Women at the Crossroads

A Prostitute Community's Response to AIDS in Urban Senegal

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Routledge
Taylor & Francis Group
LONDON AND NEW YORK

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Reprinted 2004 by
Routledge
11 New Fetter Lane
London EC4P 4EE

Transferred to Digital Printing 2004

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Printed and bound in Great Britain by TJI Digital, Padstow, Cornwall

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British Library Cataloguing in Publication Data
Renaud, Michelle Lewis
Women at the crossroads : a prostitute community's response to AIDS in urban Senegal
1. AIDS (Disease) — Senegal 2. AIDS (Disease) — Transmission — Senegal 3. Prostitutes — Senegal — Social conditions
4. Prostitutes — Diseases — Senegal
I. Title
362.1'969792'009663

ISBN 90-5699-530-8 (HB)
90-5699-531-6 (PB)

To Michael, my family, and the women of Ndangane

Introduction

Fatou leaned against the wall of her hut, her legs outstretched on her bed—a foam mattress propped on two truck tires. The walls were cardboard, hung on the thatch structure for a smooth interior. Over the cardboard were pieces of cloth hung like so many patches of a quilt. She pulled her bright yellow and red *pagne*—a long, rectangular cloth wrapped around her—down from under her arms to her hips and cooled her dark neck and chest with a plastic fan while chewing on a *cure dent*, a small stick used for cleaning teeth.

Outside, men selling perfume and clothes shuffled in blue and green rubber thongs through the dirt, silently advertising their wares. Because of the heat, few women were outside their huts, and the men passed through Ndangane without taking the energy to yell out for customers, knowing it would be a slow day. Even the goats and cats, usually wandering around in search of food, had taken quiet shelter in the shade of the women's huts.

Fatou and I relaxed as she answered my questions about her life and how she had entered prostitution. Men and money.

Men in her life had failed to support her and, needing money to clothe and feed her aging mother and young children, she drew on the only resource she possessed: her body. "Being a prostitute is like being a leaf that is blown by the wind into a hole," she said, glancing at me with her right eye. Her left eye remained lodged in the corner closest to her nose. When she saw I did not understand, she took her *cure dent* out of her mouth, leaned over the side of her bed and dug a hole in her dirt floor. She tossed the stick into the hole, sat up, and crossed her arms. "See," she tilted her head toward the stick. "A leaf in a hole can't get out by itself."

Out of the background noise of muffled conversations and footsteps, we heard a loud voice summoning assistance. Rhama, one of Fatou's best friends, was announcing that her client refused to wear a condom. Fatou quickly stood up and pulled her *pagne* over her chest, tying it tightly above her right breast. She slipped on her blue thongs and grabbed a wooden club propped in the corner of the hut. As she stepped outside she joined several other women approaching Rhama's hut, yelling at the hidden man. He peeked out at the crowd from behind a dark blue and green cloth hanging in the doorway. Instantly, he let the cloth drop. Rhama stepped out from behind the cloth, holding her untied *pagne* over her breasts and smiled thankfully at her colleagues. She stepped back in, pulled the cloth inside the hut and closed the metal door behind her. The other women returned to their huts and Fatou to hers, where she put her club in its corner, kicked off her thongs, lay down on her bed, and fanned herself again.

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This book is a story of solidarity and of independence. It is a story of life and of death and of that state in-between. It is a story of women's dependency on men and of their ability to gain power and control in spite of men. Most importantly, it is a story of the women of Ndangane, who have become prostitutes for economic survival, only to discover that they have much more at stake than their families' support, their next meal, and their ability to buy beautiful *pagnes* and a steady supply of *cure dents*.

In their effort to survive in a world dominated by men they have found that, while prostitution brings them autonomy, it is almost impossible to leave the profession on their own. They have also found that selling sex as a survival strategy can become a "death strategy" in the age of acquired immunodeficiency syndrome (AIDS) (Schoepf 1988:217). That is why Fatou keeps her club nearby, and why she is willing to use it to enforce condom use. If she does not help Rhama convince her client to wear a condom, Rhama may accept unsafe sex in exchange for money she desperately needs. If Rhama accepts, the man has won, and the group of women who share huts in Ndangane have lost a battle in their fight against human immunodeficiency virus (HIV) transmission. They have also lost in their battle to gain some sort of control in a world where they see themselves as having very few options. They do not think they can leave prostitution on their own, but within their small community, those who desire have achieved a degree of control over their professional sexual relations, their finances, and their health.

Fatou, Rhama, and the other prostitutes in this dirty neighborhood on the outskirts of Kaolack, Senegal's third largest town, point to men when asked how and why they entered the profession. Fathers did not allow them to go to school. Fathers forced them to marry against their wishes. Husbands beat them. Husbands took other wives with whom they did not get along. Husbands died. Ex-husbands did not pay mandatory child support. Grown sons did not assume financial support of their widowed or divorced mothers, as tradition dictates.

Talk to other Senegalese about prostitutes and they tell a different story. They say women choose prostitution out of "vice," they are corrupt and sinful and can never be "converted." They

insist that the women could find another source of income—other women in the same situation have—while the reality is that these women tried and could not.

When I first moved to Kaolack and began talking with people about prostitution in the age of AIDS, I was determined to uncover the "truth," to somehow scientifically prove whether the women did have other economic options. After much effort and attempted analysis I decided there were more important questions to answer. I needed to examine why different factions saw the situation as they did and believed what they believed, rather than search for an empirical truth.

Coming from a middle class American family, never deprived of food or clothes, I could relate to the people ready to dismiss the prostitutes with the judgmental brush of a hand. Knowing this, I tried to relate to the prostitutes. The stories they told shed light on the complexity of economic and social dependence, and on the even more complicated relations between men and women in a "modern" Islamic society. That they believed they had no other economic options was the pivotal issue. That they have responded so quickly and forcefully to the threat of AIDS to their economic and physical well-being was the fact I felt compelled to document. That they are so similar to me and women throughout the world is the issue that renders their story so remarkable.

CONFRONTING BIASES

Before I met Fatou, Rhama, and the prostitutes in Ndangane, and before I received funding to conduct my dissertation research on AIDS and Senegalese women, I was certain that I would not focus on prostitutes. Because of my biases and because most AIDS research—if on women at all—excluded non-prostitute women, I drafted a proposal to explore the knowledge and practices of women not involved in prostitution. I traveled from the U.S. to Dakar in June 1990 to further

define my plan by interviewing several health care professionals, including Dr. Souleymane Mboup, a professor of bacteriology and virology at the University of Dakar and head of the AIDS research program at Hôpital Dantec.

Upon reviewing my proposal, Dr. Mboup immediately and strongly suggested that I change my strategy. There was a need to interview women, he acknowledged, but the most dire need was to uncover the dynamics of HIV transmission among the people most at risk: prostitutes. Nothing had been written about them in Senegal, save clinical reports about their extremely high rate of infection. The HIV infection rate of prostitutes in Kaolack was and remains the highest in the country, leading to his interest in discerning the "culture of prostitution" in Kaolack.

Acknowledging that qualitative data can contribute significantly in the design of effective education campaigns, he and other AIDS researchers told me they were interested in an ethnographic study that would explain the dynamics of HIV transmission and prevention among Kaolack prostitutes. He explained I could join his team of AIDS researchers by working with the staff at the STD clinic in Kaolack, who had the most contact with prostitutes seeking medical treatment and AIDS information.

I agreed to consider his offer because I wanted my study to respond directly to the needs of local researchers, policy makers, and women facing the threat of HIV infection. A few days later I drove with a missionary friend, Miriam, to Kaolack to visit the Centre des Maladies Sexuelles Transmissibles (Center for Sexually Transmitted Diseases, referred to as "the clinic"). We introduced ourselves to the staff, then the head nurse and laboratory technician took us on a tour of the town. The tour included a visit to Ndangane, a neighborhood where many of the prostitutes work and live.

When we walked into the work place of the prostitutes, a few women who saw us approach talked briefly to the technician and head nurse, pulled their two best chairs into the middle of a

dusty, shadeless courtyard and said that Miriam and I should sit down. Bordering the courtyard were rows of thatch huts, probably sixty of them in an area the size of a square block. At the end of one row of huts was the latrine, a hole in the ground bordered by an eye-level, thatch fence. As we sat down, a crowd gathered to observe us. It was comprised predominantly of women, although some children ducked between their legs to get a glimpse of us, and some men milled around on the fringes waiting for the women to leave us and attend to them. I did not know if we were supposed to say something or not, so I looked at Miriam, who smiled in silence, expecting something to happen. I did the same, though I found it hard to smile surrounded by strangers saying things I did not understand.

As I waited and took it all in, I could smell alcohol, incense, and perfume, intermingled and intensified by the heat. I was thankful to be sitting down, as I could not focus on anything for the rainbow of colors whirling around me. I became dizzier when some of the women began to dance and sing, but kept smiling to show my appreciation for the entertainment. The women chided each other, shaking their rear-ends and pulling their long robes up to their knees so they could move more easily. One woman danced over to me, turned her back to me and shook herself a foot from my face, to the cheers of the audience. It was all I could do to keep smiling.

Suddenly, a hand holding two cold Cokes came out of the crowd. I felt relieved beyond words, but thought it would have made a great commercial. Miriam offered money to the woman who brought them, but the woman graciously declined. Miriam leaned over and told me that this was a true sign of hospitality, especially given the high cost of refrigeration and soft drinks relative to people's income.

Although Miriam kept smiling, I could tell she was as overwhelmed as I was—me by the actions and words I did not understand, and she by the actions and words she understood but had not seen before despite her ten years of teaching religion and heading development projects in Senegal. Later she would tell me she was glad to have the experience once to get a glimpse of life for the prostitutes, but only once.

When the women quieted down, the doctor and head nurse explained that I was visiting Kaolack and planned to return to conduct research on health issues. Because there had been another white female researcher in their midst in 1989, the prostitutes were used to being interviewed and said they would be cooperative. We said goodbye and drove back to the clinic. When I told the staff more about my proposed study, they said they were interested and would assist however they could. When I asked them to think about the issues they wanted to explore and specific questions they would want asked through interviews, they eagerly started writing. Before I left the clinic, they handed me their ideas. Looking at the page, I was surprised to find a long list of equipment and supplies they needed. Miriam was not.

When I returned to the United States I revised my proposal and submitted it to several funding sources. My new focus was to assess the extent to which the clinic's AIDS education campaign was reaching prostitute women in Kaolack and how various cultural factors were impeding or facilitating the transmission of HIV. With letters from Dr. Mboup and other prominent researchers testifying to their interest in this topic and support of my proposal, I was able to get funding.

COLLECTING AND ANALYZING DATA

In June 1991, a year after my first visit, I returned to Senegal with funding as a Fulbright Fellow and as an AIDSTECH (AIDS Technology) Fellow with Family Health International. I lived in Dakar for two months while I studied Wolof, spoken by the majority of Senegalese, and interviewed American, French, and Senegalese AIDS researchers about AIDS education campaigns

and the country's medical system. I visited Kaolack several times before moving there in August.

From August 1991 through May 1992, I lived in Kaolack. During that time, I conducted research through participant observation; numerous informal interviews with clinic staff, health care practitioners, friends and neighbors; focus group discussions with prostitutes; and two phases of interviews with Senegalese women. For the first phase, I held semi-structured interviews with every consenting prostitute and non-prostitute who attended the STD clinic for examinations and STD treatment during a one-month period. I also interviewed non-prostitutes, who comprised one-third of the total sample. In all, I interviewed one hundred women: sixty-eight were prostitutes and thirty-two were non-prostitutes.

The second phase of interviews included informal life history interviews with twenty prostitutes interviewed during the first phase: ten of these women were prostitutes who worked in Ndangane and ten were prostitutes who worked in bars and hotels in town. Many of these women and other people with whom I spent a great deal of time became key informants, individuals whom I interviewed formally and informally on several occasions over time to gain a better understanding of their perspectives, knowledge, and daily lives.

The questionnaire used during the first phase of interviews was divided into two main sections. The first focused on demographic factors and sought information about each woman's age, marital status, ethnicity, religion, education, living situation, number of children, and use of birth control. The second section focused on the woman's knowledge, attitudes, and practices regarding AIDS. First, however, I asked each woman general questions about social and health problems affecting her, her family, and her country to assess the issues most prevalent in her thoughts and to see if she would mention AIDS on her own. Responses indicated the prevalence of concerns about AIDS and, simultaneously, helped me assess

other areas of interviewee concern. This approach, modeled after Forster and Furley's (1988) survey on attitudes and knowledge about AIDS in Uganda, revealed interviewees' perceptions of AIDS-related risk and the degree to which concern has affected their likelihood to seek more knowledge about AIDS and to take measures to protect themselves from HIV infection.

Once AIDS became a topic in the interview (either through the woman's initiative or mine), I asked questions to assess the informant's knowledge of AIDS transmission, prevention, symptoms, and services offered through traditional and modern health care practitioners. I also posed questions such as: "What kinds of people get AIDS?" to determine who is stigmatized and why; "How is it similar to/different from other diseases?"; and "What kinds of treatment are there for it?". These data were used to place issues into domains as the women presented them (Bernard 1988:229; Spradley 1972). For other questions, I read lists of possible answers to the women after they gave an initial response to the question. This technique enabled me to determine if my perceptions were correct, to add to the list of domains, and to identify the various facets of each category.

To determine whether formal and informal channels of health care education had an impact on promoting AIDS awareness and "safe sex" activity (Wilson et al. 1988), I elicited information such as the type of AIDS, sex, and health education informants received at school and through organizations such as family planning clinics and community groups. I also asked whether they have changed their behavior as a result of their exposure to the media, traditional health care providers, and people living with AIDS.

The two goals of the second phase of interviews were to learn more about the women's lifestyles, life decisions, and world views and to elaborate on and identify additional domains. To this end, I asked the women to tell me their life

histories; to describe the most important thing that ever happened to them; to list types of things belonging to domains (such as types of clients, types of prostitutes, ways to convince clients to engage in safe sex, ways to make money, and ways to hide their work from relatives); and to discuss their roles as prostitutes, mothers, daughters, sisters, and wives.

I elicited informants' economic histories to gain more insight about circumstances leading women to engage in prostitution and other income-earning activities and to assess how they view their work and their position in society. I also requested reproductive histories to document similarities in their reproductive choices, marital patterns, living situations, and social roles.

To arrive at an understanding of issues important to my informants, I followed Spradley's (1972) model of ethnoscientific inquiry in urban settings, which is divided into five stages: hypothesizing that certain areas are culturally significant; recording a corpus of relevant statements in the language of informants; examining the corpus of statements for possible domains, question frames and substitution frames; eliciting the categories of culturally-relevant domains, which results in a folk taxonomy or native-category system for identifying significant objects in the subculture; and discovering the semantic principles of a number of domains. I incorporated these steps into data collection and analysis in order to interpret data on AIDS-related beliefs and behaviors in an appropriate cultural context.

Gladwin's (1989) method of decision-tree modeling guided my choice of questions to determine the circumstances surrounding the women's decisions on two major issues: whether to enforce condom use in various situations and how to earn sufficient income. The answers revealed the women's reasons for behaving in certain ways and, by extension, helped predict how they might act in the future. The model allows for the testing of initial hypotheses and could be em-

ployed in the designing of HIV education programs that are sensitive to factors affecting decisions about sexual behavior.

I incorporated a medical anthropological approach to the study of the Senegalese medical system, viewing it as a cultural system (Yoder 1980). As Kleinman (1978) suggests, obtaining information about the beliefs and healing activities that take place in popular, folk, and professional arenas sheds light on health perceptions and communal relations. In conducted interviews with clinic staff, prostitutes, and male and female informants in my neighborhood. The results led me to an understanding of the interactions between health concepts and healing activities at home, in the huts of *marabouts*, and in dorctors' offices. From this understanding, I was able to analyzer the place of AIDS in Senegalese belief and behavioural systems. People's ways of dealing with illness, including AIDS, are directly linked to their beliefs about illness causality, diagnosis, and treatment (Frake 1961; Ingstad 1990; Yoder 1980).

To analyze data accumulated during the first phase of interviews, I coded the women's responses to create a database of demographic characteristics and ran additional cross tabulations to determine whether personal characteristic variables explored in the first part of the questionnaire correlated with answers to specific AIDS questions comprising the second part of the questionnaire. I assessed patterns and consensus, or lack thereof, within and between the two groups.

I used these data as a frame of reference for interpreting responses to the in-depth interviews to determine the extent to which responses in the second phase elaborated on themes raised in the first. This involved identifying examples from the second phase of interviews that illustrate and explain these themes and, in some cases, shed a different light on preliminary impressions. Through content analysis of informants' responses as text, I obtained a sense of the meaning underlying the language they chose when they responded to questions, expanded on issues, recounted life histories (Agar 1980; Leap

1991) and categorized types of diseases, people, and occupations (Frake 1961; Spradley 1972).

In addition, I evaluated life histories to discern where individual circumstances and perceptions interfaced with the more general characteristics of the larger sample. I also identified specific factors that were consistent within this smaller sample. More specifically, the information from in-depth interviews with prostitutes enabled me to understand life in Kaolack from the point of view of female prostitutes in their roles as women, mothers, daughters, sisters, and prostitutes. I examined differences between and similarities among prostitutes' perspectives and those of their non-prostitute counterparts, who shared characteristics, such as age, ethnicity, religion, education, and motherhood.

To analyze the data obtained through observations, I studied the notes I took while at the clinic, conducting formal and informal interviews, facilitating focus group discussions, listening to health care lectures, attending medical researchers' meetings, and observing day-to-day events. Informal interviews with health care professionals aided me in monitoring the issues they deal with on a daily basis and the ways they attempt to effectively educate clinic clients. Material from focus group discussions with prostitutes helped me uncover areas of agreement and dissent about general health issues, preventative behavior, and perceptions of AIDS risk among prostitutes. Meetings with health care professionals in Kaolack and Dakar helped me assess how cultural factors come into play in the creation of education strategies, how health care professionals talk about the issues confronting them, and how discoveries in the clinic and laboratory translate into active strategies in the public education realm (Airhihenbuwa 1989). AIDS researchers' accounts about the changes that have taken place since the advent of AIDS helped me understand the types of societal and structural responses that have occurred during the last decade.

A PROFILE OF THE STUDY SAMPLE

To obtain a profile of women in the study sample, I accumulated demographic data to gain a sense of the diversity within the study sample, to assess differences and similarities among prostitutes and non-prostitutes, and to compare findings about women in the study sample to information about Senegalese women in general.

In terms of educational level, the number of years women in the study spent in school ranges from zero to twelve and the average among all the women is 2.3 years. Fifty-eight percent of the women had no education at all and three women had the maximum of twelve years. The majority of the women (sixty-two percent) did not speak French, the country's national language. However, one third of the women knew how to read and write; half of these women were prostitutes. This is higher than in the general population in Senegal, where eighteen percent of the women can read and write.

Economic activities were especially important in revealing the women's sources of income and their economic decisions. Within this study, all but one of the women lived in an urban setting and the majority of non-prostitutes considered themselves housewives. Of thirty-two non-prostitutes, twenty-seven did not work outside their homes and all but one who worked outside of the home were married. Approximately thirty percent of the prostitutes earned money through a second source, usually the commerce of goods such as food, clothes, perfume, and jewelry. Other work included doing laundry, hairstyling, and working in restaurants and bars. Analysis of the women's ethnicity revealed that thirty percent were Serer and thirty-eight percent were Wolof, resembling the ethnic make-up of Kaolack (Nelson 1974). These groups were followed by Fulbe, Toucouleur, Mandinka, Diola, Laobe, Soninke, and Maure. Laobe is the name of the Fulbe's wood-working class, but

members of the caste and others often referred to Laobe as Laobe rather than as Fulbe.

These demographic data indicate that the study sample represented the variety of characteristics among Senegalese women in Kaolack and reveals a general lack of AIDS knowledge among women not specifically targeted with AIDS prevention information. The sample of prostitutes is especially varied and demonstrative of the range within the group insofar as age, economic activities, ethnic background and religion is concerned. Most significant is that, despite these differences, knowledge about AIDS and reported enforcement of condom use is extremely high throughout the group of prostitutes registered at the clinic in Kaolack.

THE MAIN PLAYERS IN THIS BOOK

When analyzing the life histories I accumulated and the observations I made, I grouped the women according to the characteristics that seemed most significant in their lives and relations with their families, clinic staff, and each other. I drew on these characteristics to form the chapters of this book, which explore the ways in which the women cope with their lives as prostitutes and their fear of HIV infection. Although oversimplifying aspects of individuals' personalities and activities could diminish their individuality, many of the groupings mirror their own groupings of themselves and each other, as will become evident in the following chapters. The women's names have been changed to common Senegalese names. While specific statistics and findings of my research are published elsewhere (Lewis 1993; Renaud 1993), the stories recounted are drawn from my personal experiences while conducting quantitative and qualitative research. They have but one purpose: to give voices to the women and faces to the statistics.

The names and brief descriptions of the main players follow. I do not list all of the prostitutes, because they are introduced as the stories unfold. I also do not list the names of most clinic staff to avoid confusion and because some members are presented in a negative light; in all cases, I portray them from the perspective of the prostitutes who attended the clinic.

Michael—It was during the two months I spent in Dakar prior to moving to Kaolack that I met and began seeing Michael, the Army Attaché at the American Embassy. As my boyfriend, my anchor, and my sounding board, he became a pivotal part of my life during and following my fieldwork. When we returned to the United States we were married.

Youma—Youma, a young woman still in high school, lived around the corner from me in Kaolack. She became my friend, confidant, Wolof tutor, and a key informant on issues affecting non-prostitute women.

Ibrahima—Introduced to me by his niece, who was introduced to me by a mutual American friend who had lived in Senegal, Ibrahima was my adopted uncle and a key informant about life for married men in Senegal. A devout Muslim with several children and a working wife, he offered the perspective of someone critical of prostitutes and the men who frequent them.

Mbodj—Ibrahima told Mbodj to leave his two wives and four children in his village forty miles away in order to guard my house. Eager to please Ibrahima, who had done him many favors, and knowing the pay would be good, Mbodj agreed to help out. We became close during our many conversations in the shade of my cashew tree. He shared with me information about rural life and male/female relations from the point of view of an uneducated Muslim man and played host to Michael and me during our many trips to visit him and his family in their village.

Maria—As the better French speaker of the two nurses at the clinic (she is a nurse and the other is an assistant nurse),

Maria became my translator during the first phase of interviews. Following that she remained a close friend and informant about life as the second wife in a polygamous household.

Ibra—A former social worker at the STD clinic, Ibra offered insight about the nature of prostitution in Senegal and the stigma associated with its practice. His dedication to the prostitutes in Ndangane provided me with a glimpse of what educated Senegalese could contribute to the women's cause and the fight against AIDS.

The STD Clinic Doctor—Trained in Dakar and supported in part by Harvard University's AIDS research program, the clinic doctor was an invaluable authority on health care in Senegal and the dynamics of STD and AIDS prevalence rates. As an educated single male in his mid-thirties, he spoke to me of the advantages and disadvantages of marriage and the nature of male/female relations in Senegal.

The STD Clinic Head Nurse—An educated woman with the second-most powerful position at the clinic (the doctor was in charge of the clinic, while she was in charge of the other two nurses and made many decisions affecting the prostitutes frequenting the clinic), the head nurse informed me about the difficulty of balancing a successful career with a monogamous marriage. She also patiently explained the structure and function of the clinic and the difficulties of working with prostitutes.

The STD Laboratory Technician—The technician was corruption personified (by all accounts). He contributed the perspective of someone who benefitted from the prostitutes' situation by selling them donated condoms and arguing against attempts to train them for other professions.

The STD Social Worker—Although sensitive to the prostitutes' troubled lives and extremely knowledgeable about the dynamics of prostitution in Senegal, the social worker was reluctant to extend support to the prostitutes beyond the confines of his office. The prostitutes compared him disfavorably to Ibra, who was always eager to help them.

Fatou—Fatou was very active in promoting condom use among the women in Ndangane and was a proponent of the single lifestyle for independent women.

Khady—Of all the prostitutes, I spent the most amount of time with Khady, who volunteered her time as translator, story-teller, and close friend. Like Fatou, she was one of the leading players in the network of women in Ndangane who took charge of their lives in the age of AIDS by requiring that their clients wear condoms, providing condoms to their colleagues, and advocating on the prostitutes' behalf at the clinic and police station.

Rhama—Like Khady, Rhama was a key informant who explained the intricacies of life as a prostitute and of condom negotiation with clients.

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The Context of Women's Lives

Addressing prostitution as "behavior" and ignoring its psychosocial causes and context ... provides no guidance or insight into the long-term ramifications of the AIDS pandemic for the spectrum of personal relationships between and among men and women.

(DeZalduondo 1991)

A BRIEF HISTORY OF SENEGAL

Senegal, Wolof for "our boat" (*sunu gaal*), is located on the west coast of the African continent, and extends three hundred miles inland from the Atlantic. About half way down the coast is the Cap Vert peninsula, the westernmost point in Africa. Senegal shares borders with Mauritania, Mali, Guinea, Guinea Bissau, and the Gambia. Senegal covers almost 76,000 square miles, most of which are flat plains of savanna, stretching across the continent just south of the Sahara desert.

Senegal's primary ethnic groups are the Wolof, Serer, Lebou, Toucouleur, Fulbe (which the Senegalese refer to as Peulh), Sarakolle, Mandinka, Bambara, and Diola. Members of these ethnic groups, particularly the Fulbe, Mandinka and Bambara, also live in neighboring countries due to the arbitrary colonial boundaries cutting across ancient empires (Nelson 1974). Wolof (42%), Fulbe and Toucouleur (23%), Serer (14%), Diola (6%), and Mandinka (5%) are the five largest ethnic groups in Senegal (Nelson 1974).

As indicated above, the Fulbe and Toucouleur are often grouped together because they share a common language, Pulaar. Still, they retain cultural differences, most notably in their religious affiliation and means of supporting themselves; the Toucouleur are often sedentary farmers, whereas the Fulbe are more likely to lead a nomadic lifestyle as cattle herders. The Wolof have played a dominant role in the country's political system and their language is the *lingua franca*, spoken by eighty percent of the Senegalese (Nelson 1974). However, the Wolof have assimilated many of the characteristics of their neighboring ethnic groups, as is evidenced in their language and culture. (For additional history, see Nelson 1974 and Gellar 1982.)

Islam has played a large role in the lives of people from the majority of the country's ethnic groups and has often presented those from the lower classes with opportunities not previously available. In the eleventh century, Muslims reached Senegal and the leader of the Toucouleur converted to the Islamic faith. Most of his followers did likewise. Not until the fifteenth century, however, did Islam begin to penetrate the entire area and take on characteristics of Senegalese culture during a period of increasing colonial dominance (Creevey 1991).

The first Portuguese traders arrived in Senegal in the fifteenth century in search of slaves. Originally a local operation, the slave trade was quickly transformed into an international one. In addition to the Portuguese, the Dutch, British,

and French became active participants in the export of Senegalese men, women, and children. Until the end of the sixteenth century, the Senegambia region was the largest supplier of slaves to Europe. Still, traders continued to export slaves from Senegal and neighboring countries until the end of the eighteenth century (Gellar 1982).

The domination of the Senegalese by the French throughout the nineteenth century destroyed the existing Senegalese social, political, and economic structures. Although the slave trade ended in the early 1800's, other forms of trade took its place (Carr 1985). The most popular commodity was gum Arabic, extracted from trees and used to set the color of textile dyes in the booming European textile industry. Peanuts eventually became Senegal's primary crop, with much demand in Europe, where they were used as an oil base for soaps and cooking (Carr 1985).

In 1959, Senegal began negotiating with France for independence as a constitutional unit of the Mali Federation, comprised of Senegal and former French Soudan. The Mali Federation became independent on April 4, 1960. Soon thereafter, Senegal seceded and declared itself a republic, rendering it separate and autonomous. The Federation broke up in August of the same year. By the end of September 1960, Senegal had its own constitution and a seat in the United Nations. Led from 1960 to 1980 by Leopold Senghor, the poet-president from the Parti Socialiste, the country gained recognition as one of the most stable and least repressive in Africa. After a long period of single-party rule, a movement for a multiparty system in the 1970's produced eleven opposition parties by 1982 (Gellar 1982).

Senegal's post-independence administrations took control of the administrative structures, legal system, and police powers of the French colonial state. Instead of destroying these institutions, however, Senegalese leaders Africanized them (Gellar 1982). They divided the country, comprised of 13,000 villages, into new administrative districts, creating seven regions, twenty-eight departments, and eighty-five *arrondissements*

(wards) (Gellar 1982). This restructuring included the allocation of more power to local governments and the creation of councils that govern activities in rural areas (Gellar 1982).

Despite these advances and the maintenance of political stability, the Senegalese economy never took off after independence as predicted (Creevey 1991). The market for peanuts fell significantly and the export of agricultural products decreased. Overall industrial production was less in 1988 than in 1982. Phosphate exports, however, increased substantially, and the service sector (particularly activities related to tourism) also grew. Although tourism is now the largest source of national income, it has recently declined due to political conflicts in the Casamance. An area in the southern part of the country where beautiful beaches and national parks are located, Casamance has been a popular tourist destination (Creevey 1991).

Importantly, poverty remains a major problem in Senegal. A United Nations report ranked Senegal 112 out of 130 countries in an index of human development based on literacy, per capita income, and life expectancy. The average annual per capita income is around 150,000 francs (referred to as Communauté Français Africain, or CFA), which is approximately six hundred U.S. dollars (Pillsbury 1990:27). In 1965, life expectancy was forty years. Today, the average life span is forty-nine years for women and forty-six for men (Pillsbury 1990).

A BRIEF HISTORY OF WOMEN IN SENEGAL

With the arrival of French traders in the fifteenth and sixteenth centuries, many Senegalese women, particularly among the Wolof and Lebou people, became involved with European men who traveled for trade. The male traders lived most often on the islands of Saint Louis and Gorée. Attracted by the striking and ambitious Senegalese women known for their acuity as traders, many of the men took them as wives, adopting local marriage customs. Men who married slaves purchased their freedom as a wedding present (Brooks 1976:33). Wives of these traders were referred to as *signares*, the French version of the Portuguese *senhora*. They were respected and provided their husbands as many social and economic benefits as they received. They were regarded as excellent hostesses, and often earned income through trade of their own. Brooks reports that women who unsuccessfully tried to become *signares* may have "lapsed into casual prostitution" and contributed to the spread of STDs (Brooks 1976:34).

This is not to say that women did not already obtain positions of prestige in traditional society. They definitely did, although women's status was not homogeneous across ethnic boundaries (Gellar 1982:4). Despite scant information, Mandinka oral traditions refer to "queens" in the land that was to become Senegal. Other evidence indicates that some women, especially among the Wolof and Lebou, ruled west African villages. In addition to their leadership skills they, like the women of Saint Louis and Gorée, were known for their wealth acquired through trade (Brooks 1976). According to Gellar, women living in the Casamance enjoyed a higher status than did their counterparts up north, due to the equal participation of men and women in agricultural production (Gellar 1982).

As early as the seventeenth century, several prominent women traders reportedly resided in Rufisque, the first port and trading center established in Senegal located about fifteen miles from present-day Dakar. Later, in the eighteenth and nineteenth centuries, many female traders lived in the Senegambia region and the Upper Guinea Coast. The largest group was in Senegal to accommodate European traders in Saint Louis and Gorée, who outnumbered their counterparts elsewhere in west Africa (Brooks 1976).

Despite the success achieved by some Senegalese women, they have always been second to men as dictated by traditional, colonial, and Muslim ideologies (Creevey 1991). Some

traditional groups may have been matrilineal, but, as among the Serer, inheritance went to a woman's brother, not to her directly. Today, most ethnic groups in Senegal operate under a patrilineal system (Carr 1985).

Under European control, Senegalese political, social, and economic structures were made to resemble those in France, where women did not have a say in political issues or have the right to vote until the twentieth century. Consequently, early assimilation attempts completely ignored the traditional roles of Senegalese women as agriculturalists, traders, and, in some cases, household heads. Development projects also tailored training programs and equipment donations to the needs and work of men, who were seen as the country's sole breadwinners and decision-makers (Creevey 1991).

When Islam began to spread throughout Senegal, it sanctioned women's inferior status, but also granted them some new privileges. Changes in Wolof women's roles over the years is especially evident in written documentation and oral history (Creevey 1991). Islam granted women the right to the money their husbands gave to them at marriage (their bride price), which they could spend as they chose. They gained complete control over their own earnings. For the first time, they inherited land and property from their fathers, although they received half of that allocated their brothers (Koran 4:12). When a husband died, one tenth of the inheritance was divided among the wives and the rest was given to the children, who were expected to help support their mothers.

Under traditional Islamic law, men may marry up to four women if they can treat them fairly and equitably (Koran 4:4). A man can divorce a wife at will but should have serious cause. A woman can only be granted divorce by a court if she proves her husband irresponsible. Testimony of one man, however, is equal to that of two women (Creevey 1991).

Islam was "Senegalized" when it penetrated the country in that women were not forced to wear veils or put into seclusion. They still moved about freely, traveling alone, and dressing in bright, attractive *boubous* (loose-fitting, floor-length robes). Insofar as political and religious involvement was concerned, Muslim Senegalese women had fewer rights than their counterparts in other countries. Still, according to Creevey, Senegalese animist and Christian women were no better off socially than Muslim women (1991).

During the twentieth century, as women in France were gaining status, the French granted women in Senegal increased involvement in politics. After Senegal's independence, the 1960's and 1970's saw the creation of additional civil rights protecting women. Women were granted the right to vote, hold public office, earn equal pay for equal work, and receive any social benefits the state provided, including membership in state cooperatives.

One of the most significant reforms was the 1972 *Code de la Famille* (Family Code), which put in place protective laws for women not advocated by Muslim law. These laws allowed women to have a say in whether their marriages would be polygamous or monogamous, required men to provide a reason for divorce before obtaining a court agreement, and obligated men to provide financial support to divorced wives. However, the continuing problem is that men have not consistently complied with their legal responsibilities (Creevey 1991).

During the last decade, a number of women's rights groups have emerged in Senegal. Many prominent women have written about and fought for equality at home and in the workplace (Creevey 1991). Despite their right to hold public office at the national, regional, and local level, few women have been elected or appointed. Although women are politically active, it is usually within their own associations. Consequently, they continue to lack access to the government institutions and organizations that control the economic resources of the society (Creevey 1991).

Inequality persists at the household level. If a married woman commits adultery, both she and her partner are punished. If a married man commits adultery, he is punished only if the act took place in his home. His partner is not punished. Men also retain the right to legally forbid wives to work outside the home (Pillsbury 1990).

THE NATURE OF ISLAM IN SENEGAL: WOMEN ARE A STEP BELOW

Roughly ninety percent of Senegalese identify themselves as Muslim (Morgan 1984). Although there are vast differences between countries where Islam is observed, its fundamental tenets transcend cultural and geographic variation, and are expressed through the five pillars of Islam: declaring that there is but one God and Mohammed is his prophet; making a pilgrimage to Mecca (if financially possible); giving alms; fasting during the month of Ramadan; and praying five times a day (Nelson 1974). Muslim men are accorded many more rights than are women, whose observance is more restricted. This is evidenced by the fact that only post-menopausal women are permitted in mosques during prayer time and no women are allowed to enter the mosque while they are menstruating. Women may pray, but usually do so at home. These and other traditions are spelled out in Islam's indispensable documents: the Koran, which contains the words that God spoke through his prophet, Mohammed, and the *hadith*, which is an account of the prophet's teachings and deeds. Together, these two documents comprise the Sunna tradition of Islam, which is the only form found in Senegal (Nelson 1974).

Islam has no clergy or ordained priests. It has teachers and leaders, referred to as *marabouts* by the French and as *serigne* by the Wolof. Each mosque has an appointed chief *marabout* (*imam*), who is chosen by the community and serves for life.

Marabouts are said to be saintly men with charismatic qualities that help them acquire many followers. *Marabouts* also preside over religious functions and feasts, lead prayers, and teach the young. Some claim to have healing powers, as is detailed in Chapter Five.

One distinct feature of Islam in Senegal is the survival of many animistic beliefs and practices, which have been incorporated into religious observation. Often, people are uncertain of the origins of their traditions, confusing Islamic features with animist ones and vice versa. Thus, rather than conflicting, the two practices have meshed well in Senegalese society. Many self-defining Muslims believe very strongly in the power of fetishes, spirits, and *marabouts'* ability to alter the future.

PROSTITUTION IN SENEGAL

On August 28, 1969, the Senegalese initiated an interministerial effort to fight STDs. This was a direct response to increasing incidence and the moral implications of extramarital sex, held responsible for rapid and widespread transmission. The effort led to the creation of the National Bureau for the Battle against STDs (Bureau National de la Lutte Contre les MST) and the construction of several STD treatment centers in different regions of the country, including the STD clinic attended by the women in this study. To curtail activities leading to transmission, a law was passed in 1979 making it illegal for people under the age of twenty-one to practice prostitution. Offenders were sent to the town of Rufisque for imprisonment (Diop 1987).

Senegal's post-colonial legislation, however, was not the first government attempt to combat prostitution and control the spread of STDs, many informants told me. In 1960, just after French rule ended and the Senegalese began governing their own country, Prime Minister Maimed Dia, a "devout Muslim," became fed up with the "prostitution problem." He

ordered all prostitutes to assemble in front of the public defender's office. He also advertised that all interested single men should go there as well. When the women arrived they were told to cover their faces with veils or bags. The men were then told to choose a bride without benefit of a conversation or glimpse of her face. This done, the minister instructed the men to pay their brides one hundred CFA (about ten cents). He then conducted a brief wedding ceremony, congratulated the thousands of newlyweds, and sent them home. This attempt to "save" women from prostitution actually succeeded in giving some women a helping hand out of the profession. In fact, some of the couples are still together.

While the minister's effort was a one-time event that went down in oral history, prostitution laws have consistently inhibited some women from entering the profession. But the numbers remain high. Today, experts estimate that six thousand prostitutes work in Dakar, approximately two-thirds of whom are registered at the clinic there (Mboup 1992). Diop (1987) estimates that twelve percent of the entire group are university students, while the majority of the rest are rural migrants. Kaolack has the second largest population of prostitutes, with an estimated 3,500 who are registered or clandestine. Ziguinchor, in the Casamance region, ranks third.

SOCIAL ISSUES AFFECTING THE LIVES OF SENEGALESE WOMEN

The reality in Senegal is that women abandoned by men who once supported them frequently do not have any kind of support system, religious or otherwise. As a result, they have difficulty adjusting to single parenthood without the necessary training or education that would enable them to earn sufficient income. In the following pages I explore the issues that affect women, both prostitutes and non-prostitutes, in their daily lives

and search for social acceptance and financial security. I have drawn on the literature and on the data acquired during observations and interviews with prostitutes and non-prostitutes.

MARITAL STATUS AND CHILDBIRTH

In Senegal, marriage is viewed as the joining of two forces in its uniting of two families. True love is rarely a consideration, while potential economic and social benefits frequently are. The cultural norm is still arranged marriage for young women, but the age at marriage has increased slightly (Pillsbury 1990). Marriages usually take place among members of the same caste and ethnic group, with occasional heterogeneous marriages meeting familial approval.

It is not uncommon for a man to be much older than his wife or wives. The gap in the age of spouses increases as the husband takes on additional, younger wives. Among the Serer, for example, the average age difference at marriage between a man and woman is 10.6 years for first wives, 15.9 for second wives, and 18.3 for third and fourth wives (Van de Walle 1990).

When a couple marries, they sign a contract indicating whether the marriage will be polygamous or monogamous. More than half the marriages in Senegal are polygamous (Gueye 1992), although every woman I spoke with preferred monogamy. Prior to the marriage, the man is required to pay a bride price, usually offered in the form of gifts and money at various stages during the courting period. Often, the woman and her family gives him a list of the objects she wants. Although the practice simulates the purchase of merchandise, Senegalese women see bride price as necessary security in the case of divorce or desertion (Heath 1988). At marriage the new bride usually moves into her husband's mother's compound or, increasingly in modern times, may start a new household

with her husband and children, whom she is expected to conceive as soon as possible.

THE EDUCATION OF WOMEN

Traditionally, the Senegalese have educated fewer girls than boys, who are generally seen as needing more education to find jobs to support their wives and children. In rural areas, where many of the women in the study grew up, this still holds true because women's labor in the fields is essential for the production of subsistence and cash crops. In contrast, urban areas are characterized by a higher cost of living and scarce land. It is rare for an urban household to cultivate enough crops to support itself, and well-paying jobs are hard to come by.

Consequently, divorce among urban couples is often tragic for women, who are suddenly solely responsible for feeding and clothing their children in a large city far from relatives. Those who are not educated are doubly disadvantaged. Although some succeed at buying and selling goods, most do not have the capital needed to launch such an enterprise.

WOMEN AND WORK

Senegalese women, like many of their west African counterparts, are active traders of food, agricultural produce, and crafts. Most of the inhabitants in the region surrounding the town of Kaolack live in rural conditions where male and female household members contribute to agricultural production (Savane 1984). Fishing is also a source of subsistence and income (Nelson 1974). Livestock production, commerce, and handicrafts follow agriculture as the main sources of income, as there is little industry in Kaolack apart from a salt factory and a motorcycle and moped factory.

Women engaged in the informal sector in Kaolack are more likely to live in or near town, rather than in more remote villages. These women buy and sell produce, fish, prepared foods, crafts, and other goods. Kaolack women are known for their prominent role as cloth traders, bringing material from tax-free Gambia and selling it for substantially higher prices. Among those who have not been able to save the capital necessary to begin such endeavors or fail to keep them afloat, some are paid by wealthier households to clean house, cook, or do laundry. Others work in restaurants or factories in town.

HEALTH CARE IN SENEGAL

The Ministry of Health, located in Dakar, is responsible for health care throughout the country. At the regional level are *services de santé* (health departments); at the town level are *centres de santé* (health centers); at the local level in rural areas are *postes de santé* (health posts); and at the village level are *cases de santé* (health huts). The training level of staff and the quality and number of supplies decreases the further one travels from Dakar (Gueye 1992). In theory, the ministry supplies the regional services, which in turn supply those in town and so on, down to *cases de santé* .

Lack of equipment and medicine at all levels in all areas is the rule rather than the exception in African countries (Gueye 1992). Although limited supplies has always been a major concern, it is especially dire in the era of AIDS because it means that needles and other equipment that come into contact with blood are reused, often without the benefit of sterilization. Alcohol and equipment for boiling water are not consistently available at the lower levels of the system.

Six percent of Senegal's budget is spent on health care (Ndiaye et al. 1986). In Dakar, there is an average of one doctor per 23,000 people, while in smaller towns such as Louga, there

is one doctor for every 162,000 (Ndiaye et al. 1986). The Kaolack region boasts one hospital, six *centres de santé*, forty-nine *postes de santé* in the city, and four hundred *cases de santé* in surrounding villages (FHI 1989). The services performed and populations served vary from location to location. For example, the Kaolack hospital treats wealthier urban residents and people who are seriously ill, and is the only location in the region where delivering women may receive caesarean sections.

AIDS IN SENEGAL

Although this book focuses on prostitutes and the issues affecting potential transmission between them and their sexual partners, it is necessary to note other ways in which HIV is spread within Senegal and between countries. Because of Senegal's location on the west coast of Africa and its continued role in international trade, it is a major commercial center and destination for people traveling to and from Europe and other African countries, who contribute to the spread of HIV throughout Senegal through sexual contact with locals. Many rural migrants travel to Dakar and may become infected in the capital, spreading the virus through sexual activity when they return to their homes (Mboup 1992; Kane and Mason 1993).

In 1986, six cases of AIDS were reported in Senegal. The number shot to 425 by 1991 (Viadro 1991). The figure as of 1992 was closer to 650 and the estimated number of HIV positive individuals was 51,000, or approximately two percent of the population (Mboup 1992). The most recent data indicate there were 1,297 people with AIDS in Senegal in 1994 (Global Programme on AIDS 1995). These statistics demonstrate that HIV rates were low in Senegal and that immediate and efficient efforts to stem its spread were crucial.

As part of the country's sentinel surveillance, the blood of prostitutes, hospital patients, men with severe STDs, pregnant women, and people with tuberculosis was tested regularly. The

rates within these groups varied drastically from region to region. For example, HIV prevalence (this refers to HIV-1 and HIV-2 combined) among prostitutes was lowest in the northern regions of the country, such as Saint Louis (where, in 1989, 7.9 percent of prostitutes tested positive), increasing in Dakar (12.5 percent), Kaolack (30.3 percent), and Ziguinchor (46.2 percent), each further south than the previous location (Mboup 1992). Almost eleven percent of prostitutes tested nationally were HIV positive in 1991 (Ba 1991). In 1992, when this study was conducted, experts estimated that about forty percent of Kaolack prostitutes were HIV positive (Gueye 1992).

The number of seropositive men was also higher in Kaolack than elsewhere in the country. In 1991, the men in Kaolack who had severe STDs were tested for HIV; just over three percent were HIV positive. The rate of people with both tuberculosis and HIV infection in cities, however, was lowest in Kaolack at four percent, and highest in Dakar at almost six percent. The highest percentage of pregnant women testing positive was in Ziguinchor at three percent. Dakar's hospitals treated the most HIV positive individuals, who comprised almost sixteen percent of hospital patients in 1991 (Mboup 1992).

THE TWO VIRUSES: HIV-1 AND HIV-2

Senegal, like some of its west African neighbors, is faced with preventing the spread of two types of HIV, HIV-1 and HIV-2. Both forms of the virus suppress the body's immune system until the body cannot ward off infectious diseases, to which it eventually succumbs (Barabé et al, 1988).

HIV-1 is prevalent throughout the world and, among the Senegalese, is found primarily among individuals who have traveled outside of the country or have been in contact with those who have. The first two cases of HIV-1 infection in Senegal were discovered in 1985 (Barabé et al 1988). HIV-2 may have been present in Senegal as early as the mid-1960's, as the first infected individual was identified around 1970

through a Japanese survey in Senegal, Guinea, and the Ivory Coast. HIV-2 seems to be endemic to west Africa, occurring among individuals who have not left the western portion of the continent. Patients with HIV-2 tend to be older than those with HIV-1. This is partially due to the fact that people with HIV-2 seem to benefit from a longer latency period between infection and the onset of symptoms than do those with HIV-1. In addition, HIV-1 is eight to ten times more infectious per sexual act than is HIV-2 (Mboup 1992).

Until the second decade of AIDS, virtually all cases of HIV seropositivity in Kaolack and other locations outside of Dakar and Thies were HIV-2 (Mboup 1992). Recent statistics indicate that HIV-1 is spreading in Senegal, a fact that concerns researchers and doctors (Mboup 1992; Kane et al 1993).

Still, although researchers, clinic staff and others educated about HIV acknowledge the differences between the two viruses, prevention efforts generally do not separate the two. The primary reasons for this include the fact that the same behaviors lead to infection with HIV-1 and HIV-2 and the similar symptoms result from them, regardless of the time frame in which they occur. For these reasons, discussion of HIV prevention in this book does not differentiate between the two viruses prevalent in Senegal.

In setting the stage for exploring the impact of HIV on prostitute women in Senegal, this chapter has described the country's history, economy, religions and health care system with particular attention to their influence on women and their roles. As Farmer (1992) has shown, an understanding of a society's history and political economy is necessary to understanding the context of HIV transmission, prevention, and care. I now turn to a particular location in Senegal, Kaolack, and a point in time, 1991 and 1992, to examine the ways in which these factors have affected women today as they confront the challenges of sustaining their health and surviving economically.

2

Prostitution at the Crossroads

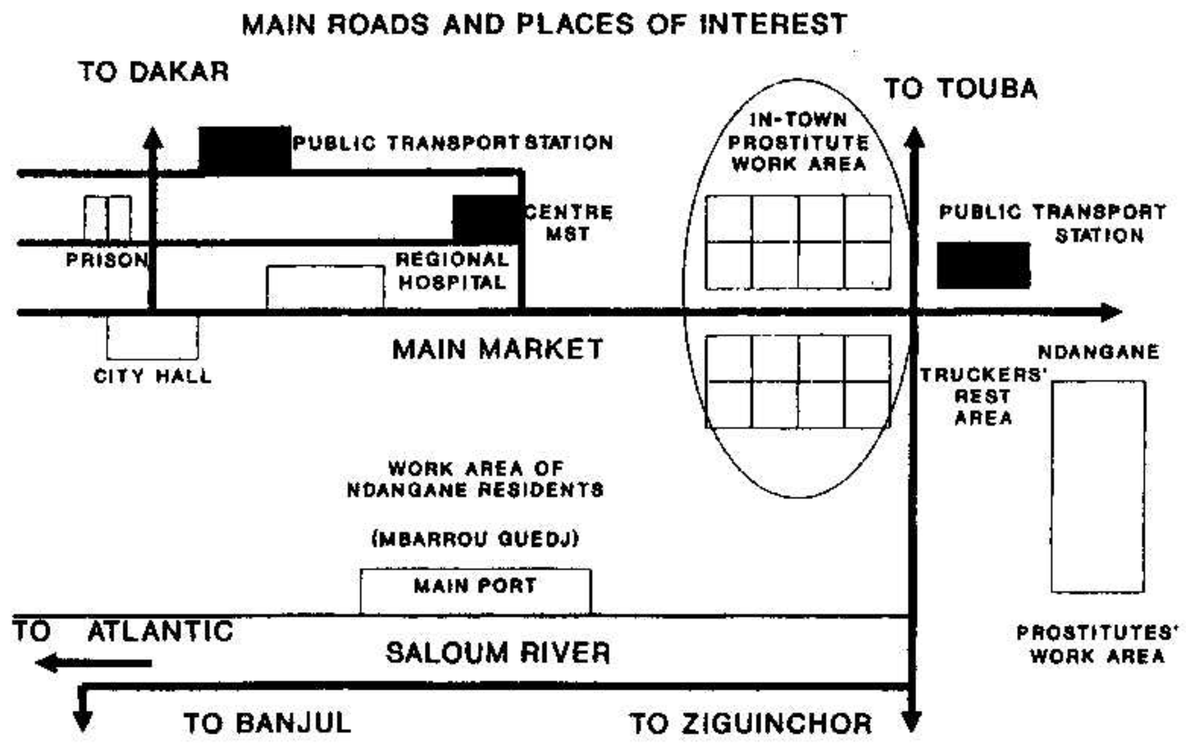
(There is a) need to understand how the macro level political economy affects sociocultural dynamics at the micro level—including the spread of disease and the social response to epidemics.

(Schoepf 1992:280)

LIFE IN KAOLACK

Kaolack is located on the Saloum River, which feeds into the Atlantic Ocean sixty miles west. Dakar, Senegal's capital and the westernmost point of the African continent, is on the coast one hundred and twenty miles northwest. In 1984 the town of Kaolack had 127,000 residents, while the region surrounding it had 1,200,000 (FHI 1989). Unlike Dakar, the "Paris of Africa"; Saint Louis, the "New Orleans of Senegal"; and Touba, the country's "Mecca," Kaolack is not a town of particular history or prestige. Mention Kaolack to a Senegalese and the standard

FIGURE 1



response is "it's too hot down there." In fact, Kaolack is most known for its heat, mosquitos, and peanut production.

Despite its negative reputation, most people traveling cross-country pass through the flat, dusty town. As one of the main intersections in Senegal, it is the junction of several national roads leading northwest to Dakar, northeast to Touba, southeast to Tambacounda, southwest to Banjul (the capital of the Gambia) and south through the Gambia to Ziguinchor. (See Figure 1 for a map of the area.) Kaolack is also accessible to many smaller cities and villages on and near the main roads. Consequently, it is frequented by rural dwellers selling crops and purchasing goods not available in small village markets. To accommodate travelers, the town boasts two public transport stations, a railroad station, a small airport, and an active river port.

As the capital of the region of Kaolack, the city has a governor, mayor, regional head doctor, regional hospital, regional

laboratory, fire station, police station, and a prison. It has two large mosques and two outdoor markets that each cover several square blocks. Many Lebanese businessmen have migrated to the area, opening businesses such as a magazine and paper store, a furniture store, an auto parts store, a grocery store, and several small restaurants. In and around the downtown area are several pharmacies and private health clinics that serve the wealthier of Kaolack's residents. A dozen night clubs and bars attract the younger crowd who congregate for dancing and drinking in crowded, dimly lit rooms. These are frequented by many of the in-town prostitutes, who, dressed in their best *boubous*, share drinks and dance to loud American and African music until finding a client, with whom they walk to one of the inexpensive hotels nearby.

Just before the road leading south to Ziguinchor crosses the Saloum River at the southern outskirts of town is the neighborhood of Ndangane ("port" in the language of the Serer). To the north of Ndangane is the heart of the city, bustling with street vendors, locals heading for the huge outdoor market, and travelers on their way to or from the nearby transport station. This lively scene is contrasted to the area south of Ndangane, a barren area marking the edge of town where the shallow river stretches toward the ocean. It is in between the transport station and the desert-like wasteland that the prostitutes of Ndangane—a group separate from the prostitutes who work in town—work and live. The location is highly symbolic of their place in Senegalese society.

Across the Ziguinchor-bound road from Ndangane is the area of Mbaaru Geej (shelters by the sea). It is the work place of the craftsmen, merchants, and fisherman whose families settled at the town's port well before colonization. In the afternoon, old men gather under the many thatch shelters to rest, talk, and drink tea. They wear wool caps despite the intense heat and chew on *cure dents* as they listen to each others' stories. A fisherman, half the teeth missing from his crooked

smile, told me a story passed from generation to generation about the days when many Senegalese were taken as slaves to Europe and the Americas. During the peak of the slave trade the Senegalese emphasis on communal solidarity was invaluable; when someone would spot a large boat approaching the port, he would alert the others and everyone would run or row to a safe distance until the purpose of the visit was determined. Too many boys and men had been grabbed up and taken away, never to be seen again.

Because of the port's activity, shelters were built to shade the many laborers and vendors who flocked to the area hoping to make money. Huts were built for lodging and restaurants constructed to feed the many men who left their families behind in villages. One restaurant owner was a woman named Sala, the old fisherman said. Likely the first prostitute in Kaolack, Sala was known as Yayi Mbaar, mother of the shelters. Men knew they could take refuge at Sala's, enjoy a good meal, and retire to her back rooms to "rest." In those back rooms Sala would join each man in private. Eventually, Sala hired other women to accommodate her growing clientele.

When the old fisherman paused, my translator, a young intellectual, began to speak. "Prostitution was started by the colonialists," he asserted. "They took something that happened normally and commercialized it. They introduced currency and seduced our women into selling their bodies. What Sala did was beautiful and natural. What has happened since then is a sin."

The discussion under the shelters turned animated and lively, the men's voices cutting through the dense heat of the afternoon. "Women have always traded sex for economic support," one old man explained. "But today it has gotten out of hand." "Those women," another remarked as he leaned in the direction of Ndangane, "those women should beg in the streets instead of sinning. They won't go to the mosque when they die. No they won't."

Although the men nostalgically appreciate Sala's cooking and other services, they do not regard women who provide such services today with the same affection. During my conversations at Mbaaru Geej and with other Senegalese men, I found that this stigmatization of prostitution, coupled with open acknowledgment that men's participation perpetuates it, reflects the attitude of most Senegalese men. Although many married men would not hesitate to visit a prostitute, they do not think twice about criticizing prostitutes for engaging in sex outside of marriage—the sin of adultery. Ironically, none of the prostitutes in the study were married, but they estimated that half of their clients were. Still, while prostitutes are ostracized for their work, clients, who can more easily conceal their involvement, are exonerated (Caldwell et al. 1992). The men in Mbaaru Geej and their families have been trying relentlessly for three decades to drive the prostitutes from Ndangane. They have shown no affection—nostalgic or otherwise—for the women during their crusades against them.

PROSTITUTION IN KAOLACK

After our fruitful conversation with the men of Mbaaru Geej, my translator, Ibra, a scholar in public health and the history of prostitution, and I walked to a local gyros stand. We quenched our thirsts with *bissap*—a sweet, red punch made by boiling bitter red flowers with cups full of sugar—while he filled me in on the events and mainstream cultural values affecting the Kaolack prostitutes over the years. I asked about the meanings of words used to describe the prostitutes and their activities. He explained that well before the advent of AIDS and media claims that prostitutes were the vectors of the fatal virus, prostitutes were stigmatized in Senegal, as they are world-wide. In Senegal, the stigmatization of prostitutes and single women is expressed linguistically. The Wolof word

caga, which originally referred to divorced or single women, is employed regularly in reference to prostitutes. Traditionally, the term described women "looking" for a husband. Looking involved going out with many men, and was accepted since it was a natural part of spouse selection.

Lacking a source of income while looking for a husband, many women asked male friends and acquaintances for money or gifts (Caldwell et al 1992; Little 1973). Ibra explained that as time went by people began to use *caga* in reference to women who were involved with several men who gave them money and material goods, whether the men were boyfriends or acquaintances associating with the women strictly for sexual relations. Eventually, the term was more commonly used to refer to women involved in the latter type of arrangement. It was adopted as the Wolof equivalent of the French *prostituée* (prostitute). *Cagatu*, therefore, is defined as the act of being a prostitute. However, Ibra said, the phrase *danga caga*, translated as "you have prostitute," means "you are attractive" and is used to compliment men and women.

Today, women react negatively to the word *caga* because it implies involvement in prostitution rather than divorce. Prostitutes do not use it to describe themselves. Instead, they speak of their work and colleagues in vague terms, referring to other prostitutes as "women who have cards." These cards show that they have registered as prostitutes with the police and STD clinic. When a woman does use *caga* in reference to a single female, she does so in either a joking or accusatory manner. When describing themselves, divorced women say *dama fasse* (I am divorced) rather than using *caga* in its original sense. Meanwhile, health practitioners are making efforts to find more neutral words to refer to prostitutes. The Wolof phrases *rafetu gudi* (beauty of the night) and *jigeen bu mbedd* (woman of the street) and their French counterparts (*belle de nuit* and *femme de la rue*, respectively) are increasingly common euphemisms.

Ibra explained that the stigmatization of prostitution is also apparent in the Senegalese people's outward treatment of women defined as *caga*. In the late 1950's, the prostitutes lived in Fangol, a residential area in Kaolack. When Fangol residents complained about the women, police began patrolling the area regularly. One night, an argument broke out between a client and a policeman. The dispute turned violent, and the client killed the policeman. The next morning, the police burned down the prostitutes' huts for revenge. Only the Diola palm wine salesmen, opted to stay and rebuild their makeshift bar. The prostitutes relocated to an uninhabited section of Ndangane. Known as the *syndicat*, the area earned its name as the location where craftsmen traditionally congregated to sell their wares. Because it was vacant at the time, the prostitutes reasoned that they too could sell their wares there.

The prostitutes built huts in the empty dirt lot bordering the paved road to the Gambia and agreed to pay rent to a Ndangane resident who said he owned the land. They also paid local homeowners for rented rooms in their housing compounds in the residential area separated from the *syndicat* by a wide dirt road. Together, the two areas are referred to as Ndangane.

The prostitutes' presence in the residential area has brought economic gain to their landlords as well as to the people who cook for them, do their laundry and sell them household goods, jewelry, and beauty products. These people are glad to have the women there. However, other residents, including the Serer fishermen and their families, have fought to have the prostitutes removed ever since their arrival. Through the years, these residents have set fire to the women's huts, beaten and kidnaped women, and summoned police assistance in attempts to scare the women away. In 1987, for example, several teenagers became angry with the lack of response to a letter they wrote to Senegal's president and set fire to the prostitutes' huts. The police arrived, showered the youth with tear

gas, and imprisoned more than thirty of them for a month. The teens and their parents remain bitter because the prostitutes were defended rather than punished.

THE RIGHT TO PRACTICE

According to current Senegalese law, the prostitutes have the right to police protection. Although the primary purpose of the legislation was to decrease prostitution and the spread of STDs, women who register with the local police and a health care clinic and make semimonthly visits to the clinic are entitled to practice in peace. In fact, although the strict laws requiring registration have succeeded at discouraging some women from entering prostitution, they have also provided a significant service to the women who have registered. With the advent of AIDS in the early 1980s, Senegal's health clinics were in the ideal position to inform prostitutes about the virus, to test them for infection, and to encourage condom use by providing the women with free condoms. Also, drawing on the pre-existing structure, foreign researchers and donors have collected blood samples and monitored the prostitutes' health since 1987.

THE STD CLINIC'S AIDS PREVENTION EFFORTS

One clinic that responded quickly and efficiently to the threat of the pandemic is the STD clinic in Kaolack, founded in 1976. Given the town's location at the crossroads of the country, the high rate of HIV infection among the prostitutes there warranted drastic measures. Clinic staff recognized that efforts needed to be made to prevent transmission of the virus between various groups, including truck drivers, migrants, local clients, prostitutes, prostitutes' boyfriends, and partners of members of these groups.

When I arrived in Senegal the clinic was approaching the end of a two-year AIDS education campaign for its 258 registered prostitutes. The effort consisted of semimonthly presentations on AIDS and other health issues. The clinic staff led lectures and encouraged the prostitutes to discuss issues, ask questions, and request presentations on topics important to them. For convenience, these presentations were held after office hours in an old room in the clinic building. With small windows and broken fans, the room was suffocatingly hot when filled with seventy people, half of whom stood in the back due to a shortage of wooden benches. The staff showed video tapes on the few occasions that the tapes arrived on time from Dakar, the video machine was operable, and the only television was not in use elsewhere. During most meetings, however, the room was filled with lively discussion about coping with AIDS, caring for people living with AIDS, and dealing with neighbors who continually menaced the prostitutes. This open forum reflected the Senegalese emphasis on community and shifted some weight from the health care givers to the recipients, who had grown tired of having little say in their lives.

The safe sex messages imparted by clinic staff also appealed to the interests and sensitivities of the prostitutes. Information about AIDS prevention was couched in philosophical debates about the implications of spreading HIV to loved ones and unborn babies. The concept of sin—so significant in Senegalese life—was incorporated into discussions about the result of unsafe sex. A woman who knows about AIDS but exposes herself and others to the virus, repeated the staff over and over, is indirectly committing murder—an unpardonable sin.

These messages, coupled with the distribution of free condoms to prostitutes at the presentations and during their semimonthly examinations, made Kaolack's education campaign a potential model for other projects in the country. Not only did my interviews reveal the prostitutes' retention of AIDS knowledge and willingness to change their behavior

and risk losing valuable income by refusing unsafe sex, their STD rates dropped substantially in the years following the program's 1989 inception. In addition, their reported use of condoms with clients doubled from forty-nine percent to over ninety-eight percent. While it cannot be determined if the drop in STD rates is directly attributable to the campaign or that reported condom use necessarily reflects actual use, both findings have positive implications. The former indicates that exposure to STDs had declined for some reason, whether due to decreased prevalence or due to increased protection. However, the fact that rates among non-prostitutes remained stable, according to clinic staff, increased protection seems a likely contributor to the decrease. Even though the finding regarding increased condom use could not be verified short of direct observation, it indicates, if nothing else, that the women understood the messages conveyed by the clinic and knew how to answer related questions. Knowledge is the first step, though not the only step, required for behavior change.

But the added fact that the women reported less frequent condom use with their boyfriends—reported use rose only fourteen percent during the same time period—indicates the women were not whitewashing their answers even though they knew clinic staff hoped to hear their use had increased. For obvious reasons, this finding was cause for concern because it pointed to the need for interventions with boyfriends and a breakdown in women's efforts to enforce safe sex behaviors. The clinic staff responded to the discovery by meeting with boyfriends in neutral locations to educate them about AIDS and condom use. Staff also focused on the issues during presentations for the prostitutes in hope of convincing them of the risks. Staff held that the disparity in the rate of the women's condom use with clients and boyfriends reflected the nature of relations between prostitutes and their boyfriends, with whom they said protected sex was not necessary because they were not strangers and could be trusted. Importantly, many of the women

feared their boyfriends would refuse to use condoms and would become angry with the women for implying the men might be infected with HIV or another STD. Thus, although the women intellectually understood the risks of unprotected sex with any man, including boyfriends, they were willing to take the chance with their boyfriends because they did not want to upset or lose them. They also wanted to believe their partners when they said they were healthy and faithful.

INTRODUCING THE *TOUBAB*

The day I arrived in Kaolack I attended one of the final AIDS presentations at the clinic. I felt small and intimidated when I peered into the room of Ndangane prostitutes, who looked nothing like the image one conjures of women in their profession. They were all shapes and sizes, with an average age of forty-six. No tight-fitting or revealing clothes for these matrons; they wore bright, multi-colored *boubous* and matching cloth wrapped around their heads and tucked over the top to cover their hair.

As I walked in, wearing a knee-length, pastel plaid cotton dress over a white tee shirt, I did not know where to sit. Should I sit up front on one of the few chairs reserved for clinic staff to establish myself as a staff member? Should I squeeze onto one of the wooden benches with the women to show I want to be seen as one of them? Or should I stand in the back to show that I do not want to be a distraction? The staff doctor motioned that I should take a seat near him. I pulled the chair toward the side wall to separate myself from the clinic staff and the prostitute audience so I could watch both simultaneously. Once seated, I instinctively propped my right ankle on my left knee, forming a triangle tented by plaid cloth. Used to wearing jeans, it took me a minute to realize the position did not work well in a dress. My female Senegalese friends in

Dakar had teased me for sitting in this distinctly American way. I quickly dropped my foot to the floor hoping nobody noticed. Exposing breasts is accepted, but exposing legs is not, nor is exposing the bottom of one's shoe, considered an insult in Muslim societies.

The doctor was silent as he waited for the rest of the staff to join him. I took a deep breath to compose myself. Being in that room seemingly in the middle of nowhere was one of those experiences that knocked me on the head and said "this is not a dream, you are here." Some of the women made eye contact with me and smiled before turning back to their friends. Others seemed not to notice me at all. Their gossip and laughter comforted me in its resemblance to family events and celebrations in which I would not take part for more than a year. Each time a woman walked through the door the room's occupants acknowledged her by saying her last name and asking how she was doing. "I am here only," each woman would respond—meaning that she is fine—as she squeezed onto a bench or walked to the back of the room to stand or lean against the wall.

Finally, three women and two men, all staff members, walked in and took their seats. The doctor tried to get the women's attention. When the conversation quieted to a low murmur he introduced me. His explanation of the *toubab*'s (white person's) presence was frequently interrupted as latecomers entered the room and the greeting ritual was reenacted; it would have been rude of the audience not to acknowledge each woman as she joined the meeting. In fits and starts the doctor explained that I had come to conduct research on the influence of AIDS on their lives, that I would be a staff member for ten months, and that they were to give me their full cooperation throughout my stay.

"She is a friend of Mary Lee's," he said poignantly, and the audience nodded and whispered in understanding. Mary was the American medical student who conducted interviews with the women two years earlier at the beginning of the AIDS education campaign (Lee 1989). Although Mary and I had spoken only once by telephone, connecting my name to that of someone the staff and prostitutes already knew and trusted helped subside concern about my presence and credibility. Fanning myself with my note pad as the doctor continued, Mary's words of advice echoed in my head. "If I were you I'd go somewhere else. Have you been there at the peak of the dry season?"

It was too late to go elsewhere and I felt confident that I was meant to be in Kaolack with this group of women. The country's leading AIDS researcher had advised me to go there to document the "culture of prostitution" and to evaluate the effectiveness of the AIDS education campaign targeted at this group of at-risk women, my study was well-defined, the findings would be useful in-country, and I would be working closely with women. All these factors were important to me and outweighed the negative reactions of people who had spent time in the Kaolack heat.

When I drifted back to the conversation, the women were raising a pressing question: "What is her Senegalese name?" I said that I did not have one, although my Dakar friends had suggested a few. Someone shouted "Coumba!" and everyone agreed. I liked the sound of it. Then came the more important question: "What will her last name be?" From the packed room came shouts of common Senegalese last names, each woman suggesting a different one. Knowing that names were tied to ethnicity and about choosing one over the others, I chose Sow, Uncle Ibrahima's last name.

Ibrahima Sow is a prominent agricultural researcher in Kaolack who, in adopting me as his "niece," found me a house, helped me order furniture, and let me stay with his family for the first few nights while my house was being painted. In the meantime, he sent a messenger to the countryside, telling one of his former house guards, Mbodj, to report to Kaolack the following day to guard my house. Ibrahima and the clinic staff insisted that, as a single white woman, I

should have a 24-hour guard to protect me and my belongings. Although there did not seem to be imminent danger, this was a precaution taken by most foreigners and wealthy Senegalese to discourage potential thieves. Ibrahima also spoke to a friend of his who lived around the corner from my house and, without my knowledge, asked if his daughter, Youma, would be my friend and Wolof tutor. When she offered to be my tutor I was surprised and excited.

Such hospitality stemmed from the fact that I was an acquaintance of Ibrahima's niece. She was engaged to an American acquaintance of mine, who asked if I would accompany her to the U.S. embassy, where she was having trouble getting a visa to move to the United States. I had just begun dating Michael, who worked at the embassy, and asked if he would ask the consulate about the status of my friend's visa. Her visa arrived a few days later and within weeks she was reunited with her fiance. Connections are everything, I thought.

"Sow?!" the women laughed and cheered. With that name I became a Peulh, or Fulbe, an ethnic group known for cattle raising, selling dairy products, and, unbeknownst to me, their supposed proclivity to prostitution.

When the meeting ended several women shook my hand as they left the conference room. In hesitant Wolof I told them I was glad to be there. I helped them straighten the room then said goodbye. I walked outside into the courtyard surrounded by decrepit, off-white buildings housing the dispensary's many offices. I leaned against my car and watched the women disperse. While some piled into taxis, others walked down the dirt road to one of the town's few paved roads, perhaps to hitch a ride or catch a bus. They would all eventually reunite in Ndangane, where they would gather to discuss what they learned at the presentation and how it affected them.

I looked at the dispensary and wondered how healing could take place within its walls. The paint was peeling, the floors

were stained, the electricity failed regularly, and the only technological equipment available was that provided by Harvard University for the STD clinic's AIDS research activities. There were always more patients than could be seen on a given day, some of whom would never be seen because they could not afford the twenty-five cent entrance fee. Wealthier patients were more likely to go to the only regional hospital or one of several private clinics, where they would get better care and more personal attention for a higher fee.

Next to the STD clinic was the dentist's office. To the right was the family planning clinic, and beyond that the public latrine: two stalls with holes in the cement floor and a hanging knob that occasionally responded to a pull by flushing water into the holes. Across from the latrine was the pharmacy. Patients stood in line outside waiting their turn to talk to the pharmacist through a hole in the wall. Catty-corner from him was the general clinic, where adults waited on uncomfortable wooden benches to see a general practitioner. One of the clinic's three practitioners was also the director of the dispensary. He lived in one of the rooms upstairs, next to the dispensary janitor and his wife. I looked up from the courtyard and saw the doctor, who was observing activities from his balcony while talking to someone on his cordless phone. I did a double-take; it struck me that such high-tech equipment could be found amid such poverty.

To the left of the director's office was the pediatric and vaccination clinic, from which rang children's cries of pain as they were given injections. Not far from there was the adult inpatient room, quiet and dark, with its half-dozen beds occupied. At the end of the hall was the maternity ward, where the mothers were quiet and the babies loud. Hearing a baby cry, I walked over, eager to see new life. He was extremely small and light brown. His mother held him, looking content but not particularly happy. Her labor had been short and, like a courageous Senegalese woman, she had not shown her pain

despite the lack of anesthesia. She would stay there with him that night then return to her village the next day because she and her son appeared healthy. In a few days she would resume her work in the fields.

The small, windowless room's walls were eggshell white, peeling and stained with spatters of blood and other body fluids. One bare light bulb hung from the ceiling. The new mother lay on a bare metal table. There was blood underneath her, and a trail of red leading from the table to the counter where the just-used forceps awaited cleaning. Two other forceps were ready for the quiet women lying on tables flanking the new mother. The instruments, which were the only instruments in the room, soaked in cold water. Three forceps for three tables, while other women in the first stages of labor waited their turn in an adjoining room. If the babies needed to be delivered before the tables were vacant, a nurse's assistant would start delivery in the waiting room, running to the delivery room to grab a forceps if one was available. If one was not, she would go without. Going without is a common activity in Senegalese life, and it accounts for people's amazing resilience and resourcefulness.

I walked back to the STD clinic and ran into the doctor on his way out. He was several inches over six-feet tall, with a quick smile, deep voice, and crossed-eyes. Trying not to look distracted, I wondered how this affected his vision and spatial perception. He asked if I wanted to join him for dinner. I accepted, reminding him that I am a vegetarian and did not want to inconvenience or insult him. He said there would be plenty of vegetables in the *mafe* his cook was preparing. Since most Senegalese dishes were made with fish or beef, I was growing used to picking around the meat and ignoring the fact that the sauce contained animal juices. In fact, I was at the point where I often craved *mafe*, with its peanut sauce, carrots, manioc, potatoes, miniature green pumpkins, and chunks of beef poured over short-grained rice.

I knew my way along the dirt roads to his apartment because I had visited on earlier trips from Dakar. The second-floor apartment was comfortable, with two bedrooms, a kitchen, and a common area with a glass dining table and mattresses on the floor for lounging. They were also used for sleeping when the apartment was crowded with the doctor's many boyhood friends who grew up in his village outside Kaolack. The only drawback was the constant buzz of flies and mosquitos that entered the room through holes in the window screens. They swarmed inside at meal time, drawn by the scent of food and humans.

Two of his boyhood friends, who had been staying with him "temporarily" for more than a year, joined us at the table. Three of us ate out of the communal bowl with spoons. The fourth used his hand to make balls of rice, which he popped into his mouth with impressive ease. I had not yet mastered the art of making rice balls single-handed, and did not want to practice in front of them. The men helped me out by taking beef from my quarter of the bowl and substituting it with vegetables from theirs. When I felt full, I put down my spoon. They were surprised that I ate so little. I said that the food was very good, but I had eaten enough. They told me that I was too thin, insisting I should eat more so I would look like a Senegalese woman, large and shapely. I was beginning to like this place.

The men finished the contents of the bowl, my section included, and sat back to relax. The cook brought out a teapot and four shot glasses. The doctor went through the ritual of mixing several cubes of sugar with the brewed tea, pouring it skillfully from a foot above each glass, and passing liquid from glass to glass until each was full, capped by an inch of foam. The men lifted their glasses and drank the entire contents in a few successive gulps. The tea was too hot for me, so I sipped it. Seeing that the cook was waiting for me to finish so she could start the second round, I drank it quickly, hoping no one noticed me wince. She then brought the second round, which was

sweeter and mellower than the first. The doctor had just poured the third and sweetest when someone knocked on the door.

It was the dispensary janitor, who had come to announce that one of the doctor's patients was ready to give birth. Normally the obstetrician would have overseen the delivery herself, but the patient was suspected of being HIV infected and it was the doctor's responsibility to take a blood sample from the umbilical cord and sterilize the forceps after use. They were taking these unusual precautions because the doctor had recently treated the woman's husband for apparent AIDS-related symptoms, but still did not know his status because the test results had not arrived.

I asked the doctor if I could join him and he agreed, swigging down what remained of his tea. He asked the janitor if he had the keys for the STD clinic laboratory, where the dispensary's only sterilizing oven was located. The janitor said he had given the spare to the lab technician, who lost his set. The doctor and I drove to the technician's house to fetch the keys while the janitor returned to the clinic. The technician's wife greeted us and said her husband was in the neighborhood performing a circumcision. He was not trained, but had taught himself the procedure so he could make more money. I already knew of his activities because Maria, the nurse who translated for me during interviews, had illustrated the technician's various money-making schemes by grasping invisible money from the air and putting it into imaginary pockets. She clearly disliked him, as did the prostitutes, I would find out later. His wife offered us tea while their daughter went to find the technician. We declined graciously, explaining we had just finished. We sat in bamboo chairs in the shade of the cement courtyard and waited. Their three-year old daughter emerged from one of the stucco rooms and walked up to me slowly. I held my hand out to her. She touched it with a finger then jumped back, expecting something to happen. When nothing did, she touched me again. I took out my note pad and drew a

cat. She identified it in Wolof, and I learned a new word. I drew a happy face and she smiled.

The technician arrived with an air of importance, impromptu medicine kit in hand. The doctor explained the situation and the technician said he was ready to go. I wondered why he could not just hand the keys to the doctor, but did not ask. Much later I learned the importance of responsibility and control to staff members; the laboratory was his domain, so he wanted to be there, even if only to turn the key. We drove to the clinic and I parked in front of the maternity ward. The technician went to prepare the lab, while the doctor and I went into the delivery room. Only the middle metal table was occupied. It was the STD patient—a young, attractive woman who was so small that in another setting I would have not guessed her pregnant. The doctor shook her hand and I greeted her from a distance. Because she did not appear to be having contractions, I walked outside to get some air.

Only a few minutes passed before I heard the baby cry. I was amazed at how quickly the small woman had given birth and walked in to see for myself. The obstetrician held the baby boy while the clinic doctor, who had donned rubber gloves, inserted a needle into the umbilical cord. It took several tries before he was able to get enough blood. I started feeling a bit queasy, but the mother and baby were too tired to be bothered by the doctor's activities.

The doctor thanked the obstetrician and promised to return the needle and forceps within an hour. He took them and the blood-filled test tube to the laboratory and gave them to the technician, who labeled the blood and stored it in the refrigerator until he could find a way to transport it and dozens of accumulated samples to Dakar for testing. He then put the needle and forceps into the oven and set the timer for an hour. I remarked that it was lucky the forceps would not be needed soon. Both men agreed, but they had accepted the limitations in their country and no longer worried themselves with what-ifs.

I looked around the laboratory, a small room divided down the middle by a white tile counter. The walls, like those inside most Senegalese buildings and homes, were sky blue, decorated with posters illustrating the ways in which AIDS is transmitted. Two large, graphic photographs of men's and women's genitalia infected with STDs hung at eye level. I looked away and took note of the donated equipment: two microscopes, two sinks, a large refrigerator, a large sterilizing oven, and a small sterilizer. In the many cupboards were test tubes and disposable needles, all sent for AIDS surveillance activities.

After forty minutes, when the technician and doctor decided the oven contents were sufficiently sterilized, the technician removed the contents with a hot pad. He took them to the obstetrician then met the doctor and me at my car. I dropped off the doctor at his apartment, then drove the technician to a house where he was scheduled for another circumcision. He asked if I could wait to give him a ride home. I said I could not. I drove home to Uncle Ibrahima's, where I drank *bissap* and watched a soccer game with him and his three sons. His wife, a nurse at a family planning clinic, and their two daughters were rarely in the common family room when I visited. When the game was over I walked outside and down the stairs to the guest room. I waited for the night guard to finish in the bathroom, then washed up. I went into my sky blue room, locked the door, sprayed for mosquitos, turned on the air conditioner, and wrote in my journal until I fell asleep. The two-inch foam mattress and low, wooden bed was surprisingly comfortable, although I always stumbled getting up in the morning, forgetting how close I was to the concrete floor.

I moved into my new house on a Friday, so Michael drove the nearly three hours from Dakar to spend my first night there with me. The electricity would not be turned on for a few days, but I wanted to unpack and get settled before I started full-time fieldwork that Monday. Michael brought candles, mosquito repellent, cheese, fruit, peanut butter, and

French bread. We picnicked on my relatively thick foam mattress—the only furniture in the house—and listened to the sounds of Senegal: drums, donkeys, goats, social gatherings, and Mbodj's footsteps as he patrolled the yard.

On Saturday we drove around town picking up supplies and scouting for places of interest. Anxious for a sense of privacy and some protection from the sun, I bought material at the market place and took it to Ibrahima's tailor to be made into curtains. On the way, we drove by the clinic so Michael could see my new place of work. His first thought was that the dispensary buildings were abandoned. The janitor let us into the offices, and their sparseness and age did little to change Michael's first impression. It was then that I realized that after only a few days in Kaolack I was noticing such details less and less.

STRUCTURE AND FUNCTION OF THE STD CLINIC

On Monday morning I waited excitedly for the social worker to arrive at the clinic. He had promised to explain his filing system to me so I could begin going through the prostitutes' records to learn about them and decide how to choose a study sample from the registration roster. During the following months I gathered information about the women and Senegalese culture by examining the women's files, conducting formal interviews with the women, and having informal conversations with clinic staff and male and female friends. In all, I interviewed sixty-eight prostitutes and thirty-two non-prostitutes from the beginning of September through mid-October.

To gain an understanding of the culture of the clinic, I analyzed the clinic's structure and function, including the staff duties and relationships with the prostitutes who visited for semimonthly health examinations and with *externes* (the staff's term for men and non-prostitute women who visit the clinic for STD diagnosis and treatment because they are external to the

program). The STD clinic had one doctor, one head nurse, one nurse, one nurse's aide, one social worker, and one laboratory technician. The technician had an assistant who was paid with the money the dispensary charged each patient for diagnosis and treatment.

The head nurse, nurse, and nurse's aide examined all female STD patients and pregnant women with health problems. The nurse listed the names and conditions of the prostitutes in a record book and wrote comments about the women's health in their files. She also entered the names and ages of *externes* in the record book, while the head nurse wrote monthly reports documenting the number and nature of the STDs they treated. When an *externe* tested positive for an STD the doctor or head nurse counseled him or her about the illness and the danger of unprotected sex, explaining the threat of AIDS. Each patient was encouraged to bring in his or her partner for STD testing and treatment to avoid reinfection.

The doctor examined patients with very serious or unique illnesses. He also interviewed newly registered prostitutes to gather demographic and health information, which he recorded on questionnaires provided by Harvard University. The staff were supposed to update these questionnaires every six months when they drew the prostitutes' blood for surveillance of seroprevalence rates, but many of the records were incomplete.

The social worker kept track of the women's files and was responsible for counseling them when they had social problems. When new prostitutes registered, he discussed their decision with them and started their files. He and the doctor had recently begun to introduce the topic of AIDS to women signing up for the first time. They also asked each woman to sign a form giving consent for AIDS testing.

The laboratory technician tested all genital cultures, saliva, and blood for illnesses other than HIV. He extracted cultures from the men, while the nurses were responsible for the

women. The nurses also took blood from registered prostitutes during their thorough examinations every six months, from STD patients with severe STDs, and from patients referred by other doctors who suspected HIV infection. The technician sent the blood to Dakar for HIV testing. Dakar clinic staff then sent select blood samples to Harvard University and the World Health Organization (WHO) within a few weeks. The results of the prostitutes' tests were usually sent to Kaolack after a few months, while those of other STD patients seldom made it to Kaolack unless staff made several requests.

Each prostitute was expected to visit the clinic every two weeks for a short visit, during which a nurse inserted a speculum into the woman's vagina to look for symptoms of STDs. Such visits took place every day of the week. If the nurse saw nothing abnormal, she gave her patient twenty-eight free condoms and told her she was free to go. If the nurse suspected an illness, she took a culture and sent it to the laboratory while the prostitute waited for her test results. If the prostitute tested positive for an STD, the nurse held her registration card and gave her a prescription. If the medication were available at the clinic, the nurse would give it to the prostitute for free. If the medication were a gift that the nurse received from a medicine salesman, she might ask the prostitute for some money in return. If the medication were not available at the clinic, the woman could request it for free at the dispensary pharmacy. If not in supply there, the woman would have to go to a pharmacy in town, where it was very expensive. She could not practice prostitution legally while waiting for the medication to cure the STD. After four or five days she would be tested again, receiving her registration card only if cured.

When menstruating, prostitutes left their registration cards at the clinic. This was difficult for them because it meant they would not make any money until cured. However, clinic staff emphasized the importance of this rule in the era of AIDS,

especially because the presence of blood increases chances of HIV infection during sexual intercourse.

Every forty-five days the prostitutes' visits were long visits, which required that they undergo a physical examination and have laboratory tests done. These took place only on Mondays, Wednesdays, and Fridays. The women arrived around nine or ten o'clock in the morning and did not get their laboratory test results until three or four. If their results were negative they were given their registration cards and free condoms. If their results were positive they could not have their cards, but were given a prescription to cure their STDs.

The wait for test results was long because the laboratory technician and his assistant took lunch breaks from one o'clock to two-thirty regardless of the workload. The women usually waited in the large room used for presentations or went into town for a few hours. Some clinic staff went home to eat, but most of them ate together in the main office. The head nurse's family usually sent over a large bowl of *ceebu jen* (rice and fish) and the staff pulled chairs around the communal bowl, propped on a chair, and ate with their hands or large spoons.

Understanding the relationship between clinic staff and the two groups of registered prostitutes (those who worked in town and those who worked in Ndangane) was crucial to understanding the context in which the prostitutes reacted to the threat of AIDS in their daily lives. The most striking feature of their interactions was the staff's ability to be simultaneously supportive and critical of the prostitutes, who appreciated the assistance but strongly resented the long waits and perceived mistreatment by staff, some of whom they described as judgmental and controlling. Similarly, understanding the distinct economic, social, and psychological factors affecting the two groups of prostitutes was salient in understanding the issues surrounding the women's attitudes, behavior, and perception of their work, themselves, and their place in society. The

dynamics of the prostitutes' daily lives are described in the chapters to follow, in which I focus on life for Ndangane prostitutes while reflecting on episodes from my daily life in their neighborhood, encounters with clinic staff, and conversations with prostitutes who worked in town.