AIDS, Culture, and Africa

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In memory of my brother-in-law, Edward Ginsberg (1928–2005)

Preface

Kigali, Rwanda, August 1985: I was in the main hospital, Centre Hôpitalier de Kigali, in the Rwandan capital interviewing AIDS patients there to try to find out how they became HIV infected. Back in the United States, most people with AIDS were gay men; but here in Africa, I was being told that most were heterosexual. What in the world was going on? Why should the same disease behave differently in two different places? Maybe, I thought, extreme homophobia was preventing the truth to come out. Perhaps African men were secretly having lots of sex with other men, but no one wanted to talk about it. Or maybe, just maybe, male and female couples were routinely engaging in anal sex in order to prevent pregnancies. So there I was, literally sitting by their deathbeds, ready to stay as long as necessary until I learned from my informants the truth.

Nine of the ten patients were men; most were fairly wealthy men who traveled throughout central Africa on business. After gaining their informed consent, I asked them about their health history and their sex history. Were they having anal sex with their wives or mistresses? All of them insisted that they were not. Were they having sex with another male? Again, they all insisted that they were not. One had confided to me that he often had vaginal sex with female partners even when he had an outbreak of genital herpes. But absolutely no same-sex or heterosexual anal sex behavior.

On my final visit to the hospital, I was told of one last AIDS patient, a woman, on a bed in the rear of the hospital ward. When I approached her, I was startled by what I saw. All skin and bones, her eyes closed, with dozens of flies swirling around her. I thought she had already died. But then she began to stir, her eyes opened, and I introduced myself and told her about the study. With great effort, she managed to sit up, and she agreed to participate. Her face was very gaunt, and her voice was little more than a whisper. And she told me her story.

Rangira (a pseudonym) was thirty-six, Tutsi, a mother of three children. When she started developing AIDS symptoms, her husband began to blame her for becoming infected, and angrily threw her out of the house. The children stayed with the husband and his family, while Rangira had no choice but to return home to her mother. The bitter irony is that Rangira had remained faithful to her husband during their long marriage, and it was her

husband who undoubtedly had an extramarital relationship and infected her, though he had not yet developed symptoms.

Over several months, her health continued to deteriorate and her weight continued to drop, until finally she was admitted to the hospital, too weak to walk on her own. She told me how she was shunned by her family, friends, and neighbors, as the word spread that she had AIDS. But as she talked, I was drawn to her quiet sense of dignity, her resolve not to let the disease conquer her spirit, even as it destroyed her body. As she attempted to sit up straight on her hospital bed, she told me how important it was to her to make sure that her health and sexual history that she was giving me was totally accurate. She had never had anal sex; she knew that her husband was seeing other women; and she was a faithful wife and devoted mother.

At the end of the interview, as I was leaving, a reporter for the British Broadcasting Corporation (BBC) was also in the hospital ward covering the then new story about AIDS in Africa. She asked if she could photograph the female patient that I just spoke with outside in the daylight. I told her that the woman was far too ill to be moved or bothered. But when Rangira heard that the reporter wanted to photograph her, she insisted that it happen. With the assistance of one of the nurses, she managed to climb into a wheelchair and was wheeled out to the daylight for her close-up. She wanted to be remembered and for the world to know about her experience, as she solemnly posed for her photo. Within days her photo was broadcast throughout the world. For a time, she became the face of the ravages of AIDS in Africa.

A few days later, as I prepared to leave Rwanda, I wanted to go back to the hospital to say good-bye to Rangira and thank her. But it was too late. I was told that she had died the day after I saw her.

Looking back today, I wonder—given that she and her husband were Tutsi, the main target of the horrific genocide that gripped Rwanda in 1994—whether she would have survived the genocide nine years after her death from AIDS. Did her husband and children survive?

* * *

The cultural and biological dimensions of HIV/AIDS in sub-Saharan Africa have been analyzed by anthropologists since 1985. Today, dozens of anthropologists are conducting research in Africa, looking at cultural factors that increase the spread of the epidemic, discovering how to most effectively prevent HIV transmission through condom promotion and other safer sex practices, and understanding how African communities are affected by this devastating disease. This volume presents all original, never-before-

published chapters by international anthropologists and other social/behavioral scientists who are leaders in this field. It paves the way for a deeper cultural understanding necessary to effectively reverse the catastrophic growth of HIV/AIDS on the African continent.

The volume begins (chapter 1) with a review of the literature on the anthropological contribution to our understanding of HIV/AIDS in Africa. This includes discussions on condoms, HIV prevention campaigns, government involvement, food policy, male circumcision, traditional healers, the role of poverty, AIDS orphans, social and economic consequences, gender inequality, sex workers, the epidemiology of HIV transmission, sex outside marriage, breast-feeding, indigenous AIDS-like illnesses, vaccine trials, voluntary counseling and testing, ethical issues, anthropological research, and policy concerns.

Lee and Susser, in chapter 2, then examine how HIV/AIDS has impacted a traditional foraging community in Namibia. They find that greater gender equality among the Ju/'hoansi may be a factor in the lower HIV rates within that population. Kornfield and Babalola (chapter 3) look at how HIV-positive men and women in Rwanda delay HIV testing and continue to practice unprotected sex long after their diagnoses. For example, some HIV-positive men continue to have sex with sex workers even after their diagnosis so that their friends do not suspect that they are HIV infected, and they get remarried after their wives die. Also, some HIV-positive women engage in sex work to bring in additional money when their husbands are not able to work, and after their husbands die.

Macintyre and Kendall (chapter 4) broadly look at societal-level behavioral change and the importance of social proximity to the epidemic. Brown (chapter 5) discusses the importance of the current research by anthropologists on male circumcision as a possible HIV intervention in Africa. Longfield (chapter 6) focuses on partner categories and risk perceptions in Côte d'Ivoire for future target-specific interventions.

Turning to research by anthropologists in Zambia, Simpson (chapter 7) looks at how ideas of masculinity lead to rejection of condom use and promotes sexual risk-taking. Feldman and colleagues (chapter 8) examine how the stigma of AIDS often results in negative attitudes and a lack of empathy toward persons with AIDS among Zambian high school students. In nearby Namibia, Lorway (chapter 9) looks at how homophobia has led to the neglect of HIV prevention for men who have sex with men throughout much of the continent and how fear of AIDS is allowing antigay African leadership to promote bigotry and hate.

Shifting our attention to Uganda, where the declining HIV rates there

have encouraged an American conservative policy of stressing sexual abstinence and partner reduction, and diminishing the role of condoms (the "ABc" Campaign—Abstinence, Be faithful, and a small "c" for a de-emphasized use of condoms), Onjoro (chapter 10) supports the ABc approach, arguing that program failures in Africa and the success in Uganda should lead us to reject condom promotion programs. However, McCombie and Eshel (chapter 11) argue that we need to reinterpret the lower HIV rates for Uganda and examine how language is used in sexual behavior surveys. They believe that the ABc approach should not be applied throughout Africa. Swezey and Teitelbaum (chapter 12), also taking an anti-ABc approach, look at the changing family structure in Uganda and decision making for care seeking and resource use within families with AIDS. Rwabukwali (chapter 13) points out that poverty is not necessarily a risk factor for HIV, since many poor Ugandan women do not engage in multiple sexual practices.

Preston-Whyte (chapter 14) tells us that political economy issues explain HIV patterns in Africa far more than do cultural issues. The conclusion (chapter 15) discusses the political and economic factors that have been turning HIV prevention, care, and treatment in a different, and ultimately alarming, direction, and what might be done to change that.

This volume brings together anthropologists and other social/behavioral scientists to discuss their research and policy issues on HIV/AIDS in Africa. However, it is written primarily for the nonanthropologist, with any anthropological terminology clearly defined. It should be of interest to international health researchers, health policy makers, epidemiologists, health educators, political scientists, sociologists, psychologists, government and nongovernmental organization officials, health practitioners, and many others, as well as medical and applied anthropologists.

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The Anthropological Perspective

DOUGLAS A. FELDMAN

Since 1985, anthropologists have been making significant contributions to the study of HIV/AIDS in sub-Saharan Africa. Without a steady or consistent source of funding, especially in the earlier years, anthropological research on HIV/AIDS in Africa has informed other major fields, including epidemiology, public health, health education, biomedicine, health policy analysis, and other social and behavioral sciences, for more than two decades. A considerable body of literature has accumulated on HIV/AIDS in Africa, contributing to the overall growth of medical, applied, and public anthropology.

Some of the earlier contributions during the mid and late 1980s by anthropologists focused on the social epidemiology of HIV—the search for sociocultural practices and cofactors that would explain the much higher rate of heterosexual transmission in Africa than in North America and Europe (Bond and Vincent 1996a). That interest of the biomedical community was based less on a concern for the fate of Africa than on a potential fear that the same pattern of heterosexual HIV transmission might quickly hit the shores (and bedrooms) of North America and Europe.

But by the early 1990s, as it became clearer that heterosexual HIV transmission was not a lethal threat to most North Americans and Europeans, and as more anthropologists entered the research arena with more diverse interests, the primary perspective of anthropologists on AIDS in Africa has moved beyond social epidemiology to an understanding of the sociocultural and economic consequences of the disease; exploration of the social, cultural, and historic context of AIDS; a critique of the political economy and gender inequality in Africa; and an examination of HIV prevention, educational, and intervention programs.

It could be argued, however, that the abandonment of social epidemiologic interests by anthropologists was too hasty, and many of the key questions on the intersection of biological and cultural factors in the transmissibility of HIV can only be answered through anthropological knowledge, insight, and research. This point is not a trivial one. The degree to which the epidemic in Africa is spread through which customs and practices, and which kinds of sexual behavior, and the precise trajectory of the epidemic are critical concerns, which a biocultural anthropological perspective is uniquely situated to investigate. And, by and large, anthropology has ignored these social epidemiologic questions and, regrettably, gone in a different direction.

Other topics pursued by anthropologists studying AIDS in Africa have been highly diverse and include: male circumcision, HIV transmission, risk behavior, food policy, the role of anthropologists, "dry sex" (the fairly common activity of delubricating the vagina prior to sex), workshops, ethics, male condoms, female condoms, churches, breast-feeding, public policy, public awareness, traditional healers, research methods, household studies, global funding, the relationship between HIV and other sexually transmitted diseases (STDs), ethnomedicine, abstinence-only programs, men who have sex with men (MSM), female sex workers, poverty, the need for antiretroviral medications, women, values and beliefs, ethnography, AIDS-like indigenous diseases, the extended family, AIDS orphans, social stigma, the origin of HIV, fear, vaccine trials, and voluntary counseling and testing. This review of the literature is by no means exhaustive, representing perhaps only a third of the works on HIV/AIDS by anthropologists, but is intended to give the reader a sense of the diversity of HIV-related research on Africa conducted by anthropologists.

Several anthropologists have looked, for example, at male condoms for HIV prevention. Taylor (1990) discusses the cosmological importance in pregenocide Rwanda of having an uninterrupted flow of fluids, including semen, and suggests that this would make it even more difficult to promote condoms there. Susser and Stein (2000) describe the Ju/'hoansi of Namibia, where a woman can insist that a man use a condom, and she can withhold sex if he refuses. Among other groups throughout southern Africa, however, the use of a condom is seen as a challenge to a man's masculine authority.

Bond and Dover (1997), in a study of migrant workers in rural Zambia, find that the underlying and pervasive ideal is that sex is essentially a procreative act. An emphasis on male potency and male and female fertility often overrides anxieties about contracting HIV and other STDs. Condom

use is only negotiated within some short-term relationships, and even then not consistently. While both men and women have negative attitudes toward condoms, women (because of their economic and ideological dependence on men) are in a much weaker position to negotiate condom use.

Rwabukwali and colleagues (1994), in a study of sixty-five HIV-positive and sixty-five HIV-negative Bagandan women, found that cultural norms traditionally encourage multiple sexual partners for men, and that women feel helpless in preventing HIV. They argue strongly for promoting condom use by men.

In an excellent study conducted by Kornfield and Namente (1997) in Malawi, where 40 percent of marriages end in divorce or separation, and women engage in ritual sexual "cleansing" (having intercourse) with their deceased husband's brother, most people are very religious, but do not use condoms. In a study conducted in the 1980s by Schoepf (1988) in what is now the Democratic Republic of the Congo (DRC), the church was teaching that AIDS is a divine punishment and only so-called sinners are at risk, while most secondary school students at that time did not know what a condom was and had never even seen one.

In a study of 100 female sex workers in South Africa, Varga (1997) learned that condoms are perceived as suggestive of filth, disease, infidelity, and mistrust. Sex workers never used condoms with their male lovers, and inconsistently with their male clients. She concludes that the high level of HIV/AIDS awareness had a minimal impact on condom use. Feldman and colleagues (1997) conducted a study of 276 Zambian teens during the early 1990s and found out that unprotected vaginal intercourse was common, and sometimes unprotected heterosexual anal sex was practiced (see below). Interestingly, Stewart (1999) found in a study of 600 young males and females in Uganda that they were three times more likely to accept condoms from male interviewers than from female interviewers. In another study in Ghana, focusing on methodology, McCombie and Anarfi (2002) learned that adolescent females were more likely to reveal to male interviewers than to female interviewers that they had engaged in prior sexual activity.

Female condoms have been suggested as a viable alternative to male condoms by Susser and Stein (2000). They argue that female condoms are the most socially acceptable device by both men and women in southern Africa, but cost factors and gender inequality have limited their availability.

Green, who originally supported the expansion of condom use in Africa (1988), has more recently questioned it (2003). Indeed, his new anticondom position has been used by some in the George W. Bush administration to

justify an abstinence-only/partner-reduction strategy for Africa that de-emphasizes condom promotion. New epidemiologic evidence from Uganda clarifies that it was indeed primarily condom promotion that reduced the HIV rate from 15 percent to 6 percent from the early 1990s to the present. However, an artificially created condom shortage that occurred during 2005 in Uganda and a policy shift away from condoms may likely lead to a return to double-digit HIV seroprevalence in that country and in other nations in Africa where the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) funding dominates. Indeed, during an artificially created condom shortage in Uganda during 2004–2005, there was a simultaneous increase in HIV rates in that country. Male and female condom use remains an important area where anthropologists need to continue doing research, and to speak out publicly in promoting an effective AIDS policy in Africa (Feldman 2003a, 2003b, 2004, 2005).

More broadly, HIV prevention and education have been a major concern of anthropologists. Early research in Rwanda showed that by the mid-1980s, the general public in Rwanda had very poor knowledge and awareness of HIV/AIDS. Even though it was at that time a highly stigmatized disease, most did not know how it was transmitted (Feldman et al. 1987). While the research in Rwanda shows no evidence of significant heterosexual anal intercourse (Feldman 1986), research among Zambian out-of-school youth shows that 35 percent of a sample of sixty adolescent females engaged in anal sex, almost always without a condom (Feldman et al. 1997). Halperin (1999) finds that women in three African countries were less aware of HIV risk through heterosexual anal intercourse than through vaginal intercourse. Yet 4 to 8 percent of three samples of females with AIDS acknowledged practicing anal sex, and 12 percent of a sample of female college students in Togo acknowledged engaging in anal penetration.

Indeed, Halperin and Williams (2001), looking at the failure of controlling HIV in South Africa and the relative success in Uganda, argue that Africa needs less of the slick Madison Avenue–type of HIV prevention campaigns found in South Africa and more of the grassroots campaigns found in Uganda. Halperin and colleagues (2004) also discuss the need to move forward in designing and implementing evidence-based prevention programs. HIV prevention workshops, particularly when they are led by peers, emphasize the cultural values of the target population, and seek to change the norms preventing safer sex practices, can be very effective in changing risk-taking behaviors (Feldman 2000).

Some anthropologists have focused on understanding the social dimensions and ethnohistorical context of HIV/AIDS. While there has been

much discussion about the need for evidence-based interventions in Africa, Bond and Vincent (1996b, 2000) looked at the historical context of HIV in Uganda. Civil war and violence were endemic in Uganda until 1986. With the new government led by President Yoweri Moseveni beginning that year, there was a strong public campaign against HIV/AIDS. At first, members of high-risk groups were targeted (truck drivers, traders, and female sex workers). But, the authors point out, now the targeting is broader, including those in "poverty, the weak, and the vulnerable" (2000: 363). Van der Vliet (1994) examines the early history of AIDS in South Africa during the apartheid era, and finds that the conservative political ideology neglected the epidemic, often blaming persons with AIDS for their predicament.

Food policy and HIV is also a topic that has interested some anthropologists. Hunter and colleagues (1993) indicate that 8 percent of households in a region of Uganda had significant reductions in crops and livestock specifically due to AIDS mortality or morbidity. Barnett and Blaikie (1989) point out that AIDS is clearly impacting food policy in Africa. They suggest that research is needed to determine the types of coping mechanisms in the face of labor and food shortages, how land tenure systems and methods of labor organization are likely to respond to falling populations, and whether a possible return to hunting in some areas of declining population would be feasible.

Male circumcision and HIV have also been a strong interest of anthropologists (for example, Halperin et al. 2002). The late Priscilla Reining and Francis Conant are two anthropologists who, during the 1980s, discussed a link between male circumcision and HIV in Africa (Bongaarts et al. 1989). Halperin and Bailey (1999) point to a greater than eightfold increased risk of HIV infection for African uncircumcised men. In a cross-sectional study conducted in Uganda by Bailey and colleagues (1999), it was learned that differences in sex practices do not account for the higher risk of HIV infection found among uncircumcised men. They argue in favor of male circumcision as a prevention intervention strategy in areas where circumcision is absent in Africa.

In a study among the Luo in Kenya, Bailey and colleagues (2002) found that the Luo accepted the idea of male circumcision to reduce risk of HIV infection, but the authors acknowledge some barriers to circumcision, as well as a lack of knowledge and resources among local clinicians to perform the circumcisions. The efficacy of male circumcision in HIV prevention is an area where anthropologists need to closely follow in the near future. Recent trial studies conducted by anthropologists and others show that introducing adult male circumcision into an area where it did not occur