

# African Responses to HIV/AIDS

*Between Speech and Action*

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## Culture, Behaviour and AIDS in Africa

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In 2007, some 33 million people worldwide were living with HIV, about 22 million of them (two-thirds of the total) in sub-Saharan Africa (UNAIDS 2008). Gains that had been made – in life expectancy, infant and child mortality and education – in the first two decades after independence began to be reversed. Those most affected by the disease were in their productive years and made up 55% of adults with HIV/AIDS. As AIDS claimed skilled labour, agricultural production was driven down, threatening food security. Increased demand for services overwhelmed the health sector. In Kenya, for example, the Human Development Index declined from 0.533 to 0.520 between 1990 and 2004 (HDR Kenya 2005: 6).

The search for causes of the epidemic has been characterised by two sets of myths. On the one hand, some African leaders have accused the West of fomenting AIDS. On the other hand, some in the West have identified various African sexual practices as facilitating or promoting the spread of HIV. The evidence against the first set of myths is well known and Gausset (2001) has made a forceful case against the second set for Tonga. In this chapter, we reinforce Gausset's position that African sexual practices are not the major problem. We make our argument on the basis of data from sub-Saharan countries and we discuss the findings of Green (2003; Green et al. 2006, 2009; Green and

Herling 2007) and others (Halperin and Epstein 2004; Shelton 2007; Kirby 2008) regarding the practice of multiple concurrent sexual partners (MCPs), which is most associated with the spread of HIV in Africa.

We stress from the outset that we do not separate the practice of MCPs from culture. The number of sexual partners considered appropriate to have in one's lifetime or concurrently is as much a cultural artefact as is the number of wives or husbands or children one is permitted or encouraged to have. We distinguish, however, between particular sexual practices and practices that are universally subject to local custom. Only some peoples practise female genital cutting (FGC) or ritualised sexual cleansing after widowhood. People everywhere can and usually do impose restrictions on the number of serial and/or concurrent sexual partners one may have. When it comes to HIV transmission, no risk is too small to ignore. Our point is that the particular sexual practices of Africans are not the major obstacle to stopping the incidence of HIV. Lowering the number of concurrent sexual partners, by contrast, is as important today in Africa as it was in San Francisco in the 1980s. The problem in San Francisco was primarily limited to homosexuals, while in Africa the HIV epidemic is a general one. The importance of lowering the number of concurrent partners, however, is the same in any epidemic of a sexually transmitted disease.

This chapter offers a critical review of the evidence of the sexual behaviours in Africa that are logically and empirically associated with the spread of HIV. The key findings are: first, having MCPs is the sexual practice most associated with the transmission of HIV; second, this practice is not unique to Africa; third, the most effective intervention programme in Africa for reducing the prevalence of HIV has been an indigenous response, 'Abstain, Be Faithful, Condomise' (widely known as ABC, begun in Uganda); and lastly, while all three components of this intervention are important, the reduction in the number of partners (the A and B of ABC) are clearly the most effective.<sup>1</sup>

### **Responses to AIDS in Africa and in the West**

When the AIDS epidemic began in the 1980s, it was met with scepticism and denial in Africa. Coming in the wake of onerous structural

adjustment programmes, and in the context of declining populations in the industrialised countries of the world, AIDS was seen initially by some leaders at the national and local levels in Africa as a Western ploy to stop Africans from increasing demographically. AIDS was referred to in popular circles as an 'American invention to discourage sex' (Schoepf 2004: 46) or, in its French equivalent, SIDA, as '*syndrome imaginaire pour decourager les amoureux*' (imaginary syndrome to discourage lovers) (Watney 1994: 103). This made sense to people struggling to make ends meet and without many sources of competing information, but it slowed the kind of response that was needed and the results were tragic. In South Africa alone, rejection by the government of antiretroviral (ARV) drugs for treating AIDS is estimated to have cost 330 000 lives (Chigwedere et al. 2008).

Denial of AIDS is now receding but has not disappeared. In 2007, the Archbishop of Maputo claimed that countries in Europe were exporting HIV-infected condoms to kill off Africans (McGreal 2007; see also Kalichman 2009). The response from industrialised countries to the epidemic in Africa was based on their experience with AIDS. In the West, HIV was initially spread by men who had unprotected anal sex with other men. People in San Francisco, New York and other cities with large gay populations responded quickly by educating men who have sex with men (MSM) about the importance of using condoms and, particularly in San Francisco, closing the bath houses. The rate of AIDS cases declined in those cities, creating the impression that condoms were the answer. In fact, the incidence and prevalence of AIDS went down temporarily, probably because gay men reduced the number of their sexual partners (Rotello 1997).

Indeed, by the mid-1990s, the rate of infection had rebounded and was 18.3 cases per 100 000 in San Francisco in 2009, higher than the national average of 11.2 for metropolitan areas (cities of half a million or more) and 27 cases per 100 000 in New York, more than double the national average (CDC 2009: Table 24). In the United States, the largest single cause of HIV transmission continues to be male-to-male intro-missive sex. Between 2003 and 2006, the number of cases of AIDS in that population increased by 22%, from 17 678 to 21 617 in the

33 states that had confidential reporting. In the same period, new cases of AIDS as the result of high-risk heterosexual contact went down by 3%, from 4 269 to 4 152 (CDC 2006: Table 1).

### **Condoms and ABC**

Today, the conventional package of interventions in the fight against AIDS includes treating sexually transmitted infections (STIs), providing easy access to voluntary counselling, fighting stigma through public education programmes and the distribution of condoms, along with programmes to educate people about using the device properly for each and every intro-missive sexual act in which a partner's serostatus is unknown. These efforts are certainly worth supporting, but they are, as Shelton (2007: 1811) points out, 'much more effective in conjunction with' reducing the number of sexual partners.

Between 1998 and 2002, international donors shipped an estimated 885 million condoms annually to countries in sub-Saharan Africa (Chaya, Amen and Fox 2004). This level of effort can lower HIV transmission substantially in high-risk groups – such as MSM, intravenous drug users and prostitutes – and in urban areas, such as Kampala (Kirby 2008), where networks of sexual interaction can be dense. For such relatively small and/or geographically focused groups, the problem is identifying them and reaching them with appropriate interventions. In a generalised epidemic, however, as is the case in parts of Africa, condom promotion as an intervention has failed to bring down HIV incidence or prevalence (Shelton 2006, 2007; Potts et al. 2008; Green 2003; Hearst and Chen 2004; Hogle et al. 2002; Green et al. 2009). Indeed, the promotion and distribution of condoms may produce risk compensation – a false sense of security leading some users to riskier sex than they might have had otherwise (Ahmed et al. 2001; Kajubi et al. 2005; Cassell et al. 2006; Kalichman, Eaton and Pinkerton 2007; Marrazzo 2007).

In contrast, the success of the ABC programme in Uganda – Abstain; if you can't abstain, then Be faithful; and if you can't be faithful, then Condomise – shows that programmes to delay sexual debut and reduce the number of concurrent sexual partners outside of stable

unions can, along with aggressive marketing of condom use, dramatically reduce the rate of new cases of HIV (Green 2003; Green et al. 2006; Halperin and Epstein 2004; Kirby 2008). From a high of 15% in 1991, the prevalence of HIV in Uganda dropped to 4% in 2003 (Green et al. 2006: 337). However, since then Uganda has seen an increase of AIDS prevalence to 7.7% and incidence, which reached an all-time low in 2005, has begun to increase as well (Shafer et al. 2008). Nonetheless, the major lesson from Uganda is clear: ABC works, when taken seriously and supported by all levels of government.

### **Culture and AIDS in Africa**

Support for more condoms as the primary intervention comes also, as Gausset (2001) has argued persuasively, from beliefs about African sexuality – namely, that African sexual practices increase the chance of transmission of STIs.<sup>2</sup>

To assess the possible role of sexual practices in Africa in the spread of HIV, Nkwi supervised a five-country study in 2003–4 for the African Population Advisory Council (Nkwi 2005). The study was funded by the United Nations Population Fund (UNFPA) through its African Social Research Program (ASRP). The study, hereafter called the ASRP study, involved ethnographic interviews with 636 local experts in Cameroon, Kenya, Malawi, Togo and Côte d'Ivoire and survey interviews with 4 802 respondents in the same countries.<sup>3</sup>

In developing the in-depth and survey interviews, Nkwi did a comprehensive review of the anthropological and epidemiological literature to identify the cultural practices in Africa that are logically or empirically associated with the transmission or prevention of disease, including STIs. These practices include: the use of unsterilised instruments in surgical procedures; various forms of the levirate (widow inheritance) and so-called sexual cleansing rituals; polygyny; ritualised and unprotected non-marital sex; prostitution; and non-commercial sex involving MCPs.

As we will see, some practices (such as ritualised non-marital sex) present a clear risk for the transmission of HIV. Others (polygyny and the levirate, for example) entail risk under some conditions but are

protective against transmission under others. And one practice, male circumcision, is highly efficient in preventing the transmission of HIV. The extent to which any of these practices expose people to HIV is, of course, an empirical matter and requires measurement. However, all such risks are small compared to that of having unprotected sex with MCPs whose serostatus is unknown. We will have more to say about this later.

### *Unsterilised instruments in surgical procedures*

Across Africa, various groups practise scarification, piercing and tattooing, male circumcision and FGC. Scarification, piercing and tattooing are widely practised for aesthetic purposes and as a means of ethnic identification. Among the Guiziga and Mafa peoples in Cameroon, for example, the perforations of lips and nose (for hanging rings) have been traditional symbols of ethnic identity and forms of beautification for women. Among the Samburu of Kenya, women traditionally underwent scarification of the forehead and chest to enhance their beauty.

Male circumcision is a common practice in many societies across Africa, though certainly not all. Among societies in the ASRP study, the Luo, a major ethnic group in Kenya, do not practise circumcision and traditionally initiated young men through the ritual removal of six lower teeth. Even where circumcision is the norm, the ideology that underlies this practice differs from culture to culture. In some cultures of Cameroon, for example, circumcision is performed without great ceremony, usually when a boy is between eight and ten years old or even younger. The operation is simply an exercise to remove the foreskin and enhance the sensitivity of the glans penis. Among the Samburu and Luhya in Kenya, by contrast, circumcision is part of an elaborate rite of passage from childhood to adulthood. It allows men to own and control property and prepares them for marriage. Among the Samburu, the circumcision ritual appears to take place every fifteen years.

FGC (also called female genital mutilation and female circumcision) primarily involves excision of the clitoris and excision of the labia minora but, in some groups, involves infibulation and excision of the labia

majora. A common reason given for these practices by informants in the ASRP study was to prevent premarital and extramarital sex by removing the most sensitive part of the sex organ and thus prepare girls for marriage.

All of these practices involve risk of disease transmission when performed collectively or when the instruments are not sterilised between uses. The extent to which such local surgeries are a vector for HIV, however, remains to be determined. Brewer et al. (2007a, 2007b) found that adolescents in Kenya, Lesotho and Tanzania who claimed to be virgins and who had been through genital surgery (circumcision for boys, FGC for girls) were more likely than adolescents who claimed sexual experience to be HIV positive. The researchers attribute this to the transmission of HIV in local surgeries. Their finding is questioned by Adams, Trinitapoli and Poulin (2007); Westreich, Rennie and Muula (2007); and Monjok, Essien and Holmes, who conclude: 'There are no epidemiologic data associating HIV transmission with FGC' (2007: 39). Across Africa, strategic initiatives against HIV/AIDS include recommendations that new blades be used in all local surgeries and some people are even bringing their own new blades with them to ceremonies that involve cutting. Yount and Abraham (2007: 74) found that only 17% of girls who underwent an FGC operation in Kenya were exposed to a common instrument. While local surgeries are unlikely to be a major cause of HIV transmission, everyone agrees that all local surgeries need to be hygienic and safe and that continued education about the importance of using sterile instruments is vital.

This must not be read as support for the practice of FGC. Several countries have passed laws against FGC and, in some countries the practice appears to be in decline. Up to two million women per year, however, still undergo one form or another of genital cutting (for a report, see Wakabi 2007). We join the many writers over the years who have argued that FGC is an assault on the human rights of girls and women (see, for example, Eliade 1958; Nkwiri 2001; Darby et al. 2007; Catania et al. 2008; Shell-Duncan 2008).

There may be little direct risk for HIV transmission in FGC practices but there may be a strong indirect risk. Yount and Abraham (2007: 80)

found in Kenya that women who had been through FGC were often married young to men older than themselves and that women with older husbands were 2.65 times more likely to test positive for HIV than were women with husbands their own age or younger (11.7% of women married to older husbands, as opposed to 4.4% of women with husbands their own age or younger).

Unlike FGC, male circumcision offers some protection against the transmission of the virus. This was originally extrapolated from population-level data in sub-Saharan Africa (Weiss, Quigley and Hayes 2000). Later, three randomised controlled trials showed that male circumcision reduces the risk of contracting HIV by 50 to 60% (Auvert et al. 2005; Bailey et al. 2007; Gray et al. 2007). In fact, the three experimental studies had to be stopped for ethical reasons in order to make the intervention, circumcision, available to those in the control condition (Klausner et al. 2008: 1). It should be noted that this efficacy is for medically supervised and full circumcision. While male circumcision lessens the risk of contracting HIV, the remaining risk is substantial. In fact, circumcision, like ARV therapy, may be incorrectly perceived as protecting fully against AIDS and this may lead to risk compensation (Cassell et al. 2006). When combined with a reduction in the number of concurrent sexual partners, however, male circumcision is estimated to reduce the incidence of HIV by at least 25 to 35% (Hallett et al. 2008) and perhaps by as much as 50 to 60% (White et al. 2008).

### *The levirate and sexual cleansing*

The levirate, or widow inheritance, is well known in Western society from the Old Testament and is practised, in one form or another, in patrilineal cultures across the world. Among the Bassa of Cameroon, for example, a married woman is considered as having entered into a permanent contract with the kin group of the husband. The death of the husband does not nullify the husband's contractual right to lineage continuity. This is achieved by transferring procreative duties to another male member of the lineage.

Among the Luhya people of Kenya, the final funeral ritual takes place 40 days after the burial of the deceased man. Relatives assemble in the house of the deceased. The widow prepares food and places it between the legs of the brother whom she has chosen (if there is more than one brother) to be her new husband. The ceremony takes place at night and ends with the consummation of the marriage the same night. The following morning, the woman shaves her pubic area, signalling a new beginning and the cutting of ties with the deceased. In the ASRP survey, 62% of Luhya respondents were against widow inheritance. However, it is still the case, as in other societies that practise the levirate, that not going through with the ceremony can stigmatise the widow and make her life difficult (Gausset 2001; Malungo 2001).

From a public health perspective, the levirate and sexual cleansing rituals for widows and widowers introduce at least one new sexual partner into each person's life, almost always without knowledge of the HIV status of either partner. Although this increases the risk of infection, it also prevents the impoverishment of widows, some of whom might otherwise be driven into prostitution. Thus, if widow inheritance does not involve the ritual practice of unsafe sex, it can inhibit rather than facilitate the transmission of HIV. In southern Zambia, as a result of the HIV epidemic, people who practise sexual cleansing of widows or widowers are seeking alternatives to the practice of penetrative sex. In a sample of 106 widowed persons there (68 women and 38 men), Malungo (2001: 375) found that 19% had been sexually cleansed, 12% had not been cleansed at all and 69% had participated in an alternative cleansing ritual that did not involve sex. This culturally appropriate change in practice was not the result of outside intervention and makes clear the importance of seeking indigenous alternatives to traditional practices.

### *Polygyny*

Polygyny is practised among many groups across Africa. In Kenya, polygyny is legal if a man's first marriage is contracted according to customary law, but illegal if contracted after civil or Christian marriage. In Cameroon, polygyny is legal if, during the first marriage, the first

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wife approves of it. In Côte d'Ivoire, polygyny has been legislated against since 1964 but it is still widely practised in rural areas.

From an evolutionary perspective, polygyny is associated with high male mortality in war and high pathogen stress (Ember, Ember and Low 2007). This helps to explain the historical origins of polygyny, but it does not account for its widespread practice in Africa today. Polygyny increases lineage-level political, social and economic alliances; it functions as a child-spacing and survival strategy (especially important for women of low-income groups); it produces more total children per household in the context of high infant mortality (although Amey [2002: 84] found that it increases the individual risk of infant mortality by 60 to 70% in six West African countries); it establishes multiple affinal relationships and alliances; and it increases the potential for wealth accumulation in traditional agricultural societies.

At a cultural level, the values and beliefs that support polygyny, across religions, include a desire by women for security and a desire by men for increased social status and for a measure of immortality through increased procreation. One ASRP informant in Butere, Kenya had this to say: 'My first wife had only three children, so I decided to marry a second wife to have more children. Also my second wife did not give me a son and she had only daughters and that is why I have three wives'.

In a newscast on 16 March 2003, a Cameroon national television journalist interviewed a popular musician known as Papillon about the content and meaning of one of his songs. Papillon said: '*Vous savez, tout homme normal doit avoir un deuxième bureau*' (You know, every man ought to have a mistress). The reference in French is to a 'second office', meaning a woman (or more than one woman), besides his wife or wives, with whom a man shares his life regularly. Many married male informants who were interviewed in the ASRP study provided similar explanations to the existence of the practice.

With regard to HIV, if the men in polygynous unions sleep around and do not use condoms in every penetrative sexual act, this practice places all women in the household at risk of HIV, along with the infants of those women through placental and breast milk transfer of the virus.

Polygyny, however, is not a channel for STIs if the partners are faithful to one another – a practice known as ‘zero grazing’ across Anglophone Africa.<sup>4</sup> In many sub-Saharan societies, however, where polygyny is normative, wives are expected to be faithful whereas husbands are expected or even encouraged to have extramarital affairs. Postpartum sexual abstinence for women is understood in many cultures as protecting the life and health of the mother and child but it also then becomes a rationale for polygyny and for extramarital sex for men (Mitsunaga et al. 2005: 478; Ali and Cleland 2001).

As a cultural practice, polygyny appears to be under pressure in Africa. In the 1970s, 33% of households in the Kisii region of western Kenya were polygynous. By the late 1990s, less than 10% of households in the same region were polygynous (Silberschmidt 2001: 662). Between 1990 and 2003 in Nigeria, the percentage of married women in polygynous unions fell from 41 to 36% (Mitsunaga et al. 2005: 479). Increasing poverty on the continent means that the cost of maintaining a polygynous household has become prohibitive for many men and, as women enter the workforce, the latter no longer need to be part of polygynous households to secure their old age. Young men and women in Africa increasingly find polygyny unnecessary and undesirable and the practice will likely erode over time, though later among some groups than others. Polygyny is nominally disapproved of across the ASRP study sites. It is rejected as an ideal form of marriage in Cameroon (79.5%), Côte d’Ivoire (80.4%), Togo (81.3%), Kenya (81%) and Malawi (45%).

As of 2005, the risk of HIV in Uganda was no higher in polygynous households than in monogamous ones (Ministry of Health and ORC Macro 2006: 105). The decline of formal polygyny, however, has been found in Uganda and in other African countries to be accompanied by informal polygyny – that is, a group of co-wives in physically separate households, who are not formally connected to one another and who may not even know one another. Under these conditions, as Parikh (2007: 1 205) found, ‘women have no reason not to have multiple male partners . . . to provide additional economic and affective support, thus intensifying HIV risk for all sexual partners’.

*Ritualised non-marital sex*

Across Africa, some ethnic groups ritualise premarital and extramarital sex. A practice that has received particular attention is the ritualised sexual initiation of pubescent and prepubescent girls. Among the Chewa and Yao ethnic groups of Malawi, the practice, known as *fisi* (hyena, in the local language), involves sexual intercourse between an adult man and adolescent girls at the end of an initiation ceremony (Kamwendo and Kamowa 1999: 168).

Data from the ASRP study show that the ritual takes three forms. In the first, girls who have reached puberty are secluded for several weeks and given instruction on sex and reproduction and on the role that men and women play in the process. Three to four male instructors will have sexual intercourse with the girls at the close of the period of seclusion. According to local belief, the process enhances and guarantees the fertility of the girls. When a man marries a woman, he expects her to have undergone the ritual. As the local saying goes: 'No *fisi*, no husband.' A second form of *fisi* can be referred to as consensual adultery. If a woman does not become pregnant, despite having undergone the *fisi* ritual, the husband can hire another man to have sex with his wife to impregnate her. Finally, in a third form of *fisi* known as *kulongosola mwana* (taking the baby back), another man has sex with the nursing mother before the husband resumes sexual relations with his wife (Sungani 1998). The HIV/AIDS status of the men who play the *fisi* role is not known, thereby exposing girls and married women to an unmeasured risk of infection.

In Kenya, some funeral rituals are said to involve sexual licence. Among the Luhya people of Wanga, for example the commemoration of the dead (*lung'anyo*, or revisiting the shadow of the dead) is based on the idea that the spirit of the deceased person needs to be provided with a peaceful entry into the spirit world. The ritual facilitates that process by cleansing the living from any evils and stigma associated with the dead and also commemorates and appeases the dead. The ceremony takes place a month after a person's death and involves all married members of the community. It consists of eating, drinking and dancing, and culminates in sexual intercourse among those

assembled. Pregnancies following this ritual are believed to be the reincarnation of the deceased. A male informant in the ASRP study described the ceremony as follows:

During the night, the dead person is supposed to be named and the naming is only supposed to be done by members of the family and hence the presence of the *abakoko*. As the festivity gathers momentum, people start picking their mates randomly, this culminates into sexual encounters. You just chose whomever you come into contact with. People say today is *omuhula* (the naming of the dead). So everybody attempts to conceive so that they can be able to name the dead. Nobody is supposed to refuse these advances because everyone knows the essence of assembling at the deceased's home. People look forward to this ceremony because of the sexual activities (Nkwi 2005).

As one would expect, the use of condoms during this ceremony is forbidden because it defeats the ideology of reincarnation through sexual intercourse. The multiple acts of sex create the opportunity for the spread of HIV.

Among the Samburus of northern Kenya, the sexual initiation of young girls and the participation of adult men (called *morans*) in the tourist trade for sex produces a high risk of exposure to HIV/AIDS. From ethnographic data in the ASRP study, circumcised Samburu men are theoretically entitled to sex with any available woman. Young men who fall in love express their feelings by adorning a young girl with beads and showering her with gifts. This beading culture has come to symbolise Kenya for many tourists and Samburu men have become the object of attraction for some female tourists who pay to have sex with them. The Samburu believe that sperm are vital for creating children and that having sex with a condom is tantamount to denying life to come into being; their liaisons with tourist women are reported to be typically without condoms. One *moran* informant in the ASRP study said this about women tourists seeking sex:

When a white woman sees you at the park they tell you I love you and I want you now. You give her two shots [sex] and you get Ksh.20, 000. *Mzungu* (Europeans) like sex; they also like the way we walk, the way we dress and our disposition . . . they need men like Samburu *morans* who eat herbs, meat and milk and they give us money so we are all satisfied but sometimes it adds AIDS (Nkwi 2005).

If the *morans* return to their home villages and engage in sex with unmarried girls, this creates more opportunities for HIV infection.

The treatment of infertility sometimes leads to so-called therapeutic sex between healers and their patients. This is reported for some ethnic groups of north Cameroon. In this case, an infertile female patient submits to the healer in the belief that this will help her recover her fertility. The risk of infection increases with the number of patients (see Runganga, Sundby and Aggleton [2001] for a report of this in Zimbabwe).

### *Multiple concurrent sexual partners and poverty*

Finally, the most important vehicle, by far, for the spread of HIV/AIDS is the practice of MCPs. Morris and Kretzschmar (1997, 2000) modelled the rate at which HIV spreads in a population characterised by serial monogamy compared to one in which people have multiple concurrent partners.<sup>5</sup> In Uganda, the observed level of concurrency in 1994 resulted in 26% more infections after five years than would have been the case under serial monogamy (Morris and Kretzschmar 2000: 124).<sup>6</sup> Empirical studies have corroborated the importance of partner reduction in holding back the spread of HIV. While the use of condoms and voluntary testing may have contributed in part, the decline in prevalence of HIV in Uganda (from 15% in the early 1990s to 4% in 2003) was fundamentally the result of behaviour change – in particular, the reduction in the number of sexual partners (Stoneburner and Low-Beer 2004; Green et al. 2006).<sup>7</sup>

One source of concurrent partners is commercial, transactional sex, mostly by women. The link between poverty, commercial sex and HIV transmission is obvious and well documented (see, for example,

Pisani 2008). Another source of concurrent partners, however, is non-commercial, transactional sex – again, mostly by young women but sometimes by young men. Poverty plays a strong role in these transactions, but there may be other causes as well. Data from the ASRP study, for example, show that young women are increasingly engaged in sexual relations with so-called ‘sugar daddies’, much older men, who take care of immediate financial needs, such as school fees, rent and food. In Cameroon, the girls call these married men *cou plié* or folded necks or *mbomas* and the transactional sex with them is considered temporary. Young women in the ASRP study reported that during these relationships they could not refuse to have unprotected sexual intercourse. Some of the young women with ‘sugar daddies’ reported also having a regular boyfriend of their own age, who may or may not have known about the ‘sugar daddy’.

On the other hand, young women in the ASRP study also reported having several sexual partners of their own age. They justified this in terms of the search for new sexual experiences and for emotional security – that is, a need to have a ‘standby partner . . . someone on whom you can rely in case you get beaten by your lover’. In any of these multi-partner relations, whether based on economic need or for other reasons, the risk of HIV increases for everyone in the network if one of the partners is an older ‘sugar daddy’.<sup>8</sup>

Poverty supports the cultural practice of marrying adolescent girls to older men, as families turn their young daughters into economic assets. This increases the risk among young girls for exposure to HIV if the older husbands are already infected with the virus or if the husbands have other, concurrent partners. In urban Zambia and Kenya, Clark (2004) found HIV prevalence higher among married adolescent girls, fifteen to nineteen years of age, than among their unmarried counterparts. Furthermore, in these unions, the husbands (typically much older than the girls) were three times more likely to be HIV positive than were the boyfriends of unmarried girls, despite the fact that the reported number of sexual partners for unmarried girls in the study ranged from 0 to 21, whereas the under-twenty married women typically have just one partner (Clark 2004: 155).

Clark's findings corroborate those of Kelly et al. (2003), who found that sexually active, unmarried adolescent females (fifteen to nineteen years old) in Uganda were significantly less likely to be infected with HIV than were their married counterparts. Among married women in this age group whose partners were at least ten years older than them, the risk of contracting HIV was twice that of women whose partners were no more than four years their senior. Older husbands are increasingly likely to be infected and to pass that infection on to their younger wives (Kelly et al. 2003: 446).

In Kisumu, Kenya and in Ndola, Zambia, Glynn et al. found that 'despite the age gap at marriage and the young age at marriage for women, almost twice as many women as men were estimated to be HIV-infected at the time of their first marriage' (2003: 532). This may be because of earlier sexual debut among women and the higher prevalence of male-to-female transmission of HIV than female-to-male transmission (Hugonnet et al. 2002). Over time, however, Glynn et al. found that 'at least one quarter of HIV-positive men [were] infected from extramarital partnerships' (2003: 530).

In other words, women as well as men can bring HIV infection home. The self-reported rate of extramarital sex for women in Africa, relative to that for men, is low but may be underreported. According to the Global Program on AIDS, about 6% of women in Africa reported extramarital sex in 1995 compared to about 16% of men (Kirby 2008: 55). In a study of five African countries, De Walque (2007: 505) found that women alone were infected in 30 to 40% of infected couples. This points either to premarital infection by women or to extramarital sex by women as the unreported source of HIV transmission.

With regard to premarital infection, Bongaarts found a strong association in 33 sub-Saharan countries 'between a high average age at marriage and a long period of premarital intercourse during which partner changes are relatively common and facilitate the spread of HIV' (2007: 73). With regard to extramarital infection, Tawfik and Watkins (2007) found that rural women and men in Malawi, especially women, recognised that women take extramarital lovers for reasons other than for escaping poverty: to obtain consumer goods that their husbands

cannot provide, for revenge against the infidelities of their husbands and for passion. Women in the rural Balaka province of Malawi, say Tawfik and Watkins, are not the 'poor, powerless, and passionless' beings they are made out to be in the narrative of the Western AIDS-fighting establishment (2007: 1091).

Finally, while many infectious diseases are the consequences of poverty, the risk of contracting HIV actually increases with wealth across sub-Saharan Africa. In a study of families in eight countries across sub-Saharan Africa, the prevalence of HIV was, in every case, 'higher among adults belonging to the wealthiest 20% of households than among those from the poorest 20%' (Mishra et al. 2007: S20). In all eight countries, the wealthier men and women were more likely to use condoms and the wealthier men were more likely to be circumcised (i.e. factors which inhibit the spread of HIV). However, in every country but one (Tanzania), wealthier men report having more sexual partners (both lifetime and in the last year) and more casual (that is, non-regular) partners than do poorer men. These findings, based on large samples and linked to blood tests for HIV (S18), corroborate earlier studies that were based on population-level statistics (O'Farrell 2001; Shelton, Cassell and Adetunji 2005) that the risk of HIV increases with wealth in Africa.

## **Conclusion**

As we develop interventions against HIV/AIDS, we should ask first: What practices increase the risk of HIV transmission and what practices lower that risk and second, how can we help discourage the former and promote the latter? Culturally appropriate interventions for eliminating FGC and for eliminating unprotected ritual sex are important, as are education programmes to ensure the use of sterile instruments in all instances of local surgery. But these and other African cultural practices are not the major obstacles to lowering the prevalence of HIV.

The evidence is now abundant that first, reducing the number of concurrent sexual partners (the combination of A and B in ABC) outside stable unions was key to the success of efforts in Uganda to

reduce the prevalence of HIV (Green 2003; Halperin and Epstein 2004; Kirby 2008) and second, that recent successes in Kenya (Green and Herling 2007: 27) and Zimbabwe (Gregson et al. 2006) are also the result of partner reduction.

All societies rely mainly on the internalisation of norms to regulate behaviour. State-level societies do not have enough police to keep people from killing one another, much less to keep them from running red lights. Even in small-scale societies, there are not enough eyes to watch everyone all the time, although informal social-control mechanisms in those societies have a better chance of working because people tend to remain in face-to-face contact throughout their lives. Policing everyone's sexual behaviour is impossible and handing out millions of condoms will not, by itself, solve the problem of HIV transmission.

We have a chance to combat AIDS by creating norms that prevent people from engaging in behaviours that carry a high risk of infection. This was clearly done in Uganda and other countries with culturally sensitive programmes that not only challenged or discouraged cultural practices deemed to increase risk of HIV transmission (for example, widow inheritance), but also built upon and reinforced practices, such as delaying sexual debut, that decrease the risk of HIV transmission. Both ways to deal with culture and HIV risk merit our closest attention.

## Notes

1. We are grateful to Edward Green, Allison Herling, and Clarence Gravlee for helpful suggestions on drafts of this chapter.
2. The practice of 'dry sex', for example, involves removing the lubricating fluids in the vagina by douching and drying. It increases friction during coitus but apparently does not increase the risk of HIV (Myer et al. 2005, 2006).
3. The researchers who collaborated in data collection and analysis were: Socpa Antoine (Cameroon), Kofi Nguessan (Cote d'Ivoire), Judith Karogo (Kenya), Wycliffe Masoo (Malawi), and Adade Messan (Togo).
4. The phrase 'zero grazing' appears to have been introduced by Samuel Ikwaras Okware, the commissioner for health services in Uganda in 1987 when that country launched its ABC programme against AIDS.
5. For more on modelling of the effect of MCP, see Anderson (1996, 1999), Hudson (1993), and Watts and May (1992).

6. See Parikh (2007) for a detailed account of this difference in expectations in Uganda.
7. See Mah and Halperin (2008) for a review of the evidence on the effect of MCP on HIV epidemics in Africa.
8. The phenomenon of sugar mummies, older, working, married or unmarried women who engage in semi-permanent, discreet sexual relations with young boys in return for material support, was earlier reported by Silberschmidt (2001: 665) and was also found in the ASRP study.

## References

- Adams, J., J. Trinitapoli and M. Poulin. 2007. 'Response to Brewer et al.: Male and female Circumcision Associated with Prevalent HIV Infection in Virgins and Adolescents in Kenya, Lesotho, and Tanzania'. *Annals of Epidemiology* 17: 923-5.
- Ahmed, S., T. Lutalo, M. Mawer, D. Serwadda, N. Sewankambo, F. Nalugoda, F. Makumbi, F. Wabwire-Mangen, N. Kiwanuka, G. Kigozi, M. Kiddaguvu and R. Gray. 2001. 'HIV Incidence and Sexually Transmitted Disease Prevalence Associated with Condom Use: A Population Study in Rakai, Uganda'. *AIDS* 15: 2 171-9.
- Ali, M. and J. Cleland. 2001. 'The Link between Postnatal Abstinence and Extramarital Sex in Côte d'Ivoire'. *Studies in Family Planning* 32: 214-19.
- Amey, F. 2002. 'Polygyny and Child Survival in West Africa'. *Social Biology* 49(1-2): 74-89.
- Anderson, R. 1996. 'The Spread of HIV and Sexual Mixing Patterns'. In J. Mann and D. Tarantola (eds). *AIDS in the World II*. New York: Oxford University Press: 71-86.
- . 1999. 'Transmission Dynamics of Sexually Transmitted Infections'. In K. Holmes, P. Sparling and P.A. Mardh (eds). *Sexually Transmitted Diseases*. 3rd ed. New York: McGraw-Hill: 25-37.
- Auvert, B., D. Taljaard, E. Lagarde, J. Sobngwi-Tambekou, R. Sitta and A. Puren. 2005. 'Randomized, Controlled Intervention Trial of Male Circumcision for Reduction of HIV Infection Risk: The ANRS 1265 Trial'. *PLoS Med* 2(11). Available at [www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0020298](http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0020298).
- Bailey, R.C., S. Moses, C.B. Parker, K. Agot, I. Maclean, J.N. Krieger, C.F.M. Williams, R.T. Campbell and J.O. Ndinya-Achola. 2007. 'Male Circumcision for HIV Prevention in Young Men in Kisumu, Kenya: A Randomised Controlled Trial'. *Lancet* 369(9562): 643-56.
- Bongaarts, J. 2007. 'Late Marriage and the HIV Epidemic in sub-Saharan Africa'. *Population Studies* 61: 73-83.

- Kajubi P., M. Kanya, S. Kanya, S. Chen, W. McFarland and N. Hearst. 2005. 'Increasing Condom Use without Reducing HIV Risk: Results of a Controlled Community Trial in Uganda'. *Journal of Acquired Immune Deficiency Syndromes* 40(1): 77-82.
- Kalichman, S. 2009. *Denying AIDS: Conspiracy Theories, Pseudoscience, and Human Tragedy*. New York: Copernicus Books.
- Kalichman, S., L. Eaton and S. Pinkerton. 2007. 'Circumcision for HIV Prevention: Failure to Fully Account for Behavioral Risk Compensation'. *PLoS Med* 4(3): e138. Available at [www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0040138](http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0040138).
- Kamwendo, G. and O. Kamowa. 1999. 'HIV/AIDS and a Return to Traditional Cultural Practices in Malawi'. In K.R. Hope (ed.). *AIDS and Development in Africa*. New York: Haworth Press: 165-76.
- Kelly, R., R. Gray, N. Sewankambo, D. Serwadda, F. Wabwire-Mangen, T. Lutalo and M. Wawer. 2003. 'Age Differences in Sexual Partners and Risk of HIV-1 Infection in Rural Uganda'. *Journal of Acquired Immune Deficiency Syndromes* 32: 446-51.
- Kirby, D. 2008. *Success in Uganda: A History of Uganda's Successful Campaign to Decrease HIV Prevalence in the Early 1990s*. Scotts Valley, CA: ETR Associates. Available at [www.etr.org/uganda](http://www.etr.org/uganda).
- Klausner, J., R. Wamai, K. Bowa, A. Kwango, J. Kagimba and D. Halperin. 2008. 'Is Male Circumcision As Good As the HIV Vaccine We've Been Waiting for?' *Future HIV Therapy* 2: 1-7.
- Mah, T. and D. Halperin. 2008. 'Concurrent Sexual Partnerships and the HIV Epidemics in Africa: Evidence to Move Forward'. *AIDS and Behavior* 14: 11-16.
- Malungo, J.R.S. 2001. 'Sexual Cleansing (*Kusalazy*) and Levirate Marriage (*Kunjilila mung'anda*) in the Era of AIDS: Changes in Perceptions and Practices in Zambia'. *Social Science and Medicine* 53: 371-82.
- Marrazzo, J. 2007. 'Syphilis and Other Sexually Transmitted Diseases in HIV Infection'. *Topics in HIV Medicine* 15(1): 11-16.
- McGreal, C. 2007. 'HIV-Infected Condoms Sent to Kill Africans, Claims Archbishop'. *The Guardian*, 26 September. Available at [www.guardian.co.uk/world/2007/sep/27/aids.international](http://www.guardian.co.uk/world/2007/sep/27/aids.international).
- Ministry of Health (Uganda) and ORC Macro. 2006. 'Uganda HIV/AIDS Sero-Behavioural Survey 2004-2005'. Ministry of Health and ORC Macro, Calverton, Maryland.
- Mishra, V., S. Assche, R. Greener, M. Vaessen, R. Hong, P. Ghys, J. Boerma, A. Van Assche, S. Khan and R. Rutstein. 2007. 'HIV Infection Does Not Disproportionately Affect the Poorer in Sub-Saharan Africa'. *AIDS* 2(Supplement 7): S17-S28.
- Mitsunaga, T., A. Powell, N. Heard and U. Larsen. 2005. 'Extramarital Sex among Nigerian Men: Polygyny and Other Risk Factors'. *Journal of Acquired Immune Deficiency Syndromes* 39: 478-87.

- Monjok, E., E. Essien and L. Holmes Jr. 2007. 'Female Genital Mutilation: Potential for HIV Transmission in Sub-Saharan Africa and Prospect for Epidemiologic Investigation and Intervention'. *African Journal of Reproductive Health* 11: 33-42.
- Morris, M. and M. Kretzschmar. 1997. 'Concurrent Partnerships and the Spread of HIV'. *AIDS* 11: 641-8.
- . 2000. 'A Microsimulation Study of the Effect of Concurrent Partnerships on the Spread of HIV in Uganda'. *Mathematical Population Studies* 8: 109-33.
- Myer, L., L. Denny, M. de Souza, T. Wright Jr and L. Kuhn. 2006. 'Distinguishing the Temporal Association between Women's Intravaginal Practices and Risk of Human Immunodeficiency Virus Infection: A Prospective Study of South African Women'. *American Journal of Epidemiology* 163: 552-60.
- Myer, L., L. Kuhn, Z. Stein, T. Wright and L. Denny. 2005. 'Intravaginal Practices, Bacterial Vaginosis, and Women's Susceptibility to HIV Infection: Epidemiological Evidence and Biological Mechanisms'. *Lancet* 5: 786-94.
- Nkwi, P. 2001. 'Demographic Behaviour and Its Socio-Cultural Context in Cameroon'. In S. Syed (ed.). *Cultures of Populations: Population Dynamics and Sustainable Development*. Hamburg: UNESCO HQ Social Sciences: 25-70. Available at <http://unesdoc.unesco.org/images/0012/001240/124028eo.pdf>.
- . 2005. 'The Impact of Cultural Practices on the Spread of HIV/AIDS: An Anthropological Study of Selected Countries in Sub-Saharan Africa'. *Discovery and Innovation* 17(Special Issue): 21-35.
- O'Farrell, N. 2001. 'Poverty and HIV in Sub-Saharan Africa'. *Lancet* 357(9 256): 636-7.
- Parikh, S. 2007. 'The Political Economy of Marriage and HIV: The ABC Approach, "Safe" Infidelity, and Managing Moral Risk in Uganda'. *American Journal of Public Health* 97: 1198-208.
- Pisani, E. 2008. *The Wisdom of Whores: Bureaucrats, Brothels, and the Business of AIDS*. New York: Norton.
- Potts, M., D. Halperin, D. Kirby, A. Swidler, E. Marseille, J. Klausner, N. Hearst, R. Wamai, J. Kahn and J. Walsh. 2008. 'Reassessing HIV Prevention'. *Science* 320(5 877): 749-50.
- Rotello, G. 1997. *Sexual Ecology: AIDS and the Destiny of Gay Men*. New York: Dutton.
- Runganga, A., J. Sundby and P. Aggleton. 2001. 'Culture Identity and Reproductive Failure in Zimbabwe'. *Sexualities* 4: 315-32.
- Schoepf, B. 2004. 'AIDS'. In D. Nugent and J. Vincent (eds). *A Companion to the Anthropology of Politics*. Malden: Blackwell: 37-54.
- Shafer, L., S. Biraro, J. Nakiyingi-Miiro, A. Kamali, D. Ssematimba, J. Ouma, A. Ojwiya, P. Hughes, L. van der Paal, J. Whitworth, A. Opio and H. Grosskurth. 2008. 'HIV Prevalence and Incidence Are No Longer Falling in Southwest Uganda: Evidence from a Rural Population Cohort 1989-2005'. *AIDS* 22: 1 641-9.

- Shell-Duncan, B. 2008. 'From Health to Human Rights: Female Genital Cutting and the Politics of Intervention'. *American Anthropologist* 110: 225-36.
- Shelton, J. 2006. 'Confessions of a Condom Lover'. *Lancet* 368(9 551): 1947-9.
- . 2007. 'Ten Myths and One Truth about Generalised HIV Epidemics'. *Lancet* 370(9602): 1809-11.
- Shelton, J., M. Cassell and J. Adetunji. 2005. 'Is Poverty or Wealth at the Root of HIV?' *Lancet* 366(9 491): 1057-8.
- Silberschmidt, M. 2001. 'Disempowerment of Men in Rural and Urban East Africa: Implications for Male Identity and Sexual Behaviour'. *World Development* 4: 657-71.
- Stoneburner, R. and D. Low-Beer. 2004. 'Population-Level HIV Declines and Behavioral Risk Avoidance in Uganda'. *Science* 304: 714-18.
- Sungani, L. 1998. 'Chiputu or Simba: Initiation for Young Girls'. B.A. dissertation paper, Theology Department, Chancellor College, Zomba.
- Tawfik, L. and S. Watkins. 2007. 'Sex in Geneva, Sex in Lilongwe, and Sex in Balaka'. *Social Science and Medicine* 64: 1090-101.
- UNAIDS (Joint United Nations Programme on HIV/AIDS). 2008. 'A Global View of HIV Infection'. Map. Available at [http://data.unaids.org/pub/GlobalReport/2008/GR08\\_2007\\_HIVPrevWallMap\\_GR08\\_en.jpg](http://data.unaids.org/pub/GlobalReport/2008/GR08_2007_HIVPrevWallMap_GR08_en.jpg).
- Wakabi, W. 2007. 'Africa Battles to Make Female Genital Mutilation History'. *Lancet* 369(9 567): 1069-70.
- Watney, S. 1994. *Practices of Freedom: Selected Writings on HIV/AIDS*. Durham: Duke University Press.
- Watts, C. and R. May. 1992. 'The Influence of Concurrent Partnerships on the Dynamics of HIV/AIDS'. *Mathematical Biosciences* 108: 89-104.
- Weiss, H., M. Quigley and R. Hayes. 2000. 'Male Circumcision and Risk of HIV Infection in Sub-Saharan Africa: A Systematic Review and Meta-Analysis'. *AIDS* 14: 2361-70.
- Westreich, D., S. Rennie and A. Muula. 2007. 'Comments on Brewer et al.: Male and Female Circumcision Associated with Prevalent HIV Infection in Virgins and Adolescents in Kenya, Lesotho, and Tanzania'. *Annals of Epidemiology* 17: 926-7.
- White, R., J. Glynn, K. Orroth, E. Freeman, R. Bakker, H. Weiss, L. Kumaranayake, J. Dik, F. Habbema, A. Buvé and R. Hayes. 2008. 'Male Circumcision for HIV Prevention in Sub-Saharan Africa: Who, What and When?' *AIDS* 22: 1841-50.
- Yount, K. and B. Abraham. 2007. 'Female Genital Cutting and HIV/AIDS among Kenyan Women'. *Studies in Family Planning* 38: 73-88.