People's Power: Local Agency among HIV AND AIDS Marginalized Groups in Mbozi District, Tanzania, 1980s-2017

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Abstract

This study examines the Mbozi society`s responses to the plight of marginal groups attributed to HIV/AIDS for the past three decades. The groups in question include people suffering from and or living with HIV/AIDS, AIDS related widows, AIDS orphans, and the elderly caring AIDS orphans. Rather than focusing synchronically on the responses from the international community, government and Non-governmental organizations as has been done by many studies, this study diachronically concentrates on the ordinary people`s responses at the grass-roots level. It argues that to cope with their plight, marginal groups associated with HIV/AIDS engage in different livelihood strategies including wage-labour, begging, sex work, petty trade, income generating groups, self-help groups, farming as well as enlisting family and neighbourhood support. By drawing on documents and interviews with people at the grass-roots level, this study not only brings to the fore the voices of the marginalized and people`s agency and resilience in the context of HIV/AIDS pandemic but it also adds to the growing body of knowledge on social exclusion in Tanzania in particular and Africa as a whole.

Key words: HIV/AIDS, marginalised groups, social exclusion, livelihood strategies.

1.0 Introduction

"*We [the people living with HIV&AIDS-PLWHA] only get white coloured pills [amalembo amazelu[266]] from the government [referring to the white coloured antiretroviral drugs-ARVs]. We do not get any other assistance from the government. We therefore sustain*

[266] In the Nyiha language *amalembo amezelu* means white coloured medicine or pills. In this case, informants refer to the white coloured ARV pills.

ourselves by taking our own initiatives such as engaging ourselves in agriculture and petty trade."[267]

Since the 1980s, the people of Mbozi district,[268] as the above quotation indicates, have been showing agency in dealing with HIV/AIDS[269] marginalisation also known as social exclusion. Social exclusion entails the disempowerment or inability of specific social groups to access cultural, social and economic resources in a given society that are enjoyed by the rest of the society thereby diminishing the groups` self-actualisation.[270] In Mbozi district as in other parts of Tanzania, the government`s restrictive policies and its inability to provide social services to the groups, the culture of stigmatization of the groups and impoverishing forces such as poverty have had a hand in the exclusion of the groups. In Mbozi district, and within the context of HIV/AIDS, the excluded groups include orphans, widows, people living with HIV/AIDS (hereafter PLWHA) and the elderly. Indeed, in Mbozi district, as in other regions of Tanzania in particular and Africa generally, HIV/AIDS has increased adult mortality which in turn has increased the number of orphans and widows. Moreover, the deaths of young adults (18-49 years of age) from AIDS have left the elderly fending for themselves besides taking care of orphans

[267] Interview with an "A" informant at Iyula on 28th November 2017. The name of the informant is not disclosed because of confidentiality. The informant is a person living with HIV.

[268] Mbozi district is one of the districts of Songwe Region, formerly and until 2016 under Mbeya Region, in the Southern Highlands of Tanzania. The district borders Ileje, Mbeya, Chunya and Sumbawanga districts; and the republics of Malawi and Zambia. In this article, Mbozi district refers to an undivided administrative area as it existed before 2012. In 2012, the district was divided into Mbozi and Momba districts. Mbozi district`s residents are mainly the Nyiha and Nyamwanga speakers who mainly engage in agriculture. The common crops include maize, beans, rice, millet and coffee. Prior to 2016, Mbozi district was, after Kyela district, the second most affected by HIV/AIDS district in Mbeya Region.

[269] AIDS is a viral disease caused by HIV. In Mbozi district, as in many other parts of Africa, adult HIV transmission is mainly through heterosexual intercourse. In Mbozi district the disease was first diagnosed in 1986.

[270] F. Kaijage. "Social Exclusion and the Social History of Diseases: The Impact of HIV/AIDS and the Changing Concept of the Family in Northwestern Tanzania," in S. McGrath *et.al* (eds.). *Rethinking African History* (University of Edinburgh: Centre of African Studies, 1997) pp. 331, 332; J. Welshman. *Underclass: A History of the Excluded 1880-2000* (London: Hambledon, Continum, 2006) chpt 9; L. Rispel and J. Popay. "Confronting Social Exclusion, HIV and Gender Inequalities in South Africa." *Agenda,* 81**,** 2009 pp. 90-91. Although the concept "social exclusion" is an import from Europe, it has relevance in Africa; thus, it has been modified to suit African context. As Rispel aptly puts it, in Africa social exclusion is conceptualized as marginalization, poverty and vulnerability. See L. Rispel, B. Molomo & S. Dumela. *South African: Case Study on Social Exclusion, A report* (Cape Town: HSRC Press, 2008), p. viii; L. Rispel, B. Molomo & S. Dumela. *Rapid Appraisal of Social Inclusion Policies in Selected Sub-Saharan Countries, A Report* (Cape Town: HSRC Press, 2008), p. 2.

who have been left by their departed sons and daughters.[271] As for local people initiative or local agency,[272] it means that the people at the local level-district authority, village, neighbourhood and homesteads are not merely recipients of external assistance from the central government, international communities and Non-governmental organisations (NGOs) but they are active actors in responding to HIV/AIDS marginalisation.[273] However, this perspective, which this article adopts, is not entirely new. Indeed, in the field of African history, the local agency framework can be traced back to the 1960s to what the late T.O. Ranger called "African initiative" or African adoption/ choice. Henceforth this perspective has withstood the test of time. Ranger`s central argument is that African history should bring at the centre stage African agency by seeing Africans not as victims but as resourceful protagonists in environment or conditions, which are not of their own making but imposed on them. The imposed conditions may include structures and/ or large external forces such as capitalism, state policies etc. In other words, ordinary people could challenge the powerful forces and structures to the extent of even changing them.[274] This article therefore applies the perspective to study the history of HIV/AIDS as it relates to social exclusion. By adopting the perspective, however, it should not be interpreted as belittling or neglecting the role of the external actors. Indeed, as the above quotation shows, the central government, in collaborations with the

[271] Interview with A. Kisiwa, Social Welfare Officer, Mbozi district, at Vwawa on 14th July 2014.

[272]The article adopts the concept of agency from a body of literature that sees individuals especially the non-elites and underprivileged-unemployed, the poor, the stigmatized, people with disability, the sick, and so forth as having the capacity to negotiate, resist, undermine and sabotage, institutions, norms and other socio-economic constraints in order to survive or access social economic resources. See, for example, K. P. Siena. *Venereal Disease, Hospitals, and the Urban Poor: London`s 'Foul Ward,' 1600-1800* (Suffolk and New York: University of Rochester Press, 2004), pp. 3-4, 7; N. Ansel and L. van Blerk. "Children`s Migration as a Household/Family Strategy: Coping with AIDS in Lesotho and Malawi. *"Journal of Southern African Studies, Vol. 30, No. 3* (September 2004): 673, retrieved on 30th May 2018 at https://doi.org/10.1080/0305707042000254155. In Mbozi context it refers to the local people`s strategies to cope with marginalization amidst socio-economic and political constraints.

[273]For the role of external actors in mitigating HIV/AIDS social exclusion in the district, see M. Sadock. "HIV/AIDS and Social Exclusion in Mbozi District, Tanzania, 1980s-2014." *Tanzania Zamani: A Journal of Historical Research & Writing, Vol. VIII No. 1* (2016): 18-25.

[274] A number of historians have documented Ranger`s thesis. See for example,J. Lonsdale. "Agency in Tight Corners: Narrative and Initiative in African History." *Journal of African Cultural Studies Vol. 13, No. 1* (June 2000): 6-7, retrieved on 30th May 2018 at http://doi/10.10801713674303, J. Mccracken. "Terence Ranger: African Historian and Activist." *Journal of Southern African Studies, Vol. 41, No. 5* (2015): 1103, retrieved on 30th May 2018 at https://doi.org/10108/030570702015.1083275. See also I. Kimambo. *Penetration and Protests in Tanzania: The Impacts of World Economy on the Pare*, 1860-1960 (London: James Currey, 1991).

international community, provided ARVs to the people living with HIV/AIDS (PLWHA). The article therefore argues that the HIV/AIDS related marginal groups have agency to internalise the external assistance as well as taking their own initiatives in dealing with the marginalisation. While the aforesaid argument builds on studies on peoples` responses to HIV/AIDS exclusion, it differs from many such studies that treat the groups at the grass-roots level as passive actors who wait for external assistance.[275] Even a few studies that have greatly enhanced our understanding of community engagement in redressing HIV/AIDS exclusion , they have mainly focused on either communities` role in giving the excluded food assistance, the role of external agents such as NGOs, or state and development agencies in empowering communities.[276] Neglected are issues such as how do the excluded earn their living given the fact that much of the communities` assistance is intermittent, insufficient and unsustainable.[277] Thus, this article investigates the livelihood strategies of the excluded in Mbozi district for the past three decades.

To document the responses, the article answers five questions: how Mbozi society handled marginal groups in pre- HIV/AIDS period? What has been the extent of social exclusion associated with HIV/AIDS since the 1980s? What has been the plight of the HIV/AIDS excluded since the 1980s? How have the excluded responded to marginalisation occasioned by HIV/AIDS since the 1980s? And how effective has the responses been to addressing HIV/AIDS exclusion from the 1980s to 2017?

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[275] Some of the studies which emphasise more on external assistance and NGOs than on people`s local initiative includes: F. Lerisse *et.al.* "Vulnerability and Social Protection Programs in Tanzania," Research and Analysis Working Group, 2003, pp. 1-2; L. Rispel and J. Popay. "Confronting Social Exclusion, HIV/ AIDS and Gender Inequalities in South Africa." *Agenda*, 81 (2009): 90-98; I. Jamil and R. Muriisi. "Building Social Capital in Uganda: The Role of NGOs in Mitigating HIV/AIDS Challenges," a paper presented at the International Conference Organised by the International Society for Third Sector Research, Toronto, 11th -14th July 2004; United Republic of Tanzania, Tanzania Commission for AIDS (TACAIDS): *National HIV and AIDS Responses Report 2013*, April 2014.

[276] A. Gibbs *et.al*. "Social Context and Building Social Capital for Collective Action: Three Case Studies of Volunteers in the context of HIV and AIDS in South Africa." *Journal of Community and Applied Psychology*, 25 (2015): 110, A. Mushonga and T. Chimbidzikai. "Communities at Work: A Case of local responses to Care and Support of Children in Zimbabwe." *Canadian Journal of Public Health*, *Vol. 99 Supplement 1* (May/June 2008): 15 retrieved on 9th May 2018 at http://www.jstor.org.stable/41995002.

[277] Sadock, *op.cit*. Similar findings of fragile and patchy community interventions have been recorded in South Africa. See, for example, a report by M. Russell and H. Schneider. "A Rapid Appraisal of Community Based HIV/AIDS Care and Support Programmes in South Africa," Centre for Health Policy, University of Witwatersrand, August-November 1999, p. 19.

This article is based on research conducted at different times in 2010, 2014 and 2017 in Mbozi district. Key informants were interviewed using interview guides and documents were consulted at Mbeya Regional offices, Mbeya Zonal Archives and Mbozi District offices. The article is divided into five sections. The first section is about marginal groups in pre-HIV/AIDS period. The second section documents the extent of HIV/AIDS exclusion, and the third part focuses on the plight of the HIV/AIDS excluded, the fourth section deals with livelihood strategies of the excluded, and the efficacy of such strategies, and the last section is a conclusion.

2.0 Social Marginalisation in Pre-HIV/AIDS Mbozi

In pre-colonial Mbozi, as in many other parts of Africa, marginal groups such as orphans, the elderly and widows existed but traditions, norms and social institutions for caring the groups minimised their visibility. Widows, for example, were cared for by relatives of the deceased. According to both Nyiha and Nyamwanga traditions, widows were not evicted from the homestead of the deceased but were given the freedom to choose either to be inherited by one of the relatives of the deceased or remain as an independent. If she chose the latter and had no children, she was required not to be re-married, if she re-married, she relinquished the right to access her deceased husband`s properties. But if she had children and decided to be remarried, her children were to inherit the properties and if the children were still young the property of the deceased was to be under the custodian of one of the adult kinfolk of the deceased until the children came of age. If the widow had children and decided to be inherited, the kinfolk who inherited the widow served as a custodian of the children`s property inherited from deceased.[278] Generally, in Mbozi although widows were not allowed to inherit the properties of the deceased, they were allowed to use them and they were never evicted from such properties.

[278]Tanzania National Archives (hereafter TNA) Mbozi District Book, Vol. 1; Interview with *Mhombe* (an advisor and juror to the Chief) Jackson Nzunda at Vwawa on 18th June 2010.

Apart from widows, the society ensured the well-being of orphans. Traditionally, child up-bringing and care among the Nyiha and Nyamwanga were first and foremost the responsibilities of parents and children`s relatives from both paternal and maternal sides.[279] The role of relatives in caring of children became even more critical whenever either of the parents died. In case of the death of a farther, a widow, as indicated earlier, was inherited by a brother of the deceased husband or any clansman. While the death of a wife made it imperative for maternal relatives to replace a new wife to a husband whose wife had died. Again, the spirit of wife replacement was, among other reasons, to take care of orphans of the deceased wife.[280] In addition to parents and relatives, the society in general had a role of ensuring that children were brought according to the Nyiha`s customs and traditions.[281]

Apart from child care, the Mbozi society had a system in place for caring of the elderly. According to the Nyiha and Nyamwanga traditions, elders` sons and daughters were responsible for caring of their elderly fathers and mothers by providing them with food and shelter. Equally, neighbours had a role to play: they worked at specific time on the farms owned by elders. The produce from the farms went directly to assist the village elders.[282]

However, with the coming of colonialism in Mbozi district in the late 19th century, new changes were introduced regarding child care and support, and the care of widows and elderly. For example, under the influence of Christianity and western education, levirate marriages, though they persisted, began to decline, as some Christians and the educated ignored them. That said, however, Christians and the educated continued with the long

[279] T. Bachmann. *Ich Gab ManchenAnstob* (Hamburg: Ludwig Appel, 1943) translated by C. Benischke. *I Made Many Things Happem*, pp. 18-19. Bachmann was a Moravian missionary who lived among the Nyiha of Mbozi between 1899 and 1916.
[280]*Ibid*. p. 18, B. Brock, "The Nyiha of Mbozi," *Tanzania Notes and Records* No. 65, March 1966 p. 10.
[281]Bachmann, *op.cit*. p.18.
[282]*Mhombe* Jackson Nzunda, interview; interview with N. Mkoma (a custodian of Nyamwanga traditions) at Ndalambo on 3rd June 2010; interview with Y. Mwashiuya at Vwawa on 22nd July 2014.

tradition of taking care of orphans of their relatives either by adopting them into their families or assisting them in the widows` households.[283]

The above social mechanism continued into the post-colonial period up to the advent of HIV/AIDs in the early 1980s. During the post-colonial period Christians and the educated continued to care the marginalised in accordance with their new acquired western culture and religious beliefs, while other residents of the district continued to uphold their traditions of care of the marginalised as explained earlier. Yet, the coming of HIV/AIDS ushered in a period of the weakening of a system of social safety nets thereby increasing the number of marginal groups.

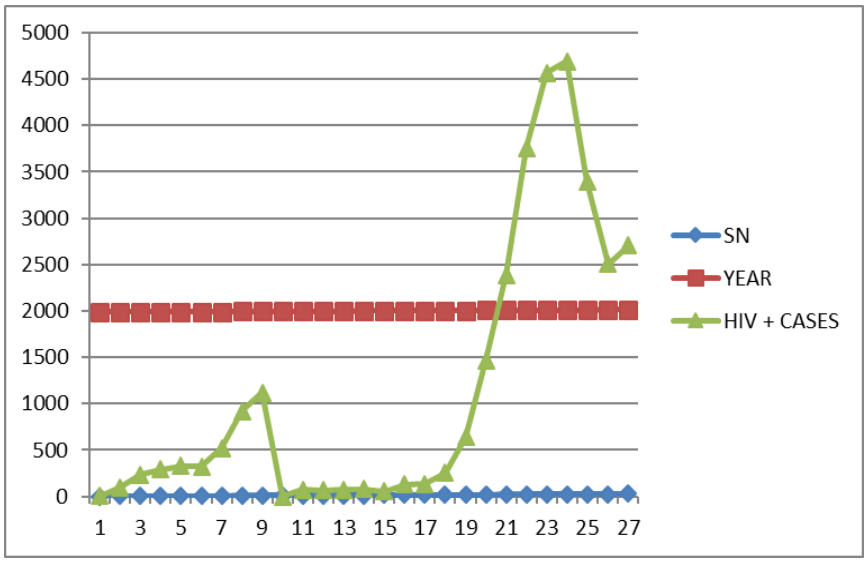
3.0 The Extent of HIV/AIDS Exclusion in Mbozi

Both government and societal sources indicate that the excluded groups in Mbozi, in large measure, increased due to HIV/AIDs. One such category of the excluded that became common in the district was the people living with HIV/AIDS (PLWHA). This groups increased due to the increase of HIV cases as table 1 below illustrates.

[283]*Mhombe* JacsonNzunda, interview

Table 1 : HIV Positive Cases in Mbozi District, 1987-2013

SN	YEAR	HIV + CASES
1	1987	6
2	1988	100
3	1989	238
4	1990	294
5	1991	330
6	1992	324
7	1993	524
8	1994	920
9	1995	1120
10	1996	0
11	1997	75
12	1998	67
13	1999	75
14	2000	78
15	2001	55
16	2002	130
17	2003	133
18	2004	254
19	2005	641
20	2006	1467
21	2007	2389
22	2008	3757
23	2009	4564
24	2010	4692
25	2011	3391
26	2012	2508
27	2013	2704



Note: No data were available for 1996
Source: Vwawa Governmental Hospital, 2017

Table 1 above shows the increase of HIV positive cases that reached a peak in the early 1990s before levelling off in the late 1990s, but increased sharply in the early 2000s.

In addition to PLWHA, orphans and widows became common in the district. Between 1986 when the first case of AIDS was diagnosed in the district and 2005 when anti-

retroviral (ARV) treatment began, many young adults (18-49 years old) died leaving behind many dependants such as orphans and widows. Illustrating this phenomenon, Ms. Kisiwa, the Mbozi district Social Welfare Officer, noted that: "The increase of orphans in the district is mainly attributed to HIV/AIDS. Before the start of ARV treatment, many people died of AIDs, and left many orphans and widows who currently [2014] need to be cared for."[284] Kisiwa's observation is also supported by government reports. A 2002 Mbozi district report, for example, indicated that the consequences of HIV/AIDS were increased orphans, widows and widowers.[285] Indeed, from 1987 to 2005 there were on aggregate 341 AIDS deaths recorded from health facilities. (see Table 2 Below).

Table 2: AIDS Mortality in Mbozi District, 1987-2005

Year	1987	1988	1989	1990	1991	1992	1993	1994	1995	2001	2002	2004	2005
Deaths	1	10	21	16	11	6	4	17	19	35	57	49	95

Note: No data were available from 1996 to 2000, and for 2003
Source: N. Malocho, *Mbozi Socio-Economic Profile (1997),* p. 62; DMO *Halmashauri ya Wilaya ya Mbozi, Idara ya Afya: Taarifa za Miaka 2002 na 2003, Miongozo ya Kutolea Taarifa za Huduma za afya Mganga Mkuu wa Mkoa: Wilaya ya Mbozi miaka 2005 na 2006.*

From table 2 above, AIDS deaths increased from 1 in 1987 to 95 deaths in 2005. Although the data from the above table give us a picture of AIDS mortality, they are conservative estimates because of missing data for some years, but mostly important many AIDS related deaths in the district happened outside the health facilities thus they were not recorded. Thus, it is difficult to know with certainty the number of AIDS deaths, but what is certain is that the deaths led to the presence of widows and orphans. In 2008, for example, out of 165,960 children aged between 0 and 17 years, 38,994 (23%) were

[284] Kisiwa, interview.
[285] District Medical Office (hereafter DMO), Mbozi District Comprehensive Council Health Plan for the year 2002, p. 20.

orphans[286] some of whom were cared for by the elderly following the deaths of their parents.

Similar to the government officials` observation, members from the Mbozi society from different parts of the district showed an increase of marginalisation in the era of HIV/AIDS. Wilson Tuyele Mwambwiga of Iyula village testified that, "From 2005 to 2007, many residents of the village died of AIDS leading to the increase of the number of widows and orphans. However, now (2010) the number of deaths has decreased due to the availability of ARVS."[287] Similar views were given out by residents of Ndalambo and Igamba.[288] According to Nelson Mkoma, an elder and resident of Ndalambo aged 74 years, HIV/AIDS increased the number of widows and orphans. He noted:

> The disease [HIV/AIDS has increased the number of orphans and widows in this area [Ndalambo]. I [Nelson], for example, have three orphans who are totally dependent on me. I am now back again to the task of child up-bringing with all its burdens, a task which I thought I had completed after my sons and daughters were married a long time ago. These problems of widows and orphans increased in the 1990s following the decline of widow inheritance, a tradition which had existed among the Nyamwanga since time immemorial. Its decline is due to concerted campaigns against it as it is associated with the spread of HIV/AIDS. The campaigns are conducted at public meetings, schools, churches, and in health facilities.[289]

The analysis in the above quotation is important because not only does it highlight the increase of marginalisation due to HIV/AIDS, it also enlightens us on one of the important factors for its increase i.e. the decline of widow inheritance. The institution of widow

[286] Prime Ministers' Office, Regional Administration and Local Government, Mbeya Regional HIV and AIDS Strategic Plan 2014-2018, Mbeya Regional Secretariat, 2014, p. 22.
[287] Interview with W. Mwambwiga at Iyula on 31st May 2010.
[288] Interview with S. Mbembela at Igamba on 19th May 2010; interview with W. Mwambwiga at Iyula on 31 May 2010.
[289] Interview with Mkoma, *op.cit*.

inheritance among the Nyamwanga and Nyiha served as a social insurance to widows and orphans. It is, however, important to note that the decline of the institution due to HIV/AIDS constitutes an immediate factor. Long term factors for the decline of the institution can be traced to the introduction in Mbozi of Christianity and western education as far back as in the late 19th and early 20th centuries. Both Christianity and western education made some residents of Mbozi to ignore traditions[290] such as widow inheritance and pursued other values and religion instead. Thus, the aforementioned change in the context of HIV/AIDs was one among a series of forces at play in the weakening of the institution; yet its timing left many orphans and widows in a vulnerable situation.

4.0 Plight of the Excluded in Mbozi District

As indicated earlier, the excluded in Mbozi were not monolithic, but consisted of different social groups namely people living with HIV/AIDS (PLWHA), widows, orphans and the elderly. Since the 1980s, people living with HIV/AIDS had faced three major problems: poverty, inability to access drugs for opportunistic infections, and stigma and neglect. Poverty especially among those who suffered from AIDS, stemmed from the fact that they were too weak to engage in economic activities or they had sold most or all of their economic assets for the management of the disease.[291]

Besides economic hardships, PLWHA faced the problem of accessing drugs for opportunistic diseases. Unlike in the 1980s and 1990s when the government freely gave drugs to PLWHA for opportunistic infections, in the early 2000s, and faced with larger number of PLWHA, such an exemption was removed. PLWHA in Mbozi were only exempted from paying the registration card fees which at Vwawa Government Hospital

[290] Brock, *op.cit*., p.24; J. Erdtsieck. "In the Spirit of Uganga-Inspired Healing and Healership in Tanzania" (Amsterdam Institute of Social Science Research: PhD Thesis, 2003), pp. 116-117.

[291]Interview with F. Siame at Ndalambo on 3rd June 2010; interview with L. Nzowa (a Coordinator of the Service, Health and Development for People Living Postively with HIV/AIDS (SHDEPHA-Mbozi) at Vwawa on 22nd July 2014.

was Tsh 3000 ($1.5).[292] Generally, PLWHA who had no health insurance were required, like any other citizens, to pay for the treatment of opportunistic infections.[293] Payment for the drugs, however, was a big challenge to many PLWHA.

Additionally, PLWHA faced stigma. The advent of HIV/AIDS was also accompanied by stigmatization of PLWHA and or AIDS patients.[294] Yet, the resultant stigma was not static but changing. According to informants, AIDS patients were more stigmatised in the 1980s and 1990s than in the early 2000s.[295] This change was partly due to HIV/AIDS education campaigns and the availability of ARVs, which reduced stigma attached to the disease. Stigma arose partly because of scary and debilitating symptoms of the disease. In the 1980s and 1990s, stigma was manifested in different forms including physical and verbal abuse, neglect, name-calling, and discrimination. Regarding the abuse, some relative care-givers used to beat up the sick on various excuses such as being too troublesome by asking for constant care and attention.[296] As for neglect, some care-givers abandoned AIDS patients due to the scary symptoms of AIDS. A typical of the symptoms was herpes zoster (*mkanda wa jeshi*).[297]

Regarding name-calling and discrimination, informants[298] noted that in the 1990s some members of the Mbozi society called sufferers of AIDS with pejorative terms such as "the dead-to be" (*mfu mtarajiwa*) and the "immoral one," to name but a few. Some even used to point fingers at any AIDS patient walking down or up the street. Name-calling and finger pointing were possible partly because of the physical symptoms an AIDS patient showed that were easily noticed by everybody: wasted body, persistence cough, periodic

[292] Nzowa, interview, *ibid*.
[293]Nzowa, interview, *ibid*.; interview with Y. Mwashiuya at Vwawa on 22nd July 2014.
[294] DMO, "Comprehensive Council Health Plan for the Year 2002," p. 20.
[295]Nzowa, interview; Mwashiuya, interview; S. Simkoko interview at Vwawa on 2nd August 2014.
[296]Interview with A. Nzunda at Vwawa on 21st June 2010.
[297]Nzowa, interview.
[298] Nzowa and Simkoko, interviews.

fevers, diarrhoea, and even boils.[299] Afraid of the aforementioned injustices, some patients became isolated and thereby refraining from participating in social gatherings and engagements. One informant brought this fact home by noting that: "I was afraid of going to funerals and public meetings because I was called names, pointed fingers at and laughed at. During those days (1990s) HIV/AIDS` educational campaigns were minimal; thus, many people were ignorant of the disease."[300] This quotation is important because it not only shows stigma but also the reason for its existence, namely lack of health education on HIV/AIDS. It was partly because of lack of this knowledge that some residents of Mbozi thought that one could contract the disease by casual touching of an AID patient, greeting someone by hand-shaking and even eating in the same utensils with an AIDS patient.[301] These misconceptions led some people in the district to ostracise AIDS patients.

Nevertheless, in the 2000s, following the availability of ARVs and massive health education campaigns on HIV/AIDS, stigma has been reduced. Underscoring this change one informant observed that people living with HIV/AIDS in the early 2000s were less stigmatised than their colleagues in the 1980s and 1990s.[302] However, the informant`s above observation is by no means an indication of lack of absence in the 2000s. On the contrary, the vestiges of stigma continued in the early 2000s. Some people living with HIV/AIDS who had openly disclosed their HIV positive status faced stigma. One PLWHA testified that her colleagues did not touch her bucket that was in a queue for fetching water at a public tap lest they contracted the virus.[303] This experience, however, was not exceptional, other PLWHA informants reported that some parents in their communities forbade their children from associating with or playing children games with the children

[299]Nzowa, interview.
[300]Interview with "B" informant at Vwawa on 22nd July 2014. I use the letter "B" rather than the real name of the informant on ethical ground. The informant was HIV positive.
[301]Nzowa, interview.
[302] *Ibid*.
[303] Interview with "C" informant 22nd July 2014 at Vwawa. I use the letter "C" to protect the privacy of the informant as she was HIV positive.

of PLWHAs for fear that PLWHA`s children might transmit the virus to their children.[304] This type of stigma indicates social discrimination at best. Yet this discrimination was not peculiar to PLWHA or their children, other social groups such as widows faced the same problem.

In Mbozi widows became more visible in the era of HIV/AIDs due to mortality from the disease and campaigns against levirate or widow inheritance. Widow inheritance was singled out as a risk factor for the transmission of HIV. This, however, as noted earlier, did not mean the end of the tradition. By 2017, the practice was still going on, but the campaigns led to the increase of independent and un-inherited widows who were prone to social injustices and deprivation. One of the major injustice widows faced in Mbozi was the confiscation by in-laws and other relatives of the properties of the deceased husband. Many cases of this type of injustice were reported in many areas of the district.[305] This can be illustrated by the following representative case. A 38 years old widow[306] on ARVs treatment was living in a suburb of Vwawa town with two children: a son and a daughter from the second marriage. She was married for the first time in 1994 at Hasamba village but the marriage ended following domestic violence. In 2000 she remarried at Isansa village until 2003 when her husband died. While in the second marriage, she, alongside her late husband built a house and owned other properties such as land and furniture. After the death of her husband, the brothers of the deceased asked her to leave the homestead of the deceased as they claimed to have traditional rights to the property of the deceased. But later she realised that they were planning to sell the house and land. Following the advice from her mother and discouraged by the lengthy legal procedures one had to follow to get his or her rights, she surrendered all of the properties to the in-laws and returned to her mother at Nambala village and in 2004 moved to Vwawa town. In 2007 she tested HIV positive and in the same year became a member of the Mbozi branch

[304] Interviews with "D "and "E" informants. The identities of the informants have been hidden for confidentiality.
[305] Interview with S. Mswima at Iyuala on 31st May 2010; interview with C. Sijame at Igamba on 19th May 2010; interview with J. Mwasenga at Ndalambo on 3rd June 2010.
[306] Because the informant is also HIV positive, I have hidden her true identity for confidentiality.

of the Service, Health and Development for People Living Positively with HIV/AIDS (SHDEPHA), a Non-Governmental Organisation for PLWHA.

The above narrative indicates, among other issues, gender-based injustices against women justified on distorted notion of traditions. The injustices, however, had, as Frederick Kaijage pointed out in the context of Kagera, nothing to do with traditions but served to advance the selfish interests of the in-laws, in this case the need to accumulate personal wealth.[307] Therefore, the above mentioned eviction which had no regard to the welfare of children was contrary to the traditions and motivated by individual greed to accumulate personal wealth. Moreover, the narrative sheds light on victim`s disillusionment with legal recourse to justice. The disincentives to this course of actions, as hinted at in the story, include lengthy producers. Yet other barriers, as aptly observed by Frederick Kaijage, include inequity of the laws in gender terms and corruption within the judiciary system.[308] Aside from the above mentioned cultural-legal problems, widows faced the problem of accessing medical drugs. According to the District Welfare Officer, widows, like many other excluded groups, were exempted from medical cost sharing.[309] Yet, perennial lack of drugs made the exemption useless.

Apart from widows, orphans faced problems. The main challenges this group faced included lack of basic human needs- food, shelter and clothes- and educational learning materials as well as access to social services such as health and education. A large number of orphans could not get the needs and services because either they lacked parents or guardians or in case where these custodians were available, they were too poor to provide for the needs or services. Similar fate of lack of basic needs and access to health care befell the elderly.

[307]Kaijage (1997) *op.ci*., p. 348.
[308]*Ibid* p. 349.
[309]Kisiwa, interview.

5.0 Family and Kinship Support

As in pre-HIV/AIDS period, in the era of HIV/AIDS family and kinship structures offered basic human needs to the vulnerable members. Yet, in the context of HIV/AIDS the capacity of the above-mentioned structures to support the vulnerable became increasingly constrained and forced the marginalized individuals to take care of themselves. This can be illustrated by cases of orphans, PLWHA, widows and the elderly who had to fend for themselves to survive the difficulties they confronted.

The above-mentioned support mechanisms continued into the era of the liberal market with its attendant structural adjustment programs (SAPs) which began in the 1980s. This period coincided with the coming of HIV/AIDS. As in other parts of Tanzania,[310] this era in Mbozi increased poverty in many families as manifested in insufficient food and failure to purchase essential goods and agricultural inputs. This economic hardship forced many families to abrogate their traditional role of supporting their marginalised kin such as orphans, and instead focused on caring of their individual nuclear families. This shift to individualism happened at a time when the government, in implementing SAPs, was withdrawing from providing free medical care and services to citizens as well as introducing user-charges in government health facilities.[311] To add insult to injury, HIV/AIDS emerged with its attendant campaigns against levirate marriages. These changes in Mbozi, similar to other parts of Tanzania, as Frederick Kaijage aptly shows,[312] had adverse impact on the care and support of orphans. Consequently, many orphans became excluded from accessing basic needs. Despite the aforementioned constraints on family and kinship structures, kinship relations showed resilience in care and support of the orphans as demonstrated in a case of an orphan below:[313]

[310]C. Chachage. "Structural Adjustments in Tanzania: the Other side of the Story," Conference on the Road to a Market Based Economy in Tanzania," Department of Political Science and Public Administration, University of Dar es Salaam, October 27-28 1993 p. 148.
[311]*Mhombe* Jackson Nzunda, interview; Mwashiuya, interview.
[312]Kaijage (1997) *op.cit*., pp. 351-352.
[313] Many such cases exist in Mbozi, but I take this one case to represent many other related cases.

A bilateral orphan and HIV positive girl was born in 1991 at Vwawa.[314] Both her parents died of AIDS related symptoms. Her mother died before she started primary education in 1997 while her father died in 2002. Following the deaths of her parents, she was taken by a paternal grandmother who took care of her until 2007 when the care-giver died. Thereafter she was taken to a maternal aunt where she stayed for a couple of months before she was taken to a maternal grandmother where she stayed until 2009. From 2010 to June 2014, she was under the custody of a paternal aunt. While in primary school and prior to the death of her father, who was a petty trader, she was used to getting all school requirements: uniform, exercise books and pencils. But following the death of her father, who however did not bequeath her any property life became extremely tough for her as her relatives who cared for her were extremely poor. Indeed, she was forced to work for wages in private farms so as to get educational materials. She continued working for part-time wages until she completed standard seven. In addition to showing the resilience of kinship support,[315] the above narrative indicates the agency of the excluded in the sense that the victim, in this case the orphan, took initiatives to redress her problems. Specifically, she worked for wages in village farms to get money for buying her needs. This type of agency was also shown among PLWHA.

PLWHA in Mbozi not only received family and community support but also showed personal initiatives to deal with exclusion. Demonstrating these aspects one informant from Igamba noted that when he was diagnosed with AIDS in the early 1990s his relatives took care of him by regularly taking him to hospital as well as providing him with food. But as the disease became prolonged, the assistance stopped, thus he had to eke out a living by making small furniture for sale and cultivating his farm, though the produce from the farm was so little because he lacked much energy required for massive production. As for hospital services, his relatives became tired of taking him to Mbozi

[314] True identity of the informant is hidden for confidential purposes, as the informant is HIV positive.
[315] Details of kinship resilience are in M. Sadock "Rupture and Resilience of Kinship and Family Networks in Support of the HIV &AIDS excluded in Mbozi District, Tanzania, 1980s-2017 (a journal article forthcoming).

Mission hospital; instead his neighbours became in charge.[316] This gloomy situation for the victim continued until the early 2000s when international and domestic NGOs rendered their support to PLWHA.[317]

Similar to PLWHA, elders` situation was not impressive. This reality is aptly demonstrated by a 67 years old man who was diagnosed with HIV in the 1990s and was on ARV treatment in 2014 and taking care of two orphans whose parents had died of AIDS related symptoms. Despite his frail condition, the elderly was cultivating in his small farm of coffee intercropped with maize and beans. When asked why he was working in the farm given his advanced age and poor health condition he remarked in the Nyiha language that, "*kwendimaje mpaka kufwa nze ataliko uwa kunavwa*" which is loosely translated into English as "I will till the land till I die as there is no one to help me."[318] He further noted that unlike in colonial and Nyerere times when the elderly used to receive assistance from their kin and neighbouring communities, "nowadays we [elders] receive no help at all."[319] The long standing tradition of helping the elderly, according to informants, ended with the coming into power of President Ali Hassan Mwinyi.[320]

Although the above narrative sounds nostalgic, it is important as it reflects changes of culture in Mbozi from communal to selfish or individualistic approaches. Yet, the claim that individualism began during the presidency of Ali Mwinyi, that is, the beginning of structural adjustment programs (SAPs) is rather off the mark. Although individualism became more entrenched during the SAPs, it predates the programmes. In Mbozi, similar to other coffee growing areas in Tanzania such as Kagera,[321] individualism became influenced by the market economy which in turn was facilitated by the coffee economy,

[316] Interview with "F" informant. I use this letter to hide the true identity of the informant as the informant was HIV positive.
[317] Interview with "F" informant.
[318]Interview with informant "G" at Ilembo village in Vwawa Ward, 22nd July 2014. I use the letter "G" to hide the true identity of the informant to conform to confidential protocol of patients and People living with HIV/AIDS.
[319] Informant "G," interview.
[320]*Mhombe* Jackson Nzunda, interview; Mkoma, interview; Mwashiuya, interview.
[321]Kaijage (1997) *op.cit*., p. 352.

trade and labour migration. As far back as the 1930s, Mbozi had wealthy coffee producing Africans. Yet, this individualistic value was a bit weakened during *Ujamaa* at which time communal values were emphasised, but the individualistic values became resurrected in the era of SAPs.[322]

6.0 **Individuals, Neighbours and Community Organisations**

In Mbozi district neighbours and self-help community organisations played a key role in assisting the excluded. One of such self- help imitative was a micro-financial arrangement popular called the village community banks (VICOBA). The VICOBA model was borrowed from Niger in West Africa and introduced in Tanzania in 2002. Generally, the VICOBA is a saving and loan giving scheme organised at a neighbourhood level. Neighbourhood members, the majority of the members being women, raise money through buying shares from the VICOBA as well as borrowed money from the VICOBA which was returnable with small interest ranging from 5% to 10%. Usually each VICOBA had maximum of 30 members who democratically elected among themselves a chairperson, a secretary and an accountant. Furthermore, the thirty members group was sub-divided into five groups and the members of the group acted as guarantors via their shares to a group member who took a loan from the VICOBA. The interest in turn was shared between the borrower and the VICOBA. The interest accrued to the VICOBA was, depending on the decision of members, used for income-generating activities of the VICOBA[323] or could be spend for social responsibly such as assisting the needy. In 2016 at Iyula village in Mbozi district, for

[322]Mwashiuya, interview; *Mhombe* Jackson Nzunda, interview. The aforementioned informants` views are also supported by researches from other parts of Tanzania: See C. Msoka "Criminal Bands and the Future of Urban Tanzania: How Life has been Redefined," in H. Moksnes and M. Melin (eds.). *Claiming the City: Civil Society Mobilization by the Urban Poor*, (Uppsala: Uppsala University, 2014) p. 185; M. Mbilinyi. "Poverty and Human Development Report, 2011," p. 3, retrieved on 3rd July 2015 at www.tzdpg.or.tz/fileadmin/migrated/../marjorie-PHDR-Reviwe-TGNPpdf. The authors note that during the Ujamaa period, that is, from the 1960s to early 1980s communal support system was strong but it was replaced by individualism with the coming of Neo-liberalism from the 1980s. Henceforth, the attitude of each person for himself or herself is pervasive.

[323] S. Lushakukuzi, *et al*. "Village Community Banks (VICOBA) and Members` Business Sustainability: Case Study of Kunduchi Ward at Kinondoni District in Dar es Salaam." *International Journal of Business Marketing and Management* (IJBMM) Vol. 2, Issue 3 (March 2017): 63, retrieved on 25th May 2018 at www. Ijbmm.com/article/mar2017/9971864285.

example, the *Wanatumaini* (those with hope) VICOBA decided to give uniforms, toiletries and stationery worth 300,000/ ($75) Tanzanian shillings to thirty orphan pupils.[324]

Another self-help initiative was income-generating group in Igamba village. In 2007 PLWHA organised themselves in a self-help group called *Tupambane* (Let us Fight). In the same year the group received one million ($500) Tanzanian shillings from the Tanzania Social Action Fund (TASAF) for initiating economic enterprises. Indeed, with this seed money on their hands, the group started poultry farming. The project thrived until 2015 when it died following the deaths of the group`s chairperson and secretary. However, in 2017 the group was in the process of reviving it. Before its demise, the project generated income to the group by selling of eggs, but the most important benefit of the project was that members ate eggs thereby improved their health given the nutritious value of eggs.[325] Yet, the demise of the aforesaid project with the death of the leaders merit close attention because it speaks to the underlying leadership and managerial problems that many income generating activities (IGA) self-initiative groups faced in Mbozi. The problems were, however, not peculiar to Mbozi but common in other parts of Africa as well. Similar to Mbozi, Russell, in the context of the early 2000s South Africa, notes that a good number of PLWHA income generating activities failed because members lacked leadership and bossiness knowledge on how to manage projects let alone to assess the profitability of establishing a given project in a given locality.[326]

Besides, VICOBA and community organisations, individuals assisted the HIV/AIDS excluded. Testifying to this at Iyula village a 12 years old pupil and PLWHA girl, whose parents died of AIDS in 2007 but was under the custody of her maternal uncle following the death of her parents, observed that:

[324] Stella, interview.
[325] Interview with G. Mera, a member of the HIV/AIDS village committee at Igamba on 1st December 2017.
[326] Russell, *op.cit*. p. 33.

> There is one neighbour called Anna Mswima who in 2014 gave me a hen to domesticate. The hen used to lay up to fifteen eggs. Out of the fifteen eggs, I would sell ten eggs to buy stationary, bars of soap and body oil to mention but a few items. It is because of that hen that now [2017) I have six hens which help me a great deal to meet sundry expenses.[327]

The above quotation is significant as it not only shows the existence of humanistic values manifested by a neighbour giving a hen to the needy but it also demonstrates the enterprising sprit of the excluded, that is the she managed, through good husbandry, to increase the number of chicken from one to six Indeed, the aforesaid enterprising sprit is shown in many livelihood activities of the excluded.

7.0 Livelihood Strategies of the Socially Excluded

The excluded of Mbozi used different strategies to earn their living. Some strategies, which many scholars have also documented in other African countries, included begging and sex work. However, and contrary to other studies in Africa which have overemphasised strategies such as begging and sex work,[328] in Mbozi rural setting[329] begging and sex work were limited to a few excluded groups especially school going orphans while sex work was confined to widowed women. Many of the excluded eked their living by doing farming and conducting small businesses.

Having introduced the above strategies, this section of the article discusses in details the strategies used by the excluded by starting with begging and sex work before moving to

[327] Interview with informant "H" at Iyula, 28th November 2017. I use the letter "H" to hide the true identity of the informant as the informant was HIV positive.

[328]M. Mhloy. "Report on the Social and Economic Impact of HIV/AIDS on Rural Households in Masvingo Province: the Case of Gutu District," in *The HIV/AIDs Challenge in Africa An Impact and Response Assessment: The Case of Zimbabwe* (Addis Ababa: Organisation for Social Sciences Research in Eastern and Southern Africa (OSSREA), 2008), pp. 45, 91; A. Pankhurst, *et.al*. "Social Responses to HIV/AIDS in Addis Ababa, with Reference to Commercial Sex workers, People Living with HIV/AIDS and Community Based Funeral Association in Addis Ababa," in *The HIV/AIDS Challenge in Africa, op.cit.*

[329] Child-begging and prostitution have, however, been reported in the towns of Mbozi district.

farming and business. As noted earlier, orphaned school going children whose guardians were poor begged for money even from strangers in order to buy school requirements such as exercise books and pens. A 12 years old HIV positive orphan girl from Iyula village aptly illustrated this. She noted: "Sometimes I beg for money from the Samaritans (*wasamalia wema*) along the road who usually give me between one-hundred and two-hundred shillings, but the money from this source is too little to buy my necessities."[330]

Nevertheless, the above-mentioned begging case, as noted earlier was an exception rather than the norm. The norm was that a great number of orphans, though under enormous constraints, earned their living by engaging in various economic activities. Two cases from Iyula and Igamba villages illustrate such activities. In 2017 in Iyula village a 17 years old orphan was the head of the other two siblings. The household mother and father had died of AIDS in 2000 and 2005 respectively. One of his siblings, a 10 years old girl was in primary school, while the other 14 years old had completed standard seven and selected to go to secondary school but never reported for studies because of lack of money. Instead he together with his old brother cultivated maize in a one-acre farm that their parents bequeathed them. However, they hardly harvested one bag of maize from the farm as they cultivated maize without the use of fertilisers and other agricultural inputs. They were too poor to buy the inputs. Consequently, the harvest from the farm hardly sustained them for six months. Given this situation, the orphans had to work as farm labourers in the farms of the rich. In addition to farm work, they worked as casual labourers doing menial jobs whose payment ranged from 1000 ($1cent) to 10000 ($ 5) shillings. [331]

Moving from Iyula to Igamba, a 17 years PLWHA orphan, whose mother and father died of AIDS in 2010 and 2011 respectively, worked in her sister`s women salon. She worked in a salon in order to supplement the meagre money she received for her upkeep from another sister of hers who was a civil servant in Dodoma. By working in the salon, she earned on

[330] Interview with a 12 years old PLWHA at Iyula on 28th November 2017.
[331] Interview with a 17 years old boy, head of a household, in Iyula Division on 28th November 2017.

average 6000 ($3) per day. Furthermore, she noted that the money she received from her Dodoma sister was used to buy stationery and uniforms when she was schooling, but it was not enough to cater for her sundry expenses such as buying soap, body oil, and sanitary pads.[332]

With regard to sex work, another rare strategy, widows deployed it to earn a living. The following narrative of a 38 years old PLWHA widow informant called "I" [333]from Iyula Division illustrates the strategy. The informant`s husband died of mental related illness in 1993 leaving her with two children. Following the death of her husband, her in-laws evicted her from the house she had built with the deceased husband accusing her of responsibility for the death of the husband by bewitching him. After the eviction, she, together with her two children, went to stay with her parents who were also based in Iyula village. Amidst financial problems, in 1995 she began to sleep with men for money in the village. While in the sex work, she got pregnant in 2002 and because of the pregnancy she decided to test for HIV and was diagnosed positive. She delivered a son and three years later she gave birth to another baby boy. In 2009 her first born son passed the primary school examination, thus he was required to go to secondary school but she was too poor to send him to secondary school. Her brother, however, assisted her second born child to go to secondary school and was in (2017) a third-year student at the university. Nevertheless, the year 2010 was a turning moment for her as she stopped sex work and non-profitable small-scale business of selling fish in the village and began to fully engage herself in crop cultivation and livestock keeping. During that year the Water Reed and SHIDEPHA - Non-governmental organisations (NGOs) - gave she-goats for domestication to PLWHA in Iyula village. She was given two goats. SHIDEPHA also trained her and became an HIV/AIDS educator. This position was accompanied by a monthly allowance of 130, 000/ shillings ($60). With the allowance and the goat project she started to fully

[332] Interview with a 17 years old PLWHA orphan in Igamba Division, on 1st December, 2017.
[333]Interview with informant "I" at Iyula on 28th November 2017. I use the letter "I" to respect the privacy of the informant).

engage in agriculture. She hired labourers to work in her maize farms. Indeed, in 2017 she harvested thirty-three bags of maize and had ten goats. Farming had changed her life for better. It was because of farming that she had a brick built and corrugated iron-sheet roofed house with a seating room and two bed-rooms.[334]

Despite informant`s aforesaid achievements, she faced one major challenge which was also typical to other excluded in Iyula and Igamba Divisions. The challenge was the low prices of maize. [335] In Iyula and Igamba Divisions, as in other parts of the district, there was a drastic fall of the prices of maize. A 100 kilograms bag of maize was sold at 30,000 ($15) shillings in 2017 while the same bag in 2015 and 2016 fetched 100, 000 ($50) shillings.[336]

Although maize price fluctuations were common in the district, the above mentioned drastic fall of prices in 2017 was partly attributed to the central government ban on selling maize outside Tanzania.[337] In Mbozi context, this meant the end of the hitherto lucrative maize markets of the neighbouring countries of Malawi, Zambia and Congo DRC.[338] The government justification of the ban was on national food security as well as discouraging the sale of unprocessed maize. In other words, the Tanzanian government aimed at selling maize value-added products such as flour. The sale of processed maize, the government argued, would in turn encourage the establishment of agricultural processing industries.[339]

Having narrated the above-mentioned informant's story and the challenge she faced, it is important to highlight the significance of the narration. The story shows a number of broad socio-political and economic issues happening at local and national levels.

[334] Interview with "I" informant in Iyula Division on 28th November 2017.
[335] *Ibid.*
[336] *Ibid.*
[337]IPP media.com retrieved on 28th May 2018 at https://www.ippmedia.com/sw/biashara/malori ya magendo-kutaifishwa.
[338] B, interview.
[339]Ippmedia.com.

Specifically, it highlights the following. Firstly, and similar to the two widows mentioned earlier, it shows gender injustices inflicted upon widows by in-laws. Secondly, it shows dynamism in individuals in terms of their livelihood strategies. The informant worked as small business woman, sex worker and a farmer. Thirdly, it indicates how national decisions, as demonstrated by a ban on maize export, impacted on individuals at the local level. And finally, it demonstrates individual`s agency. This aspect of agency was manifested in all the excluded including the elderly as shown by an elderly widow from Igamba Division called informant "J."

The life history of the informant "J" shows the agency of the excluded in profound way. The informant was born in 1957, a second wife to her husband who until his death in 2012 was a local government employee as a Ward Education Officer (WEO). The couple had two children: a son and a daughter. Before his death, the husband had built three houses: one at the nearby village of Isansa, a place where he had been working before his untimely death, the second at Vwawa, the headquarters of Mbozi district, in which the senior wife was living, and the last at Igamba village in which she was living. Following the husband`s death, the senior wife claimed sole ownership of the Vwawa house as well as the deceased`s pension contribution money and other entitlements. Except for the Igamba house, the informant received nothing from the deceased husband, not even a piece of land to farm. Given this situation, in 2015 she fell sick and admitted to the district hospital at Vwawa for months. While in hospital and given her age –being 60 years old, she was given an identity card issued to the elderly allowing them free medical care and treatment in government health facilities. She was later discharged from the hospital but henceforth she became too weak to do strenuous activities such as tilling the land. Thus, to earn a living she started, with the help of two orphans under her custody, to brew local beer made out of maize and millet locally called *kangala*. The two orphans were from her son and daughter who had died of AIDS, a disease which she called *uvuvinu vitu vupwa uva munsi* (the modern disease of our land) in 1999 and 2001 respectively. She brewed the beer twice per week: four tins (20 litres) per round. Each tin fetched 5000 ($2,5) shillings. Thus,

she earned 40,000 ($20) per week. She spent the earned money on buying maize for the food of the family and brewing beer, salt, soap, kerosene,[340] and medical treatment cost for the orphans.[341]

Despite the aforesaid success, the informant`s business faced a number of challenges including some customers who drank her beer on loan, but never repaid the debt. Nevertheless, the critical challenge that the informant faced was lack of enough capital to expand her business or even to diversify her business. Indeed, if she had the capital, she would venture into other businesses including establishing of a grocery store, and pigs and poultry farming.[342]

The above discussed informant's testimony is significant in the sense that it challenges the dominant one-sided portrayal of gender injustice whereby men are always depicted as victimising women. In this story, and in the context of a polygamous marriage, it is the senior wife who was a perpetrator of injustice to her husband`s co-wife. Thus, the underlying issue here was economic imperative to accumulate personal wealth in line with existing individualistic value, as explained earlier. The value was contrary to the *Ujamaa* and/ or *Ubuntu*[343] values which emphasised on communitarian ethos including caring for each other well-being and mutual support, to mention but a few. The story also shows the absence and or inadequacy of government assistance to the excluded. In this context, the

[340] Interview with "J" informant, at Igamba Division on 1st December 2017. I use the letter "J" in lieu of the real name to protect the privacy of the informant.

[341] Although and according to the Tanzania government policy, orphans are exempted from cost sharing in public health facilities thus they are supposed to get free medical treatment and care after getting an exemption card, transport costs and the bureaucracy of getting the card discourages many orphans from seeking it. According to the interview I conducted with Kisiwa (District Social Welfare Officer), in order to get a card, an applicant must first seek a letter from his or her village government testifying that he or she is an orphan or elderly, Whereupon, s/he takes the letter to the ward government for the endorsement and finally to the District Social Welfare Officer for the approval and issue of the card. The Social welfare Officer is at the district's headquarters many kilometres away from many villages. Igamba village, for example, is 21 kilometres away from the headquarters with un-tarmac roads.

[342] C, interview.

[343] E. Bongmba. "Reflections on Thabo Mbeki`s African Renaissance." *Journal of Southern African Studies* Vol. 30 No. 2 (June 2004): 297-9, retrieved on 28th May 2018 at http://doi.org/10.1080/0305707042000215374.

informant did not receive any economic assistance from the government in terms of social grants neither did the orphans who also had no government medical insurance cover.

8.0 Conclusion

HIV/AIDS in Mbozi district has increased marginal groups: widows, orphans and PLWHAs as well as adding the burden of caring of orphans among the elderly. Nevertheless, the groups have not remained complacent but shown agency in addressing the marginalisation occasioned by the epidemic. They have coped with stigma, poverty and inability to access medical services. By bringing the agency of the marginal groups to the fore, this article differs from many scholars who downplay individual agency while overstating the role of external players such the government and international community.[344] The aforementioned emphasis on external efforts renders passive individuals` initiatives. Yet, this article has found that the HIV/AIDS marginal groups of Mbozi district have agency by engaging in wage labour, income –generating groups, self-help groups, farming, petty trade, begging, sex work as well as enlisting, especially for orphans, family and neighbourhood support. While the findings are in line with many scholars who have documented different group`s strategies including doing activities which are socially construed as demeaning especially sex work and begging,[345] the findings from this study differ from such scholars by showing, in the rural context, that the excluded did socially respectable activities as well such as farming and petty trading. Through the activities, the excluded registered a number of successes including self-reliance, sustenance and even owning some property. Despite the successes, obstacles such as gender imbalanced laws, lack of capital, lack of managerial skills, government policies and economic hardships impinged upon the initiatives of the excluded. Given the intricate nature of the challenges, it is important that the local and central governments as well as the international community should supplement and compliment individuals` initiatives to cope with marginalisation.

[344] F. Lerisse, *op.cit*; L. Rispeland and J. Popay, *op.cit*. and I. Jamil and R. Muriisi, *op.cit*.
[345] M. Mhloy *op.cit*. A. Pankhurst, *et.al.*