abandon some at the expense of others.

Where AIDS has caused considerable mortality, expectations of the normal rewards of life have been put into jeopardy. Consider thiis quotation from a man living in south-eastern Rakai District:
"With AIDS we are now living on the front line just as we were during the Liberation War of 1979. Then we were prisoners of that war, now we are prisoners of AIDS. Those of us who are ill, are under sentence of death"

The ways in which this all-enveloping crisis, from which there is no escape threatens these expecations can be illustrated by the way in which the disease is referred to as mukenena, or the one that drains; lukonvuba, or an incurable disease; and mubbi or the robber. These three descriptions indicate how many of the expectations of normal life are threatened in a number of ways:-

(i) the threat of the disease robs adults of the expectation of sexual fulfilment and of marriage. Condoms are little known in these rural areas, and are usually unobtainable. The joy of sex is therefore is set about with extreme anxiety. The expectation of sexual fulfilment is either completely abandoned in favour of celibacy, or maintained by spurious explanations of why the disease will not be transmitted in a particular or future imaginary sexual encounters.
(ii) AIDS puts a serious strain on any permanent or semi-permanent relationship between women and men. Fears of what a partner may be bringing to the bed of their partner is a constant source of worry. Unwanted sex forced upon women is very much a live issue, discussed in womens' informal groups.
(iii) If young people die childless, they are robbed as individuals as they leave no trace. For example, "I don't mind dying, but to die without a child means thast I will have perished without trace. God will have cheated me", (said by a woman dying of AIDS at the time of the interview).
(iv) In the same way, whole families feel themselves to have been robbed as they face extinction from the communal consciousness.
(v) The disease deprives the elderly of the expectation of the care of their children in old age, and ultimately of a correct burial.
(vi) It robbs children of their parents, of the love, training and security that they provide.
(vii) The disease drains not only the sufferers, but the resources of the family to look after them, and to survive after they have died.

In these ways AIDS threatens almost every aspect of the normal expectations of family life from birth to death, and beyond in the sense that proper burial and memory of the individual in the collective consciousness are threatened. Also, the disease will also affect other expectations lower in the hierarchy, in that economic security may be threatened. Widows and orphans may face insecurity of ownership or access to land and property. Food supplies may be disrupted because of a lack of labour and cash. These downstream effects are discussed briefly in the last sections of this paper.

This section has suggested that individuals in Rakai feel that they are living in abnormal times. They have had to struggle with developing explanations of those times. In the worst affected areas, original explanation through the idiom of witchcraft has rapidly been replaced by others which take account of medical findings or in which a syncretic combination of explanatory discourses coexists. In part this reflects the success of government educational efforts. However, insofar as such information is known, it does not necessarily result in changes in behaviour. Instead, people (particularly some men) rationalise their way out of the full implications of the disease through a variety of other accounts of how the disease may be avoided, or by adopting an aggressive fatalism. In the case of adolescents,