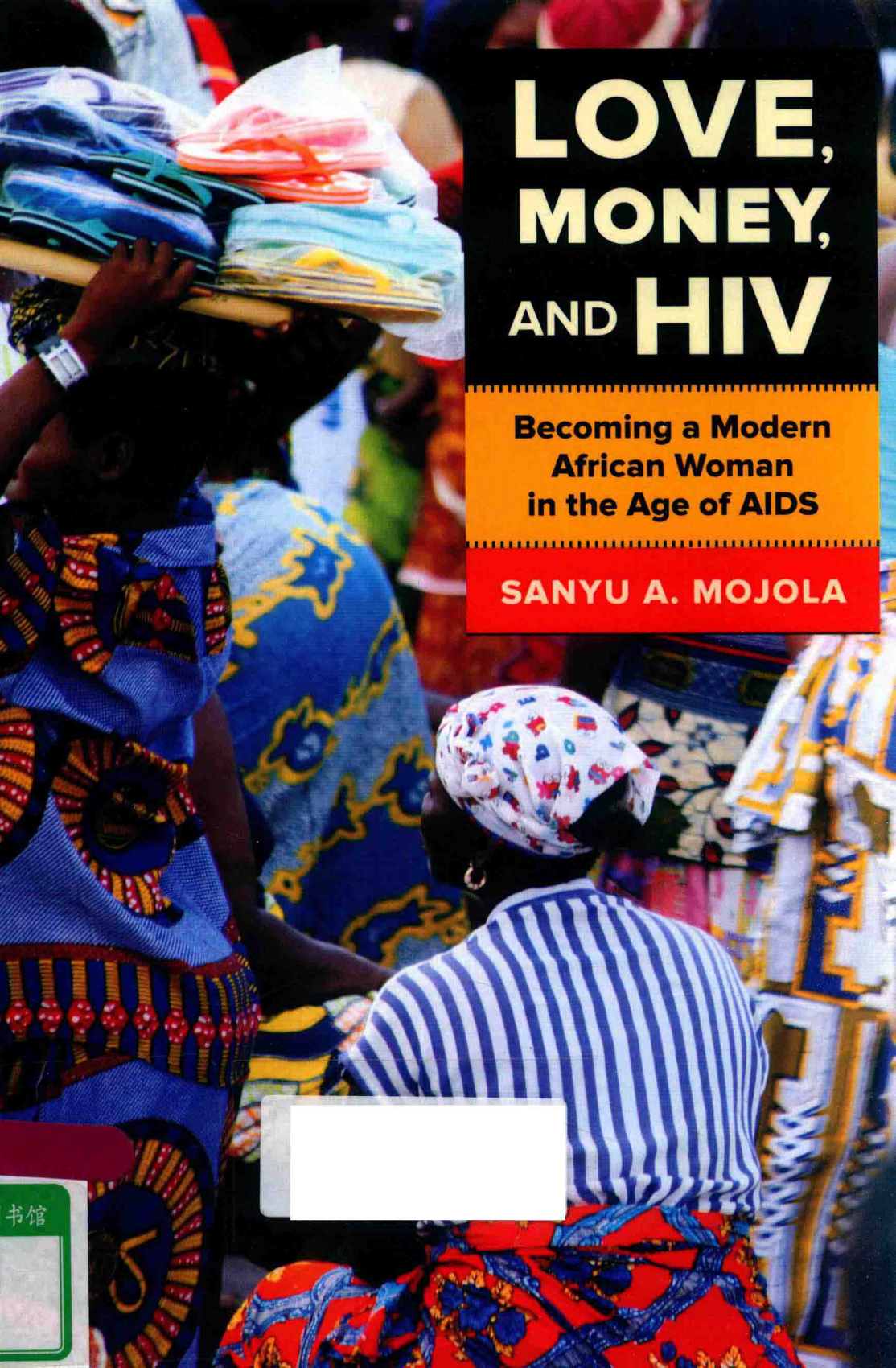
LOVE, MONEY, AND HIV
Becoming a Modern African Woman in the Age of AIDS
SANYU A. MOJOLA

Love, Money, and HIV

BECOMING A MODERN AFRICAN WOMAN IN THE AGE OF AIDS

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Love, Money, and HIV

To Papa, Mummy, Luka, and Wanga, for loving, encouraging, and believing in me.

To Kukhu Yuniya Aluoch and Jajja Gertrude Kiyingi, my grandmothers, two amazing and inspiring women. I am grateful to have reached this far in my education during their lifetimes, and that they have lived long enough to hold this book in their hands.

Preface

Becoming ill is not just a random event. I still remember sitting in David Byrne's Sociology of Health class while pursuing my undergraduate degree at Durham University in the north of England and being struck by that revelation. As the class progressed, there were more. Sociologists, demographers, and epidemiologists, I learned, could *predict* which groups of people in a given society would get sick and which would die early. Further, there was often a highly organized social-structural pattern to disease and mortality, above and beyond seemingly random and idiosyncratic individual choices—about who to love, or where to work, or which tap to collect water from—that led to illness and death. Coming from a continent plagued by one disease after another, I found these ideas revolutionary. In the decade and a half that followed, these ideas began to shape how I saw and understood the HIV/AIDS epidemic in Africa, and how I thought about how to end it.

When I graduated from Durham and returned home to Dodoma, Tanzania, where my family and I lived at the time, I interned for a few months at the AIDS control agency of the Anglican Church of Tanzania, under the program officer Neema Peter. The experience was both revealing and frustrating. It was revealing to see that most of our clients were

women, who were processing the outcomes of HIV tests without any hope of treatment, and to see the gaps that existed between knowledge and behavior. It was frustrating to realize that while the one-by-one, community-by-community approach was vitally important, the problem of HIV/AIDS in Africa, and among women in particular, required an approach that would help *millions.*

It was partly impatience—for a structural approach, for something that would help the millions—that led me to apply, with my father's encouragement, to graduate school in America (where funding was available for graduate students), to take up the fellowship that the University of Chicago offered, and to stay through the long and grueling years that followed in dogged pursuit of my doctorate in sociology. That journey was circuitous; it involved my dipping into courses across several disciplines, including sociology, demography, public policy, social epidemiology, economics, anthropology, history, and political science as I tried to gather enough information and analytical and practical tools to begin to investigate the problem of HIV/AIDS in Africa and figure out what to do about it. It has taken more years and greater patience than I ever imagined to finally have something to say.

It is my hope that this book reinvigorates ambitious thinking regarding the HIV/AIDS pandemic in Africa, not just thinking that focuses on the important task of improving and prolonging lives, but creative thinking about how to bring the epidemic to an end. In doing so, I hope it does justice to my respondents, whose voices and insights fill these pages, as well as my fellow Africans more broadly, who deserve a chance to live an HIV-free life and to navigate their sexual and romantic lives without the specter of illness and death hanging over them.

Sanyu Amimo Mojola
Boulder, Colorado
September 2013

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1 A Stubborn Disparity

The bustling city of Kisumu, the capital of Nyanza province, Kenya, lies nestled by Lake Victoria, the largest freshwater lake in Africa, and only a few miles from the equator. A stroll through its main streets yields a display of an apparent clash of worlds and cultures. There is the Africa we know: the busy human drama of *mitumba* (secondhand clothing) women, market traders and hawkers, street children, fishermen and the pungent smell of fresh and smoking fish, house flies and mosquitos, numerous bicycles and *matatus* (public transportation vehicles) hooting through the town, and travelers stopping by on the way to or from Uganda or Tanzania. And there is the Africa we are coming to know: tarmaced streets, a prominent Citibank building (taken up by another company), Internet cafes, international nongovernmental organizations (NGOs), and English billboards prominently advertising pay-as-you-go Safaricom mobile phones and Trust condoms. The exuberance, color, and activity of Kisumu, however, mask the slow and terrible unfolding of a demographic catastrophe. A survey conducted in the late 1990s revealed that, among its young women, almost 30% of 15–19 year olds and almost 40% of 20–24 year olds were HIV positive, carrying a virus that would kill them in six to ten years. These were three to six times the HIV rates of same-aged men.[1]

Unfortunately, the gender disparities in this survey were not unique to Kisumu, Kenya, but were reflected in study after study across sub-Saharan Africa, the world's most affected region. Despite having only 12% of the world's population, it has 69% (23.5 million) of people living with HIV/AIDS, 70% (1.2 million) of AIDS-related deaths, and 71% (1.8 million) of new infections.[2]

Women now make up approximately 60% of Africans living with HIV/AIDS,[3] and young women are at particular risk. In 2001, in *AIDS*, the official journal of the International AIDS Society, an influential editorial comment was published with the title, "To Stem HIV in Africa, Prevent Transmission to Young Women." The authors noted that "the high HIV prevalence among women aged 15–19 years could be critical in provoking and maintaining an explosive HIV epidemic."[4] The editorial concluded by urging policy makers to focus their efforts on this group of young people. The issue becomes much more salient in light of the current burgeoning youth population in sub-Saharan Africa: 41% of Africans are under age 15.[5] Girls in this demographic group are on the brink of their greatest period of risk of contracting HIV. This situation offers both an extraordinary opportunity to halt the epidemic and potential disaster if the HIV epidemic is not stemmed.[6]

Despite the early call for action, gender differences in HIV rates among youth in sub-Saharan Africa continue to be widespread and have been confirmed over the subsequent decade in several larger and more representative surveys than those that prompted the comment. Further, these disparities tend to persist until youth reach their mid-30s; after that point, we start to see substantial variation by country in which gender has higher HIV rates.[7]

Figure 1, for example, shows findings from a sample of national surveys of HIV-prevalence rates among young men and women in selected high-prevalence countries in sub-Saharan Africa. It illustrates not only the high burden of HIV in countries such as South Africa, which holds the world's largest HIV-positive population (over five million people), but also the *variability* across countries in the size of the disparity between young men and women. In South Africa, 31% of 21-year-old women are HIV positive, a rate that is five times higher than same-aged men, who have a prevalence rate of 5.6%. However, in Zimbabwe, 15–19-year-old females'

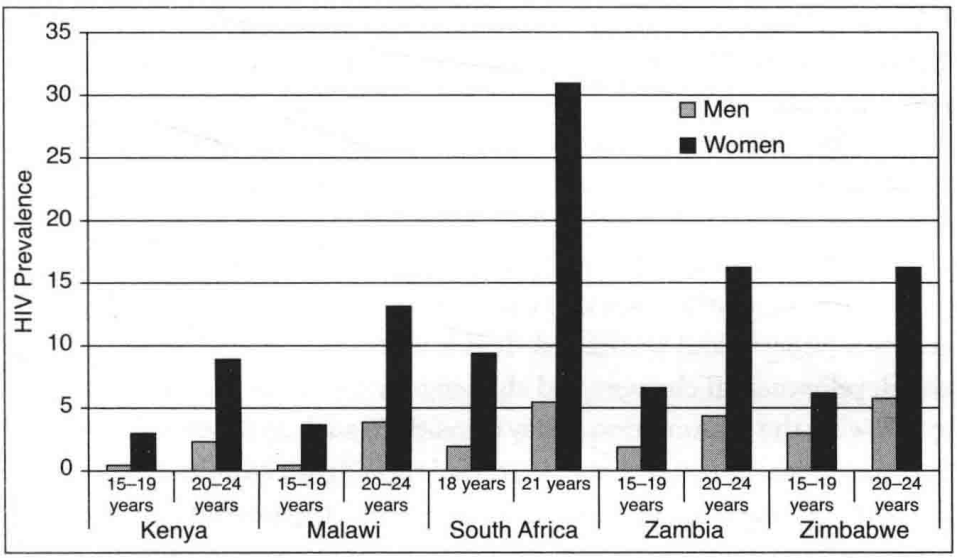

Figure 1. HIV prevalence among young men and women in sub-Saharan Africa. Sources: KDHS 2004; MDHS 2005; Pettifor et al. 2005; ZDHS 2003; ZDHS 2007.

6.2% HIV prevalence is only twice as high as same-aged men, who have a prevalence rate of 3.1%. On average, young African women are three times more likely than young men to have HIV;[8] however, as the figure illustrates, this average masks widely varying levels of disproportionate risk. Indeed, this variability in youth-gender disparities across the region suggests that this is not merely a story of biological sex differences. Something more is at work.

A LIFE-COURSE APPROACH TO HIV RISK

The *youth*-gender disparity from ages 15 to 24 matters because young women have so much more to lose than men in years of life that are disease free and in life expectancy. As figure 1 illustrates, substantial numbers of people are contracting HIV on the cusp of adulthood. In the absence of antiretroviral medication, many are dying early in their marriages, leaving behind young children. For men, not only are they acquiring HIV at lower rates than women in their adolescence and early adulthood, but their peak

HIV prevalence is also much later, in their late 30s or early 40s. This means that they lose far fewer years relative to their life expectancy compared to women.[9] An important place to start, then, in investigating the gender disparity in HIV rates is to investigate the period in the life course when these disparities emerge and self-perpetuate—the transition to adulthood.

A "transition-to-adulthood" framework provides a lens through which to examine social processes and experiences salient to youth in the period between puberty and adulthood. It is a useful way of exploring the lives and developmental changes and challenges experienced by African youth by allowing the examination of key transitions such as relationship formation processes (including sexual initiation and the culmination of relationships in marriage or a stable partnership), the pursuit of education, finding employment, attaining financial independence, becoming a parent, and transitioning residences (principally moving out of the parental home).[10] Importantly, these life-course transitions *co-occur:* relationship decisions can be shaped by educational decisions; financial independence can determine residential transition.[11] This co-occurrence of many life-changing and life-impacting decisions creates for young people a thick web of life events that is reflected in the fact that many experience their transition to adulthood as complicated and confusing. Because of the lifelong significance of many decisions made during this period, transitions to adulthood are sometimes characterized as *risky.* This recognizes the fact that mistimed (early or delayed), missed, or unsuccessful transitions to "normal" adulthood, or events and actions that interrupt an otherwise smooth transition, can have potentially long-term implications for educational attainment, lifetime income, job prospects, and health. Substance abuse, juvenile delinquency, teenage pregnancy, and HIV, for example, can complicate or even derail a young person's successful transition to adulthood by limiting their ability to enact other transitions such as finding employment, achieving financial independence, and forming stable long-term relationships.

Additionally, it is important to acknowledge that transitions have a *processual* nature. In other words, the establishing of a stable long-term relationship (and even parenthood), the completion of education, and stable employment are all transitions that can be begun, ended, elongated,

interrupted, restarted, and returned to.[12] My interest in a life-course approach, and the transition-to-adulthood perspective in particular, is to examine not so much the point at which adulthood is reached (though this is touched on), but rather the *process* of its attainment. This facilitates an analytical strategy that uses a focus on various transitions to adulthood to bring into relief the ways in which gender disparities in HIV rates emerge and are produced among young people.

THE BOOK

The consistently higher HIV rates of young women across a subcontinent with diverse countries, cultures, and ethnic groups belie a phenomenon that is only captured by biological sex differences or a patchwork of localized stories. Rather, it suggests that overarching social-structural processes are *also* occurring across the continent, mapping onto biology, individual decision-making, and culture in local spaces. The combination of these processes places young African women transitioning to adulthood at great risk, while producing temporary safety for young men. At the heart of this book is a study of how one of these processes—consumption, the desire for and purchasing of modern goods—has come to play a crucial role in producing gendered life and death outcomes among young people.

The startling statistics cited at the beginning of this chapter struck a deep personal chord as a Kenyan native with a paternal grandmother from Nyanza province, who I regularly visited during school holidays. These were not distant statistics. They numerically represented a demographic category I inhabited. The age group, gender, and ethnic heritage of those at the highest risk at the time of the survey perfectly characterized me as well as several female cousins living in or near Kisumu, Nyanza's capital. Further investigation of the statistics revealed that young African women were at greater risk compared not just to men in Nyanza province, but to men in almost every African country for which I could find data. Why were young African women at much greater risk for HIV compared to same-aged young men? Biology was clearly part of the explanation, but the *variation* in the disparity from setting to setting suggested that something more was going on, something that I felt survey analysis

alone could not quite capture. I designed a mixed-methods study to explore this disparity. Drawing on a life-course framework, the study explored young people's transitions to adulthood in the context of an ongoing HIV epidemic, drawing on the perspectives of 185 young people, middle-aged adults, and older adults, as well as 20 key informants. Rather than abandoning quantitative data, I chose to move back and forth between population-based survey data from Kenya, ethnographic and interview-based fieldwork in Nyanza province, Kenya (the setting that launched my interest in this topic), and published quantitative and qualitative analyses from several parts of sub-Saharan Africa in order to come to a more complete understanding not only of the plight of young women in Nyanza, but also of those living in many other parts of the continent.

This book examines how young African women navigate their relationships, schooling, employment, and financial access in the context of a devastating HIV epidemic and economic inequality, where extreme wealth is increasing alongside extreme poverty. Billboards in rural and urban sub-Saharan Africa advertising modern lifestyles and consumer products are an indelible part of the social landscape. This means that modernity and the consumptive goods and practices that signify it are present and highly visible in many rapidly globalizing parts of the continent, but just out of reach for many.[13] These developments are deeply gendered and have implications for young women's HIV rates. The book examines the compounding of young women's desire for consumer products that require continual replenishment with the gendered and generational nature of access to income as well as resources. Many young African women are situated within stages in their life course and social structures where access to money, resources, and paid work is tightly constrained. Continual consumption requires partners with continual access to income. This ultimately makes intimate relationships with older, employed men, who have higher HIV-prevalence rates, more attractive than those with unemployed young men, who have relatively low HIV rates.

Let us briefly listen in on a conversation typical of the many I had with groups of high school girls in Nyanza. We had been talking about who they most saw affected by HIV/AIDS, and they said it was young women. I asked them why, and the following unfolded:

SANYU: Why do you think it's mostly girls? Why not boys?

ANYANGO: Because girls are being attracted to so many things.

MARY: They are easily swayed by money.

SACHA: This is because of the financial status of the family, whereby if the family is poor, you know as girls we need several things, but if the family can't provide all this, the girl will be forced to search for them somewhere else, and if you find somebody who cannot provide all these necessities, the girl may switch to the next man she thinks might provide it. So that's the reason as to why the girls move from one man to another, and get infected to this disease easier.

SANYU: So what things do girls need? It's been a while since I was in high school.

JANE: Cosmetics, maybe your friends look smarter than you . . .

ROSA: Good dresses.

ANYANGO: And she doesn't have . . .

SACHA: Which will force you to search for a man who can provide all this. *[Laughter.]*

SANYU: So that means it can't be a fellow guy in high school? 'Cause he doesn't have the money? Or does it not matter? *[Silence.]*

ROSA: It must just be somebody from, someone who is financially stable, who can provide for all this.

SANYU: And what age would that be . . . someone not in school?

JANE: No, those in the working class.

In thinking through this and many other such conversations, a number of things became apparent. First, their knowledge about the epidemic was not lacking. They were aware that their demographic—young women—had the most risk for HIV, and further, they were aware that they could get HIV from sexual relationships, with the most risk coming from having multiple partners. Second, they were clear that the reason why girls were most at risk was because of their desire for *nonsurvival* consumption, and that it was men who worked—"working-class" men—who were most able to provide them with the money to consume. The fact that things like cosmetics and good dresses were framed as *necessities* or needs led to a compulsion, indeed something that would "force" them to look for a man to help.