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Gender and HIV/AIDS in Africa south of the Sahara: interventions, activism, identities

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Introduction

The incidence of HIV/AIDS cannot be separated from social relationships and therefore the different forms of manifestations of social relationships are bound to have different impacts. From this assumption, one can say that different identities potentially result in varied degrees of the spread of HIV. However … identities in themselves do not explain sufficiently the spread of HIV…. It is more the context within which these identities are lived that has a significant impact on the prevalence of HIV. (Kirumira, this volume, page 154-9)

As Edward Kirumira points out in the interview he gave for this special issue, social relationships cannot be separated from the incidence and prevalence of HIV/AIDS. It is now widely acknowledged that the gender dimension of the AIDS pandemic is critical both for the understanding of its impact and to the successful implementation of prevention and amelioration campaigns. Gender inequalities clearly fuel the pandemic – leaving young women particularly vulnerable to infection. In this special issue, we examine the ways in which AIDS has impacted on gender relations in Sub-Saharan Africa and the way in which gender relations themselves have shaped and continue to shape the path of infection.

By examining three discrete areas – interventions, activism, and identities – from a gender perspective, this issue weaves together threads of gendered analysis which are often separated in the popular media and in policy. The ways in which men and women, boys and girls, are affected by the pandemic must proceed, we argue, from an understanding that gendered identities are socially constructed and that these constructions are embedded in, and
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formative of, power relations. We contend that, up to now, many of the interventions that seek to address ‘gender’ still work with essentialist and static understanding of men and women and of masculine and feminine identities. Such interventions can appear either to avoid the issue of power completely or to treat gendered identities as if they were discrete phenomena unrelated to power. However, gendered social identities cannot be separated from power relations. Furthermore, the pandemic has generated an environment in which gender identities and relations are changing very rapidly. People throughout the continent are facing situations which two decades ago were unthinkable. Family forms have been revolutionised – the deaths of parents and extended family members have created households with very young heads. Old women have been propelled into parenting third generation children (as their own children have died). Marriage as a family form is changing. In some cases, men have less power in the workplace and the family than women do. On a wide number of fronts, issues that were hitherto taboo have come to the fore. Sexual orientation and traditional sexual practices (circumcision and virginity testing, for example) have pushed their way on to AIDS agendas worldwide. In turn, these have found their way into interventions of one sort or another and are currently expressed by activists. As we show, there is great diversity in these responses to AIDS and this diversity reflects and impacts upon gender relations.

Another important aspect of the HIV/AIDS epidemic in Africa is that it is taking place within a global context in which socio-economic relations, famine, indebtedness and the role of international corporations, particularly the pharmaceuticals, have a major impact. This is manifested in levels of poverty and consequently compromised immunities even before HIV infection, in the macro-economic possibilities for Sub-Saharan African countries and in the interventions offered by aid organisations and activism within affected countries. UNAIDS offers a glimpse of the scale of the problem:

AIDS in Africa
By far the worst-affected region, sub-Saharan Africa is now home to 29.4 million people living with HIV/AIDS. Approximately 3.5 million new infections occurred there in 2002, while the epidemic claimed the lives of an estimated 2.4 million Africans in the past year. Ten million young people (aged 15-24) and almost 3 million children under 15 are living with HIV.
A tiny fraction of the millions of Africans in need of antiretroviral
treatment are receiving it. Many millions are not receiving medicines to treat opportunistic infections, either. These figures reflect the world’s continuing failure, despite the progress of recent years, to mount a response that matches the scale and severity of the global HIV/AIDS epidemic. (UNAIDS 2002:17)

The failure of the rich nations of the world to deliver anything like a ‘Marshall Plan’ for Africa has meant that poverty and famine, twin drivers of the epidemic (but not its causes), are going unchecked. In this context, globalisation is fuelling inequalities between the ‘developed’ (over-developed?) and ‘developing’ world. At the same time, the enormity of the humanitarian catastrophe is one that has the potential to lead to new levels of connectedness between the rich and the poor worlds as people and both governmental and non-governmental agencies seek to address the pandemic.

The magnitude of the crisis can deflect analysis away from the link between gender equity issues and health. Gender inequality leads to ill-health. This is particularly the case with HIV/AIDS where gender violence, particularly rape (which is both a symptom of gender inequality and part of the way it is held in place), is a major contributor to infection rates. The purpose of this issue is to explore how gender and AIDS are related. In order to do this, we need in the first instance to note that ‘gender’ has been embraced by UNAIDS, national governments and NGOs. This trend might, some would argue, render further attention and analysis of gender and AIDS superfluous. We suggest on the contrary, however, that we need to know much more about the gendered dimension of the pandemic in order to contribute to dealing with its effects and ultimately ending HIV transmission. The public acknowledgement of the importance of gender provides a fertile policy environment for gender work. It may even be the case that AIDS – and its associated human costs in terms of deaths, dislocations, debilitating illness, disruption of working lives and termination of education progress – is providing a unique opportunity for unequal gender relations to be addressed.

In this article, we draw on the published data and literature about the HIV epidemic in Sub-Saharan Africa, the other papers in this special issue and our own research in KwaZulu Natal, the most populous and worst affected province in South Africa. We have already begun to outline an overview of the pandemic, which we elaborate further below. We argue that there have been two basic approaches to the problem of how to intervene in the current crisis. The first is based on the hope that the answer can be found in personal
transformation and that interventions can empower people (often, but not only, women) to take control of their lives, their sexualities, even their identities, in order to slow or stop the spread of HIV. The second approach sees the answer as lying in social transformation, in which gendered, ethnic and class relations are restructured. The first approach can, indeed, lead to immediate benefits with individuals feeling (and being) able to approach their lives and their sexual partners differently, at least for a while. The problem is that such benefits are often short-lived and cannot survive the intrusion of material differences in power, access to money, and so on. The longer term answers need to include socio-economic transformation but this is difficult to achieve. We argue, here, that both approaches are needed. Indeed, we suggest that there is a dialogic relation between the two: individual transformation is shaped by socio-economic processes and relations of power and socio-economic transformation can and do take place through the actions of individuals.

**Interventions**

For the past 15 years, many intervention strategies have been developed to prevent HIV transmission. There have been, in addition, a huge number of strategies designed to ameliorate the effects of infection – for example, administering antiretroviral drugs, supplementing nutrition, promoting home-care, developing systems to accommodate orphans.

Initially in a context where heterosexual HIV infections were predominant, strategies focused on the provision of condoms and on safe-sex education programmes. In the 2002/3 fiscal year, for example, South Africa’s Department of Health sought to procure 358,000,000 condoms and in its most populous province, KwaZulu-Natal, 16,500,000 condoms were distributed in 2002 (South Africa. Department of Health 2002). The distribution of sex technologies occurred side by side with education programmes that showed how condoms should be used, explained what HIV/AIDS was and how it could be contracted and promoted abstinence, monogamy and/or condoms as ways successfully to avoid infection. Education conceived of as providing relevant knowledge was considered to be an essential and even a sufficient method of preventing the spread of HIV. The unflagging increase in HIV transmission rates throughout Sub-Saharan Africa, however, alerted governments and aid agencies alike that this approach was inadequate. There is now a wide-ranging critique of ‘Education as Contraception’ or ‘Education as the Silver Bullet’ (for example Jeffery and Jeffery 1998). Objections range from the imperialist agenda of population policy and the
way it excludes local voices (Kuumba 2001) to the observation that for education to be effective, its delivery has to be associated with equity policies and adequate resources. The critiques note that there is nothing automatic about education empowering learners and that other factors, for example poverty, are always important and have a bearing on the power of education (Heward 1999, 1998; Jeffery and Basu 1996).

Even though it is recognised that education is not a quick fix for HIV/AIDS, and that, more specifically, transmission models of education and the provision of condoms are ineffective in promoting changes in sexual practices, policymakers are still left with education as the major means of tackling prevention. In most countries it provides the most accessible way of reaching young people with messages about how to avoid becoming HIV. Many countries have yet to implement HIV education programmes in school (Berghof 2003), but in South Africa the curriculum now includes Life Skills which specifically includes issues of sexuality and HIV/AIDS. Amongst NGOs and other service providers, more nuanced approaches to prevention campaigns have gradually been developed. An early advance over the transmission model was the Knowledge-Attitudes-Practices (KAP) approach. It recognised that knowledge did not automatically convert into changed sexual behaviour and thus attempted to develop a more intense and structured educational experience. While this was an improvement on the earlier approach, it too had limitations, which critics named the KAP-gap – the failure of the KAP approach to change practices in the way and to the extent anticipated. Health education initiatives of all kinds often fail. Their outcomes are most uncertain when their ambit is broad, the politics is highly contested and they strive to impact on behaviours in impoverished and socially tenuous circumstances (Barnett and Whiteside 2002).

For a range of reasons – limited resources, the huge extent of the problem and people’s reluctance to talk openly about sex – many of the early interventions dealt not with individuals but with groups. There is a clear distinction in emphasis between those interventions that target small groups of ‘at risk’ individuals (for example, intravenous drug users or self-identified gay men) and those interventions which attempt not only to reach a more general public but also attempt to address the broader socio-cultural and political and economic contexts that foster gender inequality, an area associated with higher levels of HIV risk. Most prevention campaigns, whether they are working with small groups of individuals or ‘society’ more broadly, have to take account of context. Prevention strategies that assume
that sex is the result of rational, health-conscious choices made freely in a
gender-neutral environment are likely to fail (see, for example, Oliviera 2000).
In fact, a large body of research material demonstrates that gender-neutral
environments, especially for women, do not exist. This is particularly well
demonstrated by Alex Kent’s examination of a Durban school (this volume).
Although the school has formally embraced the goals of gender equity and
HIV prevention, she shows that the school space is still dominated by
compulsory heterosexual values that conceal gender power inequalities and
undermine the formal work of promoting gender equality and preventing the
spread of HIV.

In the last two decades, the work of feminists and gender scholars has
influenced policy makers and NGO workers to accept an approach that
acknowledges the centrality of gender in the HIV pandemic. This permits a
more realistic engagement with issues of sexuality (as distinct from narrow
preoccupation with sexual intercourse).

Initially, gender awareness showed that the gendered impact of the
pandemic was uneven and this has affected the form that interventions have
taken. From the mid 1990s – spurred on by the International Conference on
Population and Development (Cairo, 1994) and Fourth World Conference on
Women in Beijing (1995) – specific attention began to be focused on women.
It became de rigueur for AIDS interventions to focus on the vulnerability
of women. And there were very good reasons for this. Feminist work showed
that women in the poor countries were disadvantaged in many ways, for
example suffering higher levels of illiteracy and unemployment and lower
levels of income than men. An abundance of research also began to emerge
that highlighted very high levels of violence against women. This violence,
it was noted, heightened the vulnerability of women to HIV infection.
Women were raped and were unable to negotiate safe sex for fear of male
violence against them. It was particularly young black women who were at
risk (up to six times more at risk than men of the same age in southern Africa).
Many prevention campaigns consequently emphasise the importance of
‘empowering’ women.

Efforts to empower women had broader goals than just to limit HIV
transmission. Historically gender development work had been designed to
raise literacy (Stromquist 1990; Walters and Manicom 1996), improve rates
and levels of education (Kelly 1989; Kelly and Elliot 1982; King and Hill 1993)
reduce unwanted pregnancies (Levine 1980) and improve the earning-
capacity of women (Budlender 1991; Skinner and Valodia 2001; Walby 1997).
Efforts to make HIV prevention campaigns contribute more broadly to gender transformation (Harrison et al 2001) remain important. And there is no indication that these efforts will be abandoned. However, particularly in the last five years, efforts to make gender a central feature of prevention have come to recognise the limitations of focusing only on women. Empowering women in contexts where gender inequalities are pervasive necessarily runs the risk of heightening tensions and increasing violence against women. Many women admit that they are not assertive around issues of safe sex because they fear being assaulted by their partners. Another factor that complicates analysis is that empowerment can actually increase the risk of HIV transmission when young girls, operating in an environment where human rights discourses are available, use the newly discovered power of their sexualised selves to take voluntarily numerous sexual partners (Hunter 2002).

While it is true that, by a small majority, women have suffered more fatalities from AIDS than men, and that they are more vulnerable to infection (and more of them are infected than men), it cannot be denied that men are also affected and infected by HIV/AIDS (Varga 2001). In this collection, Margrethe Silberschmidt’s contribution on East Africa shows how economic changes and the different gendered responses thereto have left men feeling frustrated and powerless and have promoted risky sex practices. For two basic reasons, HIV prevention efforts have begun to include, and in some cases focus on, men. The first is that they are themselves at risk and infected. The second is that gender inequalities cannot be addressed by working only with women (Bujra 2000). It is imperative that men be involved in gender transformation.

UNAIDS has now begun to push this position forcefully after a long period of directing attention at women alone. As Peter Piot, Executive Director of UNAIDS, has commented:

> The time is ripe to start seeing men not as some kind of problem, but as part of the solution. Working with men to change some of their attitudes and behaviours has enormous potential to slow down the epidemic and to improve the lives of men themselves, their families and their partners. (United Nations Population Fund (UNFPA) 2000)

The shift to including men has not only acknowledged the importance of involving them in prevention measures, but it has also been accompanied by a more nuanced understanding of gender relations. The best strategies now understand sexuality not as simply a physical act, the exchange of body...
fluids, but as something that is negotiated (even if tacitly and non-consensually), that involves power and emotions and is not easily susceptible to rational intervention.

It is now widely conceded that our knowledge of why people change their behaviours is at best partial. Why people choose to have safe sex or no sex at all remains a major research area. And yet some interventions that have worked closely, intensely and in a sustained way with target audiences, have been able to reduce infection levels while at the same time contributing to self-esteem and more generally to better gender relations (Makhaye 1998). On the other hand, as Marc Fiedrich (in this issue) shows in relation to an adult education setting in Uganda, there is nothing straightforward about such interventions. Where existing values clash with those of the intervention, tensions are thrown up which may impact or block the intended outcomes. His work, like that of many HIV evaluations, demonstrates the importance of context and the need to acknowledge that factors beyond the intervention setting are influential and need to be taken into account.

**Activism**

If, as we have argued above, HIV/AIDS cannot be understood outside the context of unequal power relations (based on gender, social class, race, ethnicity, sexuality and other social identities) in our families, communities, societies and the world, it is clearly a highly political issue. In this context, efforts to address the epidemic – whether via educational or medical interventions or in activist campaigns – can be understood as a response to social oppression and dispossession. There is, then, a sense in which all interventions can be seen as a form of activism. Nevertheless, interventions by educators, medical and social scientists, government departments and supranational organisations are not usually driven by the kind of emotions – for example, anger – and thinking which lead to the formation of activist groups. More directly political and politicised activism, by organised groupings, such as the Treatment Action Campaign (TAC) and community based groups like TASO (The AIDS Service Organisation), can be understood as a response to ‘indignation at one’s own deprivations [as well as] compassion for the deprivation of others’ (Van Huyssteen 2002:21). It is, however, clear that there is an overlap between community activists – often but not always themselves infected and/or directly affected by HIV/AIDS – and those engaged in more official research, health or educative interventions.
Jo Manchester (this issue: 85-104) makes the point that much HIV/AIDS activism in Africa has been led and dominated by HIV positive women and that even in those contexts where leadership roles have been taken by men, women have often been the majority of members. Despite the many similarities between activist organisations in Africa in this respect, it is important to remember that activist priorities, modes of action and politics are constructed and performed differently by the various individuals and groups involved and are framed by their different contexts across the continent. In South Africa, for example, the history of struggle against apartheid and the strength of civil movements developed in that context have been influential in new forms and foci of activism in relation to HIV/AIDS, environmental activism and global activism. In the HIV/AIDS arena, South African activism is often directly focused on issues of government policy and treatment availability, while in many other African countries, HIV/AIDS activism is often embedded within other foci such as war, violence, and poverty. Local context also makes a difference to the demands of particular campaigns and activist organisations. This is partly a response to the level of resources available in particular countries. For example, in the richest country in Africa south of the Sahara, South Africa, the most visible and powerful form of AIDS activist organisation (that is, the Treatment Action Campaign or TAC) focuses on treatment, particularly access to antiretroviral drugs. In the rest of the continent, by contrast, activism emphasises the apparently more affordable aspects of dealing with the pandemic, particularly education and home-based care.

HIV/AIDS activism, like other campaigns, takes on different meanings and formations in different political, economic and cultural situations. For example, rights-based activism (Van Huyssteen 2002) frequently advocates for people’s right to health. In this context, the right to treatment is one important aspect of the struggle. TAC’s fight for access to antiretroviral therapy is an example of this. As Zackie Achmat, chair of the TAC, observes in the edited transcript of his address to staff and students at the University of Natal (this volume), ‘[activism is] about equality, because no matter what anyone says, it’s those of us with money who can afford to buy life’. It may be that the success of rights-based activism around treatment within any one country is very dependent on whether the state is able to pay for the medical services demanded – a cost that many African countries would be unable to meet even when generic drugs are obtained relatively cheaply. Hence the importance of the link between local activism in relation to state policy, as
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in the case of TAC in South Africa, and international activism aimed at the globalised pharmaceutical industries, rich governments of the ‘developed’ world and aid agencies. As Zackie Achmat points out:

South Africa has enough money to treat people for the next four or five years, maybe 10 years. But Malawi, Mozambique, Angola, the Caribbean countries, some of the countries in Latin America and Asia do not. It’s critical that the global fund gets the 7-8 billion dollars a year that it needs – which is less than the amount of money spent annually on ice cream in the US or in Europe. So it’s very important that we keep this pressure up. (p80, below)

While some versions of rights-based activism are limited by their tendency to target individuals rather than communities and the social relations that tend to put individuals and groups at risk, at other times activists have taken on structural issues beyond the needs and rights of individuals. In such circumstances, activist demands for individual human rights have been strengthened by paying attention to differentials of social and economic power within and beyond local communities and states.

An alternative (but not mutually exclusive) framework for activism to an individualistic rights-based approach, which is often favoured by and for poor community contexts, is that of local community participation (Campbell 2003). This framework (which can be seen in the work described by both Fiedrich and Silberschmidt in this issue) is based on the notion that interventions that enable and facilitate the participation of local grassroots community in efforts aimed at addressing the social determinants of HIV, are more likely to succeed. According to this framework, social identity (such as class, gender, race, etc) may preclude powerless individuals and groups from engaging in health promoting behaviours and efforts. Interventions that do not take this into consideration are bound to fail. Such approaches would include integrated and participatory multi-stakeholder initiatives.

Informed by these differing frameworks, several levels of, and arenas for activism in the field of HIV/AIDS exist. Campbell (2003), for example, identifies a number of possible arenas: government, NGOs, partnerships between public and private sector, global activism, direct work in the area of health, and alliances between health activists and others. Many of these seem to focus on educating (for behavioural change), lobbying and advocating for and on behalf of ‘Others’ (the poor, the sick, and the marginalised). Nevertheless, as Manchester and Achmat both note, the most powerless members of society dominate much AIDS activism. At least half
of the membership of TAC, for example, consists of young people between the ages of 16 and 24, and 70 per cent of the membership consists of women from marginalised communities. Similarly, membership and leadership of the organisations discussed by Jo Manchester rests primarily with women.

Here, social identity (age, class and gender) seems to be playing a less predictable role. Instead of the powerful taking the lead, as in other arenas of activism, HIV activism seems often to be led by the most vulnerable. This may be partly because of the stigma attached to the disease, and its high prevalence among these groups – a situation that may contribute to the further entrenchment of unequal, and possibly violent, social relations, as was seen in the stoning to death of Gugu Dlamini in KwaMashu near Durban, after she disclosed her HIV status. But the story that Jo Manchester tells is not one of despair. Despite the many deaths, the activism of Manchester herself and of the women about whom she writes, sustains them and shifts the frameworks for interventions and, indeed, for the construction of identities. The activism of these women across international boundaries, and across race/ethnicity and class, provides grounds of building interventions and for, as Manchester puts it, ‘Hope, Involvement and Vision’ in the fight against HIV.

Activism is also performed at the individual level. In South Africa, examples of individual forms of activism include doctors who have defied government to treat patients and administer antiretrovirals; individuals like the satirist Peter Dirk Uys, who educates, mobilises and lobbies government and the private sector to act against HIV/AIDS; a few HIV-positive celebrities who publicly announce their status in an attempt to destigmatise the disease and educate the public; plus the countless individuals who work without recognition to assist those less fortunate in their communities. While these are commendable and much needed, they focus on the individual (to change his/her behaviour, or to assist him/her to gain access to treatment) and are thus only short- to medium-term strategies. As Campbell (2003) stresses, more long-term strategies that include grassroots community participation aimed at eliminating the social conditions that breed unhealthy sexual practices, are needed. A key problem, as Achmat warns, is that:

[while HIV affects everyone], …people who are carrying the burden of openness, the burden of justice, the burden of going to the streets and putting their bodies on the line, are the poor African women and males. The middle class people living with HIV still feel stigmatised [and can afford] to come out.
While there is an abundance of activism across the continent, some of which is already bearing fruit, major gaps still exist in our understanding of the various contexts in which such activism is performed. Mark Hunter, Marc Fiedrich and Margrethe Silberschmidt, writing in this special issue, begin to unpack many of the very specific local cultural and contextual issues involved in interventions and activism in different parts of Africa. Further research is needed to understand how war and other social conflicts impact on women’s vulnerability. Hunter considers the impact of *isoka* particularly in relation to young men. Similarly, we need to understand better the ways in which taken for granted cultural practices and norms may disadvantage girl children in rural and urban contexts (such as *lobola* – bride price). Such understandings could help activists develop programmes that focus on changing the unequal social relations that contribute to the infection of the mostly powerless, marginalised and poor individuals and groups (Campbell 2003).

**Identities**

It is already clear, from what we have said above, that it is impossible to consider either the HIV/AIDS epidemic or interventions and activism surrounding it without thinking about personal and social identities. As Stuart Hall points out (Hall 1996) identities are more fluid and fragmented than we often like to think. We are, in his phrase, always in the process of becoming – ‘human becomings’ rather than ‘human beings’. And the way we become, that is who we become, is very tied up with conscious and unconscious processes of identification: who do we like, desire, wish to be, wish to be with, who do we hope desires us? And, on the other hand, who do we dislike, who makes us recoil, who do we identify against? These are not fixed certainties. Rather they are socially constructed. To misquote Marx (1963), we make ourselves in conditions not of our own choosing.

The rapidly changing circumstances in which people are living their everyday lives inevitably produce new narratives through which they tell themselves who they are, and how they can live and act in the context of HIV and the risks associated with it. One such narrative is that described by Mandisa Mbali in her discussion of ‘denialism’. Allegiances and identifications formed in (and in response to) one context may not serve people well in others. If, as she argues, AIDS denialism is a kind of identity claim in response to racism, its continuation in the face of the epidemic is potentially disastrous and has its own impact on contemporary formations of identity. In the section on interventions we have pointed to changing
relations of gender and family forms as a result both of the epidemic and of changing socio-economic conditions. Margrethe Silberschmidt and Mark Hunter, in their articles in this special issue, consider how masculinities have changed and continue to change in the context of the epidemic. Both draw attention to the importance of socio-economic relations, Silberschmidt in the context of East Africa and Hunter in KwaZulu-Natal in South Africa. Silberschmidt points to male disempowerment. She argues that:

Patriarchy does not mean that men only have privileges. A patriarch has also many responsibilities. The key and the irony of the patriarchal system reside precisely in the fact that male authority needs a material base. Patriarchy used to be closely linked to male entitlement to control all essential resources, to ‘own’ and decide over the means of production.

Changes in the organisation of household responsibilities have, she suggests, led to both women and men playing their social roles differently (or occupying new social positions) and, therefore, constructing new formations of identity. This, she suggests, requires new kinds of intervention that engage actively in dialogue with men. Where different forms of masculinity are needed in the fight against HIV, interventions that ignore men and/or seek only to empower women may be less than effective.

Hunter’s nuanced and detailed examination of the making and unmaking of isoka masculinities gives us another example of how formations of identity are reinvented as contexts change. His interviews with three generations from the same family give a vivid picture of some of these changes. As he points out, the very existence and depth of the epidemic mean that masculinities (and, equally, femininities) are changing and will continue to change. As he says, isoka masculinity has not vanished. Its content is now contested and it is possible to say that the Don Juan understanding of isoka is no longer dominant. At the same time, activism and interventions can and will provide the resources for people to reinvent themselves as different kinds of men (and women).

The questions which Hunter and Silberschmidt’s respondents are trying to answer deal with all kinds of uncertainty and fragmentation in relation not only to gender and family but to people’s place(s) in the world more generally. The young people and teachers in Alex Kent’s study too are trying to understand who they are or can be. Particularly poignantly, they are concerned about how they can live their lives, survive and even thrive in a world where much seems risky – with the prevalence of HIV and gendered
violence playing a very particular part in the formation of identities. The women living with HIV described by Manchester are also finding their own ways of surviving and thriving, their hopes (and maybe their health) buoyed by their own visions and activist interventions.

Conclusion
We have argued in this paper that interventions, activism and identities are interdependent in critical ways. Interventions and activism both come out of and impact on social identities and their success may well be dependent on the degree to which they chime with existing formations. The narrative and discursive resources available to people are historically specific and are never independent of the political and socio-economic conditions in which they live. Overall, we believe that this issue shows the importance of taking into account a range of differences that affect people’s lives, opportunities and identities in the kinds of interventions and activism we develop. Gender, as we have shown, is a key issue here. While not independent of other differences (like race, sexuality, ethnicity and socio-economic status), it is a critical aspect of identity shaping both the forms of intervention and activism adopted in attempts to reduce the impact of HIV/AIDS and people’s responses to them.

References


Article

‘I told them not to love one another!’ Gender, Christianity and the role of adult education in the Ugandan response to HIV/AIDS

Marc Fiedrich

Introduction: acknowledging the boundaries of adult education

The only vaccine to combat HIV/AIDS is education. (…) Unlike other contagious diseases, AIDS is easy to prevent and preventive education works. (proceedings of workshop, UNESCO 2001)

The image of education as an injection drug is a popular and compelling one, particularly in the context of HIV/AIDS. But while it provides a welcome boost to health education activities, it also carries substantial risks. The most pertinent is perhaps that education here appears as an external force that penetrates societies and individuals and reforms them in a predefined way. Such an overestimation of the powers of education is not only bound to create disappointment, it also skews our interpretation of failure once it does occur. When education fails to produce the ‘rational’ behaviour changes it is believed to harness (condom use, abstinence, faithfulness), inflated expectations are rarely blamed, instead education’s unfulfilled promise is explained by pointing to ‘barriers’ that allegedly stood in its way: tradition, ignorance or, simply, ‘culture’.

In this paper I argue that it is more useful to think of the moral boundaries within which education takes place than of the barriers to it. Crucially, the idea that education may push boundaries while at the same time proceeding within boundaries allows us to consider the educational process as an expression of the historical and political contexts within which it takes place. By contrast, a focus on barriers to education easily dehistoricises and depoliticises the endeavour, forgetting that education reproduces rather than invents societies.
I start out by looking at why facilitators in one adult education programme in Madudu, central Uganda either evaded the issue of HIV/AIDS or limited themselves to hastily disseminated, moralising reminders about the value of faithfulness and abstinence. This tendency is all the more surprising when considering that the same group of facilitators eagerly discussed questions about HIV/AIDS and sex during their own training to become adult educators. Why did they regard such a discussion as inappropriate or difficult in the context of an adult education class? A first line of explanation considers the long-standing link between adult education and Christian organisations and practices. Learning rituals in the classes resonated with those of Christian worship and this I argue has consequences for the moral boundaries of debate. In short, facilitators and participants were not comfortable for class discussions to contemplate without immediate condemnation those practices and beliefs they took to be ‘un-Christian’. Some adult educators may consider this a barrier to ‘open debate’ and one that in this case may carry serious health risks. It is argued here that recognition of such boundaries is a helpful first step for exploring means of working within them as well as expanding them. This is not to say that adult education should avoid challenging the sometimes undoubtedly bigoted views of learners but it is to say that, for better or worse, the control programmes can exercise over actual debates in classes is far more limited than widely imagined. To recognise this puts into perspective some of the contradictions that have plagued adult education practitioners ever since Freirean conscientisation efforts were first criticised.

The perception of gender relations is a second important aspect explaining why debates in the classes were more likely to stick with solemn pledges to marital faithfulness than to address safer sex practices. Far from being self-assured patriarchs, I argue that many Ugandan men, rightly or wrongly, perceive their male authority to be on the wane. HIV/AIDS may well be a contributing factor, since public debate on the issue tends to condemn what was previously widely considered a virtue – men’s sexual prowess. Being the wife of a man with largely unfulfilled patriarchal aspirations can be a delicate role to assume and this may prove all the more true for women learners. That is so because schools in Uganda have long been regarded not only as a place of opportunity for women but also as a risk to their feminine integrity. Thus it may well be that women who form the majority of learners in adult education classes are particularly careful not to arouse any suspicion that their feminine virtue is in any way compromised by their attendance.
Against this background it becomes clearer why the – mostly male – facilitators are content, perhaps relieved, either to skip debates about HIV/AIDS or to collude with participants and limit proceedings to the expression of religious fervour.

**Research context**

Madudu sub-county is a rural area in Buganda, 160 km to the west of Uganda’s capital, Kampala. Here the NGO ActionAid implemented a programme using the Reflect approach. Reflect seeks to combine the philosophy of the Brazilian educator Paulo Freire with graphic tools derived from Participatory Rural Appraisal (PRA). The principal idea, summed up very briefly, is that visual tools such as village maps, rainfall calendars or health matrices are constructed by participants to analyse and discuss locally relevant issues. Proponents of the approach consider it more suitable to generating meaningful debate in adult education classes than the otherwise often used primers containing images and pictures which may or may not serve as stimulus for fruitful debate (for more information see Archer and Cottingham 1996a; Archer and Cottingham 1996b).

In this article I discuss excerpts from a larger study which followed cohorts of adult learners in Uganda as they progressed through a Reflect programme (Fiedrich and Jellema 2003). The idea was to gain a more in-depth understanding of how particularly women participants perceive adult education programmes and engage with them. Most of the findings presented here are drawn from ethnographic observations I undertook in two villages, here referred to as Kilunga and Kilemba, over a period of two years (1998-2000). The regular observation of literacy meetings and other public occasions (ie markets, church services, festivities, etc) provided information and impressions that I then followed up through repeated semi-structured interviews with participants, their partners and others with no direct involvement in the programme.

Although Kilunga and Kilemba are only a few hours’ drive from Kampala, many who live there speak of the area being ‘remote’ and its people as ‘backward’. Those who have heard of Madudu sub-county in Kampala are likely to concur with such sentiments, noting that Madudu is known for belief in witchcraft. Many of my respondents in Madudu blamed the lack of loyalty of those who moved to town for the notable absence of development efforts. Short-lived attempts at forming an agricultural co-operative and sporadic health campaigns apart, the area has rarely been the focus of
attention either for government agencies or for NGOs. This is not to say that residents were unfamiliar with development ideals but there was a tendency to assume that the rest of the world would always be a step ahead. And yet, significant changes were afoot in Madudu, perhaps the most important has been the liberalisation of agriculture that has made it much easier for farmers to market their products while also exposing them to the vagaries of the market and significantly curtailing access to inputs for those with few means. With few exceptions, everyone in the area is involved in subsistence farming activities and depends on income from crop sales (coffee, tobacco, and maize being the main cash crops).

The Reflect programme was open to all adults in the area who were interested in discussing local development and/or wanted to learn how to read and write. Initially, the interest was high among both men and women. However, as is commonly the case in adult education programmes, a large number of learners left within the first couple of months. Men were far more likely to withdraw, either because they felt that being a ‘learner’ was undignified or because their initial hope of receiving financial support from ActionAid did not materialise as expected. Hence, many classes consisted of women only after the first couple of months.

The short history of HIV/AIDS education in Madudu

In 1998, a group of ActionAid staff began to think about topics and issues to be included in the training workshop for facilitators from Madudu where the new Reflect programme was to commence shortly. As in the majority of programmes throughout the world, the staff members drew inspiration from the panoply of developmental topics that have informed adult education programmes for many decades and coupled this with some exploration of the area they had undertaken. While discussing what issues to propose to facilitators they also considered HIV/AIDS as one potential topic. They all agreed that it was an important topic but were sceptical about how far facilitators would be comfortable delving into this sensitive issue. Not only would participatory ethics have barred them from imposing the issue on facilitators, staff members were also aware that, on this particular issue, such action had little prospect of success.

During the training workshop, the same staff members were surprised by the many frank and explicit questions trainee facilitators asked about HIV/AIDS. Queries about the reliability of condoms or the various possible symptoms of AIDS were voiced with seeming ease and the trainees, far from being embarrassed, were intent on prolonging the debate, not least because
of the welcome titillation it provided. Although unexpected, the ActionAid staff were glad to be proven wrong and it was agreed that facilitators could test the grounds with their classes by discussing the causes of HIV infection and the means of treatment available in the context of broader debates about health issues. If these proved successful, it was agreed, facilitators and staff would co-operate to design more substantial discussion guidelines about HIV/AIDS related issues in due course.

The story does not extend far beyond this stage as the following three examples from classroom observations and interviews illustrate. In the Kilunga class, the facilitator started a session on the causes of diseases by asking learners which diseases most commonly affected them. After a few others had been mentioned, one woman suggested that AIDS commonly affected people in this village. Whereas previous suggestions had been recorded without further debate, now the male facilitator halted and asked participants whether they wanted to include AIDS on this list. After a moment of silence another woman stated that there was not much need to debate the causes of AIDS since: ‘men have freedom and can do what they want’. Her statement appeared matter of fact, caused a few smiles among the male audience, and the facilitator then moved on, saying that there would be a separate learning unit about HIV/AIDS in future and hence no need to discuss it now. After the session, he informed me that HIV/AIDS is not a significant problem in the area and, therefore, did not require extensive debate.

A second male facilitator, whose class consisted entirely of women participants, argued along similar lines that AIDS was a disease that affected mainly ‘city people’. He had nevertheless advised his participants ‘not to love one another’. He laughed when I asked him about condoms, said that they are available in the shops, but that he couldn’t possibly discuss that in the class otherwise ‘women would accuse me of giving ideas to their husbands’. It is not quite clear what this statement means since there are at least two equally plausible interpretations. One is that the facilitator could not contemplate married women suggesting condom use to their husbands or other partners. Consequently, the only use a woman has for a condom is to slip it to her husband to increase chances that his extra-marital affairs are conducted safely. The second possible interpretation is that the facilitator was worried about the consequences of women relaying class discussions about condom use to their husbands, leaving the husbands to wonder what business of his it was to educate their wives on this matter.
In a third class, the female facilitator had not discussed the issue at all, stating that she would get into trouble with the husbands of the women she taught if she started talking about ‘sexual things’. However one woman repeatedly forced other participants and the facilitator to contemplate the issue. ‘AIDS has started’ was the blunt disclosure she made on walking into the class one day and responding to other participants’ enquiries about her husband, who was known to be unwell. Several of the older women present looked at her with disapproval while some of the younger ones queried her judgement, demanding details of symptoms but then quickly asserting that she had no means of being sure and should therefore not say such things. ‘You can say what you want, AIDS has started’ she insisted loudly before the facilitator told her to calm down and stop disrupting the lesson. During the following weeks, similar scenes flared up several times but were thwarted much quicker and resulted only in general disbelief and disapproval about the disrespect this woman showed for her husband by publicly discussing his alleged status.

Clearly, one of the reasons why HIV/AIDS issues were either ignored or actively suppressed in the classes could be that facilitators were not sufficiently prepared to cope with such debates. This wouldn’t be surprising given that HIV/AIDS awareness was only one small part of the programme, introduced ad hoc during the facilitators’ training. And yet on most other issues, facilitators were found to harbour no inhibitions in using their own best judgement and many had developed their own style of fostering debates in the classroom. Also, at least on first sight, these three situations seem to contradict the keen interest in HIV/AIDS issues which facilitators clearly displayed during their own training. This is important to underline so as not to make the mistake of assuming that there is a generalised shyness about discussions of sexuality.

In Buganda, one context where frank words are expected is that of paternal aunts (‘sengas’) introducing their nieces to a range of issues concerning marital sex. In earlier times, it was not considered appropriate for a girl to discuss sexual matters with her mother (or others) and, although many girls now do not have access to a senga, the taboo on raising such issues with their mothers appears largely intact (Muyinda et al 2001). By contrast, Western ideals of family stipulate that social proximity between persons is a good prerequisite for discussing intimate issues and ‘good’ parents are those who openly discuss sexuality with their daughters and sons. Unlikely as it may seem, this observation helps to resolve the puzzle.
why Reflect facilitators were comfortable discussing sexual relationships in one context (their training), but not in another (their classes), seemingly similar one. The Western ideal (as opposed to practice) that social proximity breeds trust and openness is one reason why Reflect programmes are advised to recruit facilitators from the same background and locality as learners. In practice, this means that facilitators often handle an audience of relatives where mutual dependencies are ever present. Unsurprisingly, facilitators are reluctant to breach delicate topics concerning sexual practices when standing in front of their mothers, aunts or in-laws. By contrast, the training course facilitators attended took place in a small hotel in the district town. Although some of the trainees knew each other, they all came from different villages. There were thus different factors which here may have led to the temporary suspension of moral boundaries regulating sex talk: the novelty and comfort of commodified hospitality, the interaction with middle-class, professional trainers and, perhaps most importantly, the geographical and social distance from their usual places of residence.

Of course, there are many other settings where talk about sexual relationships is condoned. Weddings and funeral rites, for example, are important arenas for matchmaking and there are, on the whole, few informal gatherings from which talk of sexual relationships would be excluded. Conversations are likely to revolve around either one’s own sexual prowess (more likely in case of men) or around amusing embarrassments suffered by others. Few people would dare use this forum to ask their own questions about sex but that is not to say that people don’t receive useful information in the course of such conversations.

I now want to investigate more closely, some of the reasons why both facilitators and learners may have thought adult education classes inappropriate arenas for such discussion.

**Adult education and Christianity**

The majority of early church communities in Buganda started as adult education classes, mostly run by African missionaries. White missionaries were often surprised that on entering areas they considered ‘virgin territory’ (ie where no white man had been before) they encountered makeshift churches. Pirouet (1978) describes the conditions which led many Africans who had studied under the very earliest efforts at missionary education, and some who had not, to rapidly open up new churches in their home areas. Literacy training was an important aspect of these new institutions. Instead
of welcoming such initiatives, white missionaries were keen to downplay the trend. For one, they feared that lack of a white presence would distort the Christian message beyond recognition. Pioneering missionaries from Europe were keen not only to convey Biblical messages but also to introduce their standards of civilised living. Thus, as Hunt (1992, 1999) reports for the Belgian Congo, Europeans took it as their responsibility to live and be seen to live by example, making ostentatious demonstrations of civility out of mundane affairs such as cooking or eating. Secondly, they worried that financial support coming to them from Europe might dwindle if black missionaries were suddenly considered a viable alternative to white missionaries. But the fast spread of churches took on a dynamic of its own, not least because of the intense competition between Catholics and Protestants.

By the early twentieth century, it was mandatory to be literate if one wanted to be baptised (Jones 1926:191; see also Pirouet 1978; Ssekamwa 1997). And being baptised quickly became a precondition to having access to political resources. To this day, it is nearly impossible to discuss education in Uganda without mentioning Christianity or vice versa. Most schools retain strong religious affiliations and Luganda has one word ‘okusoma’ referring to reading, learning or worshipping.

The following snippet of conversation with an elderly literacy participant gives some idea as to why the combination between education and Christianity remains attractive and modern:

Researcher: So what is it that makes you laugh so hard about born again Christians?

Florence: Have you not seen them? They only go like this [claps hands above her head] and sing ‘hallelujah’ and ‘praise the lord’ all the time. They don’t even have a book from which to read. In the Catholic Church we have a book which God has written, his words are there for everyone to read.

To Florence a ‘serious’ religion must be solemn and have ‘a book’. The importance of this is not diminished by her inability to read books and every Sunday Florence carries her copy of the Bible five kilometres to hold it during the church service. Although the adult education programme she took part in was run by an organisation without religious affiliations, she and many other learners took it for granted that this type of activity must be firmly embedded within Christian practice. To some learners, this meant turning up for classes with their Bible or other religious texts and, at least

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initially, many of the women also dressed up as they would when going to church. While communal prayer only occurred regularly in very few classes, it was a more common practice for participants who left the literacy shelter to bow to the blackboard and cross themselves.

Christian ritual was also an important influence on the class curriculum. Current ideologies of participation are, for example, rooted in Christian traditions. PRA tools are of central significance to Reflect and are intended as a means of encouraging open debate, allowing for the voicing and systematic analysis of diverse opinions. Very few of the classes observed used them in this way. Many classes dispensed with PRA exercises entirely. Where they remained in use they were often employed to present an ‘ideal’ situation or the representation of ‘real’ situations served exclusively to draw out participants’ presumed backwardness and failings. In this respect, those classes that used PRA did not differ much from those which did not. In both cases, it was understood that debate should lead learners to see the wrong of their ways and repent.

To give a practical example, learners in Kilunga village used a health matrix to list prevalent diseases on one axis and various treatment options on the other. They then discussed treatment of each disease one by one, scoring which option they believed worked best for which disease. On the first disease that was discussed, there was a slight hesitation when it came to judging on a scale of one to ten the importance of prayer as a treatment option. An elderly woman determinedly resolved this by simply stating: ‘ten’. From then on, almost as a matter of course, prayer was assigned the highest score on each disease without any need for further debate. In subsequent conversations with some participants, it emerged that they were referring to Christian prayer. The dynamics behind participants routinely asserting the superiority of prayer is complicated. For one, the chairman of the Church council was present during this debate and his authority had to be revered to since he was also the chairperson of the local council and one of the biggest landowners around. But apart from group politics, a strong imperative for ranking prayer highly may derive from the fact that biomedical health care, combined with prayer, have always been the gospel of Christian churches in Uganda (Vaughan 1991). In fact, the nearby church ran a large health facility and Christians attending this church were left in no doubt that there were ‘Christian’ and ‘unchristian’ choices to be made about health care.

The close connection participants make between biomedicine and
Christianity may then also explain why the conclusion to this particular debate was: ‘when we are ill we go to see the doctor immediately.’ Other forms of treatment, such as local herbs, which had also been discussed, were eclipsed in the final pledge, which the class reiterated many times in the following weeks. Perhaps more interesting still, are the issues that were not discussed. Witchcraft was jokingly volunteered as a curative measure but it was taken for granted that this was an aside, not to be included in official proceedings. In this area, alcohol is also a popular means of coping with disease, particularly among men, who make less use of biomedical facilities than women. Again, learners did not point this out as one means of treatment to be compared with others.

As mentioned earlier, the Reflect class in Kilunga village, as most others in the Madudu project, did not discuss HIV/AIDS in this or other lessons. However, the above example provides an impression of the lines along which discussions on health are regulated. While development planners often assume that adult learners are simply out to learn the most effective ways of keeping healthy, my research suggests that learners are equally keen to portray education as the force that makes them sophisticated and modern. Publicly subscribing to Christian ideals of virtuous behaviour is very much part of this effort. HIV/AIDS is difficult to integrate with this ambition since it is still largely associated with sinful behaviour.

This brings us to another important boundary for classroom debates on HIV/AIDS: the long-standing attempts by Christian churches and state authorities to regulate African sexuality. One of the earliest and most prominent pieces of legislation in the Uganda Protectorate was the Uganda Marriage Ordinance in 1902, which effectively introduced separate jurisdictions for Christians and non-Christians (Haydon 1960). Although in subsequent years several efforts were made to ensure that this law really did foster monogamy, it did not succeed, even though in Buganda, the elite eventually backed it with its own legislation. In 1917, the Buganda Adultery and Fornication Law gave native courts the right to impose fines in case of divorce (rather than just negotiate compensation) and a 1919 circular from the Chief Justice of Buganda had the consequence that:

Ganda courts would not recognise customary marriage at all in the case of men who claimed to be adherents of Christianity or Islam. In effect, in order to have a customary marriage recognised by the courts, you had to declare yourself a pagan. Since this was equivalent to declaring yourself to be a benighted savage, it amounted virtually to the withdrawal
of recognition from customary marriage in Buganda. (Southall 1960: 213)

The only notable effect of these and subsequent legislative efforts was that conflict around marital arrangements was concealed from official scrutiny, that marriages were ended without divorce, and that living together ‘in sin’ became reportedly more frequent. Though technically illegal, it was still easily possible for a man to marry one wife in church and others through the native courts. Since the group to whom this legislation could have posed the biggest threat, ie the educated Bugandan elite, was also the one on which both the colonial state and the churches depended most, none of the prevalent powers had a serious interest in criminalising this important constituency.

Of course, abstinence and faithfulness remained the only permissible doctrine to be acknowledged positively in churches and church-related institutions, such as schools. Up to this day, being part of a polygamous relationship is not per se a barrier to being a respected member of a congregation as long as one keeps it reasonably quiet.4 Thus, it is not surprising that in the classroom context, adult learners are quick to make a ritualistic pledge to faithfulness, condemning adultery and polygamy in the strongest available terms. Outside of these Christian defined spaces we do not find a world of immorality but a different set of moral standards. This is an important distinction that is still commonly obscured in many literatures. However, particularly for my discussion of gender relations it is crucial to recognise that Christianity introduced a struggle between moralities, not a quest for morality (see also Heald 1999).

‘Divorce is easy and the marriage tie is loose’
I meet Nakabale on a Sunday morning, on the path leading to his house. As he gets off his bicycle he informs me of John’s recent death, shaking his head at the shamefulness of the circumstances. John died of AIDS. His death is a punishment by God for the sinful lives conducted not only by John but also by many others. Nakabale was not one of the better known moralists in the village and so I asked him whether he sometimes went to church. ‘No, at my age (73) there is no need, I will not change any more now’. But he used to go when he was young, when the church was still very new and had a French missionary whom he liked to hear preach. Thus he became convinced that Europeans are better than Africans when it comes to dealing with relationships and marriage. Europeans, he asserts confidently, do not waste lots of money on weddings.
Then he twinkles and confides that there was another reason why he liked going to church: ‘You could meet girls there!’ When meeting a girl outside of church on one of the many paths, Nakabale says, it was impossible to talk to her privately for longer than a few moments. It was also unthinkable to go and visit her in her compound. ‘If you smiled at a girl, and she liked you, she would ask you: “Are you going to church on Sunday?”’ And thus he was an ardent church visitor, exchanging meaningful glances between the segregated men’s and women’s sections, and trying to catch a moment with his love interest after the service.

To Nakabale, and no doubt many other people, churches offered an opportunity to evade strong parental control and to indulge in romance. His account of what it was like to be a young man in the early 1940s provides a different picture of prevailing morals than that painted by early missionaries. Lugard set the tone for missionary descriptions early on:

In spite of the modesty of their attire the women of these countries (i.e. district countries of Uganda) are very immoral. Death and torture are the punishment for infidelity in the king’s harem, yet intrigues are constant. Divorce is easy and the marriage tie is loose. (Lugard 1901:31; see also Hattersley 1906)

While missionaries worked with the firm conviction that churches and schools were the places where Ugandans would, for the first time, learn about morality, conservative Baganda had some reason to consider these same sites as potential sources of immorality. It appears that both Christian missionaries and Ganda culture placed emphasis on the controlling of women’s sexuality but did so in fundamentally different ways.

Thomas writing on girls’ boarding schools in Kenya, reveals that schools were a far from straightforward attempt to imbue girls with domesticity ideals (2000). Most obvious of all, removing girls from their homes demonstrated to them that other options than home life existed. Further confirmation that not all women were house-bound came in the person of the European lady teacher, who generally was a mobile, unmarried, professional woman with a salary, a wardrobe and not a child to her name. However much she herself may have believed in the gospel of domesticity, she and many of her actions effectively undermined it. For all the rhetoric of respecting male authority, at least the lady teachers in this context were not shy of putting up a challenge against the girls’ fathers if one of their protégées was to be married young or to a ‘heathen’.

The reason for dwelling on this clash of moral perceptions so extensively
is that it still persists. For example, many recent writings on HIV/AIDS and education have been preoccupied with the notion that schools may themselves be a ‘risk factor’ in pupils’ lives rather than only being places where pupils learn to avoid ‘risks’ effectively. Mirembe and Davis (2001) argue that schools reproduce prevailing gender norms in Ugandan society and consider this a major obstacle to pupils, in particular girls, gaining the self-efficacy necessary to refuse ‘risky’ behaviour. They consider a range of power dynamics which are seen to infringe on the capacity of schools to encourage ‘healthy’ habits. What remains unchallenged in this and many other accounts is the assumption that schooling itself is principally a force for good with ‘risks’ creeping in only through malevolent forces from outside.

Can this assumption still hold true if general perceptions of schooling are similar to those Nakabale earlier expressed about churches? In East Africa both churches and schools have long been viewed both as places of opportunity and of risk. Stambach (2000) has recently documented the ambiguous expectations of schooling in Tanzania. Her respondents were confident that schooling would turn children into modern and sophisticated adults, good Christians and potential wage earners. At the same time, it was also common knowledge that school ‘spoils’ girls, that the career towards becoming a ‘city sister’ involved leaving customary marriage norms and other restrictions behind (although few manage to do so for good). All of this to say that both schools and adult education classes are spaces that one should expect to contain a certain degree of sexual tension. It is important not to reduce this merely to a matter of ‘risk’ and ‘risk awareness’ for it may also involve romance (Parikh 2001), sexual gratification and/or material exchanges (Mills 1999; Nyanzi et al 2001; Pickering et al 1997; Ssewakiryanga and Mills 1995). For someone who teaches or facilitates in the midst of these various ambitions and anxieties about schooling and sexual attitudes’ strict moral conservatism may easily seem the most viable option. In the next section, I will illustrate how current gender dynamics provide a further incentive for facilitators to keep debates about sexual attitudes low key.

**Gender and ‘danger’ in adult education**

Most husbands of women who joined the Reflect classes were positive about their wives’ initiative, often expecting that education would improve their wives’ domestic skills. Such expectations are unsurprising given that domesticity training has long been the mainstay of women’s education in Uganda. Throughout the programme, most husbands maintained that their
wives’ education posed no threat to male authority, often arguing that education rendered women more sensible, thus easing the exercise of male authority. Parallel to this relatively confident stand, at least some men were also found to have anxieties about their wives’ education. In a small number of cases men barred their wives from going to the classes. They were aware that arguing against education is an uphill task and were often reluctant to explain their stand to me. This situation is relatively common in adult education programmes and the response from programme makers is usually to deny that such male anxiety has any basis. Conscientious programme makers will often try and seek out these men to reassure them that adult education is perfectly harmless.

What many outsiders do not realise is that this status of ‘harmlessness’ is not a naturally given attribute of adult education but one that facilitators and participants often struggle to maintain. In the circles studied, several single women met lovers and this was tolerated, even joked about. However, facilitators were not entirely comfortable with this and saw a risk that classes could become ‘like a bar’ (ie a place where no respectable woman would be seen). Matters became far more serious if a married woman was deemed to have an affair. On one occasion, the husband of a Reflect participant found a love letter to his wife in their compound. Although there was no indication that this affair was in any way linked to the classes, this was of immediate concern to the Reflect facilitator, who tried to calm down the husband while also reassuring him that the actions of his wife were immoral and deplorable. In the next Reflect session this woman facilitator condemned the wife’s actions and made her repent publicly. On another occasion the same facilitator learned that a woman regularly told her husband that she was going to the classes, left her home, but did not turn up for the class. Again, the facilitator saw it as her duty to intervene and ensure that nobody gained the impression that her classes could be used as a convenient alibi.

Thus, when facilitators are reluctant to discuss HIV/AIDS related issues in the classes, it may have less to do with any personal or cultural inhibitions and more with the ambiguous reputation the classes struggle with from the start. Adult education is revered by participants as a modernising force but some aspects of it are also feared and facilitators justifiably feel threatened by any suggestion that classes may endow women with sexual licence.

But why is there so much anxiety about controlling women’s sexuality in the first place? Patriarchal ideologies may explain why it is taken for granted that women’s sexuality ought to be kept in check, but they cannot explain
why this should be a cause for anxiety. Although patriarchal sentiment may be strong in many Ugandan cultures, anxieties about women’s sexual agency signal that men often have far less power over their wives than they feel is their entitlement. Both men and women in Madudu were often keen to present their realities as closely resembling an ideal of male/female cooperation with ultimate control in male hands. To this end, women sometimes downplayed the decisions they took, the money they made and also the sexual agency they exercised. Such self-diminishing statements are not necessarily proof of how deeply women are indoctrinated by patriarchal norms, in fact it is more likely that women make them so as to juggle effectively with these norms. This is so because male control does not always translate smoothly into male privilege, instead it also implies male obligations to provide and protect. Women who foreground their dependence on male guidance may often do so to re-emphasise men’s obligations toward them, underlining how much they themselves have retained ‘traditionally’ feminine traits so as to insist that men also keep up their side of the bargain (Tranberg Hansen 1992; see also von Bulow 1995).

The reality for men and women in Madudu, the research site, and elsewhere in Uganda is that most men are in no position and/or are reluctant to be providers and protectors. To be a woman in contemporary Uganda often involves the enduring of hardships and injustices but there still is relative clarity on how to be a respectable woman. Colonial, post-colonial and developmental efforts at ‘empowering’ women may have expanded the opportunities open to women but this has always been in addition to women’s ‘traditional’ roles. What it takes to be a respectable man is much less clear and has changed rapidly during the last century. The colonial project involved a radical redefinition of manhood, disallowing or restricting earlier practices such as warfare and hunting. Cash cropping and wage labour, the alternative occupations the colonial powers held in store for men, were and remain difficult to reconcile with male identity patterns of pre-colonial times. Many people in Madudu agreed that today, having money is the most reliable signifier of a respectable man. A man with money can afford to cultivate the symbols of manhood from an earlier time, he can have many wives and many children. Heavy drinking and the controlled use of violence are also not factors that would damage his reputation as long as he retains the potential to provide for his dependants.

Most men are only very occasionally in a position to act as provider and often have a far more tenuous grip on family affairs than they care to admit.
While many women in Madudu were privately cynical about their husbands’ ability or willingness to provide for them, such criticism always targeted men’s failure to act ‘manly’ and never sought to openly challenge or displace male authority in principle. To both men and women, the cultural ideal of male authority and female subservience was important so as to retain respectability in front of the outside world and also to maintain the elusive promise of being a provider and being provided for.

Debates in the Reflect circles were often carefully protective of the above arrangements. Thus, it was unproblematic for a woman participant to complain about her husband and receive sympathy for her plight. By contrast, the circles were clearly not the place for a woman to mention that she was thinking of running away, or acquiring a lover, or that she was contemplating no longer serving her husband food. Nor would any participant have contemplated advising such actions to a woman relating her marital difficulties. In fact, the earlier example of a woman participant claiming that her husband had AIDS, is one of very few cases where it was observed that a woman breached this etiquette and was openly ‘disrespectful’ of her husband. She was rebuked for it and some time later she denied that she had ever made such a claim and made visible attempts to restore her reputation, for example, by vigorously arguing that the circle should mount a campaign against women’s drinking.

It would be easy to portray women’s efforts in the circle as passive compliance with dominant gender norms. However, that would be to ignore that women actively struggled to affirm an ideal of feminine respectability against a practice that they knew to be permanently irreconcilable with the ideal. Thus contemporary gender dynamics combine with previously discussed Christian values to set moral boundaries for debates on HIV/AIDS in this particular context. It should now be apparent why such debates are far more likely to revolve around stern calls for marital faithfulness than safer sex practices. Before I move on to discuss how adult education might address this pattern, I briefly want to consider a last issue concerning gender. Much current writing looks to analyse gender relations with a view to how they must change so as to encourage ‘healthy’ attitudes. Little attention is so far paid to the way HIV/AIDS is already changing the dynamics of gender relations.

In Madudu, it seemed that one reason why HIV/AIDS was a sensitive issue was that women blamed men for bringing it into families. When I asked women during semi-structured research interviews who was to blame for the
spread of HIV/AIDS most affirmed that men were the perpetrators. Men who took part in the research were more likely to be general in their answers, apportioning blame to increased mobility or ‘city people’. The men’s answers are more in line with Ogden’s findings from Kampala where ‘town women’ were widely blamed for the spread of HIV/AIDS (Ogden 1996; see also Davis 2001). While town women have a long history of taking the blame for any perceived immoralities in Ugandan society, there is an inevitable logic to the blaming of men. Men are expected to have multiple partners while women are not. So regardless of what the statistics may say, men and ‘town women’ are seen as guilty. In the case of men, this further undermines their role as protectors of women. Instead, they must now get used to the idea that they themselves are, or are seen to be a danger to their families.

Silenced or simply silent? Sketching the boundaries of ‘open debate’ on HIV/AIDS
So far, I have outlined how two factors, gender relations and Christianity, place boundaries around debates on HIV/AIDS in Madudu. I have been careful to avoid the term ‘barriers’ since it implies an immovable hindrance that must be broken down so that progress can be made. Boundaries can be shifted or expanded without necessarily being torn down. They remain both as a source of limitation and comfort. The discussion presented here suggest that adult education takes place within boundaries and this section serves to outline some ways in which programme makers may account for these boundaries. The first real barrier to this, however, is the idea that ‘good’ education, administered in the right dose, will cure people of cultural ‘barriers’ to rational, ‘healthy’ behaviour. This section starts by looking at an example of an education-as-vaccine narrative, to then analysing some of the contradictions inherent to the genre and developing ideas on how to address them.

The following is an excerpt of an article written by a foreign consultant to Swaziland. Oliver is the author of a book about ‘study circles’ and recounts how, following a one day training workshop, the first study circle about HIV/AIDS is mounted:

…the study circle idea, where circle members learn from each other and participate democratically, did not seem foreign to the 32 women of Lobamba…. The idea wasn’t foreign, but one that capitalised on centuries of tradition in the Swazi culture…. We decided to concentrate on Session 1 to elicit personal testimony, encourage the women to talk freely, and to humanise the HIV/AIDS issue through personal
identification. Accustomed to lectures and videos, the Lobamba women were slow to warm to the study circle process. But seated facing each other, they gradually started to tell their own stories about HIV/AIDS, overcoming their fear of strangers and anxieties about such a personal issue.... All in the hut seemed to realise the gravity of the situation regarding HIV/AIDS in Swaziland and that education was the key. After several hours of talk, several women exploded in indignation. It was no longer someone else’s issue. The Lobamba women realised it was their issue.... “When we go from here,” said a participant, “we have to share this education with our extended family, with our chief, and with the men’s groups. We’re dying and our men don’t care!” … The women left the hut after three hours of non-stop discussion. They agreed to take a summary of the minutes of the discussion to their chief and the men’s council, an action few would have advocated prior to the meeting. They seemed to gather strength from each other as the session progressed, emboldened and empowered, and willing to act collectively for their survival. By speaking out candidly before peers in the non-threatening study circle atmosphere, they were building within themselves the capacity for participation, for having a “public voice”, and for deriving collective action from the collective learning that took place. As they were leaving, one asked pointedly, “What happens in a society when the women are ahead of the men?” The study circle had given them one answer – become an informed public through deliberation and act on the knowledge. A powerful lesson. (Oliver 1996:323-326)

The narrative of transformation Oliver constructs here differs from others in the same genre only through its speedy progression, accomplishing its feat in no more than three hours of ‘non-stop discussion’. Learners elsewhere may deliberate weeks and months before similar results are reported but the story of collective empowerment often consists of similar elements and contradictions. Group activity is concomitantly understood to be part of African ‘tradition’ and to transform it profoundly. It is not a foreign idea but still something that learners could not get quite right without external input. Although long-standing democratic traditions in Swazi culture are noted, it is ultimately still the study circle that is seen to act on women, ‘giving’ them answers and allowing them to build ‘within themselves the capacity for participation, for having a “public voice”’.

In this way Oliver paints an all too familiar picture of change occurring as a result of the right tools and techniques. The latter are seen to encourage women to talk freely and such open debate is considered the prerequisite to
learners adopting rational decisions. The apparent plausibility of Oliver’s account is enhanced by its exact mirroring of Western ideals of democracy. Here, the degree to which an outcome is considered rational and legitimate depends on the rationality of the procedure through which it is reached. Though most Westerners will concede that non-rational means, such as personal obligations, emotional ties, or blackmail can be far more important incentives for action than democratic procedure, this does not challenge the firm belief that ‘good’ means lead to ‘good’ ends (see also King 2000). In practice, it is of course impossible to eliminate non-rational influences by procedural rule but writings on development are awash with claims about methods and approaches that purport to do precisely that. Oliver’s assumption that ‘open debate’ is the natural route to morally upright feelings of indignation then requires a considerable leap of faith.

It is also interesting to note that, although personal testimonies and women’s own stories are said to be at the heart of ‘open debate’, they produce no diversity of accounts. Instead all women seem to share the same problems, requiring similar solutions. This is not an untypical scenario in descriptions of participatory development processes (see also Booth et al 1998) and clearly one that should be cause for scepticism. For the stories that can be told ‘freely’ in this context are limited and often predictable (see also Plummer 1995). ‘The Lobamba women’, according to Oliver, identified three major obstacles to the prevention of HIV/AIDS:

1. The male-held myths about multiple lovers and the use of condoms;
2. The prevalence of polygamy;
3. The lack of a government and public commitment to a broad-based educational programme (Oliver 1996).

Except for the mentioning of condoms, the problem identification the women present here is strikingly similar to that which has preoccupied missionaries in Africa for more than a century. It would be naïve to assume that women coincidentally replicated the missionary agenda as their own. Their efforts in this respect are far more likely to reflect their keen awareness of the possibility that ‘open debate’ is an integral part of attempts to regulate their sexuality. Thus participants can easily become complicit in turning HIV/AIDS education into Victorian calls for ‘clean’ sex or even no sex. What is missing in this record of an ‘open debate’ is any reference to instances of women’s multi-partner strategies or their reasons for not wanting to use condoms in certain situations.
The answer to the finding that open debate in adult education is inevitably contrived and circumscribed is often to search for new tools and methods that will make the atmosphere even more relaxed and still less threatening. However, this is not an answer in cases where participants are choosing to remain silent on certain issues because silence grants them greater freedoms than ‘open debate’. I have argued here that certain historical aspects of schooling and gender relations influence what participants want said in the classroom and what they do not want discussed in this context.

Regardless of how much virtue adult educators find in dialogue and open debate, the findings from Madudu and elsewhere also suggest that programme makers rarely have the means to impose their ideals. In many Ugandan societies, the ability to remain discreetly silent, to limit the information one passes on about oneself or those close to oneself, is considered a sign of moral strength and decency. In societies where personal dependencies are the norm, it is perhaps to be expected that self-mastery rather than self-expression is regarded a positive marker of individuality. Where personal obligation rather than individual autonomy define the self, issues of disclosure and stigma take on a different meaning. Speaking out is then not an unambiguous sign of ‘coming clean’ and ‘being honest with oneself’ it can also be a sign of selfishness and weakness, tarnishing not just oneself but also others. In Madudu, the causes of a death were rarely clear but premature deaths often triggered intense speculation about past sexual relationships of the deceased, ever increasing the pool of people who were ‘under suspicion’ of being sero-positive. Whenever I asked people about why very few ever spoke about their own status the answers invariably stressed the need to protect others through keeping silent (‘he has children, who will they marry?’). It should, however, also be noted that the issue of disclosure is marred by the fact that this area of Uganda, as many others, is still characterised by inaccessibility of testing facilities.

Even if the kind of (partial) silences just described are seen as ‘risky’ to health, I am arguing that adult educators must be careful about pathologising them entirely. While Ugandan society constantly debates where the boundaries of silence are to be drawn, adult educators must respect that certain silences enhance individual freedom and/or serve to protect others. Thus the main pre-occupation of adult education in the current context should not be to sharpen its tools to ensure ‘really’ open debate but to increase its relevance in the context of the various debates that go on about HIV/AIDS.
Education is clearly one factor explaining why many Ugandans today are relatively well informed about HIV/AIDS. However, there is also evidence that the knowledge passed on through awareness-raising campaigns does not displace other bodies of knowledge obtained through a wide range of sources. To know the various ways in which HIV can be transmitted and how one can protect oneself against it does not stop one from also knowing, say, that abstinence causes impotence or that malicious powers (foreign or domestic) pierce condoms so as to deliberately spread HIV, etc. People are very aware that some of this knowledge is not appropriate in an educational (read modern) context, that it is separate and that, if mentioned at all, it is advisable to discard it demonstratively as ‘rumours’ or signs of ‘ignorance’. This may be one area where sensitive programme planning can help to extend the horizons of debate so as to include aspects otherwise branded as ‘backward’. One way would be to bring people like sengas (ie paternal aunts who provide advice on sexual relationships to their nieces) into adult education classes to speak to learners. There now are commercial sengas, who will pass on advice against a small fee. Some of the advice they stand for may well contradict the awareness-raising messages conventionally associated with adult education but this only reflects a reality where Ugandans accept that there are different sources of authority to different bodies of knowledge about HIV/AIDS.

Bringing outsiders into adult education classes, whether sengas or, as already happens sometimes, conventionally trained health workers or councillors, is a positive step. As earlier discussed the social proximity existing between a local facilitator and his/her learners can sometimes be beneficial but there are also many times when social distance is an asset, making it ‘safer’ for learners to ask certain questions or listen to perspectives they would otherwise not hear. In this context, one could even think of inviting people who are ‘openly’ HIV-positive but not living locally to come and speak in the classes.

There are also several activities that may enhance coping strategies for HIV/AIDS without necessarily requiring debate about this sensitive issue. Providing assistance with the writing of a will, for example, is something many Ugandans would like to be able to do regardless of HIV status. It is an activity that arguably falls within the remit of adult education.

Also, and this has been highlighted by many others, if adult education is to maximise its contribution to increasing awareness about HIV/AIDS then it must find ways of reaching men much more comprehensively than it does
so far. In Uganda, men are unlikely participants in adult education classes, not only because they usually have had more opportunities for schooling than their wives but also because they feel more self-conscious about being seen in a classroom. To many men being ‘in school’ is decidedly unmanly. Women, by contrast, often search for opportunities to socialise respectfully away from home, rendering adult education classes an event that, to them, may prove just as attractive as the Sunday service. Thus, while it is urgently necessary for men to become more pro-active in protecting themselves and others against HIV/AIDS, the analysis here suggests that there are gender-specific factors that may render men more reluctant to hear the message. It has also been argued that the environment of an adult education class, and particularly the close and virtually unavoidable association with Christian institutions, introduces its own set of constraints when it comes to debating sexual relationships. Bars, video halls or market places then seem more likely venues for face-to-face educational activities with men although this does, of course, require changes to both the form and content of adult education.

In demonstrating some of the limits to current adult education practice addressing HIV/AIDS related issues it is important to remember that it is neither necessary nor possible for classes to be all-encompassing. Both men and women in Uganda pick up information about HIV/AIDS from a range of sources and talk about it in different fora. However, there is a tendency among educators, and particularly adult educators to insist, in line with the Enlightenment tradition, that learning knows no bounds. This stand has undoubted merit and yet it carries with it the risk that we ignore some of the context-specific boundaries to learning highlighted here. Awareness of such boundaries not only promises greater realism with regard to educational outcomes it also more importantly focuses our attention on gaps in our HIV/AIDS strategies that may be addressed by other means.

Notes
1. The views expressed are those of the author and should not be attributed to the European Commission or other institutions.
2. The study was designed and implemented by ActionAid UK with funding from the UK Department for International Development (DFID). Findings from a parallel study in Bangladesh are also published in Fiedrich and Jellema (2003).
3. Since HIV/AIDS related issues were not a specific focus of the original research, the more formal survey tools also used in this and another urban field site, produced no results of relevance to my exploration here.
4. In contemporary Uganda, churches have gone to some length to ensure that condoms retain the status of the third and last means of HIV/AIDS prevention, one that is not on a par with abstinence and faithfulness. HIV/AIDS activists are now becoming louder in their demands that condoms are treated as an equal option. Ironically, my exploration above suggests that the case for condom use might not be helped by being voiced in the same breath as abstinence and faithfulness, two Christian values whose permeability Ugandan society has long since tacitly acknowledged and accepted.

5. One example of such debates is the current controversy around Vice President Kazibwe’s announcement that she has been beaten by her estranged husband. Virtually all contributors to this debate stress that her husband should not have beaten her and most agree that she has a right to say whatever she chooses. But some argue that she should have chosen to remain silent about the affair or that she should have chosen a different audience (New Vision, March 20, 2002).

6. The thoughtful analysis Asera et al (1997) have done of letters written to a Ugandan newspaper health advice column illustrates how high levels of education and awareness of HIV/AIDS do not necessarily prevent letter writers from fearing infection through unlikely sources, such as, for example, eating. Mitchell et al (2001) report how audiences of HIV/AIDS related drama sessions in rural Masaka and Ssembambule were inclined to ignore messages they deemed morally reprehensible, choosing to emphasise aspects of the play that confirmed existing values.

7. Mitchell et al (2001) report that training well-respected villagers to be contact persons on HIV/AIDS matters was well received by respondents in their study but that most people would have preferred a slightly more anonymous setting for receiving advice.

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Article

Men, male sexuality and HIV/AIDS: Reflections from studies in rural and urban East Africa

Margrethe Silberschmidt

Introduction

Empowering women to prevent HIV/AIDS has received much lip service in recent years. However the time has come for a real focus on changing male attitudes and behaviours. In the past the focus has been on the women’s side and what they should be doing, but we need to focus on the other side of the gender equation and correct men’s misconceptions and behaviour. At the moment male power is almost synonymous with multiple relations and power over women. (Helen Jackson, UN Population Fund Advisor to IRIN NEWS, September 3, 2002)

In spite of numerous prevention activities during the past decade in sub Saharan Africa, the HIV/AIDS epidemic is still spreading (Fitzgerald and Behets 2003). Heterosexual men are often seen as the driving force behind the epidemic. The view is that gender inequalities permit men to dictate the terms of sexual intercourse and this results in unprotected sex with women being the major victims. This article offers a different view of the respective positions of men and women within the AIDS epidemic by exploring some of the less stereotyped reasons why men now seem to be driving the epidemic. It investigates the gendered effects of socio-economic change, the implications of these for male identities, masculinities and sexualities. Finally, it addresses lessons to be drawn from the research findings regarding HIV/AIDS prevention activities and campaigns.

According to Caldwell (2000:126) ‘Africans have been educated by AIDS programs to know that the disease is deadly and is largely spread among them by high-risk sexual activities. The epidemic cannot be defeated
by more education’. This sweeping (and pessimistic) claim needs to be qualified by noting that HIV/AIDS prevention campaigns that lead to behaviour change will only be successful if proper attention is given to the wider socio-economic context, and to issues of gender, gender relations and sexuality. In order to understand the role of male sexual behaviour in the AIDS epidemic the focus should fall on the social and cultural context in which sexual activity is shaped and constituted (Parker 2001; Parker and Gagnon 1995).

Based on my research from rural and urban East Africa, the aim of this article is to elucidate how socio-economic changes differentially have impacted on women’s and men’s social roles, social value, self-esteem and perceptions of self. The focus will be on the way in which masculinity and male sexual behaviours have been affected.

The research was first carried out by the author in Kisii, rural Kenya, at different periods from the mid-1980s to the mid-1990s. Research in urban Dar es Salaam took place during one year (1996-97). The Kisii research consists of both survey data (723 women and 200 men in their reproductive years) and qualitative data collection, life histories and focus group discussions with a selection of men and women from two villages included in the survey. The vast majority had not completed primary education. Most women referred to themselves as housewives and the majority of men referred to themselves as farmers. The qualitative data collection in urban Tanzania took place in three low-income squatter areas of Dar es Salaam: Mabibo, Vingunguti and Buguruni. In-depth interviews were carried out with 38 women and 53 men also at reproductive age by means of structured, semi-structured and open-ended interviews. Unlike the Kisii informants, the majority had completed a primary education. While seven out of the 53 men had attended secondary school, only one of the 38 women had been to secondary school. The vast majority of men said they were casual labourers, self-employed or involved in petty business (selling cold drinks, dried fish, etc). Women said they were housewives and at the same time involved in petty business. In addition, 13 focus group discussions were conducted with different groups of men and women of different age but with similar backgrounds.

**Socio-economic change and gender change in East Africa**

While the causes are still contested, there is no doubt that people in East Africa have become poorer in the last half century. The processes of structural adjustment have accelerated impoverishment in the last two decades.
In 1975, the regional GNP per capita of sub-Saharan Africa stood at 17.6 per cent of ‘world’ per capita GNP. By 1999, it had dropped to 10.5 per cent. Relative to overall Third World trends, sub-Saharan health, mortality and adult-literacy levels have deteriorated at comparable rates. Life expectancy at birth stands at 49 years and 34 per cent of the region’s population is classified as undernourished (Arrighi 2002:27). While development literature stresses that it is women who are most seriously affected, this article will argue that amongst certain men, the consequences of poverty are just as, if not more, serious.

With different development histories, one area rural the other urban, Kisii and Dar es Salaam necessarily show many differences. However, both areas also have some of the same characteristics with 41 per cent of the rural population in Kenya and 61 per cent of the urban population in Tanzania living under the poverty line (Fields 2000). Moreover, both rural Kisii and urban Dar es Salaam have experienced an overall population growth, overall economic decline, economic instability and a labour surplus, which has resulted in a serious lack of income earning opportunities both in rural and urban East Africa (Arrighi 2002). Contraceptive use is low and HIV seropositivity is high. Statistics both from Kisii District Hospital and Muhimbili Medical Center show that 30 per cent of pregnant women who attend antenatal clinics are HIV positive. Criminality and alcohol abuse, mainly by men, abound, and so does gender antagonism, which is increasingly acted out in sexual violence against women.

**Socio-economic change in Kisii in the twentieth century**

Kisii is among the most productive cash and food crop regions in Kenya. Yet, since the turn of the nineteenth century, the population has multiplied at least 20 times and there is now no longer enough land to secure survival. A large proportion of household reproduction remains based on peasant agriculture relying on female labour (Silberschmidt 1999; Orvis 1988). Before colonial rule men were warriors and cattle herders and took an active part in political decision-making. Cattle represented wealth and power, and constituted the major part of bride price. The more cattle a man had, the more wives he could marry, and the more land could be cultivated. Through marriage he controlled his wife’s sexual and reproductive powers. Masculinity was closely linked to self-control and dignity (LeVine and LeVine 1966).

Colonialism put an end to the pre-colonial socio-economic structure. Migrant labour became common and many women were left for years to
manage the farm. After World War II, a shift towards production of industrial goods began. This created a demand for skilled and semi-skilled rather than unskilled workers. Most Gusii migrants were unskilled and had to return home. In Kisii, though, men’s activities had disappeared. There were no more cattle camps because it was more profitable to use land for cash crops. Nor was there a need for the martial skills of men in disputes with ethnic neighbours. Unable to find a place in the cities many drowned their frustrations in alcohol consumption.

**The development of the ‘provider’ ideology and new values**
During the 1940s and 50s households were dependent on men’s financial contributions. Men occupied a new social role – that of breadwinners. New values that meshed with old ones were created. Women became the daily managers of the household, but men remained heads of households – in absentia – and they were expected to provide financial assistance to the household. However, urban wages were very low and scarcely covered the man’s own subsistence requirements. His remittances were therefore irregular or non-existent. Men’s difficulties in providing financial assistance to the household undermined their social roles and their social value. As discussed below, this has had serious consequences for men’s roles and masculinity.

The disappearance of cattle camps had a negative effect on bride price payment. Temporary unions increasingly substituted marriage. Women had to learn how to make ends meet without any assistance from their husbands. And so they did. Many even managed to send bags of maize to their husbands in town. When husbands returned to Kisii because they could no longer find employment in the cities, women continued their hard work on decreasing plots of land – still without support from their husbands. Farm work was women’s work. Men, however, still owned the land, and women were dependent on men for access to land. They were also dependent on men for access to cash as returns on coffee and tea, delivered to the respective factories or co-operatives, were issued to the head of household, the husband. Women, however, learnt to make deals with local middlemen so that they could sell part of their cash crop without the knowledge of their husband. Women’s position as managers of both food and cash crops and often as sole managers of the farm has made them crucial for survival of the household. The balance of gender power within the household has shifted. Linked to this, many women have become more autonomous. They increasingly make decisions without involving or consulting their husbands,
present or absent. It is not uncommon now for women openly to be
dismissive of men and publicly to criticise them for their lack of support.

During fieldwork, recurrent observations from women were: ‘a woman is
better off without a husband’; ‘if only he was dead’; ‘men are so delicate;
they break so easily’; ‘our sons have nobody to take as a model’. Men would
respond by emphasising their status as head of household and proclaiming
their right to ‘correct’ (= beat) an obstinate wife. However, typical comments
by men (and women) were that ‘men drink to drown their problems – and they
are many’, ‘men drink and are rude to women to forget that they cannot
provide the family with blankets’. Particularly striking was the contrast
between men’s aggressive ‘macho’ behaviour, on the one hand, and on the
other, their complaints that ‘today women do not respect their husband’;
‘they humiliate the husband and tell home secrets to others’ (Silberschmidt
1999).

But not all East African men find themselves in conditions of poverty and
hopelessness. Wealthy businessmen can afford bride price for at least one
wife and frequently use their wealth to keep ‘girlfriends’. These men are
highly admired and respected. They serve as models to be aspired to,
despite the dire economic condition in which most men find themselves. A
general observation by men interviewed was that ‘a man needs at least three
wives: one to bear his children, one to work and one for pleasure’. However,
most men have not been able to collect the bride price for even one ‘wife’.
In the 1970s, 33 per cent of the households in Kisii were polygamous
(Population and Development in Kenya 1980). Survey findings by this
author indicate that in the 1980s and 1990s less than 10 per cent lived in
polygamous unions. With one wife only, a general observation by men was
that ‘a man needs to go outside to feel like a man. Wives always complain.
To get affection he has to go to his outside partner’.

The intensification of their roles and responsibilities has made women
increasingly aware that the household cannot survive without them. Thus,
even though structurally subordinated, women have actively responded to
the new situation. They have created a new social role for themselves. Both
men and women agreed that ‘more and more women have taken command
of the home’, and ‘harmony has gone out of the window’. Men’s excessive
drinking often results in serious wife beating. The cases documented from
Kisii District hospital are many. But there are also cases where women had
used their sharp pangas and seriously injured their husbands. Persistent
rumours about men being poisoned by their wives circulate. Men’s position
Men, male sexuality and HIV/AIDS

as heads of household is challenged, and some would be called ‘figure heads’ of household. However, land is still owned by men, and men call themselves farmers.

Socio-economic change in Dar es Salaam

The population of Dar es Salaam today is over 1.5 million. In the 1950s men in the capital far outnumbered women (Leslie 1963). Today there are only 0.9 men for every woman. In 1993/94, contrary to expectations, female-headed households in urban Tanzania constituted 18 per cent of the highest income households, and only 13 per cent of poor households (World Bank 1995).

In 1978, 84 per cent of the men in Dar es Salaam had formal employment (Tanzania Population Census 1982). In the 1980s large numbers of workers lost their jobs. Today, only a fraction are employed in the formal sector. Salaries are far from enough to support a family (Tripp 1997). Thus the informal sector has become overcrowded with myriads of market vendors – men and women. Even young men with secondary education end up as street vendors.

As in Kisii, the ideology of men as breadwinners is forcefully alive. Stereotyped notions shared by both genders are that ‘a man should be the head of his family’; ‘he should provide a house (and land), pay school fees and clothes for wife and children’. Such a man has social value and respect. However, a majority of men suffer the same fate as men in Kisii: they cannot fulfil expectations and respond by withdrawing from household responsibilities. Consequently, men’s status as head of household is seriously challenged. However, when asked about their ‘status’ in the household it was obvious to all 53 men interviewed that they were ‘born’ heads of households. That was a ‘God given’ fact. ‘Women are like children and should be guided by men’. ‘Men are the lions, and women are the sheeps’ [sic]. Nevertheless, women accused men of being irresponsible husbands and failing to support their children. In fact, the 53 men interviewed had 30 per cent more children (with two to four women) than the 38 women interviewed.

Most men and women interviewed live in more or less informal/passing unions. If a couple stays together for two years they are registered as ‘married’. A proper marriage still requires the procurement of bride price. With no bride price male control over women’s sexual and reproductive powers is weakened, and women’s security is at stake. Urban life, however, has also provided women with many opportunities. While women often
express self-limiting culturally accepted expectations about themselves, in practice, they are active entrepreneurial agents. The majority who referred to themselves as ‘housewives’ were actively involved in the informal sector, baking and selling mandazis (small sweet buns), preparing ‘lunches’, selling second hand clothes, etc. Both men and women interviewed agreed that women are much harder working and enduring than men. Therefore, when women enter the informal sector, many are often able to earn more than their husbands.

The negative attitude of husbands towards women’s income-generating activities is well known (Mgughuni 1994). However, men and women agree that families cannot survive unless women contribute to income. Most women say that husband and wife should decide together on the use of ‘household’ money. In practice, what women earn belongs to them and they decide how to use it—not their husbands (also see Strauss 2000). Nevertheless, husbands are always expected to provide rent, money for food and school fees even if it is honoured more in theory than in practice. According to Omari (1994) the more women control and manage their own incomes, the more responsibilities are added to them. My findings, however, also indicate that when women have their own money they become less respectful of husbands (see also Tripp 1997).

Many men feel destitute and have no strategy to deal with their problems. According to my male and female informants ‘when husbands are crushed down economically they suffer from feelings of inferiority’; ‘a man’s ego is hurt’. As a result, ‘men lose their vigour and women take over’; and ‘when a man has lost control over his household and is humiliated by his wife, his pride is hurt’. In this situation, men agree that in order to ‘build up our pride’ and ‘boost our ego’, we men need to ‘relax’ and to be ‘comforted’. Relaxation and comfort are mainly provided by ‘extra-marital’ partners. Hardly any thought is given to the threat of contracting HIV/AIDS. If the latency period until onset of AIDS is nearly a decade, why worry? ‘I might just as well die from malaria or be run down by a dalla dalla [small bus in Dar es Salaam]’.

**Male disempowerment, masculinity/ies and sexuality**

Although the main axis of patriarchal power is still the overall subordination of women and dominance of men, my research demonstrates that the deteriorating material conditions have seriously undermined the normative order of patriarchy in both Kisii and Dar es Salaam. While men do have a relative freedom compared to women, particularly in sexual and reproductive
behaviours, lack of access to income earning opportunities has made men’s role as heads of household and breadwinners a precarious one. With a majority of men reduced to figurehead authority, male identity and sense of self-esteem are threatened. Patriarchy does not mean that men only have privileges. A patriarch has also many responsibilities. The key and the irony of the patriarchal system resides precisely in the fact that male authority needs a material base. Patriarchy used to be closely linked to male entitlement to control all essential resources, to ‘own’ and decide over the means of production. In contrast, male responsibility is normatively constituted (see also Kandiyoti 1988). This has made men’s roles and identities confusing and contradictory and many men express feelings of helplessness, inadequacy and lack of self-esteem. Alcohol consumption has become a major activity and also a major problem. Men increasingly seek psychiatric help. Advertisements in the local newspapers offer to assist men with problems of depressions and impotence.

Research in the North reveals specifically male depression caused by economic marginalisation and lack of self-esteem. These depressions are characterised by increased aggressive behaviour, lack of self-control, over-consumption of alcohol and often suicide (Sabo and Gordon 1995; Stillion 1995; Rutz et al 1997; Shajahan and Cavanagh 1998). A study from Tanzania argues that frustrations and inner disturbances may even result in men raping children and women (Masenja and Urassa 1993). Possessing no means to change their economic status, many seem to be responding by developing macho attitudes and resorting to physical violence against women. As one man interviewed put it: ‘There is always a tendency for men to want to overcome women and to show them how aggressive we are. This gives respect and self-respect to us men’. In this way men may translate their economic subordination into a symbolic expression, which is perhaps psychologically rewarding if politically displaced. The majority of men feel that it is quite legitimate to have ‘outside’ partners. All men in my research had heard about HIV transmission, ‘zero grazing’ and sticking to one partner. However, most men argue that this is not possible, simply because ‘it is against a man’s nature’. Even if the sale of condoms has increased, condoms are hated, and men have myriads of excuses for not using them: it is embarrassing; it spoils the pleasure; condoms cause painful rashes; and, not the least – sperm is valuable and should never be wasted. In fact, many men argue that ‘you are only a real man if you give your sperm to a woman’, and that ‘if you use a condom, you could just as well masturbate’. The sexual
performance, the control over women – not to mention the pleasure derived from it – is fundamental to male identity. Thus, neither sticking to one partner nor using condoms, which are standard lines of argument in HIV/AIDS prevention activities and campaigns, are acceptable solutions to most men.

My interviews with both young as well as older men indicate that a man’s need for sexual/extramarital partners is particularly urgent ‘when a man has lost control over his household and is humiliated by his wife’, and ‘when a man’s ego has been hurt’. Then ‘he needs peace on his mind’; ‘he needs to be comforted’. One way to meet these needs is to go to the bar – officially to socialise with peers – where money-hungry women (according to wives) are waiting for a catch or to go to the nyumba ndogo (small houses = concubines) who will ‘serve a beautiful meal and give nice comfort’. Wives do not have the time, energy or money for that. This raises the question as to why men’s need for sexual/extramarital partners is particularly urgent when a man has lost control over his household or his ego has been hurt? Could it be because his masculinity has been hurt or ‘dislocated’ to use the term of Cornwall and Lindisfarne (1994)?

According to Connell (1995, 2002) the male gender is constructed round at least two conflicting characterisations of the essence of manhood: first, being a man is natural, healthy and innate; second, a man must stay masculine; he should never let his masculinity falter. Thus, a man is not born masculine, but acquires and enacts masculinity, and so becomes a man. Masculinity is composed of a number of different elements, identities and behaviours that are not always coherent. They may be competing, contradictory and mutually undermining, they may vary across cultures, and they may have multiple and ambiguous meanings which alter according to context and over time (Connell 1995). There are strong masculinities and there are weak ones. There are violent ones and there are non-violent ones, etc. Masculinity (and femininity) – just like gender and sexuality – does not simply reflect a biological ‘given’ but is largely a product of cultural and social processes (Ortner and Whitehead 1989; Connell 1995; Gagnon and Parker 1995; Bourdieu 1998, and many more). Thus neither masculinity nor sexuality are constant factors but change along with different historical and social structures.

This being said, there also seems to be elements/traits of masculinity that have survived through history and different cultures – elements that constitute masculinity that are difficult to ‘bend’. In his recent work, partly based on his studies of the Kabyles in North Africa, Bourdieu (1998) stresses
the link between masculinity, sexuality and violence with the erect phallus representing the dynamic vitality fundamental to sexuality and procreation. Linked to this, masculinity has to be constantly reasserted in the continuous denial of ‘femininity’ or ‘feminine qualities’ (also see Seidler 1991). In order to exercise domination and reject feminine qualities, men are obliged to play their prescribed roles (Bourdieu 1998). From this point of view, men are also prisoners and victims of their role as the dominating sex. Thus, male privilege is also a trap (Silberschmidt 2002, forthcoming).

Drawing on Kopytoff’s distinction (1990) between existential and role-based identities sheds light on the link between different types of male identities. According to Kopytoff, some identities are based on what a person is (= existential identity), others are based on what a person does (farmer/craftsman = role-based identity). Some of these identities are negotiable; others are not (Kopytoff 1990:80). The existentially based identity is composed of features that are intrinsic, or ‘immanent’ in a cultural definition of what it is to be male or female – and not negotiable. The existential identity indicates a state of being rather than of doing. It is difficult to renegotiate, relatively immutable, and surrounded by strong sanctions that punish deviant behaviour. In contrast, features of role-based identity may be negotiated and the identities themselves relinquished with no sanctions. Following these distinctions, a man’s identity is closely linked to his (culturally defined) sexuality: it is an immanent (inherent) feature of his existential identity that cannot be negotiated.

 Returning to my own studies, male role-based identities are seriously questioned – and following this what seems even more problematic is the fact that men’s existential identities are under serious threat as well. With a majority of men not having been able to develop new role-based identities and with male sexual activity generating categories of masculinity, the need for men to pursue their existential identities seems to have become essential to their self-esteem. Kopytoff’s distinction between role-based and existential identities provides an operational tool that permits one to identify change and the impact of change on role-based and existential identities. It also clarifies why male sexual activity is so important, and why greater emphasis is placed on sexual relations and even risky behaviour. However, Kopytoff’s approach does not allow for a discussion whether these non-negotiable features are eternal – or if they can change and his model therefore becomes too simple (for further elaboration see Silberschmidt 1999:176).
According to Connell (1993) and in line with my own findings, the fact that many men experience an undermining of their social roles does not necessarily undermine existing hegemonic forms of masculinity or power relations. Nor does it necessarily lead to the construction of alternative identities that are less oppressive to women (Willott and Griffin 1996). ‘Major reform in gender relations may well require a de-structuring of the self, and experience of gender vertigo, as part of the process’ (Connell 2002:91). When men’s material base is eroded (as argued above), many men do seem to use other measures to establish their authority, for instance by developing masculinist discourses that reject alternative potentially egalitarian understandings of masculinity (Morrell 2001). Thus, developing masculinist discourses, being sexually aggressive and violent, may represent a way to regain control of women – and to regain a kind of authority. This attempt to regain control of women seems to run counter to the promotion of gender equality and women’s empowerment – in fact, it seems to constitute a serious barrier.

On the other hand, there are also men who actually abandon their immediate realm of authority (the household) and seek new forms of affirmation (in the arms of other lovers) (Morrell 2001). Domination is not inscribed in men’s nature. Nor are masculinities constant or static. They change along with different historical and social structures, the complexity of contemporary life, etc. Furthermore, there are many masculinities. While men and women have deep-rooted, often unconscious, conventional ideas of masculinity and femininity, there is always potential for innovation or creative action. This provides space for optimism, precisely because it acknowledges the possibility of intervening in the politics of masculinity to promote new types of masculinities that may embrace gender equality (as also suggested by Morrell 2001). However, in order to uncover such masculinities, there is a need to enter into a dialogue with men to enable them to redefine desired masculinities and to make them realise the fragility of their masculinity: by seeking to affirm their masculinity by having many partners and unprotected sex, men do become vulnerable. It is also important not to vilify men but to underscore that being a responsible partner is a way of expressing masculinity. It is also a means to ensure the family’s future and it is in men’s own self interest.

Conclusions
The study of HIV/AIDS transmission and prevention has centred on specific issues of risky conduct, but there are clearly larger issues involved in the social engineering of sex (Parker and Gagnon 1995; Parker 2001). This article
has shown that an understanding of the risky conduct of men cannot be achieved without analysing masculinity and paying attention to the socio-economic conditions under which it is constructed. The social engineering of sex in eastern Africa reflects not so much the power of men but the erosion of this power. Based on my research, men’s sexual practices do seem to be driven by ‘traditional’ beliefs and cultures. Or at least, men explain or justify their behaviour by resorting to traditional discourses of naturalised male behaviour. Behind these explanations, however, are more complex and less accessible explanations. Collapsing traditional structures, the emergence of new unstable situations, poverty and lack of access to income generating activities have undermined men’s role based identities. There has been a concomitant rise for men in the significance of their existential identities. Men draw on their ‘traditional’ privileges to attempt to perpetuate their dominance over women or to compensate for their loss of authority by engaging in multiple sexual relationships.

According to Peter Piot, the director of UNAIDS, ‘Men are key to reducing HIV transmission and have the power to change the course of the AIDS epidemic’ (UNAIDS 2001). While on the one hand this is helpful in moving gender approaches away from focusing exclusively on women as has been the case in the past, on the other it runs the danger of essentialising the category ‘men’ and deflects attention away from the complexities of multiple masculinities. It also leaves men with an enormous responsibility – a responsibility that most men may neither be able nor willing to take in their rather desperate situation and caught in their role as the dominating sex. It was only with the September 1994 Cairo conference on Population and Development (ICPD) that a focus on men, their role as (responsible) partners and also their own sexual and reproductive health needs became clear. The final ICPD document (1994) recognised the need to address and involve men in order to improve women’s reproductive health. This was again reflected in the Cairo + 5 meeting in The Hague, February 1999 and in UNAIDS campaign ‘Men Make a Difference’ (2000). Thus, the role of men in combating AIDS is certainly gaining importance. Operational attempts, though, to reach men are very few, and have not yet been given high priority by local governments, donor agencies or NGOs or researchers. Moreover, there is no generally accepted understanding of how to make ‘male involvement’ operational. One of the problems is that there is no clarity or agreement about how men should be approached or integrated into existing HIV-prevention or reproductive health programmes.
Despite welcome developments, many AIDS strategies continue to rely on an empowerment of women approach. As recently as the 2002 Barcelona AIDS conference ‘Empower women, halt HIV/AIDS’ was a slogan adopted by UNIFEM (Press release, July 2002). Women were also urged to couple efforts to empowerment with the ability to identify key entry points to integrate components on self-esteem development (Press release, June 2002). The ‘women as agents of change’-approach is founded upon what Andrea Cornwall (2000) calls the myth of female solidarity within the Gender and Development paradigm. Within this paradigm, women are most often portrayed as victims and men as problems. However, when it comes to efforts to operationalise gender and development, men are both missed and missing: Men are missed as target group and missing as involved active agents in ‘gendered’ development initiatives (Chant and Gutman 2000). The same can be said about men’s role in combating HIV/AIDS.

The challenge in the field of HIV prevention and reproductive health therefore remains of involving men and overcoming their resistance to such involvement. Efforts here are charged with considerable difficulties because they may threaten established male privileges as well as men’s existential identities.

One opportunity lies in focusing on men’s own vulnerability to infection. Most men have not considered their own vulnerability. Why would they? Historically women have been encouraged to pay attention to their health because of their childbearing capacities. Men have not. All they hear about is women’s vulnerability, women’s deteriorating sexual and reproductive health, for which men are often blamed. With the ABC approaches still being considered ‘best practice’ in HIV/AIDS prevention activities by many organisations (personal communication with the UNAIDS, Dar es Salaam, July, 2003) it seems that the gendered effects of socio-economic change and in particular the implications for male identities, masculinities and sexualities have been totally overlooked.

And so have male vulnerability and male self-interest in avoiding HIV/AIDS. To me, this is the crux of the matter. If men are to be key actors in reducing HIV transmission, they need to develop a concern about their own health before they can be concerned about the health of their partner. As long as men have not recognised their own vulnerability and are not aware that their sexual behaviour is lethal to themselves, men cannot be expected to adopt a more responsible behaviour or to create alternative masculinities. Also, men will not be inclined to ‘involvement’ unless they see what are the
benefits for themselves. From this point of view, the notion of ‘self-efficacy’ may constitute an important determinant (e.g. Bandura 1986, 1997). The concept goes beyond the contextualist perspective, and people are seen as producers as well as products of social environments. But they also have a hand in selecting and shaping their lives. Faced with disempowerment, the development of a feeling of self-efficacy – of having control over important aspects of one’s life – may constitute a so far neglected key to ‘male involvement’ (see also Campbell 2001).

The men in my study are caught in the trap of macro economic structural forces and are unable to escape the impoverished and futile circumstances of life that prevent them from taking their own health status seriously. This situation has not been adequately addressed by development agencies, NGOs, etc. Yet, men living under such conditions do not necessarily or automatically engage in dangerous sexual practices. But drawing on the notion of self-efficacy there is an important and so far overlooked gap of self-agency, and it is precisely into this space that HIV prevention strategies that focus on men should be introduced.

However, while this paper has highlighted the need to address issues of self-interest, self-efficacy and self-agency it is crucial that the mutuality of interests of men and women be kept at the forefront of any strategy. In fact, the mutuality of interests, the relations between genders, the position, interaction, rights and responsibilities of both women and men are pivotal (see also Baylies et al 2000:23). This requires that men are addressed in the same way as women – not at the cost of women – but in the name of mutuality, equality and empowerment of both women and men. However, with the urgent need to make a halt to the HIV/AIDS epidemic – and for pedagogical reasons – a focus on men, their vulnerability and the promotion of male self-efficacy should constitute a first step. This requires health services particularly catering for men’s sexual and reproductive health (men-friendly services). Moreover, discussion forums must be made available that respond to the needs of men and allow for a critical self-examination by men themselves and also more open dialogues with women. Moreover, and as suggested above, investigations and interpretations that look for indications of alternative types of masculinities embracing gender equality should be given priority in discussions of the potential and possibilities of male-focused HIV/AIDS prevention campaigns.
References


Article

Living life on the edge: Examining space and sexualities within a township high school in greater Durban, in the context of the HIV epidemic

Alex A Kent

Introduction

Throughout this article I demonstrate and build on the notion that compulsory heterosexuality and fixed gender roles are ‘dangerous’ especially in the context of the HIV epidemic (Morrell et al 2001). In order to challenge these dangerous gender performances it is necessary to have a full understanding of these discourses and where and how they are manifested and regulated.

Schools are complex spaces in which identities and sexualities are taught, performed and negotiated (Epstein and Johnson 1998). Performances arise from the expressive power of the body whilst being grounded in the norms of social process such as compulsory heterosexuality (Butler 1990). Space can, therefore, be a useful analytical tool through which to examine gendered performances (Paechter et al 2001).

This article will demonstrate the ubiquitous disposition of gendered performances on three levels. It will map the visible informal use of school space such as where and how males and females spend their break time. It will examine how gender differences are policed within the school walls, for example management structures. It will also discuss how performances are shaped by gender identities when students perform at a beauty pageant. However, before taking this spatial examination I will briefly describe the context of the research.
**Engendering HIV**

The HIV epidemic in South Africa is localised, racialised, affects many young people and is gendered. The epidemic has had a greater impact on women in South Africa; it was estimated that 2.65 million women and 2.09 million men were living with HIV in South Africa in 2002 (AVERT 2002). The underlying cause for this gender disparity is that females are both physiologically and socially more susceptible to HIV infection than males.

The gender inequalities of every day life in South Africa have prevented many women from taking control of their sex lives. Socio-cultural expectations prescribe female behaviour, such as being in a heterosexual relationship by the age of 20, married by 25, and allowing males to have polygamous relationships. Women have less access to money, education and power, and are forced to use sex as a bargaining tool, reducing their power to insist on the use of a condom (Mthembu 2001).

Another social norm is sexual violence. In 1999 alone 51,249 rapes were reported to the South African Police Service, which is likely to be merely the tip of the iceberg of actual rapes (Vetten 2001:31). Not only does rape put women at high risk of HIV infection but the nature and regularity of the event serves to reinforce male dominance and further subordinate and disempower women.

In an attempt to address the interrelated gender divisions and the HIV epidemic, interventions have often targeted women. However, this has been problematic when they have focused on the effect rather than the cause (Bujra 2000). This has had a fatal result in fuelling the misogynist reaction which blames women for HIV (Maharaj 2000). In 1999 Gugu Dlamini spoke openly about her HIV positive status at a World AIDS Day event in KwaMashu. Two weeks later, on December 12, she was stoned to death by members of her community.

In order for interventions to address the effect of HIV, there needs to be a full understanding of existing gender and sexuality performances. I further develop this understanding by focusing on a space upon which many hopes are pinned for HIV education interventions: a school. Lillian Ngoyi School is a co-educational school located in a Greater Durban township.

**Situating the research**

This spatial outlook was inspired by Epstein et al (2001) and Karlsson (2002a and 2002b), who have used space to examine social process within schools. Both have illuminated school performances beyond that of the
much researched formal pedagogy (classrooms and lessons) by looking at informal times (breaks), and informal spaces outside classrooms. By using ‘space’ in South Africa, Karlsson has demonstrated that although post-apartheid changes have affected formal schooling, informal spaces have retained inequalities (2002a and 2002b).

The gendered and sex expectations that students and teachers bring to school space greatly influence the rules and regulations that determine their performances, both within and outside the school walls. Heterosexual and gendered behaviour appear as ‘normal, everyday and unremarkable’ (Holly 1989) due to sexual dynamics being shrouded in silence. I intend to challenge this and uncover to what extent gendered heterosexual behaviour is grounded and unnoticed in everyday space.

This research was carried out in April and May 2002. As a feminist ethnographer, I attempted to immerse myself in school culture by teaching, and faced obvious limitations as a white, female, British researcher. I kept a descriptive journal throughout the research period and carried out informal interviews with staff and students when issues emerged. In order to protect the identity of the individuals involved, all names used in this article, including that of the school, are pseudonyms. A more in-depth reflexive account and discussion of these findings and the difficulties in obtaining post-structuralist descriptions can be found in Kent (2002).

Mapping Lillian Ngoyi

Lillian Ngoyi is a school which is on the ‘edge’. It is marginalised in terms of location, being in the former township KwaMashu. It has few resources, with only 25 basic classrooms for 1350 students and poor opportunities for the staff and students although matriculation levels are higher than many other schools in KwaMashu.

As already suggested by the case of Gugu Dlamini, KwaMashu is perceived as a dangerous place. During the research period of 25 days one teacher witnessed a women being raped and murdered close to his home. In between January and April 2002 three female students were raped. One girl was raped on her way to her friend’s house in the early evening by two men and another girl was hijacked, blindfolded and raped by five men. During the research period, teachers also reported two cases of female students being physically abused – one girl was beaten by her uncle and another by her stepfather. These reports of violence were the most visible cases, leaving countless stories of violence untold.
The dangerous setting in which Lillian Ngoyi is situated is significant in two ways. Firstly, the violence is gendered; females are commonly the victims and males the perpetrators. Secondly, the school is a spatial unit; management tries to ensure it is a ‘safe’ space into which violence cannot filter. The school stands within an iron barred fence and a guarded gate. Within this space, strict codes of conduct ensure that the students abide by the school’s rules and regulations and not those from outside. The expected result is a performing student body dressing in school uniform, moving according to the school’s timetable and showing respect for the teachers. However, as I will show below, both the expected student performances, and the codes of conduct used to regulate these, are not always ‘safe’. They are both sexualised and gendered. Schools are neither ‘innocent’ nor ‘safe’ but provide a stage which permits the development of violent attitudes and behaviours (Kenway and Fitzclarence 1997).

School is not a place for children. It is a place where you learn to love, to share and to hate. (Standard 10 student)

Rejecting the ‘safe’ view of school, this student introduces the ‘real life’ importance of school, where much more is learnt than the ‘formal’ curriculum. The informal schooling of students’ performances and sexualities is a crucial part of school life, a largely assumed practice and rarely examined. Individual cases of small spaces would provide enough evidence for many studies. As I aimed to examine gender and sexuality performances within the school as a whole, I start by mapping the whole space and provide several descriptive snapshots of performances that take place across the school.

Manning the margins: informal regulations of space and performance

Figure 1 is a map of Lillian Ngoyi School demonstrating visible sites of power and sexuality negotiation. When walking through the school gate, there was an immediately visible display of masculinities and femininities. Female students played in and out of the classrooms, on display from the public road. In this space five or six women also sold fruit and sweets. The only males around were in inaccessible positions of authority, the guard’s house, in or around the management offices or under the ‘Ultimatum Tree’. 
The ‘Ultimatum Tree’ was where male teachers spent their break and lunch time sharing a bottle of lemonade and sandwiches. Although the teachers assured me ‘girls could come here’, they claimed that ‘only the naughty ones’ would come. Female teachers instead spent this time in the staff room. This tree was introduced to me as the ‘ultimatum tree’ by the only female head of department. As all the management staff other than her spent so much time under this tree, the significance of the ‘ultimatum’, I assume, is the power this site held in decision making, from which she was excluded.

The other immediately visible sites of power were the parked cars. All students, bar one group of boys who drove, walked to school. Those fortunate enough to have their own car, displayed their wealth and prestige through their vehicle. Two of the cars were large and expensive; they belonged to the male principal and a male head of department, who came and went from school alone. The only car owned by a female teacher was old and the windows and seat belts did not work. Her car was always full of other female teachers, to whom she gave a lift to and from school. These privileges of male performance were characteristic of hegemonic masculinities and were highly visible. There were also more ‘covert’ performances of hegemonic masculinities which involved risk taking, and living life on the edge.

At the far end of the school, away from the ‘female’ public front area, behind the disused library, was the male ‘Smoking Saloon’, as announced by large chalk writing on the wall. Every break-time this area filled up with over a hundred male students, who gambled, smoked cigarettes and marijuana. There was an understanding that no female came or went back here. Being on-the-edge was significant in terms of escaping the public eye of the teacher and also in terms of physically buying cigarettes and marijuana through the fence. Every month or two a male member of the school management would come back here and discipline those found smoking by corporal punishment or compulsory gardening. During other times this performance of male youth was expected and tolerated.

This accepted male performance is linked to the grounding of masculinities in outside and dangerous spaces. When I discussed this performance with a male teacher, Musa, he expressed the apparent different gender roles:

*Alex:* Why do you think that is, that boys get in trouble?

*Musa:* Because the life of boys is physical, yeh, it’s physical, so and the fact that you know and us, we have a lot of respect, that girls must stay at home and wash dishes and all that you know, they must not be late
Examining space and sexualities within a township high school in greater Durban

around the streets and all that, this cultural bias, the cultural stereotypes. But boys, at times, may be bad models… because it is the way that we were brought up, we were brought up that way. There’s apparent rules for girls and rules for boys. Like if I might cite you an example. That girls must stay at home, she must cook, she must wash, she must clean, she must do such kinds of chores.

Musa frames ‘respectful’ girls within the rules of the ‘private’ sphere and space of the home, whilst allowing boys to prove themselves by rebelling against these regulations, by taking risks outside of the safe, private sphere of the home. The after school behaviour of the students echoed Musa’s expectations. Whilst girls performed household chores, boys played ball games outside. Boys were more likely to risk arriving late and skip classes, whilst girls commonly had the responsibility of walking to and from school with a younger sibling whom they left at the crèche next door.

Being masculine made these risky performances inaccessible to females. If females dared share these performances, they were deemed far from the norm, and likely to fail. Just as teachers expected female students to be mature and responsible, when a female student showed low attainment, it was justified by her being influenced by boys, and their marginal behaviour. A female teacher expressed her opinion why older female students achieved lower grades than male students:

Especially girls, they can’t balance. Even the girl that was intelligent in grade 8 her grades will drop in grade 10. It’s rare for a boy to be affected by this stage, especially in his school work. Some of them [girls] start smoking and also taking these drugs at school.

Whereas males had ‘male’ spaces such as the Smoking Saloon and the Ultimatum Tree, females had no ‘female’ space within the school. The only private spaces within the school were the toilets, yet privacy was hard to come by; in the female toilets the cubicle doors were either missing or broken. Despite being the school’s one ‘female-only’ space, this was neither a hang-out nor a ‘safe’ space. In 2001 a student attempted an abortion and another attempted suicide. The fact that these acts of violence were perpetrated by the victims marginalised these acts from being of a school management concern.

The female staff spent their break time in the staff room, a relatively public space, busy with members of staff and visiting students. A group of young female staff sat in the corner and shared their daily lunch in what was temporarily the ‘women’s zone’. Although sitting tightly around a table, the
space was penetrable and frequently disturbed by loud and boisterous male members of staff. Male teachers would hover round the table, talking ‘into’ and ‘over’ this space, delving hands in to eat the food that was shared. The ‘female’ space remained small, interrupted and moveable, unlike the male smoking saloon and Ultimatum Tree, no female claim could be made of this tangible table space.

As the map and descriptions demonstrate gender performances are everywhere. Where males live life on the edge and challenge the margins of school space, the females’ behaviour is closely policed enclosing their performances to largely public and ‘safe’ spaces. Each ‘space’ within the school hosts a complexity of gender and sexuality performances; they are part of everyday life and largely go unchallenged. In order to help understand what polices these divisions, the practice of formal schooling should be observed.

**Policing femininities: formal regulations of space and performance**

The school’s formal structure, rules and regulations also proved to serve a role in maintaining gender divisions. Like other schools, the formal use of time and space at Lillian Ngoyi was controlled by the hierarchy of school management, teaching staff, a timetable and a loud siren (located outside the principal’s office).

Foucault identified school discipline as an important form of regulating the body and mind of students (1978). This discipline takes a variety of measures from the set use of time and space throughout school, such as lining up for school assembly or being punished for bad behaviour. Despite being illegal in South Africa since 1996, Lillian Ngoyi, like many other former ‘African’ schools maintained the practice of regular corporal punishment. Several teachers were known for their harsh punishment, and carried sticks menacingly, in particular the deputy principal. There were no school spaces which were safe from corporal punishment as it was used frequently in the classrooms, offices, staff room and publicly by the school gate for latecomers.

Corporal punishment is a tool of spatial management used to keep students in their place and manage the behaviour of students when in the school space. The male teacher, Sipho, expressed his reasoning for using corporal punishment:

> As an African I know what it takes, I know how to discipline and when to discipline because some of them are so rude and they are, they bully
each other, and if you are not careful as an educator you might get seriously injured... if you are too strict if you give them severe punishment you put yourself in danger, I do not want to hide that. So we have to be extra careful not to forget to stamp your authority as an educator. You must demand respect from them, you know. Show them that you are a parent.

Sipho stressed the importance of demonstrating hegemony to the students, he emphasised authority rather than love or care of a parent. Corporal punishment is used as a ‘grooming’ technique, which moulds masculinities, to tolerate pain and learn to ‘act like a man’. By normalising the practice of physical discipline, violent masculinities are brought into the every day space of school culture. These masculinities are so engrained in everyday social practice, that one male student describes them as something one is ‘born with’:

For us, as black people, we are born with it... we are born to fight... born to beat somebody...a black child cannot understand without being punished. You’re a man if you don’t feel the pain when using the stick, not a little slap.

Another formal mechanism for policing sexualities and gender disparities within Lillian Ngoyi was the patriarchy of school management. Lillian Ngoyi’s principal was an older male teacher, who has been at the school for 20 years. He had the largest office, located centrally within the school. The room had the most valuable material possessions, housing the one functioning computer, important documents, such as examination results, and the school’s awards and medals. He was also privileged in terms of spatial mobility. Not teaching, he was free from the constrictions of the school bell and the school grounds, as he demonstrated using his large car to come and go as he pleased.

The two deputy principals were also male and shared an office beside the principal. This room housed the second most prized piece of equipment, the school photocopier. Both deputies taught, although considerably fewer classes than other teachers, hence they enjoyed a relative amount of freedom over time and space. These members of staff were the most feared and respected within the school grounds.

The school’s heads of department (HODs) were privileged in that they shared an office and had a lighter teaching load than the remaining teachers. However, the only female head of department, Ncane, had a larger workload than her contemporaries, as she explained:
I am a full time teacher and HOD, I’m managing some subjects and at the same time as I’m responsible for cultural activities including the drama and choir, so sometimes it’s got very difficult and I’ve got to do better preparing them for their future careers. I also work as a guidance counsellor. Just now I’ve got to be organising a career’s exhibition so they are exposed to the institutions they will be attending next year… To make classes smaller, I decided to take more classes, so I now have many more than any other HOD in the school.

Ncane was given few of the powers that come with being a head of department. Management meetings were dominated by male teachers and Ncane’s views were often dismissed or not respected. The perceived masculinities which Ncane lacked, but were relevant to the job, were those of assertiveness, forcefulness and un-emotional attachment (Morrell 1998). Being a woman, Ncane was a perceived ‘carer’, someone who teaches and looks after the welfare of the children out of the goodness of her heart. Not only are women expected to prove themselves in the management role but also be able to cope with the domestic responsibilities of the private sphere and caring for friends and family outside the public sphere of the school.

The students too had a male dominated management structure: the student council. Only three of the nine posts were occupied by girls: the secretary, the assistant secretary and the treasurer. The remaining posts: president, deputy president, recreation and cultural officer, education officer, security and safety officer, and even gender officer, were male. On expressing surprise that the gender officer was male, the school president asserted knowledge (if not understanding) of the gender discourse and assured me:

Here we do not discriminate; either sex can do the job.

The school’s gender officer, however, did not inhabit the same space or performance as the females in the school. A frequent visitor of the male ‘smoking saloon’, he occupied a position of hegemonic masculinity and focused his attentions upon talking to girls. His emphasis upon the positive nature of the job was that it gave him authority, which enabled him to get the attention of girls. Although his position had been created by the school’s aim to challenge gendered behaviour, his perceived use of the post undermined this and served to secure the patriarchal hegemony in which school social process is situated.

The practices described above illustrate how the formal performances at school policed sexualities. However a particular femininity was policed with
more rigour than any other. Despite the practice being illegal in South Africa, the school excluded pregnant students. During the research period teachers discovered four students were pregnant in grade 12 and there was another ‘problem’ in grade 8. During my time at the school the principal made an announcement in Zulu in the school assembly. When I asked him what he had said, this was his response:

Mr. Hlophe: So I was informing them that it was wrong for them to remain here at school while pregnant because should they, eh, during the labour period, we don’t have the expertise to deal with the problem. There are no ambulances here.

Alex: And when is this from, as soon as she becomes pregnant, or in the last month?

Mr. Hlophe: No. As soon as it becomes a problem, or prominent, when it becomes conspicuous. Because we are having a problem. It is not even good for the image of the school and a very, very bad example to our young ones in grade 8, they are very young, young, young girls here.

The rights of the student, therefore, decrease when she is pregnant. Once her ‘position’ is visible, her rights are superseded by the appearance of the school. Likewise female teachers expressed their opinion that pregnancy was a form of punishment, and that once pregnant motherhood was the one overarching responsibility of the female student:

Ncane: I think the girl should, eh, accept that she has committed something that is going to ruin her time.

Lulu: If you are pregnant you must know that your future is doomed. Say if you get a scholarship where will the child go? You are a mother now.

The belief that the life of new mothers’ should be ‘doomed’ or ‘ruined’ was not a consideration bestowed upon fathers. Instead the exclusion of visibly post-coital female students served to re-confirm the male status of school space and keep femininities out of the public eye and in the appropriate domestic sphere. This resulted in the confirmation of different gender performances and the subordination of women within the accepted and performed school regulations.

Performing sexualities
The findings above demonstrate the gendered use of school space and how these are regulated. One particular example is a beauty contest. Lillian Ngoyi’s annual beauty pageant was a much anticipated event, captivating all staff and students. It provided a forum in which to observe the performances
of male and female students and the starkness of compulsory heterosexual behaviour. The day was held outside the school space in a local sports complex. Out of uniform and out of school space the students were excited and dressed to impress. Interaction between individuals was less formal than school, and teachers danced and chatted with students. During the day there were parades of female students competing for the Beauty Queen and the male students for Mr Personality.

The pageant displayed a stark and explicit performance of compulsory heterosexualities. This notion is centralised on embodied sexualities, where females inhabit a passive, subordinate, body-for-others and males use their strength to detach themselves from their bodies in a display of violence, virility and unemotional performance (Kehily 2001). The female students displayed emphasised femininities, an identity focused on attracting males using their appearance (Connell 1987), whilst male students displayed indifference and clenched fists in their parades around the hall.

Where male students wore clothes ranging from jeans to suits, females wore swimwear and evening attire. One girl wearing a g-string received a very excited reaction from the crowd and a comment from a male teacher that she was ‘tempting us men’. Although a requirement of the parade, the swimwear was viewed as a male invitation to enter and look into the female space, the less she wore, the more pressing the request. The negotiation of entering this female space was acted out. The females paraded the room, before standing in two lines, facing each other, on either side of the hall. The males entered the room and stood at the far end, before taking it in turns to slowly walk around the hall. Taking his time each male would stop in front of, and gaze at, every female, some for longer than others. When seeing something that particularly interested him he paused, sometimes touching the girl’s cheek or waist. Not easily satisfied, he occasionally shook his head or walked on. On finding the right choice he would kiss and hug the girl or offer her a rose. Proclaiming her ‘taken’, he put his arms around her waist, cradling her from behind.

Throughout this performance of compulsory heterosexuality the females had no power to control this negotiation, despite being cast off time and time again, they remained constant with a fixed ‘pretty’ smile upon their faces. This performance reflects Germaine Greer’s notion of femininity, as being merely a support mechanism for masculinities:

Feminine is not a version of female, but the denial of female. Female does not fit male as the sock the foot, but feminine does. The reduction of
female to feminine is as drastic as transforming a foot into a sock (1998:125)

The performance of compulsory sexualities displayed femininities and masculinities as two very unequal halves where males control the negotiation of power and space. In contrast the femininities were embodied, unable to control their sexual function, to initiate sex, or to say no to the advances of men.

As shown above, performances of compulsory heterosexuality and gender divides occurred throughout school space. There are countless other examples such as accepted male polygamy and sexual harassment. The ‘norms’ of the school culture favour hegemonic masculinities as demonstrated by the males’ right to choose performances and where these performances take place. The performance of femininities are policed by the formal structured use of school, places visited during break and sexual culture, resulting in females being less able to control their use of space and performance.

As the above has illustrated, school space provides a forum for performing and reinforcing compulsory heterosexuality and gender divides. Throughout the school, individual spaces ground gender performances allowing men to live life on the edge and policing acceptable lives of women. This research provides rich data to reveal how gendered practices are ingrained and taken for granted in the use of school space, the management process and accepted social interaction. The findings on their own form a matter of interest but also play an important part in the future understanding of HIV in South Africa.

**Intervening in a sexual space**

Finally I will tie together how this work is relevant in the context of HIV. Firstly, by considering school HIV interventions, and, secondly, by understanding what is needed in order to improve the situation.

Schooling has been seen as the hope for reversing/containing the HIV epidemic in South Africa. The new Curriculum 2005 is intended to ensure HIV and issues surrounding it will be tackled across the board and specifically within the new subject, Life Orientation. Schools may also serve as ports of condom distribution. But to what extent are schools the appropriate places upon which to pin the hopes of change? This article has shown schools to be made up of complex spaces, throughout which gendered performances are embedded, leading to the question of whether they are safe and appropriate spaces for HIV education.
Without tackling the existing performed use of space, HIV education interventions are flawed. South African schools have already been exposed to the HIV education discourse, bringing a language regarding ‘safe sex’ and ‘gender equality’, and subjects previously undiscussed into the public arena. This discourse has made accessible a language about sex, condoms and HIV, leaving few unexposed to this information. This was demonstrated by the male teacher, Sipho, who claimed:

You see, KwaMashu is a township in an urban area. They know everything [with regard to HIV], everything and they can even tell you how to use some of these things, protective measures they know them.

However, without laying the foundations where change is possible, the ability to talk about safe sex does not easily bring positive change in practice.

Despite there being a willingness to ‘do something about AIDS’ as proclaimed by the school principal, this does not automatically lead to active change. In 2001, the school was supplied with 2000 condoms to distribute to the students. Research that was carried out at the time showed how proud the teachers were of distributing these (Morrell et al 2001b:20). Yet, a year later, when I carried out research the same boxes of 2000 condoms were, dusted over, sitting in the corner of the staff room, in a ‘safe’ place.

HIV education has introduced gender equity language, yet the gender equity discourse is yet to be understood, embraced or wanted. The use of a ‘gender equality’ language was demonstrated through sexist jokes in the staff room. Humour is a way of coping with the discomfort of unwanted change. It disguises fear, and can be used to reinforce women’s subordinate position, such as dirty jokes attempting to undermine women through discourse (Kehily 2001). This joke was printed out and passed around the staff room:

A woman comes home late from a gender meeting. The husband was waiting eagerly. When she arrived she said: “Baba Kuthiwe Kube yi 50/50 nani: nipheki, niwashe, nigezise nabantwana” (now we are 50:50 you must do the cooking, washing and look after the baby)

The man replied: “Manje am asende baninikile yini?” (did they also give you testicles so we can be equal?)

Without understanding the existing gender performances introducing a language of change is unlikely to bring about a change in practice, as demonstrated by this joke. In order to challenge gendered performances and
compulsory heterosexuality. Their current performances and investment in such must be fully understood. Change is often not wanted or accepted as demonstrated by this male teacher:

A girl might become the president of the country although this government that is in place now, has changed the mindset, has got more than 50, in terms of gender imbalances, got more women as ministers and in parliament, so that has been a little bit reversed. But men are not happy about that, when they see women taking that position...

The women we have these days are empowered, they are liberated, they are emancipated, they are focused, they are learned and educated and have careers so they refuse this kind of a system of polygamy. They say let me leave this. So everything is changing badly for us (laughs) badly for us.

This teacher described a characteristic of hegemonic masculinities. The underlying domination of hegemonic masculinity performances are emotions such as confusion, fear, uncertainty, impotence, shame and rage. It is, therefore, unlikely that males will give-up the ‘power’ of hegemony without a struggle (Kenway and Fitzclarence 1997). Challenging hegemonic masculinities may serve only to reinforce this fear and result in a stronger display of violent masculinities. In order to intervene there must be a full understanding of hegemonic masculinity performances and its regulations. Like hegemonic masculinities and gender divisions, compulsory heterosexuality also frames performance, constraining females’ sexuality to being the property of men. For any HIV intervention to be successful compulsory heterosexuality must be fully understood, and negotiated.

Without both understanding the significance of gender performances, how and where they are negotiated, HIV interventions will be limited. Schools should not be assumed ‘safe’, empty spaces in which to carry out HIV education. Embedded within school space are the performances of gender and heterosexuality.

Concluding that schools are problematic spaces in which to carry out HIV interventions is rather ominous and unpromising. Just as each space within school embeds a host of performances, each individual school will provide different experiences and performances. It is important that this richness is noted. What makes performances and sexualities so complex and requiring further detailed examination is that they are never static. However, it is their ability to change, be reconstructed and be reclaimed that offers hope for the future.
In order to realise further the potential for HIV interventions, there should be more studies like this. A deeper understanding of gender identities, the importance invested in them and where they are situated is necessary before being able to re-negotiate these ‘dangerous’ gender discourses. Without a fuller understanding, gender and sexuality performances will remain ignored and hidden within the very site of HIV education: school space.

References


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Debate

The Treatment Action Campaign, HIV/AIDS and the Government

Zackie Achmat

This is an edited transcript from a talk given by Zackie Achmat at a meeting organised by the University of Natal Branch of the Treatment Action Campaign (TAC). The guest editors would like to thank Zackie Achmat and TAC for permission to use it.

The struggle of TAC is, in the first and the last instance, a struggle about our constitutional rights to life and dignity and also to equity. Why do we say life? Life because without medicine – and also of course according to the Minister of Health, without food – people die. I don’t know how long it’s taken for the Minister to discover that. All of us have known it for a long time. Life, access to medicine and to good health care will extend the lives of many people living with HIV and AIDS. So life is the first thing to think about.

The second is the issue of dignity because dying of AIDS and dying of AIDS related illnesses is not a glamorous thing. It is not easy to die of AIDS. It is a horrible, undignified and really painful process for the people who go through it. It is a process that removes any vestige of dignity that a person might have. When you have diarrhoea, you lose control of your body. When you can’t move, you are relying on other people to carry things for you. When you can’t sleep, you are reliant on having a friend around. But most of all, especially for poor people, the big problem is the carrying of additional packages. There is, for example, the additional burden of carrying water for your mother when she’s ill. There’s having to give up important things when you are young – for instance, when you are a girl of 8 or 10 years old and have to leave school to look after ill parents. It’s about equality, because no matter what anyone says, it’s those of us with money who can afford to buy life. It is those of us who are employed, who are, incredibly, allowed access to life saving medicine. But it’s those who are poor who do...
The Treatment Action Campaign, HIV/AIDS and the Government

not have access to proper health provision. That is the case both in this country and in many other parts of the world – including Europe and the United States – where, although most people have access to good care, the poor and marginalised communities still remain outside of the formal health care services.

TAC started a civil disobedience campaign on March 20 this year [2003]. Hundreds of activists presented ourselves for arrests and demanded the arrest of the Health Minister and the Minister of Trade and Industry. We didn’t do this because we sought publicity. We didn’t do this because it was an easy thing to do. For four and a half years we have negotiated with the government. We have petitioned the government. We have used every instrument that our new democracy gave us – the Constitution, the Human Rights Commission, the Commission on Gender Equity, NEDLAC (the National Economic Development and Labour Council) – a body that most people forgot about until our debate with government began. We’ve used every single opportunity that the democratic government and our democratic constitution have given us. For us, that was not an easy decision because many of us, including myself, had previously put party politics before the right to life. And I think when one does that, one enters a zone of lack of comfort. After all, how can we speak of equality and the right to life when we ourselves put our party loyalty before people’s lives? And so, putting people’s lives first was a very, very difficult process and a very painful one in which we had to confront what we believed, still believe, is a legitimate government, a democratic government; and I believe one that is much better than those that went before.

Now let’s take this, what did we say happens? Six hundred people a day die. We note, ironically, that the government has not contested this figure. Why have they not contested it? Because we have taken the lowest figure out of all their documents. If you were to read the so-called five year strategic plan you will notice that it says that 250,000 people will die of AIDS related illnesses. If you read the requests for budgets from the enhanced care initiative, which is an internal department document, they say three to four million people will die by the year 2010. They tell you that 250,000 people will die this year of AIDS related illnesses. So we say that six hundred people a day, on average, die of AIDS related illnesses.

Most people die alone. Most people die incredibly painful and unglamorous deaths. And yet we continue to waste time. From our point of view, we would have liked government to liaise with us. We would have
liked to get anyone who wants to do something about AIDS in a room and say, ‘You don’t leave this room until you have a plan. You don’t leave this room until you deal with this issue’, because it’s about our lives. The issue of AIDS is about urgency. And it’s about our country and its future. No matter what people say, even the poorest woman in the rural areas with no employment adds to our social public and adds to our economy by transmitting values, by transmitting knowledge, by looking after her children and by looking after her community. So the loss that we will have is not only a loss to our humanity, but also a serious economic loss to the entire society and we would have liked government to show urgency. It didn’t and it still doesn’t.

So what has happened in TAC since we started our civil disobedience campaign? It was the most uncomfortable act that any of us have ever engaged in because it is a not nice thing to act against your own party in a way that we did. It was not nice for me personally to have lost my temper with the Minister of Health and to appear to be rude to her. I apologise for referring to her personal appearance. However, none of us in the Treatment Action Campaign will ever apologise for calling her a murderer. Nor will we ever apologise for saying that she and the cabinet and particularly the Minister of Trade and Industry are responsible for six hundred deaths a day.

We can no longer put our party loyalty before people’s rights to life. and so what has this done? What have we achieved? After years of existence, some government agencies suddenly woke up to the fact that there is an organisation called TAC and wanted to meet with us. Again, as all of you know, the government has sat on a report from the Joint Finance and Health Committee. I have seen this report. I was permitted to look at it – I won’t tell you the conditions under which this happened – but basically I wasn’t allowed to take it, or let anybody else see it or photocopy it and so on. But this report shows that the signs are that anti-retroviral therapy, when used correctly will save more lives than any other intervention. It also shows that the government has the option to do something about anti-retroviral treatment. It could go up to 20 per cent coverage, it could go to 50 per cent coverage, and it could go up to 100 per cent coverage. The report shows that government will be able to save many lives and that it will spend between R10–12,000 per year per person whom it treats if it uses brand name drugs. The report also shows that the benefit of each life saved is about R23,000 per year. For all of us it makes not simply social sense, humanitarian sense but it also makes economic sense.
That report is now finished. It was seen this weekend by the ministerial committee, the minister and provincial MECs (Member of the Executive Council) for Health. They have referred it to cabinet now. We hope that cabinet will take the right decision and will say, ‘Let’s start implementing!’ None of us here believes that government can roll out anti-retroviral therapy everywhere tomorrow morning. It is going to take us many years to ensure that our health care service gets it right. We have now called off our civil disobedience campaign, or rather postponed it, to give government the opportunity to take the correct decision. And from our side this is the last time that we will do it.

What do we want to do over the next few months and the next few years? We want to do the real difficult work and that’s what we need all of you here for. We need all of you here to help us train nurses. We need all of you here to ensure that there is treatment literacy programmes in all communities. We need all of you to contribute R50 a month to ensure that TAC and other organisations like us teach our own members and members of the community to ensure that we make up for where government can’t reach yet. We need all of you here to make sure that our health budgets in the provinces are spent correctly. So that is what we would like to do.

We don’t want to go back to the streets but we will if we have to! We don’t want to go back to confrontation with government on this issue. Although we are in a state of conformation at the moment, we do not want to ensure that across the globe in every capital of the world that – just as there will be candle light memorial services this weekend – there’s protest against the South African government. So from our side, we would like to help save 200, 300, 500 and maybe even more of the 600 lives per day that we lose. That’s what we need all of you to assist us with and that is what we need to assist the government with.

If the government doesn’t act, we will appeal to each of you to assist us. We will ask you to help us to go back to the streets; to assist us with a law case for a treatment plan to ensure that the national treatment plan, to ensure that the national process is respected. That is what we will ask of each of you.

But before I finish off what we want, let us see what global responsibilities are in all this. So far the United States government has given more money to the global fund than even the European Union. Japan and the Gulf States have not made their contribution to the global fund the way they should.
South Africa has enough money to treat people for the next four or five years, maybe ten years, but Malawi, Mozambique, Angola, the Caribbean countries, some of the countries in Latin America and Asia do not. It’s critical that the global fund gets the seven to eight billion dollars a year that it needs – which is less than the amount of money spent on ice cream in the US or in Europe. So it’s very important that we keep this pressure up.

But there’s one problem. We have to put pressure on the US. We have continually to deal with the Bush administration. We have to point it out if that unelected administration tries to put back the clock when it comes to prevention efforts and treatment efforts within the US itself. It’s time to attach conditions to the promotion of the pharmaceuticals and for the US government to stop taking grants away from gay and lesbian organisations. I think that it’s critical that we ask the Bush administration to put pressure on [right wing organisations] so that they don’t translate these kinds of policies into their global funding strategies. Such strategies, in terms of global funding, would mean that women don’t have rights to termination of pregnancies or family planning and that condom promotion is a serious problem and that we have to ‘address’ these issues. That’s not right! That is unnecessary interference. I also want us to say that we must put pressure on the EU, Japan and the Gulf States to contribute more to global funding for AIDS. They have enormous amounts of money that they misuse to fund all sorts of strange things.

We need an open public debate. Without it, without a rational public discussion about science, about poverty, about medicine and so on, we cannot advance and do the real work that lies ahead for us in the communities of Stanger, Mariannhill, in the communities around Durban, around KZN and throughout the country.

**Question and answers session**

Note: The questions to Zackie Achmat were inaudible on our tape, but we are reproducing Achmat’s answers insofar as they are able to stand on their own, without the questions.

1. TAC is trying to prevent an excessive pricing of drugs by the big pharmaceutical companies. They’ve now reduced their price of drugs and they claim to have given a voluntary licence to Aspen Phamacare, which is one of the generic manufacturers. We don’t believe that this so-called voluntary licence will work or end monopoly because only one generic company is allowed to produce the drugs. So what we’d like to do is this. Instead of taking the government to court to force them to
produce a treatment plan, we would really, really appreciate it if we could instead form a joint force with the government and get compulsory licences against the drug companies in order to bring the price of pharmaceutical products down.

In relation to private sector employers, I think here we need some more public debate about getting them to take responsibility for their workers. For example, Goldfields has started treating its workers because we said we were going to run a campaign calling it the ‘Killing Fields’

The real question that we have to ask ourselves about the private sector is whether we think that they’ve helped in pushing the agenda of getting treatment to people forwards. We must make sure that they make their contribution to the health care service in a proper way. The big problem that we have is that we don’t want workers to be bonded to their jobs because that is where they get their treatment. So we need a discussion about the privatisation of health care by allowing big companies to take responsibility for their workers, which can, in effect become a form of bondage of workers themselves unless there is proper protection for them via their trade unions and legislation.

There’s another area in the private sector that we are putting pressure on and that’s in connection with private medical schemes. Our new government, when it came to power, said that you can’t exclude people from medical aid when they have long-term illnesses like hypertension, diabetes or asthma. You can’t raise their premiums because the medical aid should be like a co-operative. It should share the cost among everybody. But unfortunately the medical schemes are private businesses and there’s no way of getting money out of them. And to give you a simple example, in 2000 R27.7 billion was spent on 38 million people in the public sector on health. At the same time R38.8 billion was spent on seven million people in the private sector. There is an attempt within the World Trade Organisation to help the drugs companies to cherry pick the middle classes in poor countries. They can make enormous amount of money out of them and leave the burden of the poor to the state with no proper way of sharing this burden between the rich and the poor. That is what is happening to our health care services in many ways. So what we want to ensure is that private medical schemes carry part of the burden. We know that less than one per cent of people who have coverage and require it, actually have access to private schemes’ anti-retroviral programmes at the moment.
Apparently, at the University of Natal, the medical aid scheme says, ‘it’s not our duty to let members know what their benefits are’. So you need to pressure your medical scheme here to publicise the benefits that they are offering so that people could be treated.

2. I want to pick up the question of gender equity impact and argue that this goes together with the question of race equity impact. Many of you would have seen the Minister of Health refer to my colleague Mark Heywood, as a ‘white man who directs Africans’. So the real question that we have to ask ourselves here is, ‘Who does HIV affect?’ HIV affects everyone in our country. The biggest problem is that there are not enough White, Coloured and Indian people in TAC who have HIV. The biggest problem that all of us have is that people who are carrying the burden of openness, the burden of justice, the burden of going to the streets and putting their bodies on the line, are the poor African women and men. The middle class people living with HIV still feel too stigmatised to come out. Middle class people of all races, African, Coloured, White and Indian, all of us feel much more ashamed – and I don’t know why – about having HIV, whereas poor people are prepared to take the burden of coming out with this disease. So this is a question that we need to address.

In the Treatment Action Campaign our members are made up as follows. More than 50 per cent of our members are aged between 16 and 24 and I have wondered why we have so many young people. Why is TAC a youth movement in that sense? And 50 per cent of our members are women. Now, it’s pretty obvious if you think about why. I met one of the young comrades, Lwazi, and he said, ‘I’m burying my brother next weekend in Transkei’. He lives in Cape Town and had to travel to Transkei to bury his brother who had HIV. And I realised that there is a political movement among young people on the question of HIV because they are at risk; because they are watching their sisters, their brothers and their neighbours get ill and they know that nothing is being done. So it’s very, very important to understand that TAC in essence has women membership, predominantly – although we do have a substantial number of men which is unusual for an AIDS organisation in southern Africa. Normally it’s the women who do the AIDS work and the men who do the ‘toyitoying’. So it’s a change in that sense. On the other hand it’s also primarily young people who are affected by this disease in ways that we cannot yet explain and it will have a huge impact on our society.
3. [The question of service delivery.] When this government came to power, it aimed to give health care to all. Now what did it do to implement that? It had some really great policies on primary health care, TB control and all those things, but fiscally it throws away posts. I remember Ronnie Thompson bragging in 1997 to the provincial health department saying, ‘I’ve saved so much money for keeping these posts frozen’. That’s what he said.

But our nurses are completely overburdened. They are emotionally drained. They have enormous pain that they carry in them. They also carry a burden, an apartheid deficient burden, lack of training and understanding of dealing with patients. They see many people die on a daily basis whereas in the past they were few. So if we talk about service delivery in the health care sector and in any sector, service delivery cannot be done without a mobilised civil society.

For instance, let’s take the question of housing. Why is there no movement to pressure the makers of cement, the makers of tin roofs, the makers of bricks to bring down their price because that will affect how government delivers housing, the quality, size and all those things? As activists, we need to understand that the price of drugs is a very important element for socio-economic action. But in every aspect of our work there is profiteering that is happening but which shouldn’t. We have a duty to bring the prices down to allow the government to afford to be able to deal with the needs of this country. I believe that service delivery in any part of society – and in every part of world – must go hand in hand with the mobilisation of civil society; Young people who are studying have a duty to research, to find out and contribute their knowledge to our organisation, but also to the organisation of the homeless, to the organisation of the poor people, to the organisation of working people throughout the country.

4. [The last question was about the rural areas.] TAC has exploded as an organisation and we exploded after we had won the mother-to-child transmission prevention court case. We now have about 100 branches and they range from branches in some rural areas to those in urban areas. Our biggest problem is the Western Cape where we have a branch in every African township but only in two of the Coloured townships. And the point is there to strengthen and to provide knowledge.
Why do people come to TAC meetings? They come to TAC meetings because we can offer scientific literacy. We don’t condescend. We don’t pretend that because you are poor you must learn how to cook *pap* instead of learning about how the World Trade Organisation works. You can do both things simultaneously and for us I believe that everyone here can contribute to the process. But I want to turn the question back to you. We need your help to get to rural areas, or to places that we can’t reach in the urban area. There are many places in Umlazi and KwaMashu and so on around which we need help. We have got some people in Umlazi but it is so huge. So we need to expand. But the most important thing is to expand knowledge and to expand understanding because in that way we can deal with the epidemic.
Article

Hope, involvement and vision: reflections on positive women’s activism around HIV

Jo Manchester

Introduction
AIDS has been equated with stigma and discrimination since the first cases were identified in the late 1970s. Watney (1994) recorded the traumatic impact that HIV had on gay communities in the US and the feelings of desperation and anger at the lack of concern and support from government. Altman (1994) recalled that governments at that time were reluctant to work in partnership with ‘deviants’ fearing that their action would be unpopular and misinterpreted as condoning immoral behaviour. An ethos of self-help grew out of the isolation, despair and anger. People with HIV experienced a common sense of oppression and began to speak out to challenge discrimination and force their governments to show leadership. The history of AIDS activism in the US and United Kingdom is well documented (Shilts 1987; Patten 1988; Kramer 1990; Act-UP 1990; O’Sullivan and Thomson 1992; Patten 1994; Watney 1994; Garfield 1994). However, there are very few similar works that examine the early days of community activism in other parts of the world, particularly sub-Saharan Africa.

HIV in Africa was blamed on prostitution and promiscuity. HIV positive people were seen as sexual deviants and social transgressors. The fact that HIV only seemed to affect marginalised and unpopular groups caused disinterest and complacency among governments and the general public worldwide. The response of most governments took the form of mass prevention campaigns which caused panic and often increased hostility towards positive people, or those suspected of being infected. Such campaigns did nothing to change behaviour or address the social impact of AIDS. The first community-based AIDS organisation in Africa was TASO, The AIDS Service Organisation, established in 1987 in Uganda by Noreen Kaleeba whose husband had died of AIDS. TASO provided support, care
and counselling and adopted the slogan ‘Living Positively and Dying with Dignity’ to promote tolerance and respect (Kaleeba 1995).

By the early 1990s a small number of self-help organisations, run for and by people with HIV had emerged in Africa. Body Positive in South Africa was set up in the 1980s to support gay white men. In Kenya TAPWAK The Association of People with HIV in Kenya, was led by men but was officially mixed and the members were overwhelmingly women. In Zimbabwe the Centre for people living with HIV/AIDS had been established to provide nutritional advice and counselling to women and men living with HIV. In 1992 a new type of activism emerged in Uganda, Zimbabwe, Kenya and Malawi – for the first time in the world, it was led and dominated by HIV positive women. An international meeting of positive women provided the impetus for this activism when 59 positive women from 27 countries came together for one week before the World AIDS conference in Amsterdam. I was fortunate to be among the group. As we shared our stories and experiences we grew angry. Why did so many of us have to go through the same feelings of fear, isolation, shame and despair? Many of us spoke out for the first time at that international conference and returned home determined to stand up and make a difference. We created a network, the International Community of Women living with HIV/AIDS (ICW) to support one another and to reach other positive women. We agreed upon 12 statements to express what was needed to improve the lives of women living with HIV and we used these statements as the basis for our advocacy and negotiations with governments, health professionals, media, researchers and conference organisers (see www.icw.org).

Association with ICW gave positive women the confidence and credibility to voice their concerns. They were no longer speaking just as individuals but as part of a recognised network. ICW’s real strength was in its members, the women who were speaking out in their countries. Given all the forms of discrimination and exclusion and the vast consequences of poverty that conspire to silence women, these women were exceptional because despite their circumstances they spoke out about taboo subjects of sex, power and death. They fundamentally changed the way their governments and societies responded to HIV yet their achievements went undocumented at the time and sadly many of the original founders have passed away.

**Theoretical framing**

I will reflect on the activism of HIV positive women through three themes:
Disclosure, Empowerment, and Partnerships. In 2000 I wrote a dissertation, which analysed the perceptions of experiences of women and men living openly with HIV in South Africa. There was a startling disparity between how they understood disclosure, empowerment and partnerships and how these themes are commonly treated in the literature. In this paper I will draw on that analysis and broaden out the discussion to positive women in other African countries.

Methodology
The paper is underpinned by the qualitative research undertaken in 2000 of ten life histories (three South African women, four South African men, two Ugandan women and one Zimbabwean woman) through semi-structured interviews. It draws heavily on my own experiences as a co-founder and activist for the International Community of Women living with HIV/AIDS (ICW) from 1992-1999 and as a consultant on HIV, gender and development since 2000. The paper is based on oral sources, workshops and presentations and memory of conversations with African positive women since 1992. All the quotations cited in this paper are drawn from the interviews for the dissertation (Manchester 2000) unless otherwise attributed.

Disclosure
An HIV diagnosis is a life-changing event. People with HIV often talk about their lives in terms of pre and post diagnosis. It is extremely difficult to come to terms with a severely stigmatised, life-threatening disease. People with HIV commonly experience isolation, shame, guilt, fear, grief, and a loss of power and a loss of control. Despite the intense desire to keep one’s diagnosis a secret, this secrecy becomes a huge burden. The constant fear that other people will find out often hinders access to healthcare, emotional support and basic rights. Disclosing one’s HIV status can be daunting yet it can also help to shift and lessen these overwhelmingly negative feelings. The manner and context within which one discloses one’s status can profoundly affect a person’s ability to cope with the diagnosis. This section discusses the experiences of African women who were among the first in their countries to publicly disclose their HIV status.

The predominant theme in research literature is that of disclosing to sexual partners and significant others. Disclosure of HIV status has been identified as one of the prime concerns for people who are diagnosed HIV positive. Holt et al (1998) describe it as an ‘acute and recurrent stressor’ as people commonly face rejection, abuse and even violence.
I was scared about my death, I was very worried about my family, my kids particularly, and I was very scared to tell my husband because he was very physically abusive. (Mercy Makhalamele, South Africa)

American and European studies on disclosure stress the importance of ongoing counselling for HIV-positive people to be able to disclose their status and begin to accept their diagnosis. However, there is a stark contrast between the emphasis on counselling in wealthy, low prevalence countries and the lack of counselling available in high prevalence countries.

Positive women’s activism in Africa came about precisely because of the lack of support and counselling available. After the first ICW meeting positive women set up the first support groups for women in their countries. Today these are large membership organisations, which advocate for positive women’s issues. Dorothy Onyango created WOFAK (Women Fighting AIDS in Kenya); Cate Nalugya and Margaret Nalumansi set up NACWOLA (the National Community of Women living with HIV/AIDS) in Uganda; Winnie Chikafwmbwa started NAPHAM (the National Association of people living with HIV/AIDS in Malawi); Auxillia Chimusoro and Angeline Ndlovhu set up support groups in two areas of Zimbabwe, Masvingo and Chitungwiza.

Auxillia had been the most outspoken of the positive women at the conference in Amsterdam. She was a domestic servant who had not completed primary education yet she understood and articulated, for the first time, that women’s low status and dependence on men for economic support was at the heart of women’s vulnerability to HIV. She urged ICW to act on issues around women’s poverty and women’s status. She went home and became the first person in Zimbabwe to publicly disclose their HIV status.

Women’s activism was possible because of the disclosure of people like Auxillia who paved the way and braved the climate of antagonism against people with HIV. She encouraged women she worked with to disclose to their families and other positive women. (Lynde Francis, 2003)

The initial difficulty all the women faced was how to persuade women that talking about their status would help. Winnie Chikafwmbwa, an ICW key contact from Malawi faced criticism that talking did nothing and people needed food, clothes, and medicine. Winnie found a meeting space in Lilongwe centre but could not help with transport costs or provide food. She was disheartened at first but eventually negotiated with United Nations Development Programme (UNDP) for funding for the group to be able to
cover basic costs and provide a meal. Once women came to the group they found that it was indeed a relief to talk about their situation.

As soon as they have an opportunity to share and compare with other positive women, it’s like a huge weight off their shoulders. They feel really different because they are not alone. (Lynde Francis, Zimbabwe)

The vast majority of women who attended support groups were widows. Often their HIV status was suspected because of the death of their husbands. These women had nothing left to lose: many had lost their husbands, their income, even their property. They came together for support and hoped to find ways to feed their families and pay school fees. Men rarely attended the group but it was an early feature of women’s support groups in Zimbabwe and Malawi that the chairs of support groups were men. In the early 1990s it was unheard of for a woman to be in a position of authority and they did not question the need for men to head the organisations. In time this changed as women found that men did not and could not represent their concerns.

Many women have said that their greatest relief on attending a support group was that the other women did not look HIV-positive. This way they could begin to accept that strangers would not be able to automatically tell their status, which increased their self-confidence. Peer support groups are a lifeline for many positive women. Mercy Makhalemele, set up a support group in the hospital where she was diagnosed. She explained that it was the other women in the support group who helped her to tell her husband and cope with his violent reaction.

Disclosing in a support group helps women to disclose on a personal level. Women seek support around what to say in a new relationship. How to tell an existing sexual partner without being rejected. Although support groups provided a safe space for women to share there were some issues around disclosure that for many years the groups felt ill equipped to deal with. The main issue was talking to children about HIV. I have noticed that in any new group of positive women the first question is usually – ‘do you have children’? Followed by ‘have you told them yet’? Many of the activists in ICW were speaking at conferences, attending National AIDS Programme meetings, advocating for rights and services yet they found it extremely difficult to talk to their children.

I find it easy to speak to international meetings and political leaders about living with HIV. However I found it very hard to speak to my own children – in fact it was one of the hardest things I ever had to do. Children are always left until last. I hadn’t spoken to my daughter
about my status, when she said: ‘Mummy, I hope there is a drug for HIV in 7 years time. I was really taken aback. Our children are the last to know and we take it for granted that they don’t and can’t understand what is going on. But they do. They suffer stress and anxiety just like adults. (Beatrice Were, Uganda, ICW 1998)

The first African organisation to address these issues was NACWOLA in Uganda. Their Memory Book project supported positive mothers to disclose to their children and to help them compile Memory Books about their families to instil a sense of security and solidarity through traumatic times of illness and death.

The women who established the groups were often called upon for advice and support. However, they rarely had good personal support structures of their own. The ICW network became a long-distance support system for women who understood the pressures of being visible and in demand. They did not receive support from the groups’ members and sometimes became the target of vicious accusations – were they really positive or just doing this to make money? Why were they always going abroad, were they feathering their own nest? In the year before Winnie Chikafwmbwa died the organisation had split into two acrimonious factions, people with HIV fighting people with HIV. It was eventually resolved but sadly not before her death.

Many positive people find it easier to disclose publicly, in front of strangers, particularly far from home, than to tell those closest to them. Many of the interviewees disclosed by speaking at conferences or giving interviews to the media yet in hindsight they all felt that they did not consider the impact of their disclosure and did not prepare themselves or their families for the fall-out from their public disclosure.

There are no published studies which explore the motivation and impact of being publicly open about one’s HIV status. Even the policy documents and reports which strongly advocate for the involvement of people with HIV (UNAIDS 2000:87-88; Department of Health 2000:11; World Bank 2000a) do not consider the processes involved or the psychological impact of disclosure, and the potential impact, for example, on a person’s relationships or career prospects. Whilst there are now government, UN and NGO initiatives, which encourage disclosure for prevention, they consistently fail to help positive people prepare for this or deal with the aftermath.

The South African strategy for AIDS 2000-2005, cites the number of people “coming out” as people with HIV/AIDS as a key indicator by which to judge the country’s response in terms of ‘social values, human rights and
acceptance in the community’ (Department of Health 2000:12). Yet when asked whether they thought more people should disclose, the interviewees did not consider that it was necessary for large numbers to disclose publicly. They attached a greater importance to personal disclosure for emotional and practical support, for example to support groups or for medical care. Promise explained how working with other positive people had made her appreciate how difficult personal disclosure is. She believes that support services could do more to assist people:

Having worked in support groups, I realised that people do want to disclose but that they don’t have the skills... you need a different strategy to disclose to a child than to an adult. (Promise Mthembu, South Africa)

Public disclosure is often driven by a desire to challenge stereotypes that depict people with HIV as promiscuous deviants and to be accepted. It is a powerful statement that there is nothing to feel guilty or ashamed about and being able to internalise that message is essential for coping with the diagnosis. HIV positive activists become advocates. They are driven by a wish to improve the situation of other people struggling to cope with the virus: ‘to fight for the rights of people living with HIV/AIDS,’ and ‘to be a voice for people living with HIV’. There is also a deep-seated hope that through sharing their stories, they could prevent new infections by alerting others to the existence of HIV to ‘educate others about the facts of HIV’ and ‘to raise awareness’.

A longer-term impact of disclosure is that for many people talking publicly shifted HIV from being an internal, or personal issue, to being an external or political issue. Many people who have been diagnosed and active for a long time share a feeling that HIV no longer has the hold over them that it used to.

To enable this distancing and to accept that there is much more to a person than HIV status alone, it is important that positive people are educated around the issues and trained as effective speakers so that they are not just giving a personal testimonial. This will be discussed in the next section on empowerment. What does empowerment mean in the context of HIV? Are disclosure and empowerment linked? Does empowerment lead to disclosure? Does disclosure lead to empowerment? Or is neither dependent on the other?
Empowerment has been theorised from a range of different perspectives in relation to writings on gender and development (Kabeer 1994; Afshar 1998; Rowlands 1997; Townsend 1999). Feminist advocates of empowerment distinguish between power over certain resources or agendas and power with processes that bring about change. The latter often requires some power from within entailing understanding and confidence to take action. Given gendered social relations of inequality the process of empowerment might well not result in outcomes women might value. While emerging research stresses how limited women’s empowerment often is (Khandekar 2001; Robinson Pant 2001), the term has gained currency among development agencies to describe their strategies (World Bank 2000b). Empowerment in the literature conceives of a fundamentally collective activity, which aims to redistribute power and resources. Baylies and Bujra argue that empowerment can be an effective strategy for behaviour change only to the extent that ‘it moves beyond individualistic, enlightenment formulas and embraces a collective form’ (1995:216). They point to a number of cases where sex-workers have acted collectively to protect themselves from HIV infection by rejecting clients who refused to use condoms. However, sex-workers have much more control over their clients’ sexual behaviour than married women have over their husbands. Indeed UNAIDS identified marriage as a principal risk factor for HIV (UNAIDS 1999b:36).

Rowlands (1997) describes spheres of empowerment and argues that collective action is not possible without personal empowerment. She also identifies factors that inhibit empowerment such as gender roles, when, for instance, women are prohibited from attending groups by their spouses. Rowlands remarks on the absence of critical theory about the nature of empowerment in a development context. She is concerned that large numbers of grass roots empowerment projects seem to sustain a false notion that empowerment is something that can be done to people.

Empowerment for women already diagnosed HIV positive is not considered in any of the literature studied. Empowerment in relation to HIV focuses on prevention and ends there. However, positive women interviewed have repeatedly expressed firm opinions of what empowerment is and how it comes about.

Self-empowerment
Without a doubt, self-empowerment is the most crucial aspect of
empowerment for people living with HIV. An HIV diagnosis is life changing and brings about feelings of fear, shame and isolation. It makes people feel dirty, abnormal and frightened. The first challenge is to regain a sense of self-worth confidence and dignity.

When I learnt of my HIV infection I had to start a new life. My life was in shatters. Empowerment in the context of people living with HIV means being able to cope. (Milly Katana, Uganda)

Self-empowerment implies taking back control and power over a life that has been torn apart by HIV, a refusal to give up and die, of knowing oneself, of learning to say no, or leaving violent relationships – making conscious decisions to take back control of one’s life from the grips of HIV.

It is about accepting HIV for yourself and working out how you are going to get on with your life. (Lynde Francis, Zimbabwe)

For most women this strength comes after meeting other positive people, seeing that there is life after diagnosis and why ICW advocates for peer support as the most important element in coming to terms with the diagnosis. Many people assume that an HIV diagnosis marks the end of life. Maybe it does mark the end of one life but it can also signify the beginning of another. Self-empowerment is about hope and personal strength. It challenges to the core the stigma and negative discourses around AIDS.

I may not have financial resources but I have an inner empowerment resource that can overcome the social and cultural conditions that I live in. (Brigitte Syamelevwe, Zambia, quoted in the Guardian 2003)

However even those with great inner strength like Brigitte are often trapped in cycles of poverty. HIV further impoversishes the poorest in society through the loss of employment and future earning possibilities, loss of housing and increasing expenditure on health care.

**Practical empowerment**

Practical empowerment implies coping materially and practically on a day-to-day basis. People with HIV are often trapped in cycles of poverty, as their income diminishes, their day to day expenses rise. Widows and women who have been divorced or abandoned due to HIV are often left homeless, destitute with no way of caring for themselves of their children. Within the ICW network the most commonly expressed need from women in Sub-Saharan Africa is support and training on establishing income-generating projects in the hope that they can earn income which will alleviate the difficulties they fact in their day to day lives.
We have to look for ways and means to get out of this abyss. Rather than seek alms we must look for an honest livelihood. (Positive woman from Cameroon, ICW 2000:11)

HIV positive women from NACWOLA and WOFAK shared their experiences of income-generation at a workshop for African women living with HIV (ICW 2000:10-11). It was interesting that the women recommended that income-generation projects were more likely to succeed if they were run by individuals or family groups rather than HIV support groups. This was due to the tensions that arise over workload, investment and profit distribution. Again, the focus is more on personal empowerment than the collective empowerment enshrined in the literature. Practical empowerment is closely linked to self-empowerment. HIV can destroy self-esteem to the extent that practical empowerment would seem impossible. One needs to be self-empowered to be able to consider practical empowerment.

Knowledge as empowerment
Most studies of positive women have shown that they had no knowledge of HIV at the time of their diagnosis. Lack of accurate and relevant information about HIV adds to the despair and hopelessness that many people feel when they are diagnosed. Auxillia was diagnosed when her youngest child died of AIDS:

My child died because of my ignorance, then when I was told about it, I was blamed for it. (Auxillia Chimusoro, 1995)

People with HIV are often discriminated against because they lack knowledge of their rights or are too afraid to fight for them. Many African women whose husbands died of AIDS found themselves with no inheritance rights to property, land or possessions.

My in-laws wanted to take advantage of me, grabbing my property, harassing me and accusing me and wanting to have me inherited by one of my late husband’s brothers… fighting for that and dealing with that has made me feel a very brave person and has made me very strong. (Beatrice Were, Uganda)

Beatrice, Auxillia, Winnie and many others stood up for their rights for property, for work, for education for their children. In the first instance this was self-empowerment yet it drove them to support other women, to help them come to terms with their diagnosis and take control of their lives.

Winnie was a gentle soul who forced herself to do battle and became a warrior and a victor on behalf of other people. (Lynde Francis ICW 1998)
Many self-help groups have been based on the premise that people with HIV will support other people with HIV. This is certainly true and peer support and counselling provide a lifeline to those struggling to cope. However, the success of some groups has created an expectation that people with HIV will voluntarily support and care for others with the virus. This commitment and volunteerism has been exploited by NGOs and government programmes that use this cheap or free labour in place of healthcare services.

**Empowerment or exploitation?**

When asked, positive women express great frustration at the pressures, which are placed, on them, to work voluntarily and to disclose their status as part of prevention campaigns when their own needs are ignored. Beatrice Were from Uganda described her feelings on this:

> I felt pain seeing positive people being told by organisations to stand and give your testimony, to help other people, but you spend all these years doing these things for other people but you do not spend time sorting yourself out… It is important that it is symbiotic, that if I am expected to go out there and give a message, I must be empowered to sort myself out first, to talk to my children, to plan for when I am very ill. So I think that empowering people to get others to protect themselves by telling them that I have HIV, while at the same time I am panicking to write my will, feeling very sick. Then they are looking for another PWA (person with HIV/AIDS) who is still strong to do the talks I’ve been doing and I am ignored. For me that is not empowerment for people with HIV, for me that is exploitation. (Beatrice Were, Uganda)

In February 2003 Brigitte Syamalevwe, an activist and ICW member died. She was an experienced teacher who, through her intellect and passion for women’s rights, was at the forefront of Zambia’s response to HIV. In 2000 she was selected as an HIV ambassador by the UN development programme and in that capacity worked at the education ministry in Lusaka integrating HIV education into the Zambian curriculum. In the same year Kofi Annan presented her with the UN volunteer against AIDS medal for her tireless work at community, national and international levels. Yet in 2001 when her husband, a clinical officer and activist became very ill and her 19 year old son was diagnosed with advanced cancer she was forced to give up work to care for them. Her loss of income meant that she stopped taking the anti-HIV drugs she had started just three months earlier. Her husband and son both passed away in November 2002 and she followed them three months later. People with HIV need more than medals and accolades to stay alive.
Collective empowerment

Collective concepts of empowerment, most frequently discussed in the literature did not resonate for the interviewees. They understand empowerment as something ‘personal’ which could be supported and encouraged by the group but which had to come from within. However, there is a collective empowerment emerging amongst advocacy organisations which is based on knowledge and understanding of rights. This is visible in the activism of TAC where women in alliance with lawyers have successfully won the right to antiretroviral drugs in pregnancy to reduce the risk of mother to child transmission of HIV. The Zimbabwean Network of Positive Women allied with women lawyers to introduce marital rape as a criminal offence in Zimbabwe law. The women’s knowledge and their large numbers have made them a formidable force.

HIV has given African women a voice and has enabled them to address issues which were strictly taboo: domestic violence; incest; dry sex; contraception; abortion; child rape; marital rape; prostitution; promiscuity; women’s lack of inheritance rights; and women’s social and economic status.

HIV has been the vehicle to emancipate Zimbabwean women and give them a voice. (Lynde Francis, 2003)

Women in support groups became feminists without ever saying the word, because of their HIV status. They recognised that being trapped in poverty, dependent on men for money, housing and status made them vulnerable to HIV infection.

In the mid 1990s there was no feminist movement in Zimbabwe, it came about because of the threat of the HIV infection to women, their children and their children’s future. (Lynde Francis, 2003)

In the past, individuals on national and international committees or boards found it difficult to speak past their own experience and were often daunted by the ‘qualifications’ and experience of others on the board. Positive women knew that such participation was tokenistic rather than effective and this is a subject frequently discussed in support groups. Today, as the groups grow larger and more women are actively involved the whole group is empowered when their representatives are in positions of power and they want their representatives to represent them not to sit silently in agreement. Partnerships have begun to change.
Partnerships
This section considers the current commitment to involving people living with HIV in programme planning and implementation and explores what this has meant in practice for the activists. Initially governments were reluctant to work in partnership with community HIV activists but by 1994 a consensus had developed that HIV community organisations played a key role in care, support and education (UNAIDS 2000:88). This consensus was signalled on 1st December 1994 at the Paris Summit on AIDS. Health Ministers representing 42 governments, signed the Paris Declaration on AIDS which committed to:

Support a greater involvement of people living with HIV/AIDS through an initiative to strengthen the capacity and co-ordination of networks of people living with HIV/AIDS and community-based organisations. By ensuring their full involvement in our common response to the pandemic at all – national, regional and global – levels, this initiative will, in particular, stimulate the creation of supportive political, legal and social environments. (UNAIDS 1999a:13)

The ‘Greater Involvement of People living with HIV/AIDS’ became known as the GIPA principle, an acronym that launched a tidal wave of rhetoric, particularly among the global development agencies. In March 1995, Dr Peter Piot, the first Director of UNAIDS gave his first official speech to the 7th International Conference of People living with HIV/AIDS in Cape Town. He guaranteed a new era of partnership between the UN and people living with HIV/AIDS and he pledged to involve HIV-positive people in: Planning, shaping and guiding the global response to the pandemic... (GNP+ 1995). The World Bank has demonstrated its commitment to GIPA by announcing that MAP, the Multi-Country HIV/AIDS Programme, includes the involvement of people living with HIV from national to village level in its eligibility criteria for funding (World Bank 2000).

However, the agencies have failed to define what they mean by such involvement. Often ‘partnership’, ‘involvement’ and ‘participation’ merely mean consultation, or worse, simply being present. What do development agencies and governments mean by partnerships? Are they driven to achieve the most effective response, or to be seen as politically correct? Equally, what do positive people want to achieve through forming partnerships and being involved in the response? There has been a total absence of analysis of motivations and agendas on each side of the partnership. This means that it is difficult to measure the impact of partnerships.
Policy partnerships
Having disclosed within support groups, positive people were encouraged to participate at a more strategic, influential level. This could mean strategy or policy work by serving as a board member for a local, provincial or national AIDS Service Organisation (ASO). People with HIV have made a significant contribution to policy formulation around HIV. They have a deep understanding of the need for rights and non-discrimination and their commitment and passion has kept HIV on the political agenda. However their goodwill, intentions and commitment have been hampered by the lack of practical support and training they received. People with HIV have expertise that stems from their experiences. However, they have rarely been given the opportunity to further their own skills and personal development. Auxillia Chimusoro in Zimbabwe did not complete primary school yet she was an outspoken advocate of positive women’s issues at national and international levels. Many people with HIV are aware of their limited educational qualifications and want to develop skills and a deeper understanding of the issues. Many of the forums in which they participate deal with issues such as human rights, the law, treatment, medical care, vaccine development, ethics, policy formulation, national strategic planning and much more. Being HIV-positive does not automatically mean that one knows and understands all the issues pertaining to HIV but this simple fact has rarely been taken on board by programmes seeking to involve and empower people with HIV. Participation inevitably feels tokenistic if people with HIV are struggling to participate as equals.

Partnerships with government
One of South Africa’s major strategies to deal with the epidemic was to increase the visibility of people with HIV so that South Africans would believe that the threat was real and change their behaviour accordingly. The first of these programmes, FACES of AIDS, was launched in 1996. Twelve HIV-positive people were employed by the Department of Health as Community Liaison Officers to literally ‘give AIDS a face’. This was the first partnership of its kind between people with HIV and a national government. AIDS activists celebrated it worldwide as the sign of a government committed to supporting and empowering people with HIV. After years of volunteerism, people with HIV were to be recognised and paid for their work in the community (Collins 1996). Unfortunately, the project was not a success. Prudence who worked as a Community Liaison Officer described it as ‘a good idea, which turned out to be a nightmare…’
Any day you were supposed to disclose, any day you were supposed to be ready for the press… I was called the Community Liaison Officer but when it suited them, many things would change. Sometimes you were not allowed to be at the grass roots, not allowed to choose your language, not allowed to express yourself in a way that you would like. (Prudence Mabele, Pretoria, June 2000)

The Government’s rationale for involving people with HIV was for their testimonies, to encourage behaviour change through sharing their own experiences. Positive people on the other hand, had hoped that involvement at such a prominent level would move them beyond tokenism and personal testimonies. They were to be sorely disappointed, working within government proved to be marginalizing and disempowering.

**Community partnerships**
As more and more positive women joined support groups they felt able to share their stories in community education and awareness programmes for a local AIDS organisation, school or church group. Whilst many positive people enjoy the experience of challenging stereotypes the impact of these personal testimonies on the audience and whether or not they result in behaviour change is not known.

I am not sure whether hearing a person saying ‘I am HIV-positive’ will make people go home and use condoms… people are always interested in your story. They want to know how many sexual partners you had before you were diagnosed. If you tell them three, a person will say, ‘oh well, she had three, I have only had two, that means I am not at risk’ … you know they pity you, they don’t think about themselves, they only pity you and encourage you to be strong, it is you, you are positive. (Promise Mthembu, Durban, July 2000)

Community education/awareness programmes rarely involve positive people in the design or implementation of the programmes beyond the ‘personal testimony’. This limits their effectiveness as positive people have an insight into messages which work and which go beyond Abstain, Be faithful and use Condoms.

**Associations of people with HIV**
In many countries people with HIV decided to create networks to legitimise their involvement and become more strategically effective. Most African countries now have a network of people living with HIV. The Zimbabwean Network of People living with HIV (ZNP+) grew out of established support
groups around the country. Each support group would elect a representative to the network. In other countries such as South Africa, Botswana and Zambia the national networks were established from the top-down without a core base of active support groups at local level. NAPWA in South Africa is a typical example of a top-down network. Pat Hlongwane, a volunteer with NAPWA since 1997, described it, as an organisation made up of ‘radical individuals’ not a collective movement. Women make up the vast majority of the members of the networks yet the paid or elected positions are filled mostly by men. Women’s lack of professional experience or educational qualifications often bars them from positions of authority in HIV organisations.

To date the national networks have not become the strong HIV advocacy movements that many hoped they would. The main reason for this seems to be that they are stretched too far and too wide. Organisations with a specific focus and remit have been more successful as they have clearer stated aims and engage in training and education around their key themes. In Zimbabwe the Centre for People living with HIV/AIDS is staffed entirely by people with HIV and provides counselling and nutritional advice to people living with HIV. It is a unique organisation established by Lynde Francis, a qualified nutritional therapist who believed that malnutrition is the main factor to progression to HIV related illnesses. The Centre has had spectacular success, despite low levels of funding. During the current food shortages and political crisis the Centre has provided seeds and training for nutritional gardens in urban and rural settings. Working with women’s support groups they teach members to grow and cook cheap nutritious food. Staff, volunteers and members have become informed advocates around nutrition and basic health care. By demonstrating that people with HIV can live long healthy lives, with good nutrition, they counter the messages of death and despair that people with HIV are confronted with on a daily basis.

The Treatment Action Campaign was established in 1999 soon after the South African Minister of Health refused to make funding available for antiretroviral drugs for pregnant positive women. Whilst TAC is a successful coalition of lawyers, academics, trade unions it has also empowered positive people to demand access to treatment as their right. NAPWA with such a wide, unfocused agenda was unable to mobilise people with HIV yet through TAC many positive people have become informed, articulate advocates.

Education and information is the key to effective, empowering
partnerships. ICW’s Positive Women: Voices and Choices project enabled Zimbabwean women to become researchers, analysts and advocates around women’s sexual and reproductive health (ICW 2002). The team leaders, elected by their support groups were trained for over a year and became conversant with complex issues around women’s reproductive and sexual health and women’s issues in general. Since completing the research the team leaders have gained recognition in their local communities and have served on district health boards and electoral committees.

Conclusion
The HIV epidemic is a devastating scourge but it has enabled women, finally, to act on issues that would not otherwise have been addressed. In many countries the epidemic has produced a grass-roots feminist movement which is challenging male violence, rape, incest, customary inheritance laws and women’s economic dependence on men.

For almost a decade ICW members were the only, or among a very few, people living openly with HIV in their countries. Though they gave support and voiced women’s concerns they were often unable to get the support they needed. Winnie, Auxillia, Angeline, Cate, Margaret, Brigitte and many others have died and their passing is an immense loss to women’s activism. Auxillia, a few months before she died in 1998, talked about how tired she was. How she was tired of international committees which wanted an African positive woman but who complained that she did not have the right ‘qualifications’ or give ‘appropriate’ comments on scientific abstracts. She felt torn apart and having given everything, had nothing left to fight with for her own health.

In the past UN agencies, governments and international NGOs attempted to implement GIPA initiatives which usually failed as openly positive people were selected from their groups and given benefits that were not available to their peers. As a result they were usually accused of selling out and many GIPA workers and UN volunteers have described the alienation they felt from their own communities. The best way to support the involvement of people with HIV is not to single out individuals but support organisations to nurture the individuals within them to create a collective base. The practice of UN and government organisations to implement GIPA by plucking individual activists out of their communities has undermined the whole GIPA ethos, which aimed to strengthen such organisations.

Hope, Involvement and Vision proposes a new framework. One which
emphasises Hope not hopelessness and despair; effective Involvement which is empowering not tokenistic, and the Vision to plan for the long-term impact of this pandemic, to increase access to life-saving drugs, to create climates of tolerance and acceptance and to reverse gender inequalities.

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AIDS Discourses and the South African State:
Government denialism and post-apartheid AIDS policy-making

Mandisa Mbali

Post-apartheid AIDS policy-making in South Africa has been characterised by conflict between the government, civil society and the medical profession (Schneider 2001). At the heart of this conflict has been the controversy over South African President Thabo Mbeki’s denial of the causal link between the HIV and AIDS, and claims that anti-retroviral drugs are ineffective and lethally toxic in the face of scientific evidence to the contrary. Against the backdrop of policy conflicts, which stem from government AIDS denialism, the question has often been asked: what drives this denialism? It is this central, yet largely unresolved, question that this article will attempt to answer. The central claim of this paper is that government AIDS denialism is a response to a history of racist understandings of African sexuality as inherently pathological in AIDS science and linked discriminatory public health policy responses to the epidemic by the last apartheid government and internationally. As will be demonstrated later in this article, unlike AIDS dissidence internationally, the South African version of denialism espoused by Mbeki and other high profile government officials has been obsessed with colonial and late apartheid discourses of race, sexuality and disease in Africa.

This paper argues that AIDS denialism can be understood as driven by five main factors:

- The medical findings of certain dissident scientists, which have been appropriated by government officials in South Africa;
- The extent of the crisis brought about by the epidemic, which has prompted denialism because government cannot deal with it;
• As a strategy to avoid conflict over intellectual property rights of essential medicines;

• The impact of poverty on the course of the epidemic, which has led to government denialists positing poverty as a counter explanation to the virological cause of AIDS. Simultaneously, denialism may be a smokescreen for the government’s adoption of poverty sustaining neoliberal economic policies, which may be blocking further public spending on AIDS; and

• The history of constructions of ‘the African’ as the inherently diseased racial and sexual other in both colonial and post-colonial times.

I will deal briefly with the first four, before turning my attention to the main core of this article – the exploration of the last and, I will argue, most important driver of denialism.

Science and denialism

Early into Mbeki’s presidency, in 2000, it became obvious that he and some key ministers had adopted denialist views that were referred to in the media as ‘dissident/unorthodox’ views on AIDS. In May of that year, the President (with the full support of the Health Minister) convened a Presidential Advisory Panel on AIDS including both AIDS dissident scientists such Peter Duesburg and David Rassnick (from the USA) and medical and scientific researchers holding orthodox views on AIDS to debate the basic mainstream science of AIDS. The advisory panel was briefed to debate both the accuracy of HIV tests and the causal link between HIV and AIDS. Little came of the Presidential Panel process as, in 2001, the panel released an interim report, which mostly highlighted the differences between the mainstream and denialist scientists. More research was agreed to by participants, but certain members of government claimed that they based their programmes on the ‘premise’ that HIV causes AIDS (Tshabalala Msimang 2001), a claim that was belied by the continuation of denialist utterances by other members of the government, as shall be shown.

International scandal over the President’s denialist views grew after a speech he delivered at the opening ceremony of the 2000 International AIDS Conference, which was hosted in Durban. Whereas he was expected to repudiate his denialist views in the speech, he merely restated them by arguing that not everything could be “blamed on a single virus” and that poverty kills more people around the world than AIDS (Mbeki 2000:4). The link between poverty and inequality and AIDS was not new and in
itself would not have attracted widespread criticism had it not been for the president’s simultaneous questioning of ‘the reliability of and the information communicated by our current HIV tests’ (Mbeki 2000:5). In 2000 and 2001 the causal link between HIV and AIDS was questioned several times by Mbeki. In both a *Time* magazine interview and during parliamentary question time he claimed that HIV could not cause AIDS because a virus could not cause an immune deficiency syndrome (Karon 2000; Schüklenk 2004).

Denialist views would be repeated numerous times by Mbeki until he finally, decisively and formally ‘withdrew’ from the public debate about AIDS denialism in April 2002. From this point onward, however, his Health Minister, Manto Tshabalala-Msimang, would take up the mantle of repeating AIDS denialist views in public.3

Because of the adoption of denialist views by high profile government figures such as President Thabo Mbeki and his Health Minister Manto Tshabalala-Msimang, denialism prevailed and informed and influenced government policy. This was the case despite the medico-scientific literature (Pallela et al 1998; UNAIDS 2003; NIH 2003) demonstrating the following: that HIV causes AIDS; that HIV tests are highly effective in diagnosing HIV infection; and that anti-retroviral drugs, correctly prescribed as triple therapy or to prevent mother-to-child transmission, can both prevent HIV infection and treat HIV.

This paper posits that Mbeki’s position can be seen discursively as part of a wider belief that several key tenets of science around AIDS are racist, with denialism being a defence of Africans against racism and neo-imperialism, a belief well-established within certain circles in the African National Congress (ANC).

Instead of merely pointing to and condemning very real examples of racism in the history of AIDS, government’s denialism appears to have attempted to throw out altogether the Western biomedical/scientific paradigm relating to AIDS. As will be argued below the specific history of discriminatory discourses around AIDS, may be driving the government’s denialism.

**Denialism as a response to the sheer extent of the crisis**

Denialism could also be explained as a way to avoid addressing severe policy challenges posed by the sheer scale of the epidemic. By any measure, AIDS represents a huge crisis, which presents daunting policy
and planning challenges for the government. Recent AIDS research has shown that the epidemic is a human catastrophe for South Africa in terms of prevalence, economic impacts and social impacts, such as the orphan crisis generated by the epidemic (Sishana et al 2002; Department of Health 2001; Dorrington and Johnson 2002:38; Barnett and Whiteside 2002).

Faced with the cruel reality of five million HIV infected citizens and the highest HIV infection rates in the world (UNAIDS 2000), it is conceivable that officials of a government in such a predicament would sometimes hope that the epidemic would somehow disappear, or at the very least diminish in its seriousness or intractability. AIDS denialism offers to fulfil this potential hope on the part of a government faced with such a crisis. According to the unscientific and illogical tenets of AIDS denialism: AIDS is no longer sexually transmitted and will therefore spread much less easily; therefore there is no requirement for complicated and controversial HIV prevention campaigns; there is no requirement to spend on anti-retrovirals, as they are seen as ‘poison’; and there is no requirement to take the epidemic as seriously because it is ‘exaggerated’.

**Denialism as avoiding conflict over intellectual property rights**
The adoption of AIDS denialism by key government officials and representatives may also in some cases have afforded the government the comfort of avoiding further major confrontation with the multinational pharmaceutical companies, in the wake of the 2001 Medicines Act case, over their exclusive intellectual property rights for essential medicines. Multinational pharmaceutical companies use exclusive intellectual property rights, in the form of patent monopolies, to inflate excessively the price of antiretroviral drugs (TAC 2002). Civil society groupings, and at times the government, have challenged these exclusive intellectual property rights by calling for generic or parallel imported cheaper essential medicines.

In 2001, the government faced off the Pharmaceutical Manufacturers’ Association (PMA) in their challenge to strike down sections of the Medicines Act. The Medicines Act allowed for the government to authorise the production of generic drugs and for parallel importation of drugs, and would have forced the industry to be more transparent about their pricing mechanisms. Policies such as those allowed for in the Act have dramatically reduced the price of essential medicines in other developing countries such as India and Brazil. The PMA, an organisation representing 39 multinational pharmaceutical companies, fearing their intellectual property rights and
profits to be in jeopardy, took the government to court to try to remove the price reducing sections of this act. In the event, the PMA withdrew the case. This was partly because it generated prominent negative media publicity for the pharmaceutical industry, as civil society groups in South Africa and around the world held co-ordinated protests against the PMA’s court action. It was also because of the judge’s ruling that the drug companies must produce their detailed accounts to show exactly how much they had actually spent on research to develop the drugs (Baskaran and Boden forthcoming).

If one were to accept the AIDS denialist claim that AIDS drugs are ‘poison’, there would be no need for the government to (continue to) confront the powerful multinational pharmaceutical industry to obtain them at cheaper prices. This is a move likely to be necessary in the light of US President Bush’s unyielding support for the pharmaceuticals and their increasing strength in relation to the US government and WTO (Boseley and Denny 2003). The South African government may be aiming to shy away from such confrontation with the industry and their globally powerful political supporters, through its denialism.

**Poverty, inequality and the economic rationale behind denialism**

Whilst the main argument of this paper is that government denialism is driven by the history of racist representations of Africans in relation to AIDS, there are also powerful counter-arguments that it is socio-economically driven. On the one hand, Mbeki has argued, not entirely falsely, that AIDS is ‘caused’ by poverty, whilst on the other denialism may mask a reluctance to increase public spending due a desire to adhere to the neoliberal ideal of ‘fiscal discipline’.

**Readings of AIDS as a ‘disease of poverty’**

Mbeki and Tshabalala-Msimang have presented AIDS as fundamentally a problem of poverty and poor nutrition. A strong case can be made that poverty and inequality are significant factors that have shaped the AIDS epidemic in South Africa; however, this case cannot be made, in a denialist way, to the exclusion of mainstream scientific explanations of the viral cause of AIDS in the body of HIV-infected individuals.

Mainstream scientists and public health experts, have also shown the links between poverty, nutrition and AIDS. However, unlike government denialists, such AIDS researchers believe that AIDS is virologically caused by HIV, and also hold that at a socio-economic level the epidemic can be
understood as influenced by poverty and inequality. Paul Farmer, for instance, has understood AIDS as a disease of poverty and inequality (2001) because in an unequal world AIDS disproportionately affects the poor.

South Africa has one of the highest levels of inequality in the world (May, Woolard and Klasen 2000:26-28). Whilst research into the effect of poverty and inequality on South Africa’s AIDS epidemic is often contradictory and inconclusive, there are a few things that can be said. First, the relationship between poverty and inequality and risk of infection with HIV seems to be less than clear-cut in South Africa. The Nelson Mandela /HSRC Study on HIV/AIDS indicated that whilst poorer persons from race groups other than African were more at risk of HIV infection, amongst Africans, the poorer and the richer seemed to have similar risks of infection (Shisana et al 2002:9). On the other hand, qualitative studies have shown that poverty and at times gender inequality drive women into commodified and at times commercialised relationships, which may have led to higher rates of infection amongst women (Hunter 2002; Campbell 2000; Leclerc-Madlala 2001).

One area where poverty has a clearer impact on the shape of the epidemic in South Africa is in terms of disease progression. In general, internationally, it can be said that relative wealth or poverty affects the vulnerability of individuals, households and societies to the impact of the epidemic (Barnett and Whiteside 2002:276). Whereas wealthier patients often have access to private health care and even combination anti-retroviral therapy in the private sector, poorer patients often lack access to these drugs, and only have access to overstretched public facilities. In addition, they will often have a lower level of nutrition and their immunity is likely to be compromised by this as well as by HIV.

Therefore, it can be said that there is a case for causally linking poverty and inequality and AIDS, if analysed at a socio-economic level, but not in such a way as to exclude medical understandings of HIV as the cause of AIDS.

**Denialism and Neoliberal Economic Policies**

The epidemic patterns of AIDS demonstrate the influence of poverty and inequality. There is a further development of arguments linking AIDS and poverty that denialism neatly complements the government’s adoption of poverty-entrenching neoliberal economic policies. It can, therefore, be
seen as, in some senses, a position produced by government economic policy. According to such a position government denialism can be said to be a convenient clause to avoid the drastic increases in public spending that would be required to roll out combination HIV treatment. The government’s adoption of policies of ‘fiscal discipline’ and neoliberal macro-economics, evinced in the Growth Employment and Redistribution strategy (GEAR) (Bond 2001) also indirectly affects the formulation of AIDS policy in the following ways: privatising essential basic and social services; reducing social spending (including spending on health); and liberalising trade relations, thus making developing countries’ economies attractive to foreign investment. These policies have hindered the formulation of macro-economic policy more favourable to addressing poverty and inequality in the country (Bond 2001; Habib and Padayachee 2000:3). This means that they can be said to have affected the shape of the impact of the AIDS epidemic in ways suggested by the links between poverty and the epidemic suggested above.

Whilst government opponents have argued that government has miscalculated the costs and benefits of spending on an HIV treatment roll out (Nattrass cited in HEARD 2001; TAC 2003), the government’s reluctance to spend on a roll out of combination anti-retroviral drug therapy can be seen within the rubric of its adoption of neoliberal economic policies. On the other hand, it could be argued that government is merely operating as best as it can within the constraints of a globalised economy (Turok 2002), and that there would be real consequences to the social democratic policies of defying the drug companies on intellectual property rights (such as trade sanctions), and increasing taxes (thereby discouraging investment) or going into a deficit to spend more on health.

However, in some senses it can be argued that AIDS denialism, has afforded government officials and representatives the opportunity to avoid public participation in these serious debates about the economic consequences of rolling out treatment. Comments at the height of the mother to child transmission debate by the late Presidential spokesperson Parks Mankahlana that it would use less state resources to let HIV infected children die, than to have them dependent on the state as orphans (Independent Online, July 15, 2000), gives credence to the explanation of AIDS denialism as masking neo-conservative economic rationale.

On the other hand, at this stage, the direct evidence supporting the thesis that the imperative to the denialism of some government officials is
fundamentally economic in nature is rather scant and, therefore, it rests more at the level of speculation. Alternatively, if the discourse of AIDS denialist utterances and writings of government officials and representatives themselves are taken on their own terms, the thesis of this article, that AIDS denialism is driven by older discourses of race and disease seems equally, if not more persuasive.

**In defence of African sexuality: racism and African denialist resistance**

Whatever the contribution of other factors/discourses to denialism, in the rest of this article I will argue that the type of denialism the ANC government officials have espoused has been framed by its adherents as a response to the history of racist colonial and apartheid discourses concerning African sexuality. However, by the time that Mbeki and other government leaders were making denialist arguments to counter racism in AIDS research, non-discriminatory human rights based approaches to AIDS had become the dominant paradigm as shall be demonstrated. Denialism has been rendered out of date by a local and global shift towards the discursive framing of AIDS policy in ways which do not discriminate against HIV positive people and members of groups vulnerable to infection. The following passage reveals the obsession of government denialism with the legacy of racism in AIDS science and racist responses to the epidemic:

> Thus does it happen that others who consider themselves to be our leaders take to the streets carrying their placards to demand that because we [black people] are germ carriers, and human beings of a lower order that cannot subject its [sic] passion to reason we must perforce adopt strange opinions, to save a depraved and diseased people from perishing from self-inflicted disease...convinced that we are but natural-born promiscuous carriers of germs...they proclaim that our continent is doomed to an inevitable mortal end because of our devotion to the sin of lust. (Mbeki, *Mail & Guardian*, October 26, 2001)

As the above quotation shows Mbeki has explicitly objected to the racist notion that Africans are ‘promiscuous germ carriers devoted to the sin of lust’, which he sees his opponents, the ‘placard carrying’ AIDS activists associated with TAC, as arguing.

The African National Congress (ANC) is by its nature, an anti-racist and anti-colonialist, African Nationalist party. Mbeki has often explicitly located himself within this ANC tradition, especially in his calls for an ‘African
Renaissance’ or African Renewal. His calls for an ‘African Renaissance’ stem from his arguments of the need for socio-economic and political renewal and development of Africa, which are yoked with arguments about the need for a revival and celebration of African cultural and intellectual achievements (Mbeki 2001). Significantly for the main argument of this article that government denialism rests on the historical legacy of racist discourses of Africans as being in possession of a diseased sexuality he has argued that his calls for an African Renaissance operate self-consciously in relation to a history that has

created an image of our Continent [Africa] as one that is naturally prone to...an AIDS epidemic caused by rampant promiscuity and endemic amorality. (Mbeki 2001:7)

Furthermore, the influence of the history of racism in public health and medical discourse around AIDS and reproductive public health on government denialism is evident in a denialist document written by Peter Mokaba, which was circulated to the ANC’s National Executive Committee in 2002. As the following quotation shows, the view that the mainstream science of AIDS discredits African sexuality in a racist manner has been very much evident in the denialism espoused by government leaders:

Yes we are sex crazy! Yes we are diseased! Yes we spread the deadly HI Virus through our uncontrolled heterosexual sex... Yes among us rape is endemic in our culture!...Yes, what we need and cannot afford because we are poor, are condoms and anti-retroviral drugs! (Mokaba 2002:88)

The idea that African sexuality is inherently diseased was widespread historically in colonial and apartheid medicine and there is evidence of a very real contemporary legacy of such ideas, as Africanist colonial medical historians have shown. Megan Vaughan shows how some Africans have argued AIDS is a Western health problem skilfully blamed on Africa and Africans, when it is really, according to such a view, seen as being due to Western degeneracy and homosexuality (Vaughan 1991:205).5

Historically, AIDS denialism of this type is not a new position amongst African leaders and intellectuals. Richard Chirimuuta and Rosalind Chirimuuta, two Zimbabwean Tropical Medicine experts, who espoused ideas on racism and AIDS in their book AIDS African and Racism (1989) have heavily influenced government AIDS denialism. They have been cited extensively by government denialists such as Mokaba (2002). The Chirimuututas questioned HIV as the cause of AIDS, the African origin of
AIDS and the safety of anti-retroviral drugs (1989:2-47). Like Mbeki, they also claimed that HIV prevalence and AIDS deaths in Africa were dramatically exaggerated as part of a racist plot to discredit African culture and sexuality (Chirimuuta and Chirimuuta 1989:80-81). Laurie Garrett has shown that in the 1980s, African health ministers and leaders also refused to accept HIV prevalence statistics as presented by the WHO and medical researchers from the US and Europe (1995: 353-362). Moreover, they saw the need to defend Africans against racist accusations that their sexuality was inherently pathological (Garrett 1995:353).

Chirimuuta and Chirimuuta’s book was not entirely without merit. In particular, it seems that some early arguments made about the origins of AIDS in Africa did rely on fairly flimsy evidence, and made insulting and culturally inaccurate speculations about African sexuality, which led in some cases to discrimination in the West against Africans and people of African descent. Some researchers apparently tried to claim that HIV passed from monkeys to Africans in Central Africa due to bizarre sexual practices like Africans injecting monkey blood into their anuses and vaginas and claims that Africans had more anal intercourse, had intercourse during menstruation and were excessively promiscuous.6 This had more to do with racist beliefs that Africans were evolutionarily inferior to white people, and anxieties about Africans as hypersexualised and having animalistic sexuality (Chirimuuta and Chirimuuta 1989:73-134). However, in the South African history of the epidemic, crude racist and sexist explanations for the spread of AIDS which appeared in public health literature were challenged soon after they appeared. Notions of the ‘diseased’ African prostitute as responsible for the spread of AIDS, for example, emerged in South African Medical Journal articles in the mid-nineteen eighties (Mbali 2001:25). But also, in a broader sense, they were simultaneously refuted as apartheid health and socio-economic inequalities were shown by anti-apartheid and feminist academics to be the true engine for ill health and the spread of AIDS in South Africa (Mbali 2001:42-47). This shows that government denialists such as Mbeki have ignored a key historical shift in the late 1980s and early 1990s in discourse around AIDS policy towards rights-based discourse.

Real discrimination against Africans and those of African descent did arise in Europe and America in the 1980s out of the notion that Africans were ‘AIDS carriers/victims’. Africans and those of African descent, especially Haitians were turned down for apartments, forced to have AIDS
tests before being accepted for certain academic scholarships and people with HIV or AIDS were not allowed entrance into America (Chirimuuta and Chirimuuta 1989:71-134). This formed part of a larger battery of proposed discriminatory measures in the West in the 1980s against gays, blacks, prostitutes, drug users (people deemed to be at ‘high risk’ of contracting HIV) and HIV positive people. In America, institutionalised and legal discrimination against HIV positive people on the basis of their HIV status, and ‘high risk’ groups became common in the 1980s (Brandt 1987:192). Prejudice and discrimination also informed early policy responses to AIDS in late apartheid South Africa in the 1980s. In South Africa regulations were proposed to force foreign mine workers to have HIV tests and deport them if they were found positive (Jochelson 2001). Government denialism can therefore be read as a local response to the history of local and international prejudice and racist discourses around AIDS policy-making. However, anti-discrimination has been an important principle in AIDS policy-making circles internationally for quite some time now. Jonathan Mann’s assertion, as head of the World Health Organisation’s Global Programme on AIDS, that AIDS policy internationally must protect rather than infringe the rights of HIV positive individuals, has meant that rights-based notions of AIDS policy have had international currency for quite some time (Schneider and Stein 2001:10; Garrett 1995: 67). Various agents in South Africa in the 1980s and early 1990s managed to force a shift in the way that AIDS and family planning policy would be framed: coercive practices outside a human rights framework ceased to form a legitimate part of discourse produced by government, medical and public health quite some time ago in the country (Mbali 2001), which renders denialism historically obsolete.

The ghosts of colonial and apartheid medical and public health discourse

Government AIDS denialism can be powerfully explained in terms of its being haunted by the ghosts of colonial medicine and Western culture, and their characterisation of Africans as diseased. I will now turn to this largely extinct racist discourse itself, which has influenced government denialism.

Colonial medical discourse around Africans was highly sexualised, perhaps, nowhere more so than when it was attached to STD management programmes. African sexuality was constructed in colonial medical discourse as primitive, uncontrolled and excessive, and as representative of

The influence of both of these views is traceable in government denialism. In so far as it posits that the Western biomedicine attached to AIDS aims to stigmatise African sexuality and in its frequent appeals to unspecified ‘African’ solutions to the problem, it relies on an imagined, pristine and essentialised notion of African culture. Controversially enough for African feminists, ‘African’ solutions to AIDS proposed by government officials have included virginity testing for adolescent girls, and in Swaziland the mandatory wearing of tassels by adolescents and teenagers to indicate virginity.7 This tends to point to an ahistorical ‘Merrie Africa’ vision of Africa’s past, where there were no ‘promiscuous’, corrupted, Westernised African women, and all African women avoided sex before marriage and did not ‘spread’ STDs and AIDS.

Sander Gillman has examined the history of the representations of black sexuality, as inherently diseased in Western scientific, artistic and intellectual discourse (1985). In terms of this history, the recurrent representation of blacks as inherently diseased, and disease-carrying, evident in mid-1980s South African public health discourse around AIDS (Mbali 2001:25-28), can be linked to a strong desire in post-Enlightenment Western culture to push its own fears and perceived negative qualities onto the Other (Gilman 1985).

Government AIDS denialism can be read as a reaction to this deeply rooted Western Othering cultural belief that Africans have inherently diseased sexuality. In Castro Hlongwane, for example, Mokaba comments, ‘…we are African [sic] who have overcome centuries of treatment as the repulsive and unacceptable other’ (2002:110). At an earlier phase in the epidemic some Africans may have been inverting the Western racialised process of Othering, by claiming that AIDS is a ‘white man’s disease’ due to certain ‘white’ types of degeneracy, like ‘homosexuality’. Certainly, this is a type of discourse that was attractive to some HIV positive patients at Baragwanath hospital in the early 1990s (Allwood et al 1992). Ann Laura Stoler has shown that Foucault’s notion of biopower can be expanded to understand how ‘normalising’ society in the West simultaneously excluded and differentiated itself from those of other races (1995:134-135): the nation in the West was made by differentiating sexualised, racial Others
from ‘white’ Westerners; European power and prestige in colonies ideologically depended on controlling the way that Europeans had sex, and with whom, and defining heterosexual monogamous norms of Western sexuality as ‘normal’ and ‘native’ sexuality as diseased.

If Western nationhood in the late nineteenth and early twentieth century was defined in Europe, against the negative of ‘native’ sexuality and its diseased-ness, should we see Mbeki’s misguided attempt to rehabilitate African sexuality as an attempt to redefine South Africa nationhood and the body politic, in terms of his misty concept of the ‘African Renaissance’? Can government denialism’s attempt to re-mould images of African sexuality, by denying the veracity of mainstream Western biomedicine’s model of AIDS, be seen as a nationalistic one to defend the nation against ideas that it is degenerate? Certainly metaphors and technologies of power based around notions of contaminated/pure blood, protecting the health of the racially-defined ‘nation’s’ children formed part of the legitimisation of institutionalised control of sexuality by the power/knowledge regime, both in colonies and the metropole and in late apartheid South Africa (Jochelson 2001). Government AIDS denialists have reverted to the past to argue against discourse, which for the most part had been massively surpassed in the ‘AIDS world’ by rights-based, anti-discrimination discourse and a shift to a medical, technical, non-‘moralistic’/stigmatising approach. The key question is whether key governmental actors, who still appear influenced by AIDS denialism, such as the Health Minister will be able to get out of the constraints of discourse defined by the boundaries of nationalism and colonialism?

**Better alternative responses: HIV treatment activism and rights based discourse**

Whilst denialism’s harmful consequences have catalysed critiques of it by civil society and doctors, some of the most powerful critiques of government denialism have emerged from activists using rights based discourse. The policy gridlock partially created by AIDS denialism must end by appeals to both human rights discourse around access to treatment and the human dignity of South Africans infected with HIV, and the predictive and interpretative power of biomedicine.

The Treatment Action Campaign (TAC), one of the key civil society opponents of government denialists, has so far successfully adopted a strategy of using the courts to argue for expanded access to correctly
administered anti-retrovirals in the public sector on the basis of socio-economic rights in the South African Constitution. As Zackie Achmat the Chairperson of TAC recently said:

For children, women and men with HIV/AIDS the rights to dignity, life and equality and their inter-connection with the right to health care access, particularly access to medicines including anti-retrovirals stands between us and death... These rights...are essential tools in our struggles to remove the barriers to HIV treatment and health care for all. (Achmat 2002)

At a microbiological level, Western biomedicine provides a powerful model for understanding the direct physical causes of disease and developing effective treatments, preventative methods and cures for them. Such rights-based and Western biomedical models will have to be used to devise rational government policies to alleviate the very real human suffering that the epidemic is causing. However, government AIDS denialism claims that all AIDS activists who believe in ‘AIDS orthodoxy’ and disagree with government AIDS policy are racist, in that they believe that Africans are ‘rampantly promiscuous’ and ‘endemically amoral’ (Mbeki 2001).8

Conclusion

Government denialism has fundamentally been a response to beliefs that Western biomedical mainstream understandings of the causes and treatments of HIV and AIDS are part of a plot to discredit Africans, their culture and sexuality. As a discourse, government denialism wrestles with the ghosts of colonial medicine and old traditions in Western culture projecting ‘negative’ sexual practices and sexual traits onto the Other.

The fact is, though, for the most part overwhelming consensus had already shifted by the late 1990s in the ‘AIDS world’ of doctors, medical researchers, NGOs, and most governments internationally, to more human rights based discourses around policy responses to AIDS.

There may be convincing alternative explanations for what drives the adoption of the AIDS denialism by individuals at the highest levels of government, more especially that denialism has the potential to provide a discursive escape hatch from a number of insuperable policy issues such as the scale of the problem and economic challenges posed by its links to poverty, the issue of generics and general failures of post-apartheid health delivery. However, analysed on its own, as a discourse, it becomes clear that government AIDS denialism is heavily affected by the legacy of racist public health discourse.
Seen in this light, government denialism has done nothing to address what is easily the biggest public health crisis South Africa has ever seen. It can only be hoped that the efforts by civil society and AIDS researchers to convince the government of the need for the rights-based policy response of providing HIV treatment for all who need it prevails over policies informed by AIDS denialism.

Notes
1. This paper is based upon my 2001 BA Honours thesis entitled “A Long Illness”: towards a history of government, medical and NGO discourses around AIDS policy-making. In 2002 I published an article in the Mail and Guardian which reiterated many of the arguments in this paper ‘Mbeki’s strange Aids discourse’ (March 22, 2002). It is also based on a paper I presented at the Nelson R Mandela Medical School’s Public Health Journal Club Seminar in May 2002.

2. The term ‘denialism’ is a neologism coined by AIDS activists in South Africa to describe the rejection by Mbeki and others of: the fact that HIV causes AIDS; the accuracy of HIV tests; and of the use of retrovirals as ‘safe’. I first heard TAC activists use this term in 2000, around the time of the AIDS 2000 conference in Durban.

3. It was claimed in October 2000 that Mbeki had withdrawn from the debate over AIDS denialism, a claim that Mbeki subsequently denied (Paton 2000; SAPA AFP 2000).

4. Despite the PMA’s 2001 climb down, the issue of the need for generic AIDS drugs remains. Illustrative of this is that whereas a month’s supply of generic WHO approved AZT would cost R232, a month’s supply of the patented version produced by multinational pharmaceutical company GlaxoSmithKline cost R811 (TAC 2002). In particular, provision of generics in South Africa will be vital to improving the feasibility of the implementation TAC’s proposed National Treatment Plan (TAC 2003).

5. Here she is citing authors like Richard and Rosalind Chirimuuta (extensively and favourably cited in the Mokaba piece), who argued for all the key pillars of South African President Thabo Mbeki’s current AIDS denialism.

6. Chirimuuta and Chirimuuta cite Noireau (1987) in order to make this argument.

7. Virginity testing, currently condoned by traditionalists in the KwaZulu-Natal provincial government, consists of inserting a reed into the girl or young woman’s vagina to ‘check’ if her hymen is ‘intact’. I heard Deputy President Jacob Zuma advocate it as an ‘African solution’ to the problem of AIDS at the National Beyond Awareness National Tertiary Education and AIDS conference at Kopanong Conference Centre in Gauteng in 1999. The South African Gender Commission, and prominent gender activists have been highly critical.
of the practice, because it cannot definitely establish virginity, is deemed to undermine girls’ dignity, and there is no equivalent practice for boys or men.

8. ‘AIDS orthodoxy’ is a term used to describe the generally accepted scientific view that HIV is the cause of AIDS, and that anti-retroviral therapy, if correctly medically administered, is both safe and effective.

References


Article

Masculinities, multiple-sexual-partners, and AIDS: the making and unmaking of Isoka in KwaZulu-Natal

Mark Hunter

Courting behaviour among traditional young men is a very important part of their education; for a young man must achieve the distinction of being an isoka, ie a Don Juan or a Casanova. (Vilakazi, A Zulu Transformations 1962:47)

There are no longer amasoka (pl. isoka); people are scared to die of AIDS. (Sipho, 20 year old male, Sundumbili Township, 2001)

This paper examines one dominant element of masculinities worldwide – the high value placed on men’s ‘success’ with women. In southern Africa, where HIV infection rates are typically 1 in 4, sexual networks characterised by multiple concurrent sexual partners are said to be prominent agents driving the AIDS pandemic (for instance HSRC 2002). As this paper shows, masculinities that celebrate multiple sexual conquests are meeting with forceful opposition in African communities, those the worst hit by the AIDS pandemic and the subject of this paper. Examining these trends, researchers have tended to dwell mainly on the present day, perhaps hardly surprising given the rapid onset of the pandemic. Notwithstanding the many rich resultant commentaries, this inclination to see AIDS through contemporary sources can, without care, suggest a certain rigidity, even innateness, to African sexuality. That the media is so quick in seizing upon stories of multiple-partners, sex for money, and sugar daddies makes it imperative to challenge any static representations of ‘promiscuous’ African sexuality. This is especially important of late because, although government’s suspicion of mainstream HIV/AIDS views has many antecedents, such images provide a context for President Mbeki and other critics to downplay the significance of sexuality to AIDS and to portray

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studies of African sexuality as being intrinsically racist. Thus, instead of surveying the links between poverty, *sexuality*, and HIV infection, some in government look no further than ‘nutrition’ or similar phenomenon to explain the interconnections between African’s economic hardship and AIDS.²

A major exception to this contemporary focus has arisen from the work of social historians, many contributions clustered around the 2001 ‘Aids in Context’ conference at the University of Witwatersrand (see the special editions of *South African Historical Journal*, November 2001, and *African Studies*, July 2002). These studies have questioned the uniqueness of the contemporary AIDS pandemic and shown the many precedents for the social turmoil occasioned by the collapse of apartheid. Mining and migrancy labour, in particular, institutionalised multiple-partners over a century ago as evidenced by the long history of syphilis infection in urban and rural areas of South Africa. This article builds on these themes but tries to chart a path, however fraught, between stressing the historical precedents for, and the uniqueness of, the AIDS pandemic. A tentative periodisation is attempted whereby, reviewing changes to masculinities over the last century, persistent unemployment coupled with continued agrarian collapse is argued to have set the conditions for the substantial reworking of masculinities and sexual practices over the last two decades (I also believe that sex and money have become interlinked in important new ways over the last two decades, the subject of a future paper). What is unique about the current young generation of men, I would argue, is that they are experiencing a simultaneous collapse of agrarian and wage livelihoods: while, as oral testimonies show, men in the 50s were often precariously caught between an eroding rural economy and an apartheid structured labour market, most eventually secured marriage and *umnumzana* (head of household) status through work, a path foreclosed to many in the current economic climate.

Rooted in the social changes induced by colonialism, migrant labour, and apartheid, the AIDS pandemic then is exacerbated by contemporary unemployment and economic hardship.³ Tight government spending in a climate of austerity has been widely shown to have detrimental health repercussions in southern Africa, including affecting HIV infection (for an excellent political economy perspective on health and HIV, see Basu 2003). This article does not explore further the underlying racialised political economy of South African health; instead the seemingly extraneous topic of masculinities will be used to demonstrate the intimate and contingent
relations between political economy, sexuality, and the HIV pandemic in a climate of growing inequalities. It does so by attempting to chart in KwaZulu-Natal the rise and fall of the *isoka* masculinity. Significantly reworked through the last two decades of incessant unemployment, in its contemporary form this masculinity draws from powerful symbols of ‘tradition’, notably polygamy, to associate manliness with multiple concurrent sexual partners.

The following discussion draws from ethnographic, archival and secondary sources for my ongoing PhD dissertation research based in Mandeni, a municipality 120 kms north of Durban on the North Coast of KwaZulu-Natal. The project is only partially completed and its analysis must therefore be seen as exploratory. The starting point for this narrative is the late nineteenth century, a time when certain forms of non-penetrative sexual relations encountered relatively modest control. There was also a reasonable degree of public acceptance at this time that unmarried women could enjoy sexual relations with more than one courting partner; multiple-partners were not solely the right of *isoka*, as they became later. By the 1950s, however, the *isoka* masculinity was being forcefully employed to differentiate between the ‘traditional’ rights of men, allowed to have multiple partners including increasingly concubines, and the limited rights of women (especially unmarried women), who by then, faced greater expectation to act with sexual propriety and remain monogamous. Yet particularly in rural areas unmarried men of this era were governed by an expectation that they would marry at least one of their courting partners and thus shouldn’t ‘waste’ women. Marriage, building an *umuzi* (by then an urban as well as rural household), and becoming *umnunzana* (household head) were still the most important signifiers of manhood. The high level of unemployment in recent decades, however, is now drastically impairing men’s ability to become *umnunzana*. Once a youthful phase, securing multiple-sexual took on an exaggerated role in denoting manliness. The article ends by noting how, under the frightening weight of contemporary AIDS deaths, the *isoka* masculinity is increasingly becoming fractured, though an alternative masculinity has yet to take its place.

**Late 19th century masculinities: polygamous men, women with multiple lovers**

At the turn of the twentieth century, Zulu society was emerging from a protracted period of military warfare and, consequently, bravery and fighting skills were celebrated as essential expressions of manliness. These
military masculinities jostled and overlapped with alternative meanings around manhood sourced in umuzi (the homestead), the economic centre of Zulu society. At the helm of umuzi was umnumzana (male household head) and great social weight was attached to an umnumzana’s ability to accumulate cattle, marry several wives, and expand his umuzi through childbirth. A masculinity that celebrated polygamy, cattle, and childbirth thus underpinned a man’s economic success: the more successful a man was the more wives he could take and the quicker the umuzi, and his umnumzana status, could grow (see Carton 2000 on masculinities at the turn of the century among isiZulu speakers).

As Jeff Guy and others point out, when studying this pre-colonial/early colonial period, an important distinction must be made between fertility and sexuality. It was the former, fertility, which faced the stiffest social control since reproduction was so important to the supply of agricultural labour. Court records, ethnographies and oral testimonies all suggest that, by later standards, certain sexual acts were seen as a legitimate source of pleasure, providing that pregnancy did not result. Ndukwana’s testimony to James Stuart includes accounts of how courting couples could engage relatively freely in the practice of non-penetrative, thigh sex (ukusoma or ukuhlobonga), the principle form of sexual release among unmarried lovers. Ndukwana also describes how unmarried women were engaging in relation with more than one soma partner, a point supported by court cases of this time. In her classic account of Mpondoland, albeit discussing a later period, Monica Hunter (1936:182) further says that unmarried women could engage in ukumetsha (ukusoma) relations with more than one partner: ‘The more skulls the better’. And although Zulu custom seems to have been somewhat of an exception in this regard, extra-marital affairs also appear to have been quite well accepted in southern Africa well before the onset of migrant labour (see Delius and Glaser 2003).

That some women had multiple sexual partners should not be taken to suggest that sex was somehow outside of gendered disciplining discourses, or was static and uncontested – Ndukwana himself notes how ‘loose’ women could be positioned as isifebe; moreover, practices such as ukushikilela (where men could ask passing women to show their buttocks, Bryant 1949:240), are reminders of dominant gendered rules defining male sexual aggression and female passivity. An institution of marriage that depended on cattle for ilobolo also made masculinities anything but fixed, as evidenced by the cases of elopement at the end of the nineteenth century following the decimation of cattle by rinderpest (on sexuality and rinderpest
see Carton 2000). It was, however, the control of fertility, not sexuality per se, that remained uppermost. Men were fined for breaking an unmarried woman’s virginity, and particularly for causing pregnancy, and ilobolo payments centred on the transfer of productive and reproductive rights – a wife ‘without issue’ could be replaced by her sister or have her ilobolo returned. 9

The word isoka during this period appears primarily to have signified a man’s entry into the courting stage. To begin courting was to inaugurate a process of finding a wife and thus setting up one’s own umuzi. One possible root of the word isoka is ukusoka (circumcision), a practice abolished by Shaka though formally serving as a rite of passage for those leaving boyhood. Specifically, Colenso’s 1861 dictionary defines the noun isoka as: ‘Unmarried man; handsome young man; sweetheart; accepted lover; a young man liked by the girls’. As is evident from the last definition, an isoka was also defined as a man popular with girls. Bryant’s dictionary published in 1905 contains similar definitions. As the twentieth century progressed, the meanings and practices associate with isoka were to change fundamentally as I outline below.

**Oral Testimonies from Mandeni**

![Figure 1: Central Mandeni showing Sundumbili Township, Isithebe Industrial park and the surrounding rural areas where Ekufundeni is situated (the exact position of Ekufundeni is not shown to protect informants from this area).]
The area of Mandeni, the subject of this article, lies to the north of the Thukela river, the former border between Natal and Zululand and the site of many historical battles. Dominated agriculturally by large white owned sugar cane farms, the region enjoyed industrial spurts at the beginning, middle and later part of the twentieth century. In 1908 the first sugar mill in Zululand was established at Matikulu. In 1954, SAPPI paper mill was established on the banks of the Thukela and many of its workers became housed at Sundumbili Township, built in 1964. The biggest growth surge, however, came in the 1970s and early 1980s. In 1971, the flat land of nearby Isithebe (Isithebe is a flat grass mat) was transformed into a thriving industrial park; within two decades it would become the most successful of all of South Africa’s 20 ‘decentralization zones’, employing 23000 workers at its peak. These developments created huge dislocation and inequalities in the area, ones that have been accentuated by the mobility of global capital in recent decades. The ending of industrial decentralization incentives at the beginning of the 1990s and the reduction of trade tariffs after 1994 forced many factories to close, relocate, or restructure. In contemporary South Africa, where government policy actively embraces the Darwinian instincts of the global market, the biggest employers are now Taiwanese clothing factories that can pay their predominantly female employees as little as R100 a week.10 In more unionised and traditionally higher paid industries such as metal, a small number of men can earn five times this figure. What has resulted through these changes in the labour market is a class/gender structure whereby a relatively small group of men earn comparatively high salaries, some women have access to jobs and economic independence, many women earn very poor salaries, and large number of men and women remain unemployed. The coming together in a single geographical area of very poor women, or those with few economic prospects, and some relatively rich men, has important consequences for sexual relations (I discuss the link between political economy, gender and ‘transactional sex’ in more detail in Hunter 2002). Certainly, Mandeni is famous for its high HIV rates. In 1997 Drum magazine described Sundumbili, the main township of Mandeni, as ‘Death City ... The AIDS capital of KwaZulu-Natal’.

This remaining part of the paper is divided into two main sections. The first centres on interviews with elderly people living in imizi (homesteads) in a semi-rural part of Mandeni, which is called here Ekufundeni. Most of these informants were born in the 1920s, 1930s, or 1940s. The second section is based on interviews with youth in Sundumbili Township most of
whom were born in the 1980s. Although my broader PhD project will stress the divergent spatial as well as historical dynamics of sexuality, I use the two groups here mainly to draw attention to how masculinities have changed over time. These oral statements are supplemented with court cases and other records from Eshowe and Mtunzini, the district in which most of present day Mandeni municipality is situated. Before turning attention to the interviews, recognition must be given to the constant and irresolvable tension between interpreting oral histories as representations of the past, focusing on their construction through contemporary discourses and emphasising the context of the interview, and positioning these accounts as repositories of facts. The forthcoming discussion recognizes and at times tries to stress the fluidity of memory and the performativity of interviews – the interview process is anything but the simple collection of ‘facts’. At the same time, it is acknowledged that much more space could have been dedicated to the complex processes through which this ‘data’ was collected and understood.

Coming of age in the 1940s and 1950s: working to become umnumzana, women’s ‘purity’, and the limits to isoka

Elderly Ekufundeni informants’ family trees which extend for three, sometimes four, generations make possible a rudimentary analysis of changing marriage patterns. At the outset it must be acknowledged that African marriage is difficult to quantify; betrothal refused to be converted into the single, simple, event, despite the attempts of those administering customary law. This notwithstanding, a discernible theme is the growing inability of men to secure marriage. Around one third of the elderly informants had a father who had married polygamously. These polygamists will probably have been born from the beginning of the century to the 1920s. All of the 13 men over 60 whom I spoke with had married one wife with the exception of one informant who remained unmarried. However, virtually none of the under-35 men for whom I collected data on in Ekufundeni, or knew personally in Mandeni, were married or substantially advanced in the process of marrying.

Most men of the generation born in the 1920s/30s/40s had undertaken wage labour, frequently at a great many employment sites. Leaving home and engaging in often dirty and dangerous work constantly under the duress of influx controls was an expected path, itself associated with manliness. Although a few lucky men secured ilobolo cattle from their fathers, marriage usually necessitated long periods of wage labour. Heavily
dependent on the vagaries of the apartheid labour market, men in the 1950s were marrying later than previous generations according to accounts of the time (Simons 1968). The metaphor, *wakha umuzi* (building a homestead), portrays the processual nature of building up a home, and encompassed within this figure of speech was the long and uncertain process of saving for a lover’s *ilobolo*.

To instigate courting, a man would *shela* (propose love to/burn for) a woman who, upon accepting his advances, would *goma* him (choose/choose a man). Elderly male informants graphically recounted the art of hiding by the river or in the forest to *shela* a beautiful girl over many months, even years, recollections related with equal enjoyment too by woman. Parents advised their sons not to *shela* relatives but it was largely left to ‘elder brothers’ to illicit more substantial guidance, including on *ukusoma*:

> They told us that it wasn’t allowed that we sleep up, they said sleep on your side, then do your thing … if you sleep up, there is going to be danger … they said don’t sleep with her … because then you’ll get a case against you.

The brothers are referring to the fine (*inhlawulo*) that the son’s father would have to pay for illicit pregnancies. Penetrative sex was disapproved of by elder brothers (at least when constituted in this role) though full sex was celebrated by some men as a sign of manliness. Vusimuzi said that ‘Boys used to talk to one another and say we don’t want to *hlobonga* [soma]…’ Someone who *hlobonga’d* might be derided as being un- masculine, or *isishimane* [see below].

My interviews suggest that by the 1940s/50s the concept of *isoka* was used more to describe and justify a man who had multiple-sexual partners and had become associated less with a man simply coming of sexual age. Support for this changing meaning of *isoka* can be found in Sikakana’s dictionary, compiled in the 1940s and 50s, which differentiates between an ‘original meaning’ of *isoka*, which is ‘a man old enough to commence courting’, and later meanings that include a ‘young man popular among girls’. Oral histories correspond with Doke et al’s description of *isoka* as primarily being a ‘young man’, although they suggest that the notion of *isoka* could also be employed in a more general sense to describe and justify men’s sole right to have multiple partners, for instance when married men had concubines – an increasing practice as polygamy waned, according to Schapera (1940). Justified through evoking the tradition of
polygamy, for the majority of unmarried men who were non-Christians, being isoka was highly desired and it was contrasted to being isishimane or isigwadi, a man who can not get a single lover. Vilakazi (1962: 50-51) describes isishimane as:

a social stigma ... worse than an organic disease... if he does not get one after having been medically treated, he may break down and become a psychopath.

This isoka masculinity also figured prominently in izibongo, oral praise poems that described and celebrated the characteristics of successful men.15 Prominent courting rituals practiced in rural areas further institutionalised the isoka masculinity. Many informants born in the 1920s/30s/40s vividly described how amaqhikiza (older girls already with sweethearts) would act as go-betweens who publicly gave a qoma’ed (chosen) man an ucu, a beaded necklace, as a symbolic gift to show that he was her girlfriend. The man could then raise a white flag outside his house and begin to soma with his girlfriend. While men could accept an ucu from, and thus engage in soma relations with, several girlfriends, women could not give more than one ucu without first breaking off an existing relationship. These ‘traditional’ courting practices are usually remembered enthusiastically and with great humour by informants and yet literacy and Christianity were subtly but powerfully undermining the public nature of courting. Some, although not all, Christians, preferred to court privately, including through letters. The seemingly mundane practice of penning a simple love letter could thus radically challenge the existing order.16

The isoka masculinity was dominant but not universal. Preachers looked down on isoka preferring Zulu men to espouse respectable and civilised monogamous values. One male informant recalled that as a Christian he only had one girlfriend at a time, though he admits that many Christian men paid only lip service to this rule and, certainly, the church attracted a far larger female following. Heterosexual norms were further challenged by the existence of same-sex relations, the Zulu words for a gay man being isitabane or ingqingili (see Epprecht 1998 and Moodie 1994 on same-sex relations in Zimbabwe and in the Witwatersrand mines respectively). The anticipation of marriage also placed very important limitations on the isoka masculinity during this period. It was still necessary to marry and build an umuzi in order to become a respected umnumzana (homestead head). If a man’s ability to have multiple partners was enshrined in the word isoka, its limit was contained in the concept of isoka lamanyala. Amanyala means
dirt, or disgraceful act. *Isoka lamanyala* signified a masculinity gone too far; its connotation is usually negative, although some men did celebrate their *amanyala* status. Men with more than one girlfriend, including married men who courted younger single (and thus eligible) women, were called to account for their intention or financial ability to marry these women, particularly by parents with a heavy stake in their daughter’s future marriage; thus despite the bravado around *isoka* many men only in fact had one or two girlfriends. Underlining the importance of the expectation of marriage for unmarried men with several girlfriends, Mrs Buthelezi, 74, compares, *isoka lamanyala* to *isoka*:

> An *isoka lamanyala* is a person with a lot of girlfriends, a person who takes from every place, he is *qoma’d* here and *qoma’d* there and he will never get married … [an *isoka*] … he doesn’t destroy people’s children.

Several informants also associated *isoka lamanyala* with the spread of STDs, showing how, well before AIDS became prominent, disease worked to limit the rights of *amasoka*.17

This brings us to a second apparent contrast with the nineteenth century: an exaggerated asymmetry around multiple partners such that women with more than one lover, particularly unmarried women, faced heightened public censure. Among the unmarried, the level of public intolerance around women having multiple-sexual partners was on a much wider scale than court cases, ethnographies and oral testimonies discussing the nineteenth century suggest and is indicative of a wider change in the social values. Of great significance is how moral judgements had become profoundly altered by Christian prudery, summed up by the notion of the ‘body as the temple of God’ and discussed in greater detail below. If pre-colonial society differentiated between sex and fertility, seeing the former as a legitimate source of pleasure, missionaries viewed any sexual act outside of marriage as inherently ‘sinful’.

Christianity was an enormous force for change in African society, but it became interwoven with ‘tradition’ and not simply its replacement. In the early twentieth century certain prominent champions of Zulu culture also identified themselves with Christianity, perhaps the most famous being John Dube, the founder of *Ilanga lase Natal* newspaper, and Solomon kaDinizulu, the Zulu king. Yet despite the apparent confluence of tradition and Christianity encapsulated in such figures, Christianity and education could be powerfully employed to criticize ‘tradition’, just as ‘tradition’ could be used to censure modern influences. Particularly, *amakholwa*
(believers/Christians) could look down on *amaqaba/amabhinca* (heathens or traditionalists) a fact that women, always the greatest church goers, could exploit. Men were sometimes caught in a contradictory position. Christian marriages, especially common in towns, were marks of ‘modernity’ and yet implicit in accepting God was a commitment to monogamy. More broadly, Christianisation and education, though promoting a passive ‘domesticated femininity’, stirred a certain rebellion among some women towards customs such as *ukungena* (the ‘entering’ of a deceased husband’s brother into marriage arrangements with the widow). So too could husbands’ double standards surrounding extra-marital affairs be challenged by more educated, Christian, or urban women.18 As a useful starting point to understanding gendered contestations over multiple-partners then, men’s embellishment of the ‘tradition’ of *isoka* must be seen against heightened criticism of customary rights. The concept of *isoka* provided powerful ballast for men’s right to have multiple partners and, more widely, the preservation of selected gender roles and expectations. This evoking of convention was buttressed by the Natal Code of Native Law that promoted a generally rigid interpretation of patriarchal customs, including the uneven rights of men and women to have multiple sexual partners.19

In *isiZulu*, ‘tradition’ is embedded within the powerful concepts of *amasiko* (customs) and *umthetho* (law). During interviews, informants repeatedly positioned ‘tradition’ as being diametrically opposed to Christian, modern, ways; such extremes, as suggested, could provide ammunition for groups to extol the value of either modernity or tradition. Characters such as Dube and Solomon kaDinizulu challenge clear distinctions but, more broadly, Shula Marks (1989) demonstrates the coalescence of both Christian and traditional groups in the 1920s and 1930s around Zuluness and women’s ‘purity’. White missionaries, Zulu nationalists, African Christians, and the Department of Native Affairs all railed against the disintegration of ‘tribal discipline’ evidenced by the increasing ‘immorality’ of woman in urban and rural areas.20 According to Marks (1989:225): ‘It was in the position of African women that the forces of conservatism found a natural focus’.

The category of *amagxagxa* (the in betweens) demonstrates the sometimes uncomfortable embeddedness of these Christian/traditional unions in everyday practices. The word can be used to describe those who attend church but continued to wear Zulu dress of *ibheshu* (skin cloth for men) or *isidwaba* (leather skirt for women). This subtle but pervasive blend makes it necessary to eye closely how modern and traditional forces converged
around women’s ‘purity’. Indeed, while most informants said that a woman’s restriction to have only one boyfriend was part of a timeless Zulu umthetho (law), tellingly some sourced the rule as coming from God. Similarly fashioned in the ambiguous domain spanning tradition and modernity, the meaning of isoka appears to have been re-assembled by the mid twentieth century so that implicit in the concept became men’s sole right to have multiple-partners.

Rural informants suggest that women born in the 1920s/30s were expected to act khutele (hardworking) and with inhlonipho (respect) towards men and the elderly. This was not simply a dominant gendered ideology, but a set of practices necessary for women to follow if they were to be seen as desirable for marriage. Though some unmarried women did leave for towns or have secret lovers, securing a husband was a prize that catapulted status and offered relative security. Pre-marital pregnancy, though becoming more common, brought shame on a woman and her family and for the unmarried could make future marriage difficult. Certainly, virginity was publicly celebrated in girl’s songs and through the practice of virginity testing. In this climate, woman who broke the codes of propriety, including having more than one boyfriend, ran the risk of being positioned as isifebe (a loose woman). So severe was the insult ‘isifebe’ that its calling could result in a defamation case.

The amaqhikiza were very important to the regulation of young girls. These were a group of elder girls, elevated in status since they had already qoma’d (chosen) a man. They would advise and warn unmarried girls on matters of sexuality. Describing how she was taught about the practice of ukusoma by these elder girls, Tholakele, now in her 70s, said:

The iqhikiza said that if you are told by your boyfriends not to cross your legs [a necessary part of ukusoma] nothing good will happen … you’ll now have a baby …

Discussion of amaqhikiza evokes great humour and nostalgia among the elderly; they hold a profound metaphoric role signifying stability and adherence to custom. The symbolic side of amaqhikiza is worth dwelling on since it opens up a critical window into oral histories as well as prominent ethnographies of the time. The most fascinating evidence about amaqhikiza is ironically a silence around the group; elderly female informants virtually always recounted the control that amaqhikiza exerted on them, never their own responsibilities as amaqhikiza, a stage that all must have passed through before marriage. There were often surprised
looks when this information was requested. At the same time, a small number of informants, when probed, questioned whether amaqhikiza were quite the personification of chasteness usually suggested. Several of my male informants, for instance, recounted how some amaqhikiza indulged in full sexual relations with pre-pubescent boys as ways to enjoy intercourse while preserving the appearance of virginity. Both of these examples offer firm evidence that amaqhikiza served as powerful metaphors – and not simply institutions – for the chaste control of women. They fire a stern warning against taking at face value ethnographies of the era that, crafted through structural functionalism, had a penchant for assigning amaqhikiza to definite ‘roles’ and ‘structures’ in societies (for instance Krige 1936a)

There was no comparable institution to amaqhikiza regulating married women, practically or metaphorically, though mothers in law would be the closest. Extra-marital affairs for married women, though against umthetho (the law), were relatively common as demonstrated through numerous court cases of adultery. Explaining these, many of the older female informants smiled wryly when relating how they dubbed their secret lover isidikiselo, the top of a pot, while their first man, the ibhodwe, was the main pot. Informants distinguish between this metaphor of a pot, which is related with some humour, and the more judgemental word for secret lovers amashende, associated more with a ‘loose’ woman.

For married women adultery, on its own, was rarely sufficient grounds for a man to divorce a woman. However, unmarried women, whose boyfriends often had more than one lover, faced a much greater pressure to remain faithful; men recalled how they would closely watch their girlfriends’ behaviour to decide which one exhibited the most inhlonipho and would make the most khuthele (hardworking) wife. Descriptions of rural women in the 1950s earnestly biding their time while boyfriends moved back and forth from work can be contrasted with the apparent ease in the nineteenth century with which unmarried women picked and rejected boyfriends (an element of control embodied in the word qoma – for a woman to select a lover). Men were quick to use this leverage in the most intimate moments, ironically potentially damaging their girlfriend’s chasteness. Following Tholakele’s qoma’ing of her husband-to-be, who at that stage had another girlfriend, the couple began to soma. Soon, however, Tholakele was refusing the requests of her boyfriend to have penetrative sex: ‘I was scared of being hit by amaqkikiza’ (amaqhikiza probably once again playing a metaphoric role). One time he tried to force her, as she remembers:
MH: When he tried to persuade you what did you say?
INT: I said, no, the law doesn’t allow …
MH: Did he try and physically force you?
INT: Yes, we were fighting and I pushed him … my husband said if you are refusing like this I wonder whether you can marry me or not …

Although, as I have argued, discourses surrounding sexuality gave men and women unequal access to sexual relations, it is important to recognise that the language of sexuality was also evoked in other ways. Parents in particular, could position their daughters as being isifebe or ‘loose’ women in order to deny them the opportunity to worship or school, both practices associated with possible desertion to the towns. Though churches and schools did provide important sites for courting, and school people often did see ukusoma as ‘old fashioned’ and penetrative sex as ‘modern’, it was the challenge that these institutions posed to gendered and generational hierarchies that made them particularly objectionable to parents, principally fathers. Sexuality, as Jeffrey Weeks (1985:16) points out is ‘a transmission belt for wider social anxieties’ – contestations over sexuality are about much more than simply ‘sex’. I will return to this theme later in the next section which contrasts the pressures on rural men and women for sexual restraint in the 1950s with the very different environment of the 1980s.

The Changing Umnumzana
The making and unmaking of Isoka in KwaZulu-Natal

Note: All three of these images have been selected because they exhibit change and tensions within umnumzana. Fig 2 (previous page) An umnumzana at the helm of his umuzi probably around the turn of the century. Note the moustache and children in Western cloth, both evidence of how even rural umnumzana was shaped by modern trends (Source: Natal Archives, Pietermaritzburg, C 646). Fig 3 (above left) An advert in Ilanga in 1950 showing the importance of clothing to modern urban abanumzana (pl. umnumzana). By this time the word umnumzana denoted an urban gentleman as well as a rural head of household. As the image suggests, to be phucukile (civilised) was (and still is) frequently coded as to zenza umlungu (to make yourself like a white). (Source: Ilanga, March 11, 1950:16, Killie Campbell Africana Collection). Fig 4 (above right) Love Life, an organization aimed at stemming HIV infection among youth, promotes sporty, healthy bodies as an alternative to men having multiple-girlfriends. Love Life portrays itself as a new lifestyle brand, competing with consumer icons such as Coke. In an era when umnumzana status is denied to many men, sports are promoted as fashionable alternative expression of manliness (Source: S’camtoPrint Issue 53, August 17, 2003).
Sex and money, township style: the contemporary isoka and the challenge of AIDS

Sundumbili Township, built in the 1960s, was conceived as a ‘model township’ to house SAPPI’s married workforce. In the 1970s and 1980s it was extended to house employees from Isithebe industrial park. Though constructed on a wave of new employment opportunities, unemployment is now endemic in Sundumbili. As a measure of this, only seven out of 34 students who graduated from a class in a high school I visited in 2000 had found work two years later.24

The identity of residents, like all identities, are forged in relation to ‘what they are not’. Sundumbili is frequently positioned as phucukile (civilised) in comparison to the outlying areas of rural KwaZulu-Natal that are seen as emakhaya or emafamu (rural areas). It is a ‘modern’ space. Not as modern as Durban and yet more modern than the nearby rural areas that lack reticulated water and tarred roads. Signifying this, a very prominent topic of conversation in the township among youth is ‘rights’ which are usually seen as arriving in 1994 with the new democratic constitution. A 25 year old described rights as followed:

[Rights] are to do whatever you want any time … no one can take it away from you…some are using them in the good way but … some they don’t use it good because they just go anywhere without telling their parents … when the parents ask, he says that it is my rights to do that.

Terrible political violence in the early 1990s divided the township into ANC and IFP areas, restricting residents’ movement; being in the wrong place at the wrong time could lead to a beating, or worse, death.25 Today, ibheshi (street parties or bashes) are celebrated by youth as being fashionable spaces for drinking, dancing, and romancing. A number of infamous shebeens also bustle loudly with young people on Friday and Saturday nights. Rocked by loud kwaito or house music, many young men pass the evenings drinking Black Label or brandy while women can indulge in designer drinks like Reds, the popular cider.

Ethnographies written about South African urban life from the 1930s describe how urban spaces – where co-habiting was relatively common, practices of ukusoma (thigh sex) seen as old fashioned, and ‘rural’ institutions of amaqhikiza (elder girls who advised younger girls) not replicated – were characterised by high rates of ‘illegitimate’ children, extra-marital relations, and ‘prostitution’.26 Reading against the grain, however, reveals how
township development also fostered a middle-class masculinity associated with marriage (increasingly Christian, monogamous) and the ownership of a four-room house. Images appearing in the Zulu newspaper *Ilanga* in the 1950s depict a modern urban *umnumzana* (man/head of household) who aspired to Western standards of education and clothing (see fig 3). Though many ‘marriages of convenience’ were concocted to access housing: ‘at its very core … [urban policy included] efforts to “build” stable African family units’ (Posel 1995: 237). Certainly, my informants in Sundumbili Township suggest that in the 1960s and 1970s marriage, whether to an urban or rural wife, was an important sign of manhood, even if many married men had affairs and drew from the *isoka* masculinity to justify these as ‘tradition’.

Throughout the last century, men increasingly turned to wage labour to buy cattle for *ilobolo* (bridewealth), or through which to save money in order to pay *ilobolo* in cash. From the 1970s, technological developments, slow growth, population rises, and, since 1994, tariff reductions, prompted an increase in unemployment and a greater casualisation of work. Though some African people have taken advantage of the post-apartheid deracialization of schooling and employment, for the great majority the prospects of steady work are very slim. Unlike funerals, weddings in Sundumbili are rare events. Indeed, according to the 2001 census, 80 per cent of African men in KwaZulu-Natal have ‘never married’, twice the figure for generally better off white men.

Schoepf (1988) and Setel (1999) have skilfully recorded how economic decline can amplify connections between money and sex in East Africa. Similarly in South Africa, many women are now dependent on men, sometimes many men, for survival or for consumer items (Hunter 2002). Another significant trend, and one that rubs more strongly against the historical grain, is the dependence of less successful men on women. Addressing masculinities in East Africa, Silberschmidt (2001) recounts how high unemployment, low incomes, and some men’s new dependence on women, downgrade East African men’s self-esteem. This provides a setting, she argues, for men to seize on multiple partnered relations and violence against women to express their manliness. Similarly, for South Africa, in the void by men’s inability to work and become *umnumzana*, ‘success’ with multiple women has become a critical marker of manliness. Seventeen year old township resident Sipho describes the way some men position their quest for women: ‘If he has six, I want seven, then he wants
to have eight’. It is true that young South African men and women still use the term isoka lamanyala to denote an unacceptable masculinity but the concept has become partially delinked from marriage – it is no longer common to hear men being lambasted for having many girlfriends but having no intention of marrying them. My conversations suggest that while men like Sipho exert an exaggerated bravado, multiple partners are extremely common among many, but not all, youth, although one important check on men’s actions is money. Sitting in his shack on the outskirts of the township, Vusi, 16, explains how he approaches women:

If I see a right cherry (girl) I tell my impintshi (mate), the next day I dress well, I go to her and ask her name, I tell her my name and then I tell her that I love her…

He is, however, frustrated at his lack of resources, which can provide material limits for the isoka masculinity:

… all of the girls want things they don’t have. They want money. Me, I’m a schoolboy, they look down on us, their friends say don’t qoma a schoolboy, a person that doesn’t work, what are you going to get?

Gender-based violence has multiple roots but interviews reveal strong connections between violence and girlfriends’ apparent lack of ‘respect’. Men’s own feelings of inadequacy can be literally beaten onto women. Of course, we should be cautious about interpreting violence as somehow new or a simple reflection of recent socio-economic conditions. Right back to the nineteenth century, cases of rape, including of young children, appear prominently in court cases. Ann Mager (1999) has documented an increase in violence in 1950s Ciskei as men struggled to come to terms with their and women’s changing status. Certainly, there is no doubt that in the 1950s Ekufundeni’s married men had a sizeable degree of freedom to physically abuse their wives; indeed, this was underwritten by customary law. Nevertheless, oral histories suggest that in rural areas violence against a man’s unmarried girlfriend faced important social controls. Thus, the act of forcing a women into penetrative sex during ukusoma, although virtually never seen as rape, could be punished through civil procedures, especially if pregnancy ensued. Moreover, beating a girlfriend for being ‘disrespectful’ might evoke questions as to why the man was doing so when he hadn’t yet paid ilobolo. Although much more work needs to be done to historicise sexual violence, the many cases I have come across today of young women in violent relations often with boyfriends frustrated at their inability to work, marry, and secure economic independence suggests strong links
between contemporary unemployment, evolving masculinities, and violence (see also Wood and Jewkes 2001).

In comparing the modern *isoka* masculinity with masculinities in the 1940s and 1950s one must recognize that earlier masculinities are remembered and articulated through the present. Some elderly men clearly reconstruct the past in ways that allow them to criticize young men’s ‘irresponsibility’ in the era of AIDS; indeed, masculinities can be an important focal point for generational conflict. But even allowing for the way that memory is inevitably reworked through the present, research is suggestive of important changes to masculinities. In the 1950s, a rural *isoka* could spend several years engaging in the art of wooing potential girlfriends; he could be reproached for having more girlfriends than he ‘might’ marry, usually one, two or three; whether urban or rural, he might look forward to becoming *umnumzana* (head of *umuzi*/household) through hard work, thrifty living, and eventually marriage; and he did not always see penetrative sex as a necessary part of pre-marital relations. Today, men typically court for a short time before sexual relations begin; they aspire to have very many girlfriends and are rarely held to account for their intention to marry these women (men saying that they would like to have four or five girlfriends is not untypical); they are seldom able to make the step from being *isoka* to being an *umnumzana*, even if most still hope to marry; and they typically see penetrative sex as the only proof of love. My interviews suggest that these basic trends in masculinities are similar even in more rural areas, though important spatial differences do exist.

During my first stays in Mandeni in 2000 and 2001, I tended to focus on the dynamics of this aggressive, almost self-destructive, contemporary *isoka*. Today, I am now far more convinced that the *isoka* masculinity is fundamentally changing. Day by day, funeral by funeral, AIDS bears harder down on the *isoka* masculinity. The symptoms, recognised by even very young children in the township, couldn’t be more emasculating – and de-masculinizing: some of the most virile, popular, and independent, bodies are steadily transformed into diseased and dependent skeletons, shunned by friends and neighbours. Connell’s (2000) term ‘bodily reflexivity’ neatly captures how the body sits within, and not outside of, the social world. Indeed, it is at the many funerals, as mourners walk in a slow circle around the coffin, taking a shocked glance at the deceased’s diminutive body, where the contradictions of *isoka* are most tragically played out. Consequently, men and masculinities are under huge scrutiny and critique,
even if women are still commonly blamed for ‘promiscuity’ and AIDS. It is difficult to think that a decade ago one could see men wearing government-sponsored T-shirts, saying ‘Real men don’t abuse women and children’. *Isoka lamanyala* – the *isoka* gone too far – has become linked to a man who infringes women’s or children’s ‘rights’ or spreads disease, particularly HIV/AIDS. Writing about Alexandra township, Liz Walker (2003) has demonstrated how these male doubts can be institutionalized into male groups such as ‘men for change’.

Why then do many men perpetuate practices that are literally killing them? Sexual pleasure is an obvious first answer. But to further answer this question one must return to how sexuality is deeply embedded within the power-laden practices of everyday life. Women seeking education and other opportunities have long been scorned as *isifebe* (‘loose’ women); today the disciplining of rebellious women as ‘loose’ similarly serves to bolster male power. One only has to spend a short time in any home in Mandeni to observe that women, often the young, shoulder the greatest burden of domestic responsibilities. The insult of *isifebe* hovers over women who challenge gendered taken-for-granted’s in the home and elsewhere. With this in mind, it is easier to see how men can adhere to differential claims over multiple-partners embodied in concepts such as *isoka/isifebe* that, while threatening to their lives if enacted in multiple-partnered relationships, reiterate gendered power in broader spheres of everyday life.

The principal role models for *Ekufundeni*’s elderly generation were elder brothers, neighbours with many cattle, or, for the more educated, teachers. For the most cosmopolitan, the Zulu paper *Ilanga* provided eye-catching images of an African urbanity modelled on Western ways. Women, whom I focus on below, looked up to elderly married women or perhaps teachers or nurses. Today, the media, especially television, enjoys much wider coverage in townships. Magazines aimed at Africans, such as *Drum* and *Bona*, or the newer *Y-mag* or *True Love*, together with more explicit television pictures, bring to South Africans powerful images that can connect sex with power, freedom and pleasure. These images are employed in intricate and contingent ways. Some women can tie the ‘modern’ images of ‘girl power’ to discourses of ‘rights’ and to the threat of AIDS, to strongly assert the merits of monogamy. Bolstered by discourses of women’s ‘rights’ in the post-apartheid period, some women now oppose with new energy *isoka*’s right to secure more than one sexual partner. In doing so, a
29 year old woman suggested that a man and not just a woman can *feba* (be ‘loose’):

There is nothing that can be said about an *isoka* because he has a lot of girlfriends … that is *ubufeba*. It was a long time ago that there were *isoka* — now there are just players. A man, he can *feba*.

One 29 year old woman told me that many women no longer use the tradition-laden concept of *isoka lamanyala* to criticize men: ‘the young they just call [bad men] *izinja* (dogs)’.

Nevertheless, showing women’s role in the production, and not simply the contestation, of masculinities, many other women weave sex, power and ‘rights’ into an ensemble that challenges only the *exclusiveness* of men’s right to take multiple partners. Indeed, coming of age in an environment where the prospect of work and marriage is small and often aware of their own boyfriend’s unfaithfulness, many women are quick themselves to see the benefits of securing multiple partners. As one young recently man put it: ‘now women say that it is 50/50 – if we have other girlfriends, they have other boyfriends’, a sentiment with a long history but perhaps amplified in the post-apartheid period.\(^3^0\) The pleasure of sex is openly celebrated, but these liaisons can also be brazenly about money, especially relationships with ‘sugar daddies’. Although some unemployed men or schoolboys complain that they find it difficult to secure a single girlfriend, ‘sugar daddies’ are usually said to work at well paying firms in Mandeni. Thembi, 25, says that she has a sugar daddy, who is 54. About the sugar daddy:

He does everything for me … because the cellphone he bought for me … money I’m not short… and he dresses me.

Some youth have told me that a young woman might also have relationships with boys of her age in addition to sugar daddies. These young men might know, and indeed approve of, their girlfriend’s sugar daddy, since he keeps her financially satisfied – allowing her ‘love’ to be devoted to him.

As this paper has tried to suggest, there is a definite but complicated relationship between cultural performances and the changing sexual economy. Interviews in *Ekufundeni* among elderly women over 60, showed how this generation was pressurised to invest in certain ‘acquired dispositions’ that would position them as marriageable – being seen as a chaste, *khutele* (hard working), and respectful, for example.\(^3^1\) *Amaqhikiza* (elder girls) worked to ensure that ‘respect’ was upheld, even if, at times, women ignored their guidance and the *amaqhikiza* were recalled in an
overly static way. Though there is great variety in women’s responses to modern circumstances, in today’s political economy, it is attractive clothes and a sexy demeanour that are often the ‘acquired dispositions’ that can serve to attract men – and money. Similarly, in rural areas, men faced heavy censure if they had many girlfriends whom they could not or would not marry; with umnumzana status so difficult in the present day the penalty for having many relations is more limited. Without wanting to posit a simple connection between material interest and cultural performances, this framework helps to explain why the virtues of ‘positive living’, prominent in many anti-AIDS strategies – working hard at school, making sacrifices to aim for a middle-class career, and practicing ‘informed choice’ – may resonate among what lesser fortunate South Africans sometimes disparagingly call amaModelCs (African students in formerly white Model C schools) but have less meaning for the vast majority who attend schools where poor results are endemic. It is in this context, that some women make implicit or explicit investments in the sexual economy. Sibongile’s conversation with Nonhlanhla, my research assistant, in 2001, underlines these points, showing how even the ultimate insult of the past, isifebe, can now be justified:

Nonhlanhla: How many boyfriends do you have?
Sibongile: Three.
Nonhlanhla: Why do you have three boyfriends?
Sibongile: Because I have many needs.
Philiswe: What needs?
Sibongile: To dress, I don’t work, a cell-phone ... doing my hair so that I am beautiful for my boyfriends, they won’t love an ugly person.
Nonhlanhla: What do they give you?
Sibongile: One money... another Checkers groceries ... another buys me clothes.
Nonhlanhla: Does your mother know where the groceries come from?
Sibongile: She knows, she doesn’t say anything because of the situation of hunger at home.
Nonhlanhla: Do other people know that you have many boyfriends?
Sibongile: Yes they know, my neighbours they criticise me, but not in front of me, they gossip about me, they say that I am isifebe. But my friends they understand the situation, they say nothing...

And yet, these type of comments are, I believe, becoming less common today. More recent interviews suggest that, in the face of AIDS, many
women, like men, are reducing the number of sexual partners that they are having or seeking protection through condoms.

**Masculinities on the move**

Political economy approaches towards AIDS often downplay masculinities and issues of sexuality seeing them as peripheral to health concerns. Yet resting heavily on the symbolism of polygamy, and with a long, unsettled, history, this paper has argued that the **isoka** masculinity has been significantly reworked in the era of high unemployment. Men celebrating multiple sexual partners, widely seen as an ‘innate’ feature of Africa sexuality, are in their present form, a product of an economic crisis that has ripped the core out of previous expressions of manhood – working, marrying, and building an independent household. Today’s tragedy of AIDS cannot be separated from the crisis of development in contemporary South Africa.

**Notes**

1. Many thanks to Ben Carton, Gillian Hart and Robert Morrell for comments on previous versions of this paper. I also acknowledge the constructive criticism of participants at a University of Natal History seminar where a version of this paper was presented. For hosting me in Isithebe, gratitude is due to the Dlamini family and for their patience and generosity I wish to thank the many residents of Mandeni whom I spoke with. I owe Nonhlanhla Zunguthe the greatest debt, however, for facilitating and transcribing most of the interviews upon which this article is based. The research upon which this article is based was assisted financially by fellowships from the Wenner-Gren Foundation for Anthropological Research and the International Dissertation Field Research Fellowship Program of the Social Science Research Council with funds provided by the Andrew W Mellon foundation.

2. See Mbali (2002 and in this issue) for a critical review of Mbeki’s stance on HIV/AIDS showing the importance of racist representations of African sexuality and disease to the President’s stance on the pandemic. Vaughan (1991) and McClintock (1995) describe in detail the sexualisation of colonial discourses and practices. Though focusing on masculinities in KwaZulu-Natal, generally thought to be the province worse affected with HIV, I should make it clear that I am not attempting to link a particular ‘Zulu masculinity’ to the severity of the pandemic in this area. Indeed, masculinities that draw from polygamy to celebrate multiple concurrent partners have a much wider geographical scope than KwaZulu-Natal, as demonstrated by writings from Lesotho (Spiegel 1991) and West Africa (Wa Karanja 1987). Furthermore, I am not endeavouring to give priority to masculinities over other historical factors that have affected the AIDS pandemic, for instance the racialised health system that fostered high rates of STIs and general poor health (including nutrition) in African areas; the historical promotion of Depo Provera and the pill as contraceptives for Africans rather than condoms; or, of course,
segregation and the migrant labour system.

3. The shift in South African economic policy away from the redistributive, employment creating priorities of the RDP towards the neo-liberal GEAR plan will not be explored here but have been rehearsed in this journal over a number of years (for example Adelzadeh 1996)

4. In 2001 Mandeni municipality was renamed eNdondakusuka municipality. I use the original name in this article since it is still widely used in the area. Beginning with a four month stay in 2000, I have so far lived in Mandeni for over a year in total, staying in Isithebe Informal Settlement with the Dlamini family. From the start of 2003, I have also worked part-time as a volunteer in a local youth centre. All of the names of people appearing in this paper are pseudonyms.


6. Although polygamy remained the domain of only the most wealthy men. Welsh (1971:95) charts how, in the wake of the colonial interventions in African marriage, and a declining rural economy, the number of second or subsequent marriages declined from 44 per cent in 1870 to 30 per cent in 1909.

7. See Guy (1987) for a materialist analysis of pre-colonial African society that makes this distinction. Caldwell et al (1989), from a demographic tradition, also come to a similar conclusion.

8. Ndukwana, in a long and complex testimony to Stuart, makes several references to unmarried women being allowed to have a number of soma partners, as long as she soma’d with only one per month so that pregnancy could be accounted for. Testimony of Ndukwana in Stuart Archive Vol 4:300,353. For an earlier period see Fynn’s diary, recorded in the first half of the nineteenth century, which describes how men who visited a kraal were allowed to hlobonga with available girls ‘The plan is repeated as often as strangers make their appearance, so that one girl may have 100 sweethearts, as also a man the same’, Stuart and Malcolm (1986:295). Accounts of courting contained in evidence for criminal court cases from this period also suggest that unmarried women had a significant degree of sexual freedom, see RSC II/1/42 Rex v Gumakwake (85/1887) and RSC II/1/44 Rex v Ulusawana (45/1888).

9. An interesting example of the lessening emphasis on fertility during the twentieth century is the relatively swift reduction of the practice of compensating a groom’s family if his wife was found to be barren. In the nineteenth and early twentieth century if the bride was childless, a woman’s family was required to return ilobolo, or to allow the bride’s sister to bear seed, but by the mid-twentieth most of my informants are not even aware that this practice had taken place. For return of cattle because a woman was ‘without issue’ see civil court case 1/ESH 2/1/1/2/1 Vanganye v Makanyezi, 1907. On ilobolo as ‘child-price’ – the transfer of productive and reproductive rights – see Jeffrey’s (1951) and Guy (1979).

11. The interviews in Ekufundeni were conducted in 2002, while research in Sundumbili took place from 2000-2003. In Ekufundeni, I spoke to elderly informants with a research assistant conducting 100 interviews, involving 21 old people, returning up to five or six times in some cases. We also conducted approximately 100 interviews in Sundumbili Township crossing three generations. With only a few exceptions, all interviews were conducted and transcribed in Zulu. My own position as a white, male, researcher from overseas did, of course, fundamentally shape these interviews and indeed my entire stay in Isithebe. I was present at all of the interviews except some of those involving young women, where it was felt that my presence might hinder informants’ openness.

12. I find Hofmeyr’s (1993), Moore and Vaughan’s (1994) and Hamilton’s (1998) work to be invaluable guides in combining African social history and sensitivity to the discourses through which informants, ethnographers, and the archives, speak.

13. Much more could be said about the ambiguity of marriage, an enduring theme in testimonies as well as court cases. Ilobolo payments, for instance, were sometimes not fully completed and were frequently disputed. While economic restraints could, even in the 1940s when the eldest of informants married, make ilobolo payments difficult, at other times, the bride’s families could implicitly or explicitly approve the non-completion of ilobolo: a well-known Zulu saying is ‘intombi ayiqedwa’ (the girl’s ilobolo isn’t finished). One outstanding cow could leave the groom’s family with an almost indefinite ongoing obligation. For a useful guide to the changing legal framework of customary marriages see Simons (1958).

14. Inhlawulo is the payment of a fine in lieu of the daughter who had been ‘seduced’. When customary law was first codified in Natal, ‘seduction’ was taken to mean deflowering. The greater acceptance of penetrative sex (linked to the decline in virginity testing) increasingly led ‘seduction’ to be associated with ‘rendering pregnant’. See Dlamini (1984).

15. See Koopman (1987), Turner (1999), and Gunner and Gwala (1991). Koopman sees Izibongo zokushela (courting praises) as one of six important izibongo types. On women’s izibongo, which can often scorn at male machismo, see Gunner and Gwala (1991). Koopman collected the praises he analyses in the early 1980s, Gunner in the 1970s, though they hare likely to have been composed before these periods.

16. Love letters, as Breckenridge (1999) recently noted, constituted a critical private sphere about which we know very little – one that sat in stark contrast to the public nature of courting described in this paragraph. The ability to enjoy the privacy of letters was often given by my informants as a great motivator for basic literacy.

17. District Surgeons’ reports from the 1940s and 1950s for Eshowe and the adjacent Mtunzini district show at first great concern at STIs, particularly syphilis, and the
lack of resources to cope with these. By the 1950s, however, returns were more optimistic reporting that a greater number of infected people came forward for treatment. See GES 48 56/1 C; GES 48 56/1/D; GES 126 143 1B; GES 127 56/1 C; GES 143/1 C; GES 143 1/D. Describing the effect of STIs on masculinity, a doctor’s assistant practicing in the area in the 1960s remembers the embarrassment attached to syphilis and suggests that, like AIDS, it could provide a check on male masculinity, although its curability of course contrasts strongly with AIDS today.

18. Showing how Christianity fostered great gendered conflicts in rural Mpondoland, Monica Hunter (1933: 274) notes how ‘In the relations between husband and wife the greatest change lies in the introduction of the ideal of a single standard of morality for men and women …’ But she also says, ‘There is a double standard of sexual morality, and most of the quarrels between husband and wife turn on this’ (266). On contestations over men’s use of the ‘idea’ of polygamy in urban areas to secure concubines see Longmore (1959) and Wilson and Mafeje (1963). Men’s objections to Christianity on the grounds that it would impose too heavy a duty on faithfulness are described well in Mbat’ha (1960) writing about the Botha’s Hill area.

19. In South Africa, customary law was codified only in Natal, in 1878. As well as sanctioning polygamy, native courts could be used to claim damages from any male who committed adultery with another’s wife, although unemancipated women, as ‘perpetual minors’, had no such claim. For vigorous critiques of the effects the Natal Code had on women see Simons (1958, 1968) and Horrel (1968).


21. Krige (1936a:106,157) says that the worse insult a woman could face is to be called a isihobo, a deflowered woman, and such woman would be sworn and spat at. A central theme in adolescent girls’ songs collected by Krige (1968) was the celebration of woman’s ability to deny men full sexual penetration.

22. Most of the small number of defamation cases that I have seen from this period are when a women has been called isifebe – a great offence for a Christian as well as a non-Christian woman. See Majozi v Khuzwayo (1/ESH uncatalogued Civil case, 65/63) for a rural setting and Buthelezi v Ntuli (1/ESH uncatalogued civil case, 66/66) for a more urban setting.

23. Mtiyeni Vilakazi v Matini Vilakazi (d/a M Gumede) is a typical case. Mr Vilakazi claimed dissolution of customary union saying that his wife bore two children when he was working in Durban. She denies this and claims that he wasn’t sending her money. See Eshowe civil cases (uncatalogued) case 50/54. For woman claiming lack of support, violence, or failure to render conjugal rights as grounds for dissolution of customary union, see Eshowe civil Cases (uncatalogued) 38/55; 65/55; 70/55.

24. In 2000 I visited a local school and stayed in contact with several students, including Simpiwe, now 22. Only four out of his class of 52 passed matric at the
end of that year. Two years later, in December 2002, I asked Simpiwe to try to obtain information on the whereabouts of his former classmates. Of the 34 whom he obtained reliable information about, two had left the area, only four were studying further, only seven were working, mostly in Isithebe, and the majority, 21, were unemployed.

25. In 1993 and 1994 alone 120 people died from political violence between the ANC and IFP in the Mandeni area, see de Haas (1994).

26. See Krige (1936b), Hellman (1948), Longmore (1959), and Mayer (1971), though Mayer also provides a fascinating account of how acts of apparent ‘immorality’ in towns, such as co-habiting, were championed by migrant men as a way to guard against the lure of having many sexual partners and thus undermining his commitment to a rural umuzi. For recent reviews of some of this literature see Delius and Glaser (2002) and Burns (2002).

27. See Mager, 1999 on the production of middle-class values in Zwelitsha; Edwards, 1996 for KwaMashu. In contrast to many urban ethnographies in South Africa that stressed the sexually degenerative forces of modernisation, the Rhodes-Livingstone institute based on Zambia’s copperbelt pioneered a series of studies emphasising ‘adaption’ and the production of modern urban men and women. See Epstein (1981).

28. In KwaZulu-Natal, the common ilobolo figure of ten cows (plus one beast, the ingqutu, for the mother) was set as a maximum payment by the colonial administration in 1869 and later incorporated in the Natal Code (Welsh 1971). Today in KZN it is ironically seen as one of the most timeless of all African ‘traditions’ (although not in other provinces where, unlike in Natal, customary law was not codified). It is, however, showing some flexibility, most notably through generous cash equivalents being granted for the 11 cattle, though even these changes still place marriage outside the scope of most men’s financial capacity. Census statistics were calculated from the Statistics South Africa web site <www.statssa.gov.za>.

29. Thanks to Catherine Burns for challenging me to consider sexual violence in this paper.

30. I have emphasised the explosion of sexual images in the post-apartheid period, particularly through TV, and the complex ways in which they can be drawn from. Nevertheless, from the 1950s magazines such as Drum contained bold and sexualised images, stories, and letters read by African women, particularly in towns.

31. The term ‘acquired dispositions’ is Bourdieu’s, see Bourdieu (1990). I give agents more of an ability to choose, or at least develop, dispositions, than Bourdieu does. See Moore (1994).

32. The importance of schooling to stratification – across and within ‘race’ – in post-apartheid South Africa, and its relationship to behavioural changes and AIDS, is an immensely important topic about which we know very little.
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Interview with Edward Kirumira

Can an Analysis of Social Identity Contribute to Effective Intervention Against the HIV/AIDS Pandemic?

Relebohile Moletsane

This special issue of *Transformation* examines three themes: Identities, interventions and activism in the context of HIV/AIDS in Africa. In this electronic interview, carried out on behalf of the guest editorial team by Relebohile Moletsane, Edward K Kirumira, Dean, Faculty of Social Sciences, Makerere University, Kampala, Uganda, comments on the role of the social sciences, particularly an analysis of identities, in contributing to a better understanding of, and effective interventions against the HIV/AIDS pandemic.

**RM:** What do you see as the major issues/problems surrounding social identities and HIV/AIDS in Uganda and the rest of Africa south of the Sahara?

**Kirumira:** Although evidence exists that challenges the argument of social identities as the determinants for the spread of HIV, strong perceptions continue to exist and to influence HIV/AIDS policy programming. This has not helped to reduce stigmatisation often based on identities.

Secondly, in Uganda just like most of sub-Saharan Africa, the family and community provide the only consistent safety net, in the absence of formal health and general social insurance. The HIV/AIDS pandemic has stretched these safety nets tremendously thus putting in question advantages accruing to social identity(ies). That is, identifying oneself with an extended family, or a community may unfortunately not present the same advantages it presented two decades ago!

**RM:** How do you see social science contributing to understandings of the HIV pandemic and to the development of effective interventions to combat transmission in the region?
Kirumira: When the first cases of what looked like HIV presentation were identified in southern Uganda (current Rakai District), the local population was quick to associate it with unscrupulous traders who had cheated across the Tanzanian border and were therefore bewitched. As the pandemic gained ground the bio-medical explanation gained prominence. However, by 1993, the Uganda AIDS Control Program started looking beyond for behavioural-based approaches to the prevention and control of the pandemic. Today, care and support are presenting themselves as critical in containing the impact as well as a powerful motivating factor in accessing and utilising counselling and testing services for the infected and affected. In all these, it is demonstrated that the individual, the community and the state are major players in the spread, prevention and control of HIV/AIDS.

Relationships, whether social, economic and/or political, are central to the understanding and manifestation of the pandemic in the sub-region. Social Sciences, therefore, present a very strong opportunity for studying, planning and evaluating the incidence, prevalence and most importantly the impact of the HIV/AIDS epidemic in sub-Saharan Africa. Uganda is an example of this where the breakthrough has been associated with factors like political will and commitment, community mobilisation and involvement, and care and support systems. The latter have been characterised by initiatives such as the Philly Lutaya Initiative (PLI) and the Post Test Clubs (PTCs).

The Philly Lutaya Initiative derives its name from a Ugandan singer, based in Sweden at the time, who was one of the first celebrity Ugandans to declare publicly that he had AIDS. He wrote and sang many songs based on and with AIDS prevention messages including ‘Alone and Frightened’. NGOs – including AIDS Information Centre (AIC) and The AIDS Support Organisation (TASO) adopted the approach by having or supporting drama groups that composed songs and plays depicting HIV/AIDS prevention and control messages. The Post Test Clubs on the other hand were formed as support groups for people that had undergone HIV testing, whether or not they were HIV+. People share their experiences and at the same time PTCs are used by agencies and NGOs to channel medical and social support to people living with AIDS. PLI and PTCs have had considerable success.

To consolidate these gains, social scientists will play an increasing role in providing models and frameworks for understanding the individual and group dynamics that make for risk reduction, de-stigmatisation, and the development of responsive policies and programs.
RM: In your view, how do different identities (social class, gender, race, sexuality) and resultant relations among individuals and groups contribute to the spread HIV?

Kirumira: The incidence of HIV/AIDS cannot be separated from social relationships and therefore the different forms or manifestations of social relationship are bound to have different impacts. From this assumption, one can say that different identities potentially result in varied degrees of the spread of HIV. However, studies in different Ugandan populations or identities show that identities in themselves do not explain sufficiently the spread of HIV, but that the recorded decline in HIV incidence and prevalence in Uganda cuts across all identities (UNAIDS 2000; UAC 2002). It is more the context within which these identities are lived that has significant impact on the prevalence of HIV, in that they influence individuals’ interpretation of their social realities and identities. Studies on differential risk perception among women in Uganda, have consistently shown that women of the same social status perceived risk differently according to their individual life experiences. Evidence from Uganda also shows that identities need be understood from a social network perspective – for instance peer pressure, friendships/relationships, workplace dynamics, and need for self-actualisation driven by the reference groups that are part of the individual’s daily milieu (Kirumira 1996; Bohmer and Kirumira 2000).

RM: Do you think critiques or explorations of such identities are useful or do they obscure more important issues and social dimensions?

Kirumira: It is certainly important that these identities are recognised because in many ways they form the basis of our self-concept and therefore influence behaviour outcomes. However to assume that they are a priori the determinants of the character of the spread of HIV in sub-Saharan Africa is an over-simplified reality of much more dynamic and often contradictory behaviour and behaviour outcomes – within the parameters of such identities. A critique or explanation of such identities may therefore be useful in as far as they provide a starting point of inquiry but should not be construed as the end of the inquiry.

RM: In particular, do you see the HIV pandemic as contributing to a change in gender relations in Africa south of the Sahara? Can you explain what kinds of changes you see taking place?
Kirumira: The HIV pandemic has most definitely impacted gender relations in Africa. First and foremost talking about sex and sexuality was a taboo in many African societies. Information, Education and Communication programs on HIV/AIDS have invaded this private space. Although many HIV/AIDS prevention and control programme have been at pains to find a culturally appropriate language for the messages, they have tested and expanded the permissible sphere for communicating about sex and sexuality.

Secondly, prevention campaigns have used an empowerment discourse. Women, most especially have been encouraged to ‘say no’ to unwanted and unprotected sex – initiation and negotiation of sex is no longer the privy of men. To empower women to say no or to negotiate sex, HIV programmes have also sought to empower women economically thus perceptively contributing to changes in power and therefore gender relations.

Thirdly, the pandemic has moved the realm of sex education from the family – and therefore domestic/private sphere – to the school environment, which is associated more with the public sphere. Such education has challenged sex education for social reproduction and by so doing has interrogated gender relations especially among the young generation. Maybe this is why statistics beginning to come out show a higher level of behaviour change and HIV prevalence decline among the youth than in the older population of 35 years and above (UAC 2002).

RM: What approaches do you think could be used to change the way such relations (eg gender relations) contribute to the spread of HIV?

Kirumira: Initially it was thought that women empowerment alone would tilt the balance in gender relations. Increasingly the realisation is that understanding and addressing social context factors is critical in impacting on relational construction, especially gender relations. Approaches should be seen to go beyond the individual behaviour change models and those that treat women as homogenous and inactive participants in social relationships that predispose them to HIV infection. The pandemic has been demonstrated to be a household, community or/and collective responsibility, and approaches for relations change must therefore be collectively-oriented. The focus should be on the institutionalisation of meaning and value and therefore the construction and reconstruction of identity(ies) in response to or as a result of HIV/AIDS.

RM: Uganda is hailed as a ‘success’ story in curtailing the spread of HIV/
AIDS. In your view, is this an accurate characterisation of the situation? If so, what factors have contributed to this success? For example, how much is this success due to effective interventions and specific gender equity campaigns? How much is it due to people’s proximity to death?

**Kirumira:** As a social scientist, it is always very difficult to characterise a situation as accurate! Some authors have for instance argued that in a mature epidemic, prevalence may be stable, but this stability simply means that the number of new infections every year equals the number of people dying from AIDS each year (The Futures Group 2000:67). Furthermore, one may argue that only a proportion of people know or are known to be infected and that therefore a significant percentage that is potentially infected is not documented. Having said that however, I think that Uganda has made very strong and visible gains in the fight against the epidemic. Three areas are worth noting:

1) **Political Will and Support**
   In Uganda one of the major reasons for the gains made in stemming the epidemic has been government’s will and commitment to the struggle against HIV/AIDS coupled with the Presidency’s open policy on gravity, incidence and prevalence of the epidemic (Kaleeba et al 2000). It was safe and politically correct to talk about HIV/AIDS to the extent that people were confident enough to declare publicly their sero status.

2) **Financial Resources**
   The country has benefited from tremendous donor (development partners) support for research, program and coordination activities to combat the epidemic.

3) **Community Involvement**
   The involvement of religious leaders, civic and cultural leaders in a highly religious population that Uganda is, has also benefited the fight against the pandemic. The fight against HIV/AIDS has consistently been based on a multi-sectoral approach and cognisant of multi-cultural belief systems. HIV/AIDS has been made a household disease rather than a disease that afflicts a single individual. The prevention and control programmes have addressed and continue to address the afflicted and the affected. As mentioned earlier, Clubs such as the Post Test Clubs were not only for those who tested positive but for everybody that has gone through counselling and been tested for HIV/AIDS.
RM: How would you characterise the various forms of social activism linked to HIV in Africa?

Kirumira: The first is a form of social activism that deals with the question of identity reformulation. As Butler (1990) argues, it would be wrong to think that the discussion of ‘identity’ ought to precede the discussion of gender identity, for the simple reason that ‘persons’ only become intelligible through becoming gendered in conformity with recognisable standards of gender intelligibility.

A second form of social activism seeks to consolidate the gains from gender equality to the social locale of individual experience of the HIV pandemic – dealing with the need to socialise discussion about the pandemic and thus challenge the dominance of bio-medical discourses around the HIV/AIDS pandemic.

A third form of social activism derives from being HIV positive and addresses itself to issues such as access to ARVs and employment policies responsive to persons with HIV. Especially with the Global Fund for HIV/AIDS, Malaria and TB Control efforts, this form of social activism has become very strong and produced powerful lobbies at HIV/AIDS national, regional and international meetings.

References


Review


Claudia Mitchell

‘HIV/AIDS appears to be on the ascendancy’ (emphasis added) writes Michael Kelly, the well-known Zambia-based scholar and spokesperson on AIDS and schooling in Sub-Saharan Africa, ‘and to have virtually overcome education, swamping it with a wide range of problems’ (Kelly 2000:24). In using the quote at the beginning of this report, the authors draw attention to a key objective of their study, that being to find out what the situation really is in this region of Africa. Drawing on case studies of three countries Botswana, Malawi and Uganda (BMU), they are interested in mapping out both the extent of the impact of AIDS on the education sector, and some of the ways that the education sector might also be addressing the issues.

Methodologically, the study is an ambitious one, and it is worth noting at the outset that one of the conclusions of the study is that there is a need for ‘detailed, robust and on-going empirical research in each affected country’ (109). The study is important because it does attempt to do exactly this kind of work by interviewing and surveying teachers and students in the three countries. The report is divided into nine short chapters, and an
Executive Summary, with each section very clearly laid out in terms of the focus. Chapter One provides a background and outlines the overall design, team members and funding sources (including the Rockefeller Foundation in Malawi and Uganda, and the UK Department for International Development in Botswana). Chapter Two deals with Methodology. I will return to this later in the review, but it is important to note that just for the valuable observations noted in this section alone, the study is worthwhile reading. Trying to make cross-country comparisons can be difficult, and the paucity of good record-keeping and data collection more generally can be very challenging. Chapter Three focuses on the overall policy frameworks for each of the three countries, and reports on the questionnaire and focus group data on four main sources of evidence for gauging the effectiveness of school-based prevention programs: overall trends in HIV prevalence, changes in key indicators of sexual behaviour, changes in information levels about the causes and consequences of the epidemic, and qualitative assessments by students and teaching staff about HIV/AIDS education. Chapters Four and Five address directly the impact of AIDS on children and especially orphans. Chapters Six and Seven focus on teachers (impacts to date and future impact). Chapter Eight is of particular interest to those working in the area of Human Resources in that it looks at AIDS in the workplace. Chapter Nine looks at management issues and the need for further research.

The study serves as an excellent model for others to follow, both in relation to studying other AIDS affected countries besides Botswana, Malawi and Uganda, but also for ‘testing out’ other hypothesis on rural/urban differences or considering other age and cultural variables. Perhaps what is most interesting about the study is that the authors are very transparent about the difficulty of doing this kind of work, and the challenges to getting ‘good data’. A case in point is their treatment of teachers’ sexual misconduct. Following from the work of Fiona Leach (2001) and others on teachers as perpetrators, they report on the difficulty of even having respondents understand the question. They note, for example, that while the teachers and administrators in Uganda seem to understand the term, Botswana respondents had to have it explained. Malawi administrators, they report, seem to confuse sexual harassment and ‘normal’ sexual relations. As one administrator apparently put it:

No sexual harassment has been reported. However, it has been remoured that some teachers are having affairs with girls but this leads to
consensual sex … these are normal discipline issues rather than sexual harassment. (40)

One of their main conclusions from the three country studies is that there is very little ‘hard evidence’ to suggest that school programs have much of an impact on students or teachers, and that while knowledge of the causes of consequences of HIV/AIDS is high, the actual incidence of behaviour change (condom use, delaying time of first sexual encounter) remains low. On the one hand, this might be taken by those of us who work within educational contexts as very dismal news. At the same time, though, it might suggest that we need to look more closely and more ‘thickly’ at programs where there does appear to be some success. In a study like this one, as the authors acknowledge, it is not easy to get at the personal and social variables that seem to make a difference. As noted above, there is a great deal to be done in terms of addressing method in work on gender and AIDS prevention. What is the appropriate discourse? How do we get at the personal and the social? A current study on sexual harassment in teachers’ colleges in Ghana, for example, reveals that this idea of what is normalised within the culture is not easy to ‘tease out’ through questionnaires or short interviews (Teni Atinga 2001). The researcher in this study, herself a Ghanaian, admits that even with ‘insider knowledge’ it is challenging to try to understand how teachers are allowed to abuse the positions they are in. Indeed, it is only after spending close to a whole semester with the students that she begins to get a deeper understanding of the complexity of the issues that spill over into institutional practices more generally (assessment, admission policies, location of the dormitories, etc).

If there is an overall lesson that the authors want us to take away from this study it must surely be that as researchers we need much more sensitive instruments for collecting data on the gendering of HIV/AIDS, and for understanding how teachers and students ‘see themselves’ within situations of gender and risk (Kumar, Larkin and Mitchell 2001). Perhaps one of the answers is to have more detailed ethnographic studies which set out to ‘unravel’ the data, as Holland et al (1999) describe it, and which could accompany studies such as this one which set out to include larger samples. Such work might include life-histories, individual case studies, action-research groups that could attend more to the ‘how’ of behaviour change, and that could become central to the ‘detailed, robust and on-going empirical research’ suggested by Bennell et al. Their own careful work goes a great distance to setting such an agenda. Indeed, if there is a need for ‘an AIDS
in the workplace strategy’ or for identifying a ‘literacy of AIDS’ (Mitchell and Smith, in press), perhaps it is timely to name and elaborate a framework for AIDS-methodologies.

**References**


Review


Kerry Cullinan

A poor household sells its animals, its implements and then the thatch from its roof in the hopeless quest for treatment. They then cease to farm or to herd and go to the city. When those individual changes become communal and then social, history’s trajectory has been irreversibly altered… (but) it is hard to measure things – quality of life, quality of relationships, pain of loss – for which measures are partial or non-existent. If it is hard to see these things, it is all the easier to deny them. (7)

Barnett and Whiteside have constructed a monumental book that attempts to provide a philosophical context in which to understand the social and economic impact of HIV/AIDS, ‘the first epidemic of globalisation’. It wrestles with complex moral dilemmas such as how we define our responsibilities to others, as well as providing a wealth of informative graphs and tables that nail down the statistics and trends behind HIV/AIDS.

The authors argue that health and well-being need to be seen as public issues rather than as individual states of being. A ‘medieval approach’ to HIV/AIDS, in which those with the disease are placed in quarantine, is not possible. Much as wealthier nations may try to contain the infectious diseases of ‘the poor’ by excluding the sick and the poor, the global world is too flexible and porous for this to happen. Instead, HIV/AIDS should ‘wake us up to the emergency of global public health’ and galvanise a global approach that addresses people’s social and economic circumstances.

However, while the wealthy burghers may also get infected by HIV, access to anti-retroviral drugs defines who gets saved and who is left to die, thus drawing deeper boundaries between those who can buy their health and
those ‘wretched of the earth’ who cannot. ‘Will we build just and cohesive societies both within and beyond national borders? Or will we continue to isolate and defend ourselves in islands of prosperity… while remaining surrounded by an increasingly hostile, desperate and suspicious world?’ ask the authors.

While parts of the book grapple with how the globalised world should deal with HIV/AIDS, large parts simply provide information about the disease in accessible bite-sized sections broken up by information boxes. It briefly explores theories around the origins of HIV/AIDS, as well as how the virus is spread and what the virus does once it enters the body. While the medical and scientific explanations are brief, they provide the reader with an adequate basic explanation of the workings of the virus.

The bulk of *AIDS in the 21st century* is devoted to defining who is most vulnerable to HIV/AIDS, and what the impact of the epidemic is on individuals, households and communities.

Measuring impact internationally has generally been inadequate, based on small samples and failed to address complexity. ‘This means that we understand impact very poorly. In particular, much impact is unmeasured’, argue the authors.

A key concept when considering impact is vulnerability, which is defined as identifying the features of a society, institution or process that makes it more or less likely to be negatively affected by the sickness and death associated with HIV/AIDS. Some groups of people are more vulnerable than others are, and I feel the book pays inadequate attention to the fact that girls and women are most vulnerable to HIV/AIDS.

Despite this drawback, the book is a very valuable resource. Stylistically easy to read, it provides clear, sharp and incisive commentary on the unfolding epidemic. It can be used as a reference book for both novices in the HIV/AIDS field and those who need quick access to a range of studies and statistics.

Barnett is development studies professor at the University of East Anglia and Whiteside is the director of the Health Economics and HIV/AIDS Research Division (HEARD) at the University of KwaZulu-Natal. The book is the fruit of 10 years’ worth of global policy research workshops on the social and economic impact of HIV/AIDS that the authors have conducted in seven countries including South Africa, the Ukraine, India and Malaysia.
Review


Tim Quinlan

This book sums up Professor Nattrass’ criticism, spanning several years, of the South African government’s responses to the HIV/AIDS epidemic. It is a sustained demolition of the values, approach and content of HIV/AIDS policies (emanating from the President’s office and Ministry of Health) up to 2003. Beginning with an outline of why HIV/AIDS deserves particular attention that revolves around the public debate on the need for national, as opposed to ‘pilot’, private and independent, anti-retroviral treatment (ART) programmes, she goes on to unpick the rationale of the government’s actions.

Her book provides a useful summary of the responses from the mid-1990s, followed by consideration of the key contentious issues that have arisen since. These include the use of ART to ‘prevent mother-to-child-transmission’ of the virus; the costs and benefits of a national ART programme; and the relationship between HIV/AIDS infection, poverty and development. Throughout, Professor Nattrass provides a clear exposition of the politics of AIDS and the government’s and its critics’ economic assessments of the effects of the epidemic, and the demands on the country’s resources. At root, she counters the government’s assertion that it could not afford to provide ART by showing clearly why it cannot afford not to.

This contention inspires the title of the book; in effect, looking beneath economic orthodoxy – how best to allocate scarce resources – to the values that shape assessments and conclusions. The ‘moral economy’ in this instance is defined by who is included and excluded through a decision to allocate resources in a particular way. Citing the philosopher, Richard
Rorty, she summarises, “if society lacks the political will to help those in need, then the notion of a moral community of citizens in empty”. Put bluntly, by refusing for nearly a decade to institute national ART programmes, the South African government excluded from membership of ‘South Africa’ a rapidly growing proportion of the country’s residents.

In her concluding chapter, Nattrass draws together threads in the preceding chapters to consider how society can help those in need. Here she looks at debate that was simmering in the early 2000s over the government’s social security policies, encapsulated in the proposal for institution of a Basic Income Grant and, more broadly, in the quest for a ‘social contract’ between the post-apartheid state and its citizens. These are issues that Nattrass could only draw attention to, for they have become more open since she wrote the book and were subordinate to the central purpose of her book: to close the debate on whether South Africa can afford to provide anti-retroviral treatment to those in need.
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- As Davis said:
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