

https://dspace.org/

Unimagined community: sex, networks and AIDS in Uganda and South Africa

Thornton, Robert

2007-06-01
University of California Press
http://hdl.handle.net/10539/3889

Downloaded from a DSpace repository. https://dspace.org/

1

INTRODUCTION

AN ANTHROPOLOGICAL APPROACH TO AIDS

This book offers an anthropological or 'ecological' approach to the study of AIDS. It departs from purely epidemiological and demographic approaches expressed in statistical measures, and from the 'behavioural' approaches expressed in tables of 'behaviour change'. I examine the dimensions and processes of everyday life in order to understand how sexual networks that transmit HIV are formed and work. My principle finding is that change in HIV prevalence is primarily determined by the differences in configuration of large scale sexual networks, rather than by cumulative effects of 'behaviour change' (although this is a necessary but not sufficient condition).

This is also a comparative study, focusing on two African countries that appear to be diametrically opposed in the way AIDS has progressed and in their respective social, cultural and political responses to AIDS. Comparisons between South Africa and any other country in Africa are rare largely because South Africa is taken to be an exception. Here, I treat South Africa as an African country among other African countries. In an effort to explore and to explain the differences between these two countries, I compare the structure of sexual networks and the factors that shape these networks, thus promoting or inhibiting the transmission of HIV. In doing this, I am assuming that South Africa is indeed part of Africa and generally comparable in other respects to Uganda. As a long-term resident of both countries, I believe this is the case.[1]

While this is not a policy study, it presents a way of understanding AIDS in its specifically African context that may help us shape effective policy in future. I sketch some new directions for policy at the end.

In southern Africa today, it has become a truism that even if one is not *infected* by the human immunodeficiency virus, one is certainly *affected* by it. Well over 2 million people, most of them in the prime of their lives, have died in South Africa alone as the result of HIV infection by mid-2007.[2] Some have died slowly after painful illnesses that have left them wasted and too ill to speak. Others have gone quickly from diarrhoea, tuberculosis or malaria. All have left a gap in the lives of their families and homes, their businesses or places of work, in education, and communities. In South Africa, AIDS currently accounts

[1] I assume comparability despite the fact that comparative studies involving South Africa and other African countries are extremely scarce. I cannot argue the case more fully here due to limits of space, but merely assert it on the basis of years of experience.

[2] HIV/AIDS barometer, *Mail & Guardian* 18–24 May 2007, p. 45. According to this news item, estimates indicated that 2,133,490 people had died of HIV/AIDS by noon by 16 May 2007. The source was cited as Plusnews (www.plusnews.org), but the article did not discuss the methodology used to arrive at this estimate.

for almost 50% of all deaths.[3] Nearly one thousand people will die each day of AIDS in 2006[4], and these numbers will continue to increase. South African life expectancy will drop to 50 years of age by the end of the decade in a country that has the best health and economic infrastructure in the African continent.[5] South Africa's child mortality and maternal mortality rates are rising, largely because of AIDS, with most of the increase since 1970 occurring in the last seven years.[6] On weekends in South Africa, the cemeteries are the busiest places in town. The dead already fill to capacity twenty-seven of Johannesburg's 33 cemeteries, and city managers struggle to find enough space to bury those that are dying now while they worry about where the dead will go in future.[7] In Uganda, by comparison, these rates fell in the early 1990s around the time HIV prevalence started to fall, and have remained stable[8] although by 2007 there were indications that HIV prevalence was beginning to rise again.[9]

Yet South Africans continue to deny the impact of AIDS on the country. The president, Thabo Mbeki, formerly claimed that HIV did not cause AIDS or death, and thought that it was a plot by major international drug companies to poison his people with dangerous medications. Now he mostly remains silent about the threat of HIV. The Minister of

---

[3] Dorrington, Johnson, Bradshaw & Bradshaw (2006) show that 47% of all deaths in 2006 were probably due to HIV/AIDS although they were classified under several different categories in the Statistics South Africa report on causes for death for years 1997–2003 (Statistics South Africa 2005). This statistic rises to 71% of death in the 15–49 age group.

[4] Approximately 350,000 people died of AIDS, or around 960 per day in mid-2006, according to an estimate of the Actuarial Society of South Africa (2006); South African Inst. of Race Relations gives a figure of 393,777 who died in 2006 or 1078 deaths per year (South African Institute of Race Relations 2007).

[5] Actuarial Society of South Africa (2006) says that life expectancy had dropped from 63 in 1990 to 51 in 2006, while 'Country Profile: South Africa (IRIN, PlusNews: Global HIV/AIDS news and Analysis, http://www.plusnews.org/profiletreatment.aspx?Country=ZA&Region=SAF# viewed 20 May 2007) reports life expectancy for men as 47 years and for females 49 years. The South African Institute of Race Relations (2007) gives a life expectancy at birth of 50.4 years. UNICEF reports a life expectancy of 46 (http://www.unicef.org/infobycountry/southafrica_statistics.html).

[6] Under-five mortality in 2007 was 71 (South African Institute of Race Relations 2007) compared with 59.4 in 1998 (South African Inst. of Race Relations 2002), or according to UNICEF, 60 in 1990 versus 68 in 2005 (Online: http://www.unicef.org/infobycountry/southafrica_statistics.html; viewed 24 May 2007). Most of increase in under-five child mortality occurred in the first years of this century. By contrast, Uganda's child mortality rate fell from 160 in 1990 to 136 in 2005 (UNICEF op. cit.).

[7] South African Institute of Race Relations 2006:2.

[8] Beresford 2006; Green, Halperin, Nantulya and Hogle 2006; Ssewanyana & Younger 2005.

[9] See Waswa 2005; Kaplan 2006; Baryarama, Bunnell, McFarland, Hudes, et al. 2007. UNAIDS and WHO report, 'AIDS Epidemic Update of December 2006' (UNAIDS 2006: 6, 17, 19–20) point to 'discrepant trends in rural areas' of Uganda where HIV prevalence is apparently rising slightly. According to UNAIDS, "Prevalence rose from a low of 5.6% in men and 6.9% in women in 2000, to 6.5% in men and 8.8% in women in 2004, according to data gathered in a study done in 25 villages" (UNAIDS 2006:17). This report was based on a report presented at the Toronto World AIDS conference (Shafer et al. 2006) and a report from Ministry of Health Uganda and ORC Macro (2006). The latter report, however, gives a prevalence of 7.5% for women and 5.0% for the age group 15-49 in 2005 (Ministry of Health and ORC Macro 2006: 101). It is not yet clear how significant these data are. These levels are still at or below the prevalence levels reached in 2002 after a period of declining prevalence since 1992. Baryarama, Bunnell, McFarland, Hudes, et al. (2007) report, however, that prevalence rose to 15% in 2003 from 13% in 1999 for clients of voluntary counselling and testing (VCT) facilities, and that incidence rose from 0.9% (95% confidence interval [CI]: 0.8 to 1.1) in 1993 to 2.3% (95% CI: 2.2 to 2.5) in 2003.

Health, Manto Tshabalala-Msimang, steadfastly advocates vitamins and a 'healthy diet' as a cure for AIDS, while overseeing the slowest and most bureaucratically encumbered medical response to AIDS in southern Africa. President Mbeki's silence on HIV and AIDS in the last several years makes it difficult to determine whether the president is following the will of the people, or whether they are following his lead. There is a consensus that no one will speak about it across the country. When people die from what must certainly be AIDS, the survivors say 'we don't know why he/she died'. This 'denial' does not mean that they do not suspect witchcraft, or even malicious harm caused by those who are jealous. Many are also fully aware that the cause of death is AIDS, and the very *act of denial* is itself taken to be an acknowledgement that the death was caused by AIDS. But few say this directly. The South African 'denialism', then, is not merely a refusal to acknowledge a reality. By not speaking about it, South Africans brush AIDS out of the picture. But this silence is a statement that points to another cultural reality. This alternative reality, this silence, is one of the issues that this book explores.

The shadow of AIDS, the great unmentionable, creeps quietly across the face of the country. And yet, there is scarcely a person in the country who does not actually know what is going on. The devastation is obvious, but only a few 'HIV activists' choose to make it an issue. They bring suits against the government's department of health, and win their cases, but little changes in the administration. Some provincial and municipal administrations go ahead regardless of government policy in seeking to provide antiretrovirals for those who are already infected. Prevention campaigns have been largely glitzy, costly failures (if judged in terms of prevalence rates), the most notable one called LoveLife. This organization, with the support of the South African government has sponsored huge billboards and other costly advertising campaigns with little evidence of success. It has been a great boon to the advertising companies, now partly owned by the rising black business elites, but HIV has continued to rise faster. Countless NGOs, church and educational organizations have rallied to provide care for the afflicted and prevention messages for those who are not, but without coordination, and often with conflict between them. As if to highlight matters, on or about 4 November, 2005, the former Deputy President, Jacob Zuma, already charged with corruption and awaiting trial, was alleged to have raped an HIV-positive AIDS activist and family friend in Durban.[10] He was tried and eventually found not guilty. It is difficult to avoid seeing this as being symbolic of the conflict between government and people in South Africa today, but in fact, it is seems to have been much more banal than that. Zuma testified in court that he knew that his victim was HIV-positive, but declared that he knew it was much more likely that HIV would be

---

[10] See Motsei (2007) for a comprehensive discussion, especially from the viewpoint of a black South African feminist writer. News stories include: (1) Jeremy Gordin 'Zuma afraid for rape accuser' Viewed on IOL.CO.ZAJanuary 29 2006 at 11:29AM Agence France Presse http://www.int.iol.co.za/index.php?set_id=1&click_id=3011&art_id=vn20060129081949238C693726 . (2) Zuma rape case 'investigated' 19/11/2005 08:46 (SA) News24.com. Viewed 30 January 2006. ['According to Beeld the complainant is a 31-year-old HIV-positive Aids activist'] http://www.news24.com/News24/South_Africa/Zuma/0,,2-7-1840_1837093,00.html . (3) Jenni Evans and Yasheera Rampersadh | Johannesburg, South Africa. Close watch on Zuma 'rape' developments. Mail & Guardian Online. 21 November 2005 02:07. Viewed 30 January 2006. http://www.mg.co.za/articlePage.aspx?articleid=257129&area=/breaking_news/breaking_news__national. Zuma was found not guilty of the rape charge in June 2006, and his trial for corruption has been indefinitely postponed. His alleged accomplice in the corruption case, Schabir Sheik, was found guilty in late 2005, and the court recorded that there was a 'generally corrupt' relation between them.

passed from male to female, and since he was HIV negative, he did not think the risk was great enough to deny himself the pleasure. The problem was not lack of knowledge: indeed, as the chair of the government's AIDS programme and the leader of a 'moral regeneration' drive, he used his superior knowledge of the statistical probabilities to justify the alleged rape and his decision to have unprotected sex with her. Moreover, he told the court that he took a shower after raping the woman because he believed this would guard him against HIV. All of this, he testified, was a consequence of his deep commitment to Zulu traditional culture that required the satisfaction of sexual desires for men and women whenever they became apparent. It was just another day in the complex interplay of sex, money, violence, and politics … but also of love, trust, joy and relationship-building that characterizes South Africa in these times.

There is nothing simple about this. The problem of AIDS and the spread of HIV throughout southern Africa involve every aspect of life, love and the pursuit of happiness. No single approach is capable of comprehending it all because of its human complexity. A comprehensive summary of most of the research on AIDS in Uganda noted, in July 2006, that the reasons for the decline in HIV prevalence in Uganda are still 'complex and not yet completely understood.'[11] An anthropological approach is likely, at least, to shed the most light on the problem. Effective response is another problem. That depends on how the problem is represented in popular culture and in political discourse, on whether there exists a political will to make the necessary changes, and on how the myriad institutions and social networks are able to respond. To understand these processes, to know AIDS, is a complex task indeed.

KNOWING AIDS

I first arrived in Uganda in 1969. I was 20 years old. The country then seemed a miracle of beauty and calm. The population then numbered less than 10 million but has nearly trebled since. I lived with my parents, brother and sister in an airy white house with dark parquet floors and lush gardens all around. From the deep red soil of the small vegetable patch planted by my mother and tended by James Atieno, our feckless gardener, we had a constant supply of fresh greens, tomatoes, peppers and aubergines. The nearby markets supplied a cornucopia of sweet fruit and other vegetables. The staple food, *matooke*, literally grew on trees. It is made of mashed, steamed green banana of a starchy sort, and was cheap and plentiful. Eaten with a handful of beans or a bit of chicken, it made a nutritious and filling meal. Both beans and chickens seemed to grow naturally under every banana grove. In the rainy season, rains seemed to arrive just as one sat down to lunch, and were generally finished by the time the meal was over, leaving the air fresh and clean. It was high enough for the air to be always fresh and never too hot or dry. It was perfect.

I taught science and geography at a Catholic girls' high school in Kampala, and attended Makerere University. My father was Deputy Director of the US Peace Corps, and my mother taught at the teacher training colleges. My brother and sister attended high school. In the evenings, I went out to the many nightclubs that featured Congolese jazz, or to one of the downtown hotels, and danced and drank Bell beers until late. During the holidays I travelled to all corners of the country, sleeping where ever I could, often in small country '*hoteli*' that were really just bars with a few rooms with beds in back. Roads were mostly

[11] Green, Halperin, Nantulya & Hogle 2006.

dirt, with one paved highway from the Kenyan border to Kampala and on to the western border through Mbarara to Kigezi, and to the mining town of Fort Portal on the Congo border. The only other main road made a loop to the north through Mbale on the slopes of Mount Elgon along the Kenyan border, then across the lower part of the northern districts, and back again to Kampala from Gulu. Although peaceful then, Uganda is deeply divided by strong ethnic differences. The southern half is inhabited by people speaking languages of the Bantu family. Politically, they were well organised into several ancient kingdoms with royal lines and histories stretching back five centuries or so. Buganda was the central kingdom that had eventually conquered and dominated most of the rest of the southern part of the country by the time Europeans arrived in the late nineteenth century. With their help, the northern part of the country was brought under the control of the Kingdom of Buganda, eventually as a Protectorate of the British Crown. The northern half of the country, however, was inhabited primarily by loosely organised tribes of warrior-pastoralists and small agriculturalists without large-scale political organisations like the kingdoms of the south.

These were the glory days of Uganda's short history as an independent country. Everything looked set to go from good to better. In some respects, it seemed that it could scarcely be better. Ugandans themselves were apparently happy and content. They partied and danced freely. University students and people in the villages were openly sexual and seductive. For most, the land provided a good living. Communities were often self-contained economic entities with limited needs for commodities from outside. The few things that were purchased—cloth, salt, cooking oil and lanterns, candles and paraffin—were always locally available from trading shops run almost exclusively by Indian traders. Villages were wholesome places with little apparent hunger—except perhaps in the far north near the Sudanese border and in the dry regions of northeastern Uganda. The Karimojong and Jie herdsmen continued to fight over cattle with long spears and shields when they were not grazing their large herds. Although the economically poorest of Uganda's people, from the several months that I spent in their large *manyattas*, I could see that they also were fully self sufficient, proud and happy with their lot. For the vast majority of Ugandans, however, money was scarce but food, most of it home grown, was not. People stayed close to their lands and villages as a result.

All of that changed in 1972 when Idi Amin Dada, then commander of the armed forces, staged a coup that overthrew President Milton Obote Shooting started early on the morning of the coup, just before elections were to be held. By first light, it was clear that the rosy future that once seemed certain would not dawn. Radio Uganda played the same British military marches all day, and BBC repeated the line 'heavy fighting in and around Kampala; it is not known if the European population is safe.' We did not know either. Later that day I ventured from Makerere University campus into Wandegeya market with a Sudanese friend of mine to see if we could find out what was happening. Heavy-calibre machine gun fire soon drove us back. I wanted to run, but with the help of my friend, already used to battle in his native Sudan, I managed to stand quietly behind a bush until the shooting stopped and we were able to retreat without raising suspicion from the undisciplined troops. Cordite smoke and fog already filled the valleys of the many hills on which Kampala is built. We later found out that Idi Amin had routed the forces of the President.

A few years earlier, Obote and Amin, together, had attacked the king of Buganda, Edward Muteesa's palace and had ended the kingship that had endured for five centuries on the

shores of Lake Victoria. The king, Kabaka Edward Muteesa, had fled to England where he died a few years later of alcoholism. Now it was Obote's turn to flee the country. He took shelter in neighbouring Tanzania under the protection of Tanzanian president, Julius Nyerere. Most of the small population of people of Indian and European origin were driven out of the country, and for the next fifteen years, Uganda plunged deeper and deeper into chaos of warfare, coups, economic collapse and the decay of infrastructure, farms, industry and governance in all areas. Ugandans moved from their villages in desperation, and soldiers roamed the country freely. The soldiers took women and sex where and when they pleased, and pillaged the country. Ostensibly to alleviate the ravages of the Amin régime, Nyerere's Tanzania attacked Uganda in order to restore the previous president, Milton Obote who had lived under Nyerere's protection since his former comrade, Idi Amin had driven him from the country. Obote returned in 1979 and set up a new government. Most Ugandans blamed the arrival of AIDS in the country on events at this time. A new disease had appeared, or a new name, 'Slim,' was invented for one that was gradually taking hold in southwestern Uganda. It was first perceived in the area where Tanzanian troops first crossed into Uganda, and continued to grow along the shores of Lake Victoria as smugglers in boats carried goods across the Tanzania-Uganda border in the army's wake.

Obote turned out to be even more ruthless and despotic than Amin, and the country continued its decline to complete social collapse and barbarism. A large trade in contraband goods developed along the Uganda/Tanzanian border in the extreme northwest corner of Tanzania and the southwest corner of Uganda in a district called Rakai. Smuggling trade and raids took place especially across Lake Victoria, involving the previously isolated fishing communities on its shores and on the islands. Even today, Rakai District, neighbouring Masaka, and the communities along the lake shore and on the islands have the highest HIV prevalence in Uganda. This may not be due entirely to the fact that enduring violent conflict, unrestricted smuggling and raiding, and outright warfare gripped this area for nearly a decade, but it is likely to be at least an important factor in the rise of HIV infection in this area. By the end of the 1970s, AIDS—called 'slim' or *siliimu* by the locals—was already noticeable in this corner of Uganda.

Ten years after arriving in Uganda, I went to live in Cape Town, South Africa. After leaving Uganda, I completed a PhD in Anthropology at The University of Chicago in 1978, spending two years in a village in central Tanzania to do my research. I arrived in Cape Town, South Africa, as a lecturer in Anthropology at the University of Cape Town. This was a very different country. From the perspective of Cape Town, it scarcely seemed like the same continent. The land was drier, the people better dressed and business-like, the lifestyle urban and often more 'European' than African. During the years that I had lived and worked in East Africa, South Africa had never seemed to me to be part of Africa. We could buy the South African *Drum Magazine* in Uganda and Kenya, and this showed an Africa that was apparently modernised beyond the dreams of East Africans. It was certainly in their dreams. Photos of black South African models decorated the walls and cupboards of many young Ugandans in those days. It looked like a place that I would one day like to visit, and I finally had my chance: a three-year teaching contract that would acquaint me with a part of Africa that none of my lecturers at Makerere, Stanford or Chicago had deigned to mention in my many African Studies and anthropology courses. Several of my Makerere lecturers were refugees from South Africa, but they did not talk about it to their students. It was off the map of Africa for African Studies in the US.

South Africa in 1979 was still in the grip of Apartheid, but after 30 years of National Party rule its grip was clearly failing. The population, at 25 million, was little more than half what it is today (48 million), and similar to Uganda's now (28 million). In Cape Town, racial segregation had never been as rigid as in the rest of the country because the large 'Coloured' population formed a sort of racial middle ground. I bought a house in an area that had never been fully segregated, and my family became integrated into the South African life style. South Africa was not what I had expected, as an anthropologist. In Chicago where I had lived for a number of years while completing my PhD, racial segregation was virtually absolute, though informal and illegal. Single streets marked dividing lines in Chicago that few dared to transgress. Black and white people did not, in the main, work together or inhabit each other's houses. Although they spoke the same language, there was very little communication and what there was often tinged with fear and misunderstanding. In South Africa, although racial segregation was formal and legally sanctioned, black and white people were in constant daily contact. Many white people had servants living in their houses and interacted at close quarters in the daily domestic routine. The great majority of non-white people worked in white-owned businesses, in government, or had daily contact with people of other races. Unlike Chicago, where a white person might rarely meet a black person (and vice versa) who lived only a few hundred meters distant and spoke the same language, daily social interaction in South Africa was ordinary, uncomplicated, cordial, and routine despite linguistic differences. By contrast, political and economic inequalities between what were then called 'races' or 'population groups' in South Africa were apparently absolute. Despite the daily reality, perceived transgression of legal separation could result in long imprisonment or even death. These contrasting and unjustified realities made South Africa a 'very strange society'.

Clearly, by the beginning of the 1980s it could not endure in this fashion. The Apartheid state began desperate efforts to save itself as these gradually segued into end-game politics. Two new 'separate but equal' parliaments were set up, one for 'Coloured People', and one for 'Indians'. Coloured and Indian politicians emerged who were willing to play the game, and some people voted for them. Although illegitimate except in terms of the local legal 'game', these events brought increasing numbers into a normalised political process. In one of the more grotesque political burlesques of these days, the South African state granted independence to the 'separate' homelands of Transkei (Xhosa), Ciskei (also Xhosa), Venda (Venda), and Bophutatswana (Tswana). This had the overall effect of highlighting the absurdity of the system, and it was an absurdity that no one could miss. Bombings by ANC and other anti-Apartheid movements became more frequent, but remained generally marginal and scarcely disruptive because they were operated from outside the country. By 1985, however, internal resistance groups became bolder and violence began to increase. As a lecturer at the University of Cape Town, it became routine to administer examinations in Pollsmoor Prison for those students who had recently been arrested for protest action. Police attacks and tear gas on campus were a regular occurrence. Ironically, the overall effect was to bring a degree of widespread interaction across most political and social barriers together with a clear sense that change was inevitable. When Apartheid ended, officially, with the release of Nelson Mandela in 1990, and the formation of a new ANC dominated government in 1994, it had already long been over in minds of the vast majority. South Africa in 1979 was still in the grip of Apartheid, but after 30 years of National Party rule, its grip was clearly failing. In Cape Town, racial segregation had never been as rigid as in the rest of the country because the

large 'Coloured' population formed a sort of racial middle ground. I bought a house in an area that had never been fully segregated, and my family became integrated into the South African life style. South Africa was not what I had expected, as an anthropologist. In Chicago where I had lived for a number of years while completing my PhD, racial segregation was virtually absolute, though informal and illegal. Single streets marked dividing lines in Chicago that few dared to transgress. Black and white people did not, in the main, work together or inhabit each other's houses. Although they spoke the same language, there was very little communication and what there was often tinged with fear and misunderstanding. In South Africa, although racial segregation was formal and legally sanctioned, black and white people were in constant daily contact. Many white people had servants living in their houses and interacted at close quarters in the daily domestic routine. The great majority of non-white people worked either in white-owned businesses, in government, or had daily contact with people of other races. Unlike Chicago, where a white person might rarely meet a black person (and vice versa) who lived only a few hundred meters distant, daily social interaction in South Africa was ordinary, uncomplicated, cordial, and routine. By contrast, political and economic inequalities between what were then called 'races' or 'population groups' in South Africa were apparently absolute. Despite the daily reality, perceived transgression of legal separation could result in long imprisonment or even death. These contrasting and unjustified realities made South Africa a 'very strange society'

At the beginning of the 1990s, HIV infection in South Africa was still barely noticeable. But by 1994 when ANC took power under the new constitution and after the first fully democratic elections in South African history, HIV prevalence was already at 7.6% among women attending ante-natal clinics. Shortly after the new government was sworn in, they had drawn up a comprehensive National Health Plan in collaboration with the World Health Organisation and UNICEF.[12] The plan was never effectively implemented.[13]

There were large differences between sub-regions, however. KwaZulu-Natal Province, predominately Zulu-speaking with South Africa's third largest city, Durban, had a prevalence of 14.4%. The Western Cape Province, home to Cape Town, the second largest city and predominately Afrikaans and English speaking, had a reported prevalence of only 1.2%.[14] With all of the political and other work that had to be done to ensure that the peaceful transition to democracy and an open society remained peaceful, Nelson Mandela, the first president of the New South Africa (as it was called), effectively ignored the hidden AIDS crisis. Even Mandela did not speak openly about AIDS until over a decade later, when his own son by his first marriage died of AIDS.

By then, the presidency of Thabo Mbeki had entrenched the effective government position that there would be no leadership from government in the question of AIDS. President Mbeki stated his reasons in an infamous 'monograph' awkwardly entitled '*Castro Hlongwane,*

---

[12] African National Congress 1994.

[13] Despite the lack of action, the Minister of Health, Tshabalala-Msimang stated that this document "has guided the health sector for 10 years and is still relevant today. Almost everything we have done is in there, and we intend to continue with the unfinished business" (Tshabalala-Msimang 2004).

[14] South African Institute of Race Relations 2004: 297. However, since these Provinces did not yet exist in 1994, these figures are reconstructed, and based on generalisations from ante-natal clinic (pregnant women) data. In view of the subsequent progress of the disease, and later population-based sero-prevalence surveys, these figures are approximately correct.

caravans, cats, geese, foot & mouth and statistics, HIV/AIDS and the struggle for the humanisation of the African'.[15] Primarily circulated within the ANC at first, the document was not signed but was widely attributed to President Mbeki and several of his close associates. It begins with an epigram from the John Le Carré novel, '*The Constant Gardener*', and expresses concern that

> … there are many people and institutions across the world that have a vested interest in the propagation of the HIV/AIDS thesis, because they have too much to lose if any important element of this thesis is proved to be false. … [T]hese include the pharmaceutical companies, which are marketing anti-retroviral drugs that can only be sold, and therefore generate profits, on the basis of the universal acceptance of the assertion that "HIV causes AIDS".[16]

Above all, the document accuses those who 'accept the assertion that HIV causes AIDS' that their position 'is also informed by deeply entrenched and centuries-old white racist beliefs and concepts about Africans and black people.' Suspicions of racism and of drug profiteering apparently drove the ANC government's rejection of what they called 'normal science'. Again, the South African 'denialism' did not come from any lack of knowledge about AIDS; quite the opposite.

Thus, twenty years after Museveni had come to power in Uganda with the attack on AIDS at the top of his nation-building agenda, the new South African government continued, as much as possible, to avoid the issue. Unlike Uganda, where the struggle against AIDS could be integrated into a programme of political development, the South African leadership apparently feared that open talk about AIDS and sexuality would be divisive. President Thabo Mbeki, in particular, expressed the view that discussion of AIDS implied that black people were sexually promiscuous and 'uncivilised'. For these and other reasons, he failed to lead a struggle against the progress of HIV infection in the population. By 2007, HIV prevalence was pushing towards 50% amongst young females in some parts of the country, and continued to rise in most other segments of the population.

South Africa today is a remarkably open society, despite its recent past. At the beginning of 2005, direct black ownership of companies listed on the Johannesburg Stock Exchange amounted to R60.6 billion, up from a zero percent base a dozen years earlier.[17] Unlike most of the rest of Africa, specific ethnic or other group identities of any kind are no more than two centuries old. The Afrikaners, and the Zulu kingdom, perhaps the best known of South Africa's ethnic communities, only came into being in the 1820s and 1830s and did not exist before then as self-conscious political entities. At about the same time many more white, English-speaking and other Europeans began to arrive and to settle in larger numbers. Other African identities and political communities—Tswana, Sotho, Swazi, Xhosa, Venda, etc.—only began to emerge in the middle of the century around the time that Tswana, Sotho and Swazi states were carved off in the third quarter of the nineteenth century. Bechuanaland (becoming Botswana at independence), and the kingdoms of Swaziland and Lesotho were created. Widespread warfare and pervasive migration of

---

[15] Castro Hlongwane, caravans, cats, geese, foot & mouth and statistics, HIV/AIDS and the Struggle for the Humanisation of the African', http://www.virusmyth.net/aids/data/ancdoc.htm (African National Congress 2002).

[16] African National Congress 2002.

[17] South African Institute of Race Relations *Fast Facts* 1/2006:5.

virtually all of the population in the 1830s and 1840s, the rise of gold an diamond mines and labour migration in the 1860s to 1880s, and the Anglo-Boer war from 1898 until 1910 served both to mix the population and to formalise ethnic, linguistic and political boundaries. The country of South Africa was finally created as a single entity less than a century ago. The struggle against Apartheid had much the same effect as the wars of the nineteenth century and first years of the twentieth. By the end of the century, South Africans continued to live and work together in a single nation and a single national economy in which everyone was dependent on each other in a highly complex, modern, globalised capitalist economy, and in which virtually no independent 'peasantry' or subsistence farmers existed. The inescapable irony of South African life is that the same processes that led to racism, ethnic divisions and Apartheid also created an ethos of equality, an unremarked daily routine of integration and a tightly knit single national economy and society.

Unlike Uganda, in South Africa very few people live directly from the land, that is, by subsistence agriculture, or even small-scale farming. Legally, most of the land was owned by a small class of white, male, farmers, who were effectively local chiefs in charge of large tracts of deeded land. The minority of farm owners of other races (today, approximately 16% of owners) managed their 'farms' in the same way. Of South Africa's total 122 million hectares, 82 million is classified as 'commercial farm land' and this is owned by only 45,000 largely white owners in 2005. Approximately 1 million hectares of this land has been 'restored' to non-white (mostly black African) claimants under the Restitution of Land Rights Act of 1994. While this includes some urban land, usually residential plots, most of it is rural farm land. The bulk of this has been restored to claimant 'communities' under the terms of 'communal property associations', however, that do not permit private ownership. Much of the rest of South Africa is too arid or mountainous for any form of agriculture. The remaining portion is urban land or roadways and transportation facilities, state and company-owned forests or game reserves, protected watersheds or parks, mining reserves, and government land, . Although the privately owned tracts were called 'farms' in South Africa, they bore little resemblance to farms in Europe, the UK or the USA. Most of the land of these farms was simply bush or pasture, with active intensive farming restricted to small parts of their holdings.[18] Large populations of Africans lived on most of these farms, some as labour, some as tenants with small fields of their own, some as labour managers or tradesmen, and others just resident there. Households of other family members, helpers, employees of all races often lived on these lands as well. But 'farming' was almost exclusively commercial and contributed no more than 3.4% to the GDP in 2005. Farming through the twentieth century was capital intensive, often resting on large 'loans' from government that were frequently written off in order to keep the farms successful and under white ownership. Food was either purchased or—on the farms—doled out sparingly in wages-in-kind. Another large portion of the country was communal 'tribal trust' land in the so-called Homelands. These were also run by chiefs in ways that were similar to those on the private farms, but the chiefs in these cases were called 'traditional authorities', and had a sort of loose legitimacy rooted in the pre-colonial political order. The chiefs had been recruited by the Apartheid regime, like the farmers, to regulate movement of people around South Africa. Indeed, the movement of people was

[18] Centre for Development and Enterprise 2005:12.

perhaps the most urgent concern of the entire Apartheid state apparatus, with most of the legislation directed to its control.

Unlike Uganda, too, few people owned land in South Africa. The pervasive and constant movement of people across the face of the land was both motivated and constrained by the peculiar political and economic geography. Work opportunities existed primarily in the areas owned by mines, the state, the 'farms' and in urban areas, while most of the people still lived in the communal, homeland areas and specially designated peri-urban areas called 'townships' or 'locations' to distinguish them from 'towns', and 'cities,' where, officially, only White, Indian and Coloured people could live in separate segregated suburbs. In fact, however, almost as many black people lived in these areas as domestic helpers, labourers and other sorts of 'assistants' (*handlangers)*. During most of the twentieth century—not just under the Apartheid regime of the National Party that held sway for 44 years from 1948 to 1992—huge efforts were devoted to concentrating most of the 'White', 'Indian', and 'Coloured' population in the so-called 'Urban Areas' and most of the Black population in townships and rural 'Native Reserves' or, later, 'Homelands.' State policy aimed to encourage the development of local and ethnic differences while, at the same time, the real social, political and economic forces drove the people of the country towards social integration and breakdown of ethnic barriers. All South Africans participated in the same national economy as consumers, purchasing food and necessities for cash, rather than producing it themselves. Production was the preserve of large commercial farms and industry (some of it parastatal), while transport, roads, and services (water, electricity, waste removal) were exclusively the domain of the state. A highly efficient paved network of roads linked all but the most remote parts of the country in a common network for those with access to cars and trucks, and extensive rail and bus links serviced the rest. It was possible to travel anywhere in South Africa in little more than a day or two. The number of bus tickets sold in Cape Town in one year in the 1980s to and from Transkei (one of the Homelands) was equivalent to the entire population of Cape Town.

In the end—that is the end of the century and the end of Apartheid—the unintended consequences of government policy won out over its explicit intentions. South Africa entered the time of AIDS as a highly mobile, largely urbanised population with few significant ethnic, regional or linguistic barriers to social interaction. One of the most enduring legacies of Apartheid, and perhaps its greatest success during its existence, was to convince South Africans, and much of the rest of the world, that South Africans were divided far more than they actually were, by race, language, ethnicity and class. This was possible partly because virtually no South Africans had experienced life in the rest of Africa, and for those who justly aided or participated in the struggle against Apartheid, explicit comparison between South Africa and the rest of Africa was effectively forbidden for complex political reasons. There is, consequently, almost no explicit comparison between South African society and the rest of Africa even today. This still hampers our understanding of the radically different regional HIV epidemics in the continent.

Half way into the first decade of the twenty-first century, South Africa has the most vibrant economy in sub-Saharan Africa. It is the 'power-house' of the southern half of the continent. A great deal of the trade and almost all of the financial business comes through South Africa from central and eastern Africa. The South African economy is beginning to dominate those of countries as far north as Uganda. Where once *Drum Magazine* puzzled Ugandans about the strange land to the south, today South African retail, transport, banking and tourism businesses have began to take hold in Uganda and Tanzania especially.

The characteristic branding of South African mega-retailers such as Pick 'n Pay, Shoprite, Protea Hotels, and others is highly visible in East African capitals. Formal unemployment remains high in South Africa, but it has become clear to me in my ethnographic work in South Africa's small towns and villages that there is a huge underground or informal economy involving most of the 'unemployed' in enterprises that produce a reasonable living for most people. For instance, the South African government has built 1.7 million housing units throughout the country for the poor and homeless.[19] This has created a huge underground (because illegal) economy in rentals, price speculation, bribery, services (renovation, expansions, decorating, furniture, repairs) and other activities that seem to absorb much of the time of the unemployed. Thus, while formal statistics show South Africa far ahead of other African countries in terms of its GDP, its real wealth is even greater.

This does not mean that it has become a fully-integrated class-less society; far from it. As in the rest of the world, the rich got richer and the poor got poorer, but the racial mix of rich and poor changed rapidly from the last decade of the twentieth century. By 2005, there were significant numbers of exceptionally wealthy Black business people and professionals and an increasing number of poor and indigent Whites. Coloured and Indian populations, for the most part, held their own somewhere in the middle income levels with growth of Indian incomes and wealth increasing much more rapidly than all other 'races'.

But even when I arrived in South Africa in 1979, I found that South Africans of all colours and social positions were relatively wealthy compared with Ugandans or Tanzanians. Even the urban poor in South Africa lived more comfortable lives than most of the Ugandans or Tanzanians I had known. Above all, South Africans interacted intensively across most social categories in one way or another. Although divided in many ways, informal networks based in common language (mainly Zulu, English, Afrikaans, and Sotho), religion (Christian, Muslim, Jewish and Hindu), place of employment, sporting team support and participation, among other activities and shared interests brought South Africans of all categories into daily contact. The informal or 'grey' economy, especially during the times of 'sanction busting' under Apartheid, created further networks of exchange that crossed most boundaries, national, racial or other. Where ethnic or 'tribal' differences were strong and unambiguous in Uganda or Tanzania, in South Africa these identities were most often shifting, negotiable, and varied depending on context.

AIDS, known as 'slim', was just beginning to be noticed in south-western Uganda by the time I arrived in South Africa. The causal agent, HIV, had not yet been identified by science. In my new home, however, there was no awareness of the disease that would kill 2 million people in the next 25 years, and infect 5 million or more out of a population that was estimated at about 46 million in 2005. Its impact was first felt on the west coast of the USA, and then, as doctors noticed similarities in symptoms between gay men in California and patients in Uganda, it became apparent that HIV had gone global and was becoming 'the ultimate global disease'.[20] No one then knew how bad it might be. Certainly, in South Africa, no one was even thinking about it yet.

My first contact with AIDS came in the middle of the 1980s. A colleague at the University of Cape Town was invited by his cousin to scout the possibility of making a film about the

---

[19] Centre for Development and Enterprise 2005:17.

[20] Marks 2002: 16; Posel 2003b.

anthropologist and primatologist, Diane Fossey, whose pioneering work on the mountain gorillas of Rwanda had brought them to the world's attention. She had died, or been murdered, under mysterious circumstances in her house in the *Parc des Volcans* in Rwanda. Her earlier swashbuckling style and unorthodox methods had brought her personal notoriety. Some five years earlier, my brother had been shocked to meet her deep in the Kigezi forest in Uganda with two pearl-handled revolvers strapped to her hips. Now she was dead, and my colleague, Andy Sillen, and I were engaged to investigate the circumstances in case the story proved movie-worthy. We met in Kigali, the capital of Rwanda and began to travel around the country to make enquiries. After a couple of weeks, Andy became too ill to continue with a mysterious illness that did not seem life-threatening but became increasingly debilitating. We returned to Kigali and eventually found a Belgian doctor who advised us that he had contracted sleeping sickness (Trypanosomiasis) from the bite of a tsetse fly. Worse, he was about to go into coma from which it was unlikely that he would recover. She refused to treat him in Kigali, saying that the treatment she had available would in all likelihood kill him, and if that did not, he would almost certainly be infected with a new disease that was only then becoming known: AIDS. She advised us to get back to South Africa as quickly as we could, but added that even so, his chances were not good. We barely made it to Nairobi where he was successfully treated. There we found a *Time* magazine that featured a picture of the Kigali Hospital. The caption read: 'Rwanda's "AIDS Central", the Kigali Hospital.' At home, however, there was still no indication that HIV would travel that far south. By the end of the 1980s some notice was taken. One of the vilest of the South African government-aligned news reporters, Cliff Saunders, travelled to Uganda to ask some questions. AIDS was still thought of in South Africa as a disease of homosexual men. His report appeared on the TV evening news. He was shown asking a Ugandan man if he had sex with other men. 'Eh?' the Ugandan responded incredulously to the microphone thrust in his face, 'but there are so many women!' Cliff Saunders smiled and shook his head in comical resignation. At that time, the government-controlled South African Broadcasting Corporation presented AIDS as a joke.

In the late 1980s, South Africa looked like it, too, would descend to political chaos and violence as the Apartheid government struggled to remain in power and as several democratic resistance movements sensed that the dénouement of the Apartheid story was approaching. A few years later, in 1990, Nelson Mandela was released from prison, and contrary to the expectation of most, South Africa began a rapid transformation to political freedom, universal voter franchise, democracy, and the peaceful integration of all aspects of government and civil society. During that time, too, the HIV epidemic began to take off with a vengeance in South Africa. Paradoxically, in that same year, HIV prevalence began to fall dramatically in Uganda. Once it was clear that the epidemic was headed in radically different directions in the two countries, a few people began to ask why. But not in South Africa. There were too many other issues at stake, and problems to solve. As the first president of the New South Africa, as it came to be called, Nelson Mandela effectively ignored it. So, too, did his successor, Thabo Mbeki … at first. Remarkably, it was not until the beginning of the new Millennium that AIDS really began to focus the mind of the South African nation. By then, it was no longer possible to halt the epidemic in its early stages. The initial failure to deal with the epidemic under Mandela segued into a staunch denial of its impact under Mbeki who even expressed doubt that HIV caused AIDS.

In my own research in the small towns and rural areas of South Africa it had now become apparent that it was impossible to carry on 'as usual'. AIDS was everywhere; all aspects of society and culture were beginning to be affected and my attention as an ethnographer turned, perforce, to AIDS, sex and sexual behaviour. My studies of traditional healers in the South African lowveld (also known as the eastern Transvaal, or northeastern South Africa) provided an excellent access to traditional and popular ideas about HIV and its associated syndromic diseases and symptoms. It also proved to give me a different point of access to attitudes about sex and its practice in the small towns and rural areas.

In 2003, I had the opportunity to return to Uganda for the first time in thirty years. I was invited to be a member of a team that would study the reasons for the Ugandan decline in HIV while it continued to increase in the rest of the world. The project was funded by the United States Agency for International Development. As originally conceived, the project would examine three countries where HIV had fallen (Uganda, Thailand) or where there was some evidence that local declines in prevalence were observable (Lusaka, Zambia). These would be compared with three in which it was still rising (Zimbabwe, Cameroon, and Kenya).

Arriving in Kampala in July, I felt like I had come home again. I was able to find many of my old familiar places despite the vast changes that had taken place in those thirty years. I was able to make my way back to our old house on Mbuya Hill. It was still as lovely as I remembered it, even though goats were now stabled in my old bedroom. The science laboratory that I had set up at Rubaga Girls High School during my first adventure in education was still almost as I had left it despite the growth of the school and vast changes everywhere else. Notably, the many nightclubs and bars where I had once hung out, and where sex was always available for the price of a beer, were gone. In their place, there were huge Evangelical and Pentacostal churches in tent marquees and buildings. The music one heard in the street was no longer Congolese jazz, but Christian Born-Again pop music. Much of this activity, it turned out, was funded by wealthy American Christian missions.

Our research began, and we soon found that Ugandans everywhere were overwhelmingly aware of AIDS and that huge changes had happened in many aspects of their lives as a result. The hidden agenda of USAID gradually became apparent, however. President George W Bush and his administration had become convinced by some researchers who asserted that sexual abstinence and churches had played the major role in reversing the AIDS trend. Our project was meant to prove conclusively that this was the case. As our interviews and focus groups and textual research progressed, however, it was clear that this was not the case, or, at best, only part of a very complex story. It appeared that the sponsors of our research in Uganda believed that the Ugandan President, Yoweri Museveni, had insisted on abstinence, especially in the military that he commanded when he came to power in January 1986. We were therefore surprised when a colonel in the medical corps told us, 'Thank God, Museveni never told us not to have sex! He would have been laughed out of the country!' Instead, Museveni had promoted what he called 'Zero grazing'. Based on the colloquialisms and metaphors of his own pastoral tribe, the Hima, this phrase meant, in practice, 'carry on having sex, but keep it local and close to home.' The slogan referred to the situation in which a cow or ox would be tethered to a peg in the middle of a patch of good grazing. As the animal ate the grass that its tether permitted it to reach, it would clear a circular area around the peg. This was the 'zero' of 'Zero grazing'. It did not mean abstinence—zero sex—as some earlier researchers, and President Bush's advisors, seemed to think. It simply meant 'Eat (have sex) as much as you like, but don't roam too widely'.

As it turned out, this simple rule may have turned the tide in Uganda because it altered the configuration of the sexual networks on which the spread of HIV depends. But the misunderstanding in Washington killed the research. Alarmed by the fact that our research was not producing the desired results, a USAID manager came to Kampala from Washington. He arbitrarily sent our research collaborators away, and attempted to end the research. Appeals resulted in our being allowed to finish a curtailed project in Uganda, but the overall project involving other countries was cancelled. Another dimension of the politics of AIDS was brought forcibly to my attention.

After thirty years of devastation by warfare and AIDS, I did not expect to find many old friends alive from the late 70s. Apart from Makerere student colleagues who left the country, I had lost touch with everyone from those times. My mother had not. She emailed me to try to find the family of Kamondo, one of her favourite students from Ggaba Teacher Training College. He had become a Headmaster of a school in Mbarara and had stayed in touch with my parents who now lived in the US. My father had kept a spear that Kamondo had given them beside his bed for all of those thirty years. At that time, other friends of mine had told me that in Western Uganda, a husband would jam his spear across the doorframe while he was having sex with his wife so that no one would interrupt them. But, by the same token, if he came home and found someone else's spear across the door to his wife's quarters, according to custom, he must be polite and leave quietly. The gift of the spear had been a joke, but was meant to say how fond Kamondo had been of my mother. My father had taken it in good humour. But, perhaps by these same customs of western Uganda, Kamondo had died of AIDS many years before my arrival. I managed to track down his wife, now headmistress of the school where Kamondo had taught for the rest of his life. We walked past his grave as we entered the family house, still feeling the loss of their father and his brothers who all lay buried in the courtyard of the family compound. All may have been victims of AIDS.

Inside the house, we talked of old times, and paged through the family's photo album. On one page I found my own picture (Figure 1.1**Error! Reference source not found.**). In it, I am standing with my first-born son in my arms with my parents, siblings, and wife. The picture was taken in 1979, the year we moved to South Africa. My mother had sent it to Kamondo's family some time after that. Above the picture was a much more recent picture of Kamondo with his wife. Kamondo is dressed in the 'traditional' Ganda formal dress of a white *kanzu*, a long white floor-length gown that had originally been introduced by the Arabs in the nineteenth century, and a grey suit jacket, introduced by the English at about the same time. Behind them is a traditional banana leaf screen. In the picture, Kamondo already looks ill.



Figure 1.1. Kamondo's family photo album, Mbarara, Uganda; showing the Thornton family's picture from 1978 (lower) and Kamondo with his wife (upper). The author is in the middle with his newborn son.

Back home in South Africa, colleagues, friends and friends of friends were also beginning to be infected in larger numbers. Some were dying; others managed to obtain anti-retrovirals and were living with varied degrees of success in beating back the infection. As in Uganda in the early 1990s, a decade later in South Africa it was not possible to ignore the impact of AIDS on friends, colleagues and family. Still, the President and other members of the South African government continued to downplay the issue or ignore it altogether. And things began to go wrong again in Uganda. The US President George Bush had managed to

recruit Ugandan President Museveni into his 'coalition of the willing' in the prelude to the American attack on Iraq. Museveni was heavily dependent on American funding for AIDS programmes, and for his own efforts to stay in power beyond his constitutional term limit. For that, he needed to follow the US president's line on AIDS, sex and the 'war on terrorism'. Museveni's wife was a born again Christian with much sympathy for the Bush government and its policies that promoted abstinence in the face of overwhelming evidence that it did not work, and on reducing the emphasis on condoms despite all evidence for their effectiveness. As a consequence, Ugandan HIV prevalence is creeping up again. South Africa's levels are showing some evidence of reaching a plateau, but even so, in some age groups in some areas, HIV prevalence has reached nearly 50%.

My long and intimate acquaintance—indeed, affection—for these two countries, Uganda and South Africa, gives me a special perspective as well as a personal motive to understand the progress of this epidemic. It has convinced me that the epidemic must be seen in the broadest possible cultural and social perspective, over time, and across space.

TEMPORAL AND SPATIAL ASPECT OF THE HIV EPIDEMIC

The HIV/AIDS epidemic is, of course, a medical fact. The temporal and spatial aspects of this pandemic, however, are largely social and cultural. The growth of the epidemic, the processes by which it is transmitted from one person to another, the huge regional and local differences in prevalence and in the types of the virus that are responsible, are, for the most part, the consequence of social and cultural factors.

In the first place, there are actually multiple epidemics. Each country and each region of each country manifests different characteristics that either predispose it to rapid spread of the infection or tend to retard the spread. Transportation networks and travel between regions link different regions in different ways. Moreover, economic differentials between regions and countries tend either to encourage or to discourage travel and other contacts between them, thus leading to different rates of transmission between regions and countries. Sexual practices, numbers of sexual partners, rates of prostitution, and other sexual practices also differ spatially, and create different spatial distributions of the HI virus. Above all, however, the specific configuration of sexual networks determines much of the landscape of HIV transmission and AIDS morbidity.

This, in itself, is not enlightening. All pathogens are transmitted from one person to another (or, rarely, from some non-human source to a human), and if we could draw up a 'graph' or diagram of who infected whom for any pathogen, it would look like a network. This would be true for any pathogen that is transmitted directly from person to person, such as the pathogens responsible for leprosy, tuberculosis, warts or mononucleosis. Pathogens that cause diseases like cholera and flu, are transmitted through the common medium of air and water, and thus utilise channels that can affect anyone who breathes or drinks from these common resources.

Effective public health regimes can offer protection from these kinds of pathogens. So can wealth, because it permits a degree of 'filtering' of the common resources (air, water, food), and limits the networks of contact with others through customs and behaviours associated with what may be called 'class' or other social differentials. In principle, the pattern of infection could be represented as a network if we were able to trace who, when and what in all cases. Of course, we cannot do this because most of these pathogens are invisible. Instead, we resort to statistical methods that assume a more of less equal chance

of infection for all members of a vulnerable population—that is, a population of people who are susceptible to the disease and who have not (yet) built up immunity. In the case of HIV, this gives us a measure of 'prevalence', or the proportion of the population that is infected. It tells us virtually nothing about how HIV is transmitted.

This is because, unlike other epidemics, HIV is not transmitted 'randomly' but through sexual networks. Sexual networks are a specific kind of social structure. Sex has a value, and this value is what is 'transacted', exchanged, re-valued, and 'consumed' through the interactions that constitute the sexual network. Moreover, sex, for the most part, takes place only under highly constrained and structured social conditions—especially in the context of what we call 'intimacy' or 'privacy'—among others. It is not a social act like any other despite its everyday-ness and 'normality'. It is, in fact, a kind of foundational social relation on which many other social relations are built.

These facts make HIV and its consequence, AIDS, different from any other disease, and, at the population level, different from any other epidemic. This difference is wholly apart from the fact that HIV infections cannot, so far, be cured or prevented through natural or induced immunity (vaccination). It also is a social disease like no other because it moves through and by means of social structures and because only social and cultural measures can (so far) prevent it or slow its progress.

Thus, the sexual network, although largely invisible, is unlike the invisible networks that link people in other epidemics. The networks through which the virus flows are not easily disrupted by public health initiatives, and wealth alone has no impact on its spread. Only other humans are potential threats to the health of any other, and only, for the most part, when engaging in what is among the most fundamental and valuable of human pursuits. The process of transmission of HIV is therefore imbued with deep meanings, fundamental values and with all the complexity of society as a whole.

HIV/AIDS is an infection of society, of social structures and of culture itself, as much as it is also an infection of an individual. It is not enough to treat it merely as a medical condition, as an epidemic, or as 'behaviour'.

In this book, I try to find ways to view AIDS as a property of the social—especially with respect to sexual networks as a type of social structure—and to understand its cultural and social-structural dimensions. This involves the examination of AIDS in relation to all of civil society and the state. The way in which people absorb the knowledge of AIDS into their cultural repertoires also determines the kind and quality of their response to it. This approach requires a re-examination of the meaning and value of sex itself. This amounts to a broader ecology of AIDS in which the large-scale systematic and environmental aspects are taken into account.

Time and AIDS

As we seek to develop responses to AIDS, we make the social and cultural context of the epidemic ever more complex. Medical and social interventions have different effects on different regions, and differ from individual to individual. Prevention and treatment methods evolve over time, and their efficacy and possibilities for implementation depend on the degree of development of delivery infrastructures, receptivity of the population, educational and media interventions, cultural responses and social structures. Cost of treatment implies that there is a strongly marked differential between the ability of regions, countries or continents to afford treatment. The nature and severity of stigma associated

with the infection and its manifestation as AIDS, and the ability of the society to respond effectively and creatively to death and dying are also factors that distinguish different responses in spatial terms. After death of parents, siblings and other members of the households and of members of the various productive units of society such as farms, industry, transportation firms and so on, it is clear that different regions are affected in different ways.

These factors are related in complex temporal ways as well. The epidemic has changed its spatial distribution over time as sexual networks link up or break over time. It is most likely that HIV had already become endemic in human populations from the 1940s or 1950s[21] and perhaps for generations.[22] For many years, it remained unnoticed, accounting for few deaths, in western and central Africa. It was an endemic infection that seems to have remained under some sort of control or limit. Today, it is probably impossible to say precisely where it began, how it began, or how it was previously contained in small isolated populations. It did not become an 'epidemic' until it went global.[23] Thus, an epidemic which seemed at first to have begun in rural western or central Africa, eventually appeared in the USA where it was first recognised as a distinct disease or syndrome in the early 1980s, and retrospectively, by 1979 at least.[24] At first, it appeared that it existed only among small populations of homosexual men.[25] But it soon began to appear elsewhere, and in other populations. It spread to the Caribbean[26] and began to be recognised across Europe. By July 1982, there were 452 cases that had been reported to the CDC in Atlanta, and in August, the syndrome acquired its name, AIDS, for the first time.[27] Eighteen months later the number of cases known to the CDC had increased by a factor of 17. By late1984, the CDC had recorded 7699 cases in the USA alone, and 3665 deaths up to the end of 1984.[28] A group of doctors and researchers first noted instances in Uganda at the same time and soon took the lead in the Ugandan response to the crisis.[29] From the early 1980s, then, it spread rapidly but differentially to other parts of the world. As it spread, it appears that the types of especially vulnerable sexual activities also shifted from early concentrations of homosexuals and drug users to the vast majority of heterosexuals. By the beginning of the twenty first century, the latter were responsible for the bulk of transmissions.[30] Clearly different social and sexual practices in different areas led to greater

---

[21] Lemey, Pybus, Wang et al. 2003; Zhu, Korber, and Nahinias 1998.

[22] Caldwell & Caldwell 1996: 563.

[23] Mann 1989; Mann, Netter & Tarantola 1992.

[24] Marx 1982.

[25] Gottlieb, Schroff & Schanker et al. 1981; Masur, Michelis, Greene et al., 1981. Although Gottlieb, Schroff & Schanker et al (1981) was one of the first published notices of the syndrome, Gottlieb and his co-authors were not yet aware of the causal agent involved. They suspected that the immune suppression among homosexual men in San Francisco was due to high levels of infection by cytomegalovirus.

[26] Center for Disease Control 1982; Guerin, Malebranche, Elie et al. 1984; Liautaud Mellon, Denizé-Vieux et al. 1992; Pape & Johnson 1988.

[27] Marx 1982.

[28] Centre for Disease Control 1984.

[29] Serwada, Sewankambo, Carswell et al. 1985.

[30] Barnett & Whiteside 2002.

or lesser degrees of vulnerability and thus to different rates of transmission in different regions. The geographies of other epidemics and endemic infections such as TB, malaria, pneumonia and other co-infections influenced the rate of transmission within and between regions and greatly affected the speed with which the viral infection gives rise to AIDS.

Thus, we need to seek to understand the HIV/AIDS epidemic in both spatial and temporal terms and in the context of complex cultural and social structures. We can divide the temporal progression into three broad sequential periods:

- *The time before AIDS (which remains indefinite, but roughly before 1979),*
- *The time of AIDS, and*
- *The time after AIDS … that may never come.*

We are in the second of these 'periods'. The third 'period' is notional—we might say 'cultural'—because it does not exist—not yet—and may never exist as far as we know. It is an essential though possibly imaginary part of the temporal process, because this is what must motivate social action in response to AIDS. It fulfils the function of the Second Coming, of the dream of salvation, the notion of 'the final stage of capitalism', the 'pure market', or the once-promised coming of the pure communist paradise. It may never happen—indeed, many may declare it an impossible dream—but it is still essential to our well-being and to the social imaginary.

The first period is real but merely antecedent. In the period before HIV, societies will already have developed and entrenched multiple factors—ideas and ideologies, values and practices, social forms and cultural norms, demographic densities and distributions—that will influence the vulnerability of the society to HIV infection. This will influence, in turn, the rate of transmission as well as the rate of progression from HIV infections to full-blown AIDS and death. These are the social pre-conditions for the epidemic. Once the virus has become fully endemic to a population in the second period, each responds differently and meets the crisis of disease and death in different ways. The ability to acknowledge the severity and to deal with it either effectively or dysfunctionally differs dramatically.

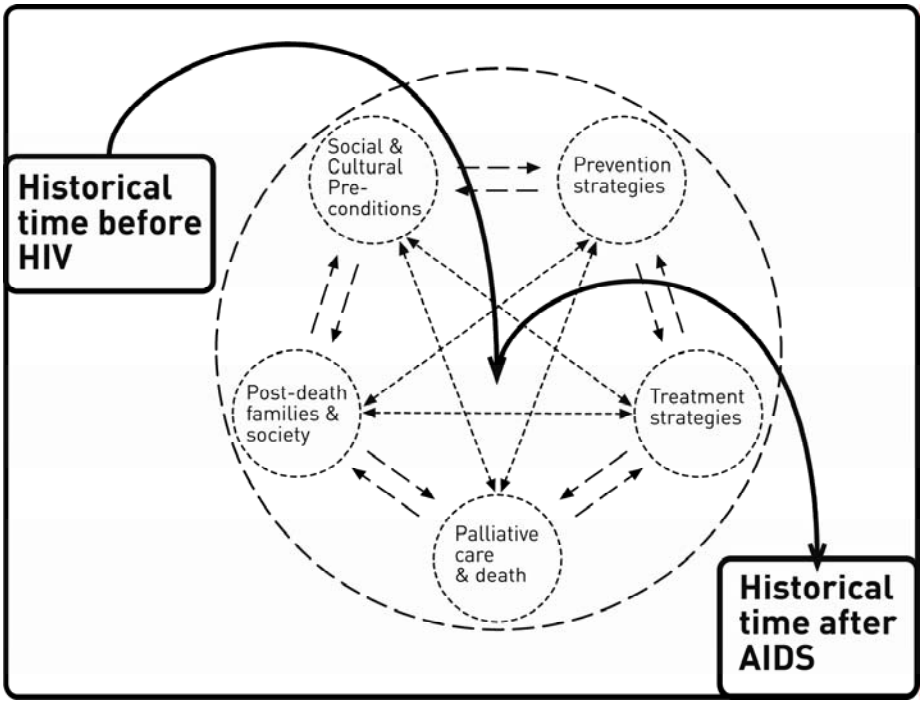


Figure 1.2. The time of HIV/AIDS: sub-processes are linked in complex feedback and feed-through loops, although situated in historical time.

The second period is the current empirical reality and context of the current work.

Within the second period, there are a further five or so phases in a cycle. There is a phase in which the virus begins to take hold of the sexual network that supports and transmits it. The pre-existing cultural and social features of the demographic landscape that it will inhabit determine how, and to what degree it takes hold. Second, there is the response. An effort must be made to cope with the infection and its consequences. Here, the political and social structure of a community, society or country must begin to change in order for its sexual networks to change. It must seek to cope with fear, stigma, and public health crises of many sorts. In some cases, there are political demands for effective action. Third, several different types of treatment strategies must be formulated. It has become clear that single or isolated responses, no matter how effective each might be in isolation, do not work. The Ugandan Multi-sectoral approach demonstrates this, as the fragmentation and conflict that has characterised the South African response demonstrates it in the negative. This includes medical interventions such as anti-retroviral therapy, but ways to begin to effect changes in sexual behaviours and sexual networks must be found and implemented. Fourth, as people begin to sicken and die, there must be responses that aim to ameliorate suffering, to ease the passing of those who will not make it, and to arrange for death itself. On this scale, this must include orphans, the consequence of broken and damaged webs of kinship and support, and, in some cases, changes in the way we deal with death. Fifth, there is the emergent social framework in which AIDS exists as a more or less permanent unpleasant fact. In other words, as it becomes endemic, and not merely epidemic, its consequences become part of the cultural and social landscape. As new frameworks of belief, knowledge and action emerge, people must come to terms with living in a different way.

In a mature AIDS epidemic, these temporal periods and phases eventually exist together. Although we can think of the social and cultural 'pre-conditions' as existing before the epidemic—as they certainly did—they continue to exist as other stages develop, both for the individual and for the larger communities and society. Each set of conditions, strategies and outcomes develops at its own speed but also in response to the other processes.

Each also manifests different temporal scales. The 'pre-conditions' —the entrenched traditions and social forms—continue to exist and change very slowly if at all. Meanwhile, the disease is transmitted and progresses at a much greater rate than social institutions and cultural responses can change to meet the challenge. Both prevention and treatment issues evolve at different rates relative to one another, and with respect to the overall historical process of the epidemic. Responses to death and dying, like the social pre-conditions for infections and transmission, are also likely to change slowly, but since they must meet the absolute volume of increasing mortality with limited resources, increasing mortality must force a change. Overall, however, there is also a broad historical trend in which the epidemic has developed from nothing to its current stage at which it constitutes a significant threat to health, well-being and life of large numbers of people. Eventually—we must assume—HIV, too, shall pass. This must occur in the scale of historical time that subsumes the temporal scales at which each sub-process takes place and can be measured.

The key to this lies in understanding first of all, the unique properties of sexual networks that are responsible for its spread.

TOWARDS A THEORY OF SEX AND NETWORKS

In order to develop an anthropological approach to AIDS—a holistic or ecological approach that integrates understanding of the person with the full social context and system—the 'problem of AIDS' must be conceptualised as a problem of understanding historical process and social process in cultural terms. This is a kind of historical anthropology.[31] The problem of HIV/AIDS is a problem involving change in cultural meanings, norms and social action. It is clearly not enough to see it merely as a problem of 'knowledge', and/or 'behaviour' without seeing, as well, the broader context. Decreasing prevalence—or, for that matter, plateau of the epidemic or stasis—is as much a *problem* in these terms as increasing prevalence. From a public health perspective, a fall in prevalence—such as occurred in Uganda—is a 'success' and therefore NOT a 'problem'. Seen in the perspective of sexual networks and the kinds of unique social structures that they entail, however, a decline in prevalence is equally problematic. The question that is raised has to do with a logic of social structure and its role in shaping the history (or process) of the epidemic. Since HIV is transmitted in the context of deep, explicit and intimate meanings, this approach entails grappling with the problem of meaning in the *process* of transmission that leads to new infections ('incidence'). While AIDS has generally been understood as a biological phenomenon, or as one that will cede eventually to a practical reason, the structure of the epidemic has to do primarily with meaning and culture. While many have addressed the question of meaning, this has been in the context of *response* to HIV—stigma, denial, representations in popular culture and in public discourse, declaration of one's 'status', knowledge, attitudes—rather than an exploration of the meaning of sex and the

[31] Sahlins 1981, 1983; Comaroff & Comaroff 1992

values and motives that are deployed in the social organisation of the sexual network. This problem is one of the primary concerns of this book.

But there is a fundamental theoretical difficulty with this approach, one that no amount of empirical knowledge or ethnography can amend. This difficulty has to do with the way we conceptualise sex itself, and with how we might understand the special types of networks that are built through sexual relations. This difficulty arises especially from the difficulty in trying to understand sex as 'social action' and sexual networks as social institutions. In terms of the canonical theory of 'social action', we must seek to interpret what people do ('action') in terms of the *social* meanings that motivate it. Social meanings are, however, public, shared, negotiated amongst other members of 'society'—the social groupings to which we belong as humans—and therefore properties of culture and/or society that exist at a scale that is larger than the individual. This theoretical perspective presents problems when we seek to understand sex because it is private, specifically not public or shared by groups, and apparently motivated by 'biology' (the drive to procreate), desire, pleasure. These 'motives' are, apparently, psychological or are properties of the person. Similarly, sexual networks are 'invisible' to social theory, as they usually are to their participants. They are what I call '*unimagined communities*'.

These problems must be taken seriously since they seem to lie at the root of the failure of a great deal of effort to change sexual behaviour by means of methods that are apparently very effective in changing other kinds of social behaviour. Advertising, political rhetoric, and public discourse of all kinds are evidently highly effective in changing consumption patterns in modern consumer societies as the vast wealth of the major corporations that use them shows. Coke is preferred worldwide, despite the evidence of blind taste tests that show people actually prefer the taste of other drinks such as Pepsi. Nike shoes offer no measurable physical advantage apart from status display. Apple computers are clearly better products, but Microsoft/Intel sells far more software and hardware. Political parties that are obviously corrupt and offer few, if any, services or advantages to the people who elect them maintain power through rhetoric against all odds. Despite the success of political rhetoric and advertising in these other contexts, it seems that they do not work in changing *sexual* 'consumption' behaviours.

Sexual action, as opposed to 'social action' has a number of special qualities that make it resistant to public discourse, rhetoric, advertising, and other means of public persuasion. Sex has some of the qualities of ritual or of 'ritual process',[32] that is enacted within the context of intimacy—what I call the 'space of the dual'. This unique 'space' of the sexual couple/coupling lies between the psychological space of the person and the social space of the many. Like the healing rituals that Victor Turner studied among the Ndembu people of what is now north-western Zambia, sex is not public, proceeds in stages, distinguishes the experienced from the virgins (uninitiated), and entails status and conflict. The values of sex extend well beyond the values of desire, its fulfilment in pleasure, and procreation. Indeed, entry into sexual activity is a 'life crisis' handled in many different ways by different cultures and different ages. These features have scarcely been theorised in cultural terms, primarily because the field has been monopolised by psychological, medical and biological understandings of sex. In order to intervene effectively and where necessary, we must first understand the cultural value of sex. What we seek in the case of AIDS is an understanding

[32] Turner 1969

of how the meaningful acts of sex—quintessentially private, personal, intimate, local and familial—is magnified by the presence of a new lethal virus to world historical proportions. In other words, we seek to account for the fact that intimate acts of sex, under certain conditions, have historical and structural effects that are public, political, global and demographic in their scope.

Viewed as social action, sex has properties of motive, intention, unintended consequences, and 'working misunderstandings',[33] but unlike theory of social action,[34] it is not public. In the public domain of HIV/AIDS, discussion of sex and sexuality, and rhetorics of intervention constitute a kind of *theatre of sexuality and AIDS*. Uganda has made this literal by developing a huge cultural industry around 'AIDS theatre' in churches, schools, government departments, work places, and villages (Chapter 6 & 7). The 'theatre of sexuality and AIDS' in SA has been of a much different sort, played out in courtrooms and on the street in demonstration, and in the press. While the Uganda theatre has been collaborative and part of the entire nation building project after the installation of the new government under Museveni—and after the fifteen years of post-colonial collapse from 1971 to 1986—the SA theatre has been oppositional, combative, and often secretive. In this sense, the Uganda approach seems to reflect and demand a 'social integrationist', or even 'functionalist' approach, while SA demands an approach that understand conflict as a fundamental part of the 'normal' social process, as integral to social integration, and as 'peace in the feud'.[35] Indeed, as I have argued elsewhere[36] the anthropologist Max Gluckman's theoretical perspective—one that emphasised the political *process* and conflict is essentially a South African perspective. Max Gluckman's influence on anthropology, especially political anthropology that examines process and conflict at the local level, has been profound, but he was a South African and brought a South African perspective to anthropology. It reflects the way things work, worked and continue to work in South Africa, even in the time of AIDS. Other approaches are more appropriate to elsewhere, for instance in Uganda, where the contemporary political order forbids political parties altogether.

African 'local knowledge'[37] is explored here in some depth because this knowledge gives us access to the structures of knowledge. For instance, the early development of an indigenous cultural category for AIDS in Uganda, 'slim' or *siliimu* (in Luganda and other Bantu-family languages in southern Uganda) went a long way towards making it possible for Uganda to develop an early indigenous response. In South Africa, deep cultural values of what I call 'flows of sexual substance' provide a alternative way of seeing HIV in the body for traditionalists in South Africa (especially among traditional healers, *sangoma*s, and their clients.

The central problem of this book, then, concerns the 'structure' of the social and cultural context of HIV transmission. I attempt to go beyond the issues that the sociologists of AIDS have addressed, that is, to show how it related to the macro-categories of

---

[33] Sahlins 1985.

[34] Weber 1979.

[35] Gluckman 1963; Gluckman 1965; Thornton 1994:151-152.

[36] Thornton 1994.

[37] Geertz 1983.

wealth/poverty,[38] gender,[39] region,[40] age, and race—even economy[41] and politics[42]—in order to look instead at the social structure of HIV/AIDS transmission and sexual networks in particular.

The first step involves acknowledging that sex is a *social relation*, not (simply) a 'behaviour'. This is deceptively simply, and seems obvious once stated, but for the most part sex acts have been understood as acts of individuals that take place in the context of other kinds of social relations characterised as economic, sociological, political or ethnic/racial. But to take sex as a social relation entails seeing sex as autonomously creative of other social relations and cultural categories. The sexual relation is not merely *influenced* by culture,[43] or *constrained* by political-economic factors, but is itself a fundamental building block of society as a whole and is a social relation *sui generis*. This theoretical step amounts to revaluing the sexual act for the sociological enterprise. The empirical problem lies in trying to understand how some sexual networks are pervasive and extensive (as in SA), while in other areas and countries they are more fragmented, fragile, and susceptible to interruption (as in Uganda). Clearly, HIV transmission is much more efficient in a maximal, cross-linked, pervasive and extensive network than it is in a fragmented, limited, set of smaller networks or clusters. Nevertheless, the sociological causes and co-ordinates of differing configurations of sexual networks have so far eluded researchers. This book offers some answers to the question: why and how the specific configuration of sexual networks differs, and, in particular, why there is such a vast difference between South Africa and Uganda in the patterns of HIV prevalence.

[38] Farmer 1995.

[39] Farmer, Lindenbaum & Good 1993.

[40] Asamoah-Odei, Calleja & Boerma 2004.

[41] Nattrass 2004.

[42] Parkhurst J & Lush L 2004.

[43] Vance 1999.