

## Ambivalence Surrounding Elderly Widows' Sexuality in Urban Uganda

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**Abstract** The elderly are commonly stereotyped as asexual beings. Alternatively mainly negative images abound about the sexual activities of elderly people. Based on ethnographic data this article explores diverse sexualities of elderly widows and widowers in an urban periphery of Kampala city. Widowhood is socially constructed as an asexual period in this patriarchal society where heteronormativity and marriage prevail as the accepted norms. While widowers are generally encouraged to remarry after observing proprieties of mourning, sexual activity among elderly widows is heavily proscribed against particularly because it is not procreative. Adult children control the sexuality of their elderly parents, often by discouraging sexual liaisons. Adult children may also arrange for new spouses with utilitarian value such as providing healthcare for ill elders. Post-menopausal widows have less sexual appeal than younger widows for whom reproduction is a viable outcome of sexuality. Widowers and younger widows are more likely to remarry than elderly widows. Consequently for some older widows, the cultural institution of widow inheritance provides an opportunity to resume sexual activity, and benefit from the levirate guardian's support. However other older widows rejected inheritance by levirate guardians because of fears of catching HIV/AIDS. HIV does infect elderly Ugandans, although prevention and care interventions generally exclude targeting the elderly. Loneliness was widespread among elderly widows. Many felt isolated, dislocated from former social circulation and missed being relevant. However there were a few elderly individuals who were actively engaged in providing sexual education, advocating for sexual health promotion, and defending the sexual rights of the younger generations in their immediate environs. There is an urgent need for

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more research about the realities of elderly people's sexualities, sexual health and sexual rights particularly in resource-poor contexts.

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## Introduction

Although sexualities are critical to every stage of the life-course (Rossi 1994), there is a paucity of research, programmes and policies focusing on the sexual lives of the elderly relative to other age-groups (Help Age International 2008). Studies (Thornton et al. 2009; Oloka-Onyango 2008; Ortner 2007) generally stress the gap in scholarship and research about sexuality in old age. Current efforts mainly target puberty/adolescence and the reproductive years. Consequently key elements of sexuality interventions focus on 1) the protection of minors from prematurely engaging in sexual activities, 2) the preparation of adolescents for safe and healthy sexual experiences mainly through information, education and communication strategies, or 3) availing people of reproductive age with products and services that ensure they have safe and healthy sexual experiences. In the main, the sexualities, sexual health and sexual rights of older people tend to be ignored, or else they receive very limited attention (Levy 1994).

The widespread assumption that people of advanced age are asexual (see Gott and Hinchliff 2003) may perhaps explain why there is limited interest in the sexualities of the elderly. Although the conflation of old age with lack of interest in sexual activities is widespread, this perception is not necessarily informed by research and knowledge about the sexualities, sexual experiences, preferences and behaviour of older people. Rather, the basis for this perception is often ageism, prejudices, myths, misconceptions or misinformation. After reviewing available literature, the anthropologist Sjak Van der Geest highlights a critical disparity: the bulk of available scholarship focusing on the sexualities of older people mainly base on individuals and social groups located in North America and western Europe. He asserts that '...studies on *sex at old age* [emphasis in original] in Africa are practically non-existent' (Van der Geest 2001). Furthermore, while studies focusing on old age in Africa are limited, of those studies that do exist on this demographic group, the very topic of sexuality and sexual behaviour is often ignored (see also Gott and Hinchliff 2003). However, the scant research studies about the sexualities of older persons in Africa include Van der Geest's (2001) study among rural elderly individuals in southeastern Ghana, Ortner's (2007) study among diverse racial groups from working class areas in Cape Town in South Africa, and Cattell's (1992) work among elderly widows in Kenya.

In this article I explore the reported sexual experiences, sexual health and sexual rights of the elderly, as well as examine the diverse roles that elderly people are playing in the sexual lives of people around them. After a description of the context and methodology, the results sub-sections are thematically presented. These include analyses of loneliness and remarriage in old age, widows' sexualities enacted within the customary institution of widow inheritance, the realities of HIV infection among the elderly, appropriating HIV

infection to inform other people's sexuality, and an elder bishop's struggles for the rights of sexual minorities in Uganda. The paper ends with a comprehensive discussion of issues arising from the research.

## Study Context and Methods

This article is based upon data from a larger ethnographic study that explored the varied experiences of widowhood and widow-inheritance (with specific focus on sexualities during widowhood) among residents of an urban slum in Kampala city (*for details see* Nyanzi 2009; Nyanzi and Emodu-Walakira 2008; Nyanzi et al. 2009). During this study, it was established that within the context many of the older people were widowed or had ever experienced widowhood, sexuality among widows was highly contested and often socially condemned—particularly if they were of advanced age, and that widowhood was a highly gendered experience. Elsewhere (Nyanzi 2009), I discussed the important surrogate roles that older grandmothers play as buffers of support, child care and provision in households that are affected by the HIV/AIDS epidemic. That paper analyzed the multiple and complex ways in which elderly widows actively took control of their everyday lives in spite of various structural challenges. This paper specifically focuses on the ageing body as one that is sexual, and indeed imbued with potential to play diverse roles in the realms of sexuality, sexual health and sexual rights. The paper responds to reflection questions raised by Nyanzi (2011):

'Grey-haired, wrinkled, toothless and bent over with age—do senior citizens have sexual needs? Do the elderly have sexual desires? Does anyone find them sexually attractive? Do they consider themselves sexually appealing? Do the elderly have sex? Is the aged body still a sexual body?'

The research design was premised on the grounded theory (Corbin and Strauss 1990) because it was important to generate emic explanations for the diverse forms of experiences that widows encountered within the study area. Data collection combined both qualitative and quantitative research methods. Ethnographic fieldwork lasting 10 months spread across 2007–2009 triangulated participant observation, seven focus group discussions, forty-four repeated individual interviews, literature review and policy analysis. Demographic data of the participants were obtained using a mini-questionnaire administered to each individual who took part in the study. Research participants were selected using a combination of purposive, snow-ball and theoretical sampling techniques (Marshall 1996). A total of thirty-five widows and nine widowers from ten village zones of Kasubi-Kawaala in Rubaga-North Division of Kampala city were recruited into the study. These individuals were identified by key gatekeepers including the Local Council 1 Chairpersons, Women's Leaders, and priests in the area. After explanation about the study, both verbal and written informed consent were obtained from participants. Stamp pads for thumb-prints were provided for individuals who were unable to write. Participation was voluntary and depended upon the willingness and availability of individuals to take part in the different activities of the study. Refreshments were provided during research activities. A standard transport

refund was given to the study participants. All the interviews and discussions were conducted by well-trained researchers drawn from diverse disciplines including a social worker, a community health nurse, a public health nurse and myself—a medical anthropologist. These sessions were mainly held in Luganda language and recorded on audio-cassettes. The interviews and discussions were then transcribed verbatim, translated into English, and entered into a computer word-processor. Thereafter, these textual data were subjected to thematic analysis using Atlas.ti (Scientific Software Development, Berlin)—computer software that is based on the grounded theory and designed to facilitate the analysis of large volumes of qualitative research data. The quantitative data from the mini-questionnaire were numerically analysed to generate descriptive statistics using EPI Info (Centers for Disease Control, Atlanta).

A general shortcoming of many research publications about the elderly or the widowed tends to be about them, rather than for or by them. According to Gott and Hinchliff (2003), “Indeed, in both studies that reinforce, and those that challenge, stereotypes of later life sexuality, one set of voices is conspicuous by their absence—namely those of older people themselves” (p. 1618). Obbo (1986) makes a similar observation about the limited available research about widows, “The women’s point of view is muted” (p. 91). In response to these critiques about the absence of the perspectives of the elderly (and of widows) in much of the available scholarly literature on the elderly, I incorporate excerpts from the transcribed interviews of participants in order to allow their voices to come alive within the article. In order to protect the identity of my research participants, pseudonyms are used in the article when reference to a person is made.

### **Loneliness in Old Age**

Mrs. Juliet Mugerwa—a sixty-two-year-old retired social worker described her immense ire at her widowed mother who was considering re-marriage at 80 years of age. Juliet acknowledged that indeed her mother was very lonely particularly after the demise of her second husband—Juliet’s step-father. However she reported that she was embarrassed by her mother’s immodesty.

“Imagine how mad I got when I went to visit my mother and she told me that one of the men in the village was proposing marriage to her. You see, my father left us about two and a half years ago. She nursed him in his weakness until he passed on. They were in love, they were! Although they were old and she was many months dry up, he loved her because they had gone through so much together. So, I can understand that she was lonely and missed her husband. But to have another man, ah ah no! I told her off in no uncertain terms that this was not going to happen. I was crude. I said to her, ‘Maama, do you really want to have another wrinkled body climbing on top of you and going, going, going every night? Think about this Maama.’ She has never talked to me about marrying since that time.”

Many of the widows in the study, particularly the older ones reported that loneliness was among the biggest challenges experienced after the death of a spouse.

Other scholars (e.g. Van der Geet 2004; Van der Geest 2007) reported similar findings of loneliness among older persons. For younger widows, sexual need and the desire to continue a healthy sexual and/ or reproductive life often led to new sexual liaisons of varying permanence ranging from casual to regular or even permanent spousal partnerships. Older widows reckoned that youthfulness was advantageous if one wanted to remarry because often the male partners were interested in a fertile woman with whom there were still some reproductive possibilities. Remarriage was a more challenging outcome for older widows especially if they were post-menopausal because of heteronormative ideals which link sexuality to procreation. Levy (1994) explained, “This view partly arises from traditional values that equate sexuality with procreation. Because pregnancy and children are not part of the older person’s experience, they are believed not to need or want sex” (p. 291.) Thus the sexuality of an older widow was suspect because its immediate outcomes were pleasure rather than procreation.

Often the children of the elderly person were responsible for controlling the sexual choices of their parents (see also Steege 1986). Rather than encourage and empower sexual activity of elderly parents, research participants reported that the children instead applied ageist sanctions and prohibitions premised on the assumption of the asexuality of the elderly. When probed about the reasons for this sort of refusal on the part of the children, research participants reported the fear of intruders, suspicions that the proposing sexual partner was more interested in accessing the property of the deceased rather than the sexual services of the older widow, and considerations of the rigorous physical demands on an elderly widow resuming an active sexual life. The data indicate, that while it was easier for male elderly widows to challenge the repressive controls of their children, their female counterparts mainly circumbed.

Jaja Gureme, who is 84 years of age, is also a retired senior civil servant who continues to contribute articles in the local print media. Although not a resident of Kasubi-Kawaala, I interviewed Jaja Gureme because he was excited about my article on the sexuality of the elderly. Widowed about 15 years ago, he recently remarried against the better judgment of some of his adult children. I met him twice for interviews directly focused on his remarriage and renewed sexual activity. With a dry sense of humour and such eloquence in the English language, Jaja Gureme retold his experience. From his account it was obvious that he still deeply loved his first wife—whose pictures he showed me from different photograph albums as he fondly narrated many memories of their time together. In addition, it was also evident that he cherished his new bride. Discussing sexuality in advanced age, Jaja Gureme stated:

JG: ... Of course the libido does not die down simply because one has become an old man. No way. In fact I think that our sexual need is so powerful that it lives with us until the day that we die. Things may change because some of my friends lost their ability to function as men when they were barely in their sixties. But some of us have kept on going. Of course sometimes there may be a need to use Viagra or other local herbs which help. But then I hear that this Viagra is not very good for people who may have heart conditions. For me, all that I need is a deep Nyakasura kiss.

Me: What is this Nyakasura kiss?

JG: It is the Nyakasura kiss (chuckle). You ask my bride, she will tell you. We are trying for children and I know that way that the libido does not die down. I know that as a much younger person than me, it is important for her to have a child or two with me. So we are trying for children. My adult children from my first marriage were not all comfortable with the idea of me remarrying because they wondered who would take care of these other children I would produce in old age. But then, if my new wife badly wants to have a child, who am I to stop her? For me I remarried because I believe it is better to have a wife than to go for release from this woman to the next woman and the other. If neither of these options is taken, then I think that a poor man has to masturbate—otherwise what is he to do?

In a brief discussion involving one of his adult daughters, I learnt that the children conceded to their father's wish for a bride mainly because of his insistence, the length of time was past the appropriate period of mourning, as well as the utilitarian value of having a loving person to take care of their elderly father in his advanced age. Jaja Gureme further intimated:

“I am slowly starting to forget things, but then my bride is very good for me because she keeps on reminding me what to do. In fact she is very good for me because she can stand all the games I play in the house to exercise my mind and memory to stay active and awake.”

In a focus group discussion, a younger widow retold the experience of an elderly bridegroom whose children sought for his younger bride because their father needed a carer who could cope with living with catheters.

‘My grandfather remarried when he was in his early seventies. Some of his children were abroad, others were in their homes and had grown-up children, and two were dead. He fell sick. After sleeping in hospital he came home with a tube which poured his urine into a bag by his side. That is how he passes urine. So the children looked around for a wife for him. And they got another youngish widow from the village. They had a wedding. She looks after him—emptying his urine bag. I think that it was a shame for children to see their father's private parts. But the new wife is okay with that. She looks after his needs and he also looks after her needs for food and shelter in a nice area.’

In this reported case of remarriage, the children engineered the relationship in order to provide a carer for their elderly father who has special health needs. The relationship sounded mutually beneficial to both parties. According to van der Geest (2006), “Reciprocity is the oil of any love relationship” (p. 222). While the children of some elderly people encourage (or otherwise do not object to) them obtaining a new spouse to take care of their daily needs, many other children instead take care of their elderly parents. Thus it was not unusual to find that an elderly parent was residing in the home of an adult child and sometimes even became one of the permanent house-hold members.

Kezia Baliddawa who is 72 years old was introduced to me by her 58-year-old son when he heard that I was interviewing widows dwelling in the urban study area. “You must meet my mother who now lives in my home. I brought her to live with us a few years back because she was very lonely living on her own in the village,” he

told me. The first day I went to visit her, Kezia was unwell and thus I was unable to interview her in detail. Her son led me to her room, where he made the introductions and then left us alone. The room was small and seemed congested. The tiny wooden window at the back of the room was closed. I could make out a wooden cloth rack at the foot of the bed. There was also a wooden shelf stacked with all sorts of items on the wall besides the bed. Taking up most space in the room was a single-size bed in which Kezia lay. Lying in bed, Kezia looked frail but welcomed me. She told me that she was glad to get a visitor because it was very rare for her to engage in conversation with any adults these days.

“People no longer have time to sit down and talk with me. They have no time to listen to me. They are very busy doing this and doing that. The people I am now used to talking with are my grandchildren. But sometimes I really miss having adults to converse with.”

When I asked about her ailment, Kezia replied that she was feeling poorly and quickly added her gratitude to her son who spent an enormous amount of money on her transport fares to hospital, the medical fees as well as buying special nutritious foodstuffs to boost her recovery. She showed me her hospital cards, diagnosis and prescription slips, and the khaki square envelopes containing different medicines. There was also a bottle of syrup multi-vitamins, and another bottle of chalk-milk magnesium trisilicate solution to help soothe abdominal ulcer pains. Thus some of the immediate benefits of shifting from her own hut located in a rural village into her son’s house in an urban slum were evident. Kezia’s son was able to provide for her health and medical welfare including the expensive transportation to requisite healthcare professionals, purchasing medicines and other pharmaceutical products, ensuring she promptly took her medicines and food-supplements in adequate dosages and on time, etc. Kezia also benefitted from the shared household meals prepared by her daughter-in-law and grandchildren. In addition to availing foodstuffs, the added benefit of regularly accessing the labour for domestic chores—particularly cleaning, washing up, but also preparing food in ample proportions—was evident. Later on, during individual in-depth interviews with Kezia, I learnt that there were mixed blessings in shifting from the rural hut into her son’s urban household.

“I thank God for my son because he thought about bringing me here. I live well with his wife and his children who are my grandchildren. They take care of my needs by cooking for me, washing my clothes, cleaning my room and even helping me to collect water. These had become very difficult chores for me to do when I was living alone in my hut in Kyaggwe. And I appreciate. But then I miss my home. It was my place. And people knew me in that village. There they would come and visit me, just for me. Here there are people in the house, but then they are busy. They have to go to work and the grandchildren have to go to school. So I am sometimes left here on my own. But I do not complain about it because my food needs are met.”

The complexity of dealing with the expressed loneliness of elderly people is clear in this case. Kezia’s son was concerned about her apparent loneliness when she was living on her own in her hut in a rural village. Therefore he uprooted her from a local

context in which she was previously deeply embedded. He transferred her into his urban household where he was meeting her needs for food, health, shelter and labour. He also felt that because his urban household had many residents, their numerical presence would cater towards Kezia's loneliness. However, it was clear to me that Kezia still felt lonely. In my first interaction with her, she expressed her yearning for adult conversation because she mostly conversed with her grandchildren. Her need for adult companionship was still largely unmet. Therefore interactions with me—a researcher who interviewed and recorded our conversations—were genuinely appreciated.

Beyond companionship and conversation at the household level, analysis reveals that the transfer to the urban area was also a form of dislocating Kezia from her wider social network of connectedness to the people, processes and events in her rural village. Although Kezia may have previously presented as an individual elderly woman living alone in her rural hut, she was also connected to several rural processes within this community. She played the specific role of 'Mukadde Kezia'—(loosely translated as 'Elder Kezia'), to whom many cases of marital discord were brought for guidance, counsel and even arbitration sometimes. When I asked about what she missed from her home in the village, Kezia explained in an interview:

"There in my village, I was very well respected by the men and women in my area because I had at one time or another given them advice about how to handle a problem in their marriages. Yes, when there was a wife who was not pleasing her husband very well, she would be brought to me for about 5 days and I teach her or counsel her about what to do. If there was a husband who was using a cane to rule his home, where he was always fighting with his wife—beating her instead of loving her, I would come in and talk to him about how to be a real man without just using a cane. Even where daughters were going to get married, before the introduction ceremony, it was me who would teach them about how to live as a good wife or mother, how to take care of your home, how to look after your husband, how to raise the children, things about women's cleanliness at all times of the month, like that. But then if someone was just looking at me at home in my hut alone, that person would not know how these people were coming to me for help. I miss that..., but now I am sick and I need help. So I think it is good to get the help of my son. But I miss my home in the village. And I know that those people in my village—I know that they must miss me."

Loneliness in this case perhaps also represents the loss of a sense of usefulness created by contributing towards the wellbeing, stability and development of the social relationships in one's community of abode (see also van der Geet 2004; 2007). Kezia was lonely because she missed being useful to the people with whom she lived. She had transformed from a resource that built other people's social wellbeing into a near invalid who needed the care and support of others. This sense of losing their value and usefulness was commonly reported by older respondents—particularly if they were retired from formal employment and/ or not engaged in the daily chores of the household. Among these widowed research participants, loneliness was reported much more frequently than missing sexual intimacy previously shared with the deceased spouse.

## Widows' Sexuality Within the Institution of Widow Inheritance

Although the sexual activity of widowed individuals is widely socially proscribed against—especially if they remain single and unmarried, this patriarchal society provided for the resumption of sexual activity among widows through the customary institution of widow inheritance. This is one of the concluding rituals conducted within the last funeral rites ceremonies in Buganda. After the burial (*okuziika*) of a person, it is customary practice among the Baganda to conduct last funeral rites (*okwabya olumbe*). In the past, these rites were traditionally held some months after the burial in order to allow the immediate kinsmen, clan members and family to conduct specific rituals in preparation for the closure of the earthly affairs of the deceased. Specifically the widow underwent several taboo observances including the neglect of her bodily hygiene such as trimming her hair and nails, baring her shoulders, tying a ritual belt made using the insides of banana stems around her waist, publicly wailing and lamenting her loss, and also wearing menstrual protection in order to ward off the ghost of her dead husband (Nyanzi et al. 2009). At an agreed time, the deceased man's relatives, kinsmen, clan members and friends would gather to celebrate the last funeral rites. Scholars describe the last funeral rites as rife with sexual activity. For example Mukiza-Gapere and Ntozi (1995a) state that “sexual intercourse with non-relatives attending the rites was encouraged by custom to ensure replacement of the dead” (p. 198). Furthermore, Mukiza-Gapere and Ntozi (1995b) describe them as “...the Baganda's sexual indulgencies at the last funeral rites” (p. 207). However, research participants reported that contemporary society changed and generally no longer observed several of the customary rituals surrounding death, disposal and closure. For example the extended period between the burial and the last funeral rites had diminished. Many people held these rites immediately after burial. And some other families altogether did not hold these rites. Aspects of the last funeral rites are ignored. For example Mukiza-Gapere and Ntozi (1995a) report that “the sexual orgies are disappearing and are discouraged by the elders” (p. 195).

The last funeral rites customarily presented the widow an opportunity to officially end grieving, engendered closure between herself and her deceased husband, as well as marked her freedom to rejoin society. The cleansing rites (*okumwabya k'olumbe*) she underwent in the night of the last funeral rites allowed her to end the abstinence enforced because of mourning and grieving her loss. The following day, the widow was customarily assigned a levirate guardian (*omukuza*) alongside a female assistant (*lubuga*) to facilitate the raising of the orphans under the leadership of the deceased man's heir (*omusika*). Customarily the levirate guardian was supposed to take over the widow, ensure she produced more children for the deceased man's clan and also support her in raising the orphans.

The institution of widow inheritance has faced multi-faceted criticism from feminists, human rights activists, and anti-HIV/AIDS campaigners because it is blamed for the transmission of HIV infection, the violation of women's individual liberties to make their sexual choices, and the commoditization of women as chattels to be handed over from one male kin to the next (for details see Nyanzi et al. 2009). While this discourse is powerful, it also negates the agency of widowed individuals by homogenizing and victimizing all of them. Cattell (1992) found that in

neighbouring Kenya older widows were empowering themselves within their homes and in their everyday lives by publicly refusing to be inherited as a wife by their husband's brother or other kin. The ethnographic data reveal ambivalences in the ways that different widows experienced, negotiated and contested widow inheritance. The research participants agreed about the value of widow inheritance in the past including that it was important for the social cohesion of society, provided a medium of closure from and containment of the deceased man's influence upon the clan, availed widows with a strategy of obtaining support and care from the in-laws, allowed younger widows to continue their reproduction functions within one lineage, and ensured that a man's property remained within his clan. However, they stressed that widow inheritance was also a potentially high risk custom particularly because when it involved sexual intercourse there were possibilities of transmitting HIV.

The fear of contagion or re(infection) with HIV was the main explanation for why widow inheritance was transforming to exclude sexual intercourse, or altogether being rejected (see also Nyanzi et al. 2009). This echoes Mukiza-Gapere and Ntozi's (1995a) finding that:

“...men no longer inherit widows for fear of AIDS. In the past, women were taken over and the clan members used to share property with orphans... Widows are heading the households because the old practice of widow inheritance by brothers-in-law is disappearing since they fear contracting HIV from the widow. Widowers are also finding it difficult to get remarried because women are afraid of being infected by them” (p. 195).

Nyanzi et al. (2008) report similar findings from rural southwestern Uganda, where rural-based Baganda reported that rather than indulge in sexual intercourse during widow inheritance, individuals were enacting symbolic sexual rituals such as the levirate guardian jumping over the outstretched legs of the widow, jumping over her inner belt, or even both urinating in the same spot. Furthermore, they found that traditional medicine was evolving to appropriate the prevailing environment of fear of HIV such that there were prophylactic medicines and charms to protect individuals against the effects of avoiding penetrative sexual intercourse to mark the taking over of the widow. There were a few older widows who argued for the benefits of widow inheritance for the widow and orphans—especially in cases where the levirate guardian did provide support. In such cases, the sexual services of the widow were often given in reciprocation and appreciation of the levirate guardian's good will. In this regard, widow inheritance presents another avenue for sexual opportunity for widows in advanced age.

However, the majority of research participants felt that within this patriarchal society, clan members and in-laws often violated the autonomy and sexual rights of widows by coercing them into sexual activities with partners they neither chose nor approved of. Often when this sexual activity occurred, it was without condom-use or contraception because it was important for the sexual juices of the widow and the levirate guardian to mix, just as it was also important to claim the reproductive rights of the widow in order to restrict her progeny within the deceased man's clan. Fear of losing property, progeny, and social status often meant that widows felt powerless

against the customary dictates of their in-laws and thereby merely yielded to engaging in coercive sexual rites. This fear was associated more with older widows than younger ones because they suffered from frailty, immobility, dependence on the spouse's provision, higher loss of sex appeal because of inability to reproduce, and the lack of extended family to turn to if driven away from the deceased man's property. Although none of the research participants admitted experiencing rape, they often referred to the trickery and forcefulness involved in actualizing the conduct of full-fledged customary funeral rites.

### **Contracting and Living with HIV at Advanced Age**

People of advanced age are at risk of HIV infection (Mtei and Pallangyo 2001). However, AIDS-related research mainly focuses on individuals within the reproductive age-groups who tend to catch HIV through sexual transmission, as well as infants and children who become infected with HIV through vertical modes of transmission. Studies (e.g. Nakimuli-Mpungu et al. 2011; Nankwanga et al. 2009; Help Age International 2008; Williams and Tumwekwase 2001; Mtei and Pallangyo 2001) highlight that HIV infects elderly people in Uganda. Williams and Tumwekwase's (2001) study in rural Uganda found that while none of their aged study participants suffered, or died from, an illness that was said to be HIV-related, "most older individuals have a sound understanding of the sexual transmission of HIV, and some consider themselves to be at risk of infection through having multiple sexual partners" (p. 221). Ssengonzi (2007) reported that most of the elderly respondents he interviewed had a lot of anxiety about their future health and well-being, which they attributed in most part to the HIV/AIDS epidemic. In their discussion of the effects of the epidemic on elderly people in Uganda, Nankwanga et al. (2009) reported that "some elderly people had to face discrimination and stigmatization as a result of suffering from the disease [HIV/AIDS]" (p. 24).

Through the Community Based Health Care Program of Mengo Hospital, I was able to access a few elderly widows who also were infected with HIV. Most refused to participate in the research because they did not want their voices to be recorded. The Counselor revealed to me that it was difficult for many elderly people to admit to themselves, let alone accept that they were infected with HIV. Upon accepting one's diagnosis, the counselor also reported that elderly people found it very difficult to disclose an HIV-positive sero-status to family members. Many struggled with this as their "inner secret", until late into their illness—perhaps after developing full-blown AIDS. There was shame associated with HIV-infection in advanced age; it was as though one condemned oneself for they should have known better than to catch HIV. The narratives of the elderly who were HIV-infected were often couched with moralizing undertones, as well as regret over past sexual choices. An example is Goretta Zziwa<sup>1</sup> whom I met shortly before she passed away. Gray-haired, physically wasted, constantly coughing and with a visible skin irritation, she revealed to me that her body was not responding at all to the AIDS medicines available in the post-test clinic. She told me that she now only collected tablets to

<sup>1</sup> Gorretti died three months after the end of the fieldwork upon which this paper is based.

ward off new opportunistic infections. I also learnt that although she looked much older, Gorretti Zziwa was only 58 years of age. “The virus ate the youth out of my body. This virus makes me look very old but then I am still a bit young,” she explained when I asked about her age.

Describing her shock and pain at the selfish manner in which her husband disclosed his HIV-positive sero-status to her, Gorretti Zziwa narrated:

‘Fredrick and I were married for a long time. But that marriage had its happy moments and also its sad moments. When our children were in secondary school, he left me and went off to a big job where he was making the big monies. I know that he picked up many young girls that time. They took his money. Me I struggled with the food, children’s school fees and rent for the house. I kept myself for him while him he was busy having a good time. After many years he came back. My children warned me severely about him, but you know what love can do to a woman. [Prolonged silence] It was the morning after when I realized that his waist was covered with a belt of sores. We used to call it *kisipi*. And when I asked him about it, he told me, ‘Eh, did you want me to die alone? If I am going to die with this disease, I will die with you.’ I tell you, I nearly died that morning. I thought about all the warnings from my children and friends but then it was too late. Too late.’

Later on as we left the post-test club, I noticed that members were taking supplies of free condoms on their way out. However, Gorreti did not collect any free condoms. “I have no need for condoms. Who would I use them with? No, I did not use condoms when my husband was still alive and even now I cannot start taking them,” she explained to me when I inquired about this.

Generally, there was widespread refusal of the idea that people of advanced age needed condoms. This was reported by both older and younger research participants. Condoms were mainly discussed for their contraceptive value and not their disease prevention abilities. Thus the notion of an elderly person accessing condoms was described as ‘that person is spoilt’, ‘it is foolish’ (*abeera asiluwadde*), ‘a waste of limited resources’, ‘sheer madness’ (*okwo kugwa ddalu*), etc. Although accessing condoms to elderly people made perfect public health wisdom, it was deemed irrelevant to expected social norms.

### **Appropriating HIV-Infection in Old Age**

Assumpta Mukasa, a seventy-year-old mother of five and grandmother of twelve, is among the few elderly people I met who freely talked in public about being infected with HIV. I was introduced to Assumpta by a medical doctor working in a post-test clinic where counseling and free anti-retroviral therapies are provided. During our interactions, I learnt that Assumpta is a devout member of the Church of Uganda. In her local church, she was actively engaged in the Mothers’ Union, as well as the Widows’ Fellowship. Often in the year, she was called upon to address girls and young women who were unmarried on topics related to holy living amidst adolescence, sexual abstinence until marriage, female hygiene and good behaviour.

I attended two of these seminars organised by the church, and was struck at the charisma with which Assumpta captivated and engaged her audience. On both occasions, she disclosed she was infected with HIV and had lived with the virus for over 20 years. She also stressed that despite marriage, she was unable to protect herself from contracting HIV because her husband was polygamous. She implored the young women to be careful about the type of people they eventually chose for sexual partners, instructed them to get informed about how to prevent HIV, and also encouraged them to submit their adolescent sexual passions and dreams to God through Jesus Christ. Each of these times she ended her talk with prayer and an altar call for members of her audience to commit their lives to Jesus.

‘When you come to Jesus, your life will be safe. He will give you wisdom to choose between right and wrong. His words in the bible will guide your feet in the ways to go. He will choose for you the right partner who will be your husband. Jesus will protect you. Come to Jesus. Even if you have sinned [sexually] Jesus can forgive you. Jesus can make you right again...’

Subsequent interviews with Assumpta revealed that she had come to fashion herself as a ‘loud-sounding gong’—warning young people against the dangers of ‘sinful sexuality’. Amidst struggling to accept and live with a positive HIV diagnosis, Assumpta recreated meaning for herself and her life by working towards preserving the sexual purity of the younger generation.

‘For me, although my life became reduced to being a woman with HIV/AIDS, I thank the Lord because he got my very life and is using it as a warning sign to these youthful girls. You see, God got my life which was useless—totally useless and made if useful. That is what the bible says that he can use anything even those things that seem useless. You find that in the bible in 1 Corinthians 1:27.’

During another interview she re-echoed this sentiment:

‘When I had just known that I had this disease [HIV/AIDS], I used to feel very much shame because all of us in the church knew that it was an illness for those women who have no sexual morals, the ones who have relationships with different men. And me I was on the Executive Board of Mothers’ Union. I kept on fearing the reaction of the members of the Mothers’ Union and the other members of the church when they learnt that I have HIV. It would make me cry whenever I thought about what they were saying behind my back. I was just only denying that it is me who has this virus. If anyone talked about the disease, I would stop talking and if possible just walk away. And I kept away from the church for very many months. But after counseling from the health workers, I decided to speak up and warn the younger people not to fall in the same trap as me. I never used to be brave like you see me now. It took me some years to become bold and speak up. But now I speak and speak and speak because someone has got to tell them.’

It was striking that this elderly woman’s energy was focused on spreading a message of preventing HIV infection through sexual transmission among young

people. This ability to renegotiate meaning and thereby recreate a purpose for living although infected with HIV, highlights how the tragedy of HIV infection can be reversed and appropriated to benefit the individual with HIV, as well as the community surrounding this person. Thus HIV is constructed in this scenario as a catalyst bringing a new lease on life during old age when many retire from active community service.

I variously probed Assumpta about whether or not she ever talked to other elderly people about safe sex in a bid to prevent HIV transmission. Her responses revealed the discomfort of talking about sexuality, sexual behaviour and sexual health even among elderly people themselves. An excerpt from recorded interview went thus:

*Interviewer: So, it is very clear that you enjoy talking to young people about preventing HIV.*

*Assumpta: That is true. I talk to them now and again whenever I am invited by the church or the schools.*

*Interviewer: But then, do you ever have the same type of talks with people who are in your age group?*

*Assumpta: Eh? You mean to talk to other people who are grown up like me?*

*Interviewer: Yes, to talk to grown-up people like you about preventing HIV through risky sexual behaviour. Do you get chances where you talk to them as well?*

*Assumpta: Why would I talk to them about this topic? It is not proper to talk about sexual relationships with these elderly people. They would find it very disrespectful. If I called them to church to talk about sex and HIV/AIDS, that will be the talk of the year. They will say that Mrs. Mukasa is spoilt in the head. They will see it as a waste of time.*

*Interviewer: What about if you talked to them as individuals, not as a group invited to the church? Have you ever talked to individuals when you are chatting?*

*Assumpta: No, not the older grown-up people. Even me, I would feel embarrassed to start talking about those things to them. You know? I believe that God called me to talk to these young people who have not yet seen the world because they need to be protected. That is where my calling is, the youthful people...*

The data highlight an absence of targeted sexual health interventions for the elderly—be it in the form of sex education, information or communication, or tailor-made STI services including HIV/AIDS prevention programs, providing access to sexual health commodities, voluntary counseling and testing of HIV, free or subsidized treatment of STIs including HIV/AIDS, availing affordable/ free antiretroviral therapies, etc. Critiquing available programmes aimed at preventing the transmission of HIV and AIDS, Oloka-Onyango (2008) states:

“There are also many assumptions about older persons’ sexuality. In some respects, older persons are considered to be ‘beyond’ sexual activity. Existing programs on HIV/AIDS largely target adolescents, the youth and middle-aged, ignoring the fact that many older people remain sexually active while at the same time they are not necessarily well-informed about the dangers of

unprotected sex. Without a doubt, there is a need to alter these perceptions of the needs and interests of older people. Issues such as menopause, impotence and other issues that may affect older people are still not given much attention” (p. 21–22).

### **Bishop Christopher Senyonjo: Supporting Sexual Rights of Peripheral Sexualities in Uganda**

A draconian bill that proposed the re-criminalisation of homosexuality in Uganda was tabled before parliament in October 2009 (Tamale 2009). Although homosexuality is already outlawed in the country’s penal code and constitution, this proposed Anti-Homosexuality Bill recommended several stringent punishments for homosexual acts including heavy monetary fines, mandatory policing and reporting within 24 hours any known homosexual person—whether it be one’s child, patient, student or client—or else risk imprisonment, compulsory testing for HIV of convicted individuals in order to prove intention to transmit HIV, and the death penalty for ‘aggravated homosexuality’. This bill generated intense debate in society, casting the topic of homosexuality from a position of denial and invisibility right into the realm of public discourse. Analysts and sexual minority activists traced the genesis of this bill to a series of public events organized by local Christian fundamentalists in consultation with their counterparts from the American Christian Rightist movement specifically involving Evangelicals (Kaoma 2009). In addition to intensifying the homophobia, hate crimes, naming and shaming in the public media of members of the local lesbian, gay, bisexual, transsexual and intersex (LGBTI) fraternity, this bill legitimated multiple violations against the person, property, privacy and rights of individuals perceived to be homosexual in Uganda (Gettleman 2011). Many LGBTI people returned to the closet.

Amidst this intensely homophobic social-political environment, an elderly bishop stood his ground and supported the right to life, the right to protection and security, the right to privacy, the right to health and education, the individual liberty of sexual choice and the human-ness of LGBTI Ugandans using the framework of sexual rights. Given this background, an account of the interactions between sexuality and aging in contemporary Uganda would be incomplete if it excluded a description of the role of this elderly advocate of social justice for sexual minorities.

Bishop Christopher Disani Ssenyonjo is 78 years old. He retired from active service in the Anglican Church of Uganda in 1998. At that time he had served the church for twenty-years, rising from the positions of priest, reverend and then to bishop. His base then was West Buganda Diocese. Married to a woman, and father to eleven children, Bishop Senyonjo revealed that although he self-identifies as a heterosexual, he is an ally of the LGBT movement in Uganda because ‘they are also created by God. And they are created in his image’. Upon retirement, Bishop Senyonjo started a private counseling service. In 2001, after the publicization of a gay wedding in the local press, a couple of homosexual men sought his guidance pertaining to their sexual orientation. He ministered to them without discrimination, leading them to refer many other members of the local LGBT community to the bishop.

When public debate about homosexuality flooded the local press media, Bishop Senyonjo was among the few brave voices that advocated for the rights of these sexual minorities in a largely heteronormative society. This immediately led to his ostracization and public ridicule from mainstream society. Bishop Senyonjo continues to provide guidance, counseling, solace, refuge and fellowship to many members of the local LGBTI community mainly through his ministry which was recently renamed St. Paul's Reconciliation and Equality Centre. In public forums, debates and conferences, his is often among the few elderly voices that non-compromisingly advocate for the rights, dignity and safety of sexual minorities in Uganda. Concerning the propaganda published in the local press media that he was ex-communicated from the Anglican Church of Uganda, Bishop Senyonjo clarified:

You know, once one is a bishop, he will always be a bishop. Nobody can take the call of God on my life away from me. I am a bishop. I served my church very well until I reached retirement. Nobody can take this away from me. Actually, I still fellowship with believers. In fact I still partake of the Holy Communion. It is just very unfortunate that my church did not understand that God came for all of us including those people whom we think are very sinful. That is what I was telling them; that even the homosexual person must be allowed to come to church. I was telling them that God does not discriminate persons. But then the church did not want to hear this message. Instead they took away my pension and spread false stories about threatening to ex-communicate me.'

In my current anthropological fieldwork (from November 2009 to the present), I have interacted with several individuals who identify as LGBTI. Many testify to the rarity of an elderly cleric who appreciates the sexual diversities within society. Some have personally benefited from Bishop Senyonjo's counseling and guidance—particularly when they were struggling with internalized homophobia, suicidal tendencies, self-hatred, self-doubt brought on by confronting the 'Ex-Gay' fellowship of believers who preach that God is able to convert one from a life of homosexuality into a life of heterosexuality. Some others went to him when they were in need of prayer, Christian fellowship or other spiritual guidance. Data from my interviews with LGBT members contain diverse reports in favour of Bishop Senyonjo's ministry to sexual minorities.

'...he is a true reflection of the love of Jesus even for sinners. If people say that homosexuality is the worst sin, and that it is totally an abomination in the scripture, why don't they allow us to come to church so that we can learn about this? That is why I say that Bishop represents for me the love of Jesus who sat and ate with sinners like that prostitute woman who wet his feet with her hair' [26-year-old lesbian].

'Bishop is an old man and he has seen the world. His advanced age gives him much more wisdom than these young hot pastors who just preach hate, and preach more hate for homosexuals. For us in the community, we know that Bishop is there for us as a spiritual father. It is great to have an elderly man of

God giving us a blessing unlike all those young pastors who just curse us to hell because of our sexuality which is different' [31-year-old bi-sexual man].

'The counseling that Bishop gave me when my family rejected me and sent me away from home because I am a gay [man] is what helped me to be strong. He told me that God created me this way and I cannot run from it. He comforted me and advised me to learn the truth about who I am sexually because this truth will set me free [24-year-old gay man].

'David Kato's burial was a testimony to Ugandans that Bishop does not discriminate just like God does not. While the local priest who was supposed to lead prayers insulted all homosexuals who had come to bury David, doomed us all to hell, preached at us to change and become heterosexual, and was unnecessarily aggressive, Bishop instead was comforting for us during our grief and loss of an LGBTI leader. Bishop was respectful. He blessed David and led us in the burial prayers' [34-year-old gay man].

In response to my question about what motivates him in his old age and retirement to take on the cause of sexual minorities (indeed at great risk for himself, his family and work), Bishop Senyonjo reiterated that he was certain of God's call on his life to be an apostle to the homosexuals in Uganda. He also added that his graduate and doctorate studies in human sexualities had grounded him in the realities of the diversities of sexualities particularly as espoused by Alfred Kinsey.

## Discussion

The elderly are generally stereotyped as a homogenous asexual unit. This article discusses the diverse sexual opportunities that are played out in the lives of elderly widowed individuals located in an urban periphery of Kampala city. Attention is also paid to the multiple roles that the elderly play in the sexual lives of younger generations around them. While the narratives about the elderly study participants facilitate an examination of their lived experiences, the data from the younger ones reveal widely shared values and perceptions about sexualities in later life. Although the findings from these ethnographic data cannot be generalized to all widows and widowers of advanced age in Uganda (Marshall 1996), they provide an in-depth and contextual understanding of the varied and complex sexualities of the elderly.

The demographic category of the elderly is rapidly growing in developing countries, although there is limited research focusing on this population group (Help Age International 2008). Moreover, the sexuality of the elderly is a highly neglected topic particularly because sexual activity is heteronormatively associated with procreation. Thus post-menopausal women are widely assumed to be asexual because they are past the biological reproductive age (Thornton et al. 2009). Elderly widows and widowers offered a special study population group because in addition to being of advanced age, each individual experienced the loss of a spouse—i.e. the legitimate sexual partner. Focusing on widowed elders facilitated examination of the question of post-marital sexualities i.e. beyond the marital encounter (see also Levy 1994).

The sexuality of elderly widowed individuals is surrounded by ambivalence (see also van der Geest 2006). Due to prevailing heteronormative and patriarchal standards, sexual activities are socially approved only within the context of marriage. Therefore widowed individuals' sexualities are regarded as post-marital sexual activities, unless they are conducted within the boundaries of remarriage. While adult children may disapprove of their elderly parents' resumption of sexual activities even within the confines of remarriage, in circumstances where the elder stands to benefit (be it in terms of care, support or materially) from a new spouse, adult children may also scheme to get suitable remarriage candidates for these elders. These arranged remarriages involving elderly persons have potential to be coercive. Ntozi's (1997) caution in reference to arranged remarriages for widows captures this well, "Often remarriage is forced on the widows and widowers by custom, which is dangerous to the new sexual partners" (p. 140).

However, as Calasanti and Kiecolt (2007) highlight, intimate relationships in old age can go beyond marriage and remarriage to include cohabitation, "living apart together", and dating. For the elderly widows and widowers interviewed in this study, cohabitation was reported to occur in contexts where a levirate guardian took on the responsibility of providing for a widow and ultimately resorted to regularizing sexual intercourse within this partnership. Dating in old age was highly decried and relegated to drunkards, social misfits, shameless people and women without modesty. Furthermore, masturbation and casual sex relationships were mentioned as options available mainly to elderly widowers, but not for elderly women.

Gender, generation and class impact upon the sexuality of widowed individuals. Remarriage is more possible for widowers and younger widows than older widows. Celibacy was widely reported among the elderly widows, particularly because propriety demanded that one abstained from sex in the absence of a socially approved spouse (Potash 1986). In comparison, the widowers and younger widows had more remarriage opportunities. The ability to conceive and reproduce gave these younger widows more sexual appeal because they were perceived as still able to contribute towards the expansion of their new spouse's clan within this patrilineal society (Nyanzi et al. 2009). Younger widows faced more pressure than older widows to distance themselves from possibilities of being infected with HIV (which supposedly was responsible for their deceased spouse's demise). Thus many younger widows migrated to new locations in which their sexual histories and sexual networks were unknown in order to catch a new unsuspecting spouse (see also Ntozi 1997). The strategy for disassociating from HIV infection employed by older widows on the other hand was to lay claims over non-HIV-related causes of death of spouse such as traffic accidents, and civil war. Widowers had fewer social proscriptions against remarriage than their female counterparts; many receiving encouragement from kin and friends to remarry. Often these older widowers remarried younger spouses and were thus perceived as having higher risks of exposure to HIV infection in advanced age (see also Mtei and Pallangyo 2001).

Many older widows chose to remain single. Some of these older widows were female household heads who were looking after dependent children and grandchildren who were either infected with or affected by HIV and AIDS (Nankwanga et al. 2009; Seeley et al. 2009; Ssengonzi 2007; Nyanzi 2009; Mukiza-Gapere and Ntozi 1995a). Some other older widows were living as dependents of their adult

children who took them in as a means to mitigate against loneliness, illness, immobility, and insecurity. Whatever the circumstances of older widows who were residing with several other household members, they faced immense challenges to their privacy (Levy 1994). Access to privacy is important for adult sexual liaisons and sexual activities to occur particularly within inter-generational households. Social norms demand observing secrecy between generations about sexual matters (van der Geest 2006); discussing or exposing one's sexual activities to members of a younger generation is strictly taboo. It is shameful for one's children and grandchildren to know about, let alone witness one's sexual activities. Therefore giving or receiving care to other family members greatly restricts older women's sexual opportunities. Social responsibilities interacting with habitable space limitations negate sexual possibilities of these elders.

Sexual autonomy, sexual choice and the right to determine one's sexual lifestyle are important individual liberties (for details see Yogyakarta Principles). However, often the sexual choices of elderly widowed individuals are made by other people including adult children, in-laws, clan leaders, carers and medical practitioners. These decisions are often informed by ageism rather than actuality (Thornton et al. 2009). According to van der Geest (2006), "The phenomenon that the younger generation disapproves of continued sexual activity among the elderly and that the latter tend to comply with that disapproval, seems nearly universal" (p. 230). Apparently, other players take over the decision-making, regulation and control of the sexualities of many elderly people. While adult children may apply protectionist arguments against the resumption or continuation of sexual activity by their elderly parents, there is evidence that these same adult children may also seek out candidates for remarriage of their elderly parents—especially for those with labour-intensive caring needs caused by failing health. Therefore a new spouse who is younger than the elderly widower often comes in to play the role of carer much more than that of sexual partner, although the two roles are not mutually exclusive. This control of the sexuality of elderly widowed individuals occurs at the private level of the family.

The sexual lives of widowed individuals are also controlled at the societal level through the cultural institution of widow inheritance which often involves diverse rituals of sexual cleansing (Nyanzi et al. 2009; Ntozi 1997; Cattell 1992). Customarily among the Baganda, it was a requirement for a deceased man's clan to provide a levirate guardian (*omukuza*) for the orphans during the last funeral rites ceremony. Often this levirate guardian also took over the widow. Recent research conducted after the advent of HIV highlights that widows were variously contesting, challenging and negotiating the sexualisation of this customary practice (Nyanzi et al. 2008; 2009). Nyanzi and Emodu-Walakira (2008) summarise the strategies contemporary widows employed to refute having sexual intercourse with their given levirate guardian, including referring to avoidance taboos, giving religious proscriptions against extra-marital sex, proposing alternatives such as requesting the clan for a female levirate guardian, threatening recourse to the law, and appropriating the fear of HIV infection. Cattell's (1992) study among elderly widows in Kenya found that they were appropriating their religion to contest against remarriage through widow inheritance.

Elderly people are playing active roles as sex educators and sexual rights defenders for younger generations. Customarily in Buganda society, the *jaja*

(Luganda for grandmother) in addition to the *ssenga* (paternal aunt) were responsible for the sex education and preparation of young women for marriage (Nabaitu et al. 1994). However with the current breakdown of the extended family system<sup>2</sup> caused by urbanization, migration, and extended periods of formal education, the information and communication flows embedded within these intergenerational linkages are truncated.

Therefore the elderly individuals who take on the surrogate role of sex educator—whether addressing public gatherings or giving private individual counseling sessions—are filling a gap in society’s socialization process. Often they use their own resources and innovation. Their energies are privately mobilized by interested parties and thus the remuneration depends on the generosity of the invitee. Their lessons are drawn from their life experiences. While there is an advantage of information reaching the younger generations, there is also a danger that only normative sexual values and knowledge as known by the elderly sex educators are relayed to the audience. It is important to identify, recognize, remunerate, support and harness such efforts of the elderly sex educators and sexual rights defenders.

The ministry of retired Bishop Dr. Christopher Disani Senyonjo to sexual minorities in Uganda is commendable particularly because he is advocating for LGBTI rights amidst intense state-inspired homophobia which is incited by the proposed anti-homosexuality bill (2009). In addition to maligning Senyonjo from mainstream society, this advocacy cost him his pension, exposed him to homophobic hate speech, infringement of his personal security and exposed him to virulent public exposure in the media. However, this elderly minister of Christ determinedly asserts that God’s calling on his life is as ‘the apostle to the homosexuals living in Uganda’. Contrary to gerontocratic stereotypes in which the elderly are presented as conservative traditionalists who reify culture, Senyonjo’s advocacy is premised on the conviction that ‘[sexual] culture is not static but rather evolves with time and exposure to other cultures’, and that ‘God delights in diversities including the entire spectrum of human sexual orientations’. This elderly bishop provides a rare local example that dispels the homogenizing effects of stereotypes that present all people of advanced age as having no interest in the topic of human sexualities.

HIV/AIDS not only affects people of advanced age necessitating them to take on caring and provider roles for ill children and orphaned grandchildren (Ssengonzi 2007; Kanya and Pointdexter 2009), but also infects elderly people in Uganda (Nankwanga et al. 2009; Mtei and Pallangyo 2001). Unfortunately there is a paucity of research, interventions, programmes and policies concerning the experiences of HIV-infected elders. Current HIV prevention efforts—whether targeting the sexual transmission or that obtained through other modes—generally exclude the elderly. There are gaps in locally available information, education and communication strategies targeted at availing the elderly with resources to protect themselves against HIV infection. This limitation is evident in the broad sexual wellbeing and reproductive health arena of the elderly. Oloka-Onyango (2008) highlights that even

<sup>2</sup> The label ‘extended family system’ has been critiqued by several Africanist scholars who argue that it is Westocentric to consider the wide network of family and kin as performed in African societies as extended. Instead they argue that the small nuclear family unit should be deemed ‘constricted’ from the normative large family as emically appreciated in Africa.

mainstream organisations and public bodies are yet to target elderly people—particularly the older women:

“...there is very little systematic focus on the situation of older women. This situation is compounded by the lack of attention to the issues by mainstream women’s rights groups as well as by women representatives in parliament and other state bodies, not to mention within the workplace and within institutions representing organised labour (p. 23).”

However, as Seeley et al. (2009) assert, “Information is important too; knowledge of not only HIV and AIDS prevention but also about treatment options that help older people plan with their infected younger relatives for the future as well as protect themselves” (p. 131). It is important to provide the elderly with education and information about the aging body and the associated psychogenetic dysfunctions which might impact their sexual desire, sexual function and sexual performance in advanced age (Kellet 1993). An important area embedded with myths and misconceptions is the sexuality of women during and after menopause. Information must be availed to women and the larger society about the changes that occur during menopause and how these may affect sexual desire and activity. It is also important to dispel myths about the desire and desirability of post-menopausal women in order to create a supportive environment for the sexual health and rights of elderly women. Information must be availed to older men about use of local aphrodisiacs to enhance their sexual performance, as well as the positive and negative effects of popular sexual pharmaceutical products such as Viagra.

Free voluntary testing and counseling services for HIV/AIDS and other sexually transmitted infections must be availed to elderly people. Protection commodities including condoms, lubricants, contraceptives and microbicides must be availed to the elderly in non-discriminating presentation. In addition to addressing the shame and stigma attached to an elderly person (whether man or woman) accessing condoms or lubricants, it is also important to dispel the discrimination facing HIV infection in old age. Antiretroviral therapies must be made more accessible to the elderly, and cases where immobility interferes with travel to the health unit for new supplies of medication, follow-up and outreach services must be created to ensure the elderly have a good quality of life even when they may be HIV-infected (see also Nakimuli-Mpungu et al. 2011). The available dense network of pre- and post-test counseling services must be enhanced in order to become relevant to the needs of elderly individuals. Capacity-building of staff of these services should include routine refresher courses about how to handle elderly clients without assuming that they are all asexual. As highlighted by Ajwang et al. (2010) the training curricula for health care providers in Uganda generally lack transfer of knowledge about how to handle the elderly. Thus there is an urgent need for tailored geriatrics continuing education programmes to bridge the knowledge and skills gaps among health care providers.

Attention should be paid to the issue of elderly abuse—whether overt or covert. This may present as rape, sexual harassment, sexual assault, gender-based violence, lack of sexual autonomy, repression or denial of control over one’s sexual choices. As Help Age International (2008) highlight, ‘Judicial systems are often inaccessible

to older people for reasons including cost, distance, lack of literacy, the absence of free legal assistance, and a judiciary unawareness of ageing issues' (p. 3). With the rapid growth of the elderly sub-population group, there is an urgent need for establishing links between the elderly and the available mechanisms of enforcing law and order, meting out justice as well as ensuring the protection and security of the elderly from elderly abuse. A starting point can be the creation and provision of free paralegal services specific to the elderly.

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