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Chapter 9

Deconstructing and Reconstructing Cultural Representations to Strengthen HIV/AIDS Interventions in Africa[1]

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Whatever one may think about his politics, Ugandan President Yoweri Museveni is hailed globally for leading a highly effective national response to HIV/AIDS. When Museveni became President in 1986, Uganda was ravaged by AIDS with about one in every four adults HIV-positive (Singhal and Rogers, 2003). Within a decade, with concerted political acumen, Museveni helped turned the tide on HIV/AIDS. In a meeting of African Heads of State in 2001, when Museveni was asked how he did so, he responded: "When a lion comes to the village, you don't make a small alarm. You make a very loud one. When I knew of AIDS, I said we must shout and shout" (Mutume, 2001: 21). Museveni emphasized that the 'village chief' had the responsibility to shout the loudest.

The cultural representations of HIV/AIDS (a hungry 'lion') that Museveni invoked for his fellow African Heads of State, emphasizing the role of the leader (a "village chief") to muster urgent political and social mobilization (a 'shout'), is nothing short of brilliant. In many sub-Saharan African countries, tales of heroic valor emphasize the vanquishing of mighty lions with human guile, dexterity, and bravery. By framing HIV/AIDS in highly resonant cultural, linguistic, and colloquial terms, Museveni mobilized Uganda's civil society – the schools, the churches, the mosques, and its mass media – to spread the word on AIDS. So, in Uganda's public schools, student assemblies were the place where headmasters (the educational 'Chiefs') 'shouted' about AIDS. In its mosques, *Imams* (the religious 'Chiefs') 'shouted' about AIDS during congregational prayers, home visits, and community-centered ceremonies such as marriage, birth, and burials (Singhal and Rogers, 2003).

While Museveni orchestrated Uganda's national response to HIV/AIDS, by astutely evoking highly-resonant cultural and linguistic frames, often it is the prevalent cultural representations of HIV/AIDS in societies that impede the implementation of effective HIV/AIDS programs. For instance, in many African countries, including Uganda, masculinity and sexuality go hand-in-hand. The more

1 This chapter draws upon some of the author's previous writings: Singhal (2003a; 2003b); Singhal and Rogers (2003); Singhal and Howard (2003).

girlfriends (or 'trophies') a man can boast about, the more virile he is considered (Brown, Sorrell, and Raffaelli, 2005; Campbell, 1997). Other manly pursuits such as serving in the military, getting drunk, and injecting IV drugs further exacerbates the link between masculinity and HIV/AIDS. An extreme and twisted representation of masculinity comes into play when having an STD becomes a marker of manhood.

The purpose of the present chapter is to describe and analyze cultural representations of HIV/AIDS in Africa, mainly focusing on heterosexual (man-woman) experiences. The chapter argues that the dominant biomedical approaches to HIV/AIDS have paid inadequate attention to grasping the socio-cultural representations of the disease, stymieing local, national, and global responses to preventing and controlling AIDS. Through concrete examples from Uganda, Senegal, South Africa, Zambia, and Kenya, we illustrate how cultural representations can be deconstructed and reconstructed in the fight against HIV/AIDS.

Understanding Socio-Cultural Representations of HIV/AIDS

The cultural representations of HIV/AIDS in Uganda (as the 'lion'), and Museveni's (the 'village chief's') ensuing response ('shouting') suggest that cultural, linguistic, and contextual variables can be highly important in inspiring effective HIV/AIDS programs. However, insufficient attention has been paid to understanding cultural factors in the spread of HIV infection and in its prevention and control (Airhihenbuwa, 1995; Basu, 2011; Dutta, 2008; Farmer, 1995; Singhal and Rogers, 2003).

A basic problem with HIV/AIDS prevention and control programs is that the epidemic has been over-defined as a biomedical problem. The biomedical approach looks at the body as diseased, and focuses on 'fixing' the diseased individual. Consequently, adequate attention is not given to the social and cultural factors that fuel the epidemic. This situation seems strange for a disease without a vaccine or a cure. The dominant bio-medical approaches construct HIV/AIDS as a life-threatening disease to be feared, resulting from promiscuous and deviant behaviors of the 'others'. Hence most HIV/AIDS interventions have been anti-sex, anti-pleasure, and fear-inducing (Singhal and Rogers, 2003). While 'sexuality' involves pleasure, bio-medical approaches have rarely constructed sex as play, as adventure, as fun, as fantasy, as giving, as sharing.

The social and cultural context in which HIV infection occurs is important to grasp. The wife of a migrant worker can hardly refuse sex, when her husband, who may have been infected in the city, returns home after a long absence. Nor can she insist on condom use for she may be deemed 'promiscuous'. So, HIV/AIDS prevention programs that routinely advise women to negotiate sexual behavior with a husband/partner fail to adequately grasp the connections between masculinity, sexuality, and patriarchy in a given cultural context. These structural and cultural factors need to be taken into account in designing HIV/AIDS prevention and

control programs. Devoid of such cultural considerations, HIV/AIDS programs can easily miss their mark as we illustrate in this chapter.

Certain cultural beliefs in Zambia, for instance, fuelled the epidemic. For instance, "when a married man dies in Zambia, his widow must cleanse herself of his spirit by having sexual intercourse with one of her late husband's brothers or other male relatives" (Singhal and Rogers, 2003: 210). This traditional belief about purification helped spread HIV infection. If the husband died from AIDS and his widow is HIV-positive, she may infect his brother or other male relative, who may in turn infect his wife and future children. A similar cultural belief among the Luo in Kenya led to extremely high rates of HIV/AIDS among this ethnic group.

HIV/AIDS programs that are anchored on the bio-medical approach to 'fixing' the individual's disease "suffer from some certain mistaken assumptions" (Singhal and Rogers, 2003: 211-212).

1. They assume that all individuals are capable of controlling their context. However, whether or not an individual can get an HIV test, use condoms, and be monogamous, s/he is affected by cultural, economic, social, and political factors over which the individual may exercise little control.
2. They assume that all persons are on an 'even playing field'. However, women commercial sex workers (CSWs) are usually most vulnerable to HIV/AIDS. A meta-analysis of HIV/AIDS interventions focusing on commercial sex workers noted that a majority of them simply focused on imparting education about HIV and promoted condom negotiation and use (Shahmanesh, Patel, Mabey, and Cowan, 2008). None of the interventions focused on altering the deep-seated socio-cultural structures that perpetuate inequality and vulnerability of CSWs (Basu and Dutta, 2009; Dutta, 2008).
3. They assume that all individuals make decisions of their own free will. However, whether a woman is protected from HIV is often determined by her male partner (Bujra, 2002).
4. They assume that all individuals make preventive health decisions rationally. Why would one logically put one's life in danger by engaging in unsafe behaviors? In Kenya, a popular Kiswahili saying is "*Aliyetota hajui kutota*", which means "The one who is wet does not mind getting wetter" (Singhal and Rogers, 2003: 212).

Anthropologist Richard Parker's work in Brazil demonstrates why understanding socio-cultural representations of HIV and sexuality is important (Parker, 1991; Daniel and Parker, 1993). Parker notes that the "erotic experience" is often situated in acts of "sexual transgression", understood as the deliberate undermining in private of public norms. Common Brazilian expressions such as "*Entre quarto paredes, tudo pode acontecer*" ("Within four walls, everything can happen") or "*Por de baixo do pano, tudo pode acontecer*" ("Beneath the sheets, everything can happen") signify how the erotic experience lies in the freedom of such hidden moments (Daniel and Parker, 1993 cited in Singhal and Roger:

213). This social and cultural construction of eroticism may explain why a married man, with a home life and children, visits CSWs. Within four walls, a CSW may perform a range of sexual acts that a 'proper' wife would not.

Parker's (1991) work in deconstructing "sexuality" provides social and cultural explanations for why the act of anal sex is perceived as relatively more routine in Brazil than in most Asian or African country contexts. Parker explains that anal sex is widely practiced in Brazil both between men-men and men-women, and that such sexual scripts are learned early. In the game of *troca-troca* ("exchange-exchange"), adolescent boys take turns inserting their penises in each other's anus (Daniel and Parker, 1993). Sexual encounters between adolescent boys and girls routinely involve anal intercourse to avoid pregnancy.

HIV/AIDS interventions rarely take into account such contextually-bound cultural and social constructions of sexuality. Understanding such social and cultural constructions of masculinity, sexuality, and vulnerability in a society, is a crucial ingredient in launching more effective HIV/AIDS prevention and control programs (Jana et al., 2004).

Toward Culture and Context-Centered Approaches

Many culture-centered scholars and practitioners have called for moving away from individual-centered biomedical approaches to preventing and controlling HIV/AIDS to more multi-level, cultural, and contextual interventions (McMichael, 1995; McKinlay and Marceau, 1999; 2000). Others have called for viewing culture not just as a hindrance or barrier but also for its strengths (Airhihenbuwa, 1995; 2007; Parker, 1991). Culture-centered scholars have called for exposing, deconstructing, and reconstructing the coupling of culture and barriers in HIV/AIDS interventions, so that new, positive cultural linkages can be forged (Airhihenbuwa and Obregon, 2000). For instance, smoking cessation programs among Latinos identified the cultural strength of the value of *familismo* ("family ties"), harnessing it to reduce smoking (Airhihenbuwa, 1995; 1999; Diaz, 1997). Similarly, close family ties are valued in Indian society, where the definition of the family includes neighbors and colleagues. Understanding and harnessing these strong family bonds can lead to more effective HIV/AIDS prevention, care, and support interventions (Mane and Maitra, 1992).

Senegal is one country that has done a noteworthy job of strengthening its national response to HIV/AIDS by strategically tapping into several socio-cultural and spiritual aspects of Senegalese society. For instance, the cultural norms in Senegal value the universality of marriage and the rapid remarriage of widow(er)s and divorced persons. These practices uphold the sanctity of both marriage and partner fidelity. Senegalese culture also morally condemns all forms of sexual cohabitation not sanctioned by religious beliefs, curbing irresponsible sexuality (Lom, 2001). The fear of dishonoring one's family provides a strong motivation for acting responsibly (Diop, 2000). Such cultural "entry points" for HIV/AIDS

interventions exist in every other society or country; however, few programs have strategically explored or actively pursued this cultural path.

HIV/AIDS intervention programs can fare better if scientific explanations of the disease are couched in local, cultural contexts of understanding (Harris, 1991). Such context-based explanations are called syncretic explanations (Barnett and Blaikie, 1992). A diarrhea prevention campaign in northern Nigeria illustrates the importance of providing syncretic explanations. When missionaries in Nigeria were alarmed by the number of infant deaths due to diarrhea, they tried to teach mothers about water-boiling. The mothers were told that their children died because of little animals in the water, and that these animals could be killed by boiling the water. Talk of invisible animals in water was met with scepticism. Babies kept on dying. Finally, a visiting anthropologist suggested a solution. There were, he said, "evil spirits in the water; boil the water and you could see them going away, bubbling out to escape the heat" (Okri, 1991: 134-135). This message had the desired effect, and infant mortality due to diarrhea dropped sharply.

So, how can HIV/AIDS intervention programs more strategically harness peoples' local, context-centered cultural understandings? We illustrate with some examples from the African context: The cultural attributes of the Nguni people in Southern Africa, for instance, reveal points of entry for implementing HIV/AIDS interventions (Airhihenbuwa, 1995). Among the Nguni, responsibility for providing sex education to the young is usually delegated to an aunt or an uncle, at the onset of a youth's puberty. Cultural emphasis is placed on sexual abstinence. Further, "a strong taboo exists against bringing one's family name to disrepute. Members of an extended family take turns in caring for the sick, to avoid burdening one person. No orphans exist, as extended family members take care of children without parents" (Singhal and Rogers: 219).

Among the Zulus of Southern Africa, the practice of *ukusoma* (or non-penetrative sex) is commonly practiced, both to preserve virginity and to prevent pregnancy (Airhihenbuwa and Obregon, 2000). The woman keeps her thighs closely together, while the man finds sexual release. Other groups use a bent elbow for a similar purpose. Similar non-penetrative sex practices exist among certain groups in Ethiopia (commonly referred to as "brushing") and the Kikuyu in Kenya.

The Ngunis, Zulus, and Kikuyu cultures in Africa are not unique when it comes to non-penetrative safe sex practices. A range of "outercourse" (in contrast to "intercourse") practices manifest themselves in all countries and cultural contexts: From kissing, to fondling, to masturbation, to rubbing and stroking. Compared to penetrative sex, these outercourse practices significantly reduce the risk of pregnancy and sexually-transmitted diseases. While no substitute for sexual abstinence, non-penetrative sexual practices do expand the range of behavioral options to prevent and control HIV/AIDS.

Deep cultural understandings can lead to the identification of alternatives to existing harmful practices. Consider the case of HIV entering Nyanza Province, the heartland of the Luo people in Western Kenya, in the mid-1980s, where it spread rapidly. Like many other East African cultures, the Luo practise widow

inheritance. When a husband dies, one of his brothers or cousins marries the widow. This tradition guarantees that the children remain in the late husband's family, and that the widow and her children are provided for. Sexual intercourse with the late husband's relative cements the bond between the widow and her new family (Blair et al., 1997). However, this cultural practice led to disastrous consequences in an era of AIDS.

Focus group discussions in Nyanza showed that the widow-cleansing practice is important for the Luo to "avoid *chira*, a curse that befalls a person who does not perform traditional rites" (Singhal and Rogers, 2003: 221). However, focus group discussions with community elders also suggested possibilities for replacing the rite of "intercourse" with alternative rites, such as the male relative placing his leg on the widow's thigh, or hanging his coat in her home (Blair et al., 1997). Elders noted that such alternative rites were quite acceptable, as the Luo used to practice them decades ago. Such culture-specific understandings are critical in designing effective HIV/AIDS interventions.

Cultural insights from Nyanza Province suggest that HIV/AIDS program managers should go beyond the identification of harmful cultural practices (such as 'wife-cleansing') in order to implement culturally-acceptable alternative rites. PATH (Program for Alternative Technology in Health) and WGEB (Women's Global Education Project) have worked with local NGOs in Kenya, such as Ntanira Na Mugambo Tharaka Women's Welfare Project, to create an alternative ceremony for young girls in Kenya called 'Circumcision with Words'. In this alternative rite of passage, young girls (12 to 17 years) are "secluded" (as is common with the traditional ceremony) for one week. During this time they undergo empowerment training with their mothers and other female leaders. After one week, "community members gather to celebrate the girls' passage into adulthood. The girls perform uplifting songs and dances, and local leaders, especially women, give speeches. And, instead of genital cutting, a cake is cut to celebrate the girls entering womanhood" (www.womensglobal.org). Several thousand Kenyan girls participate in these ceremonies, thus avoiding the risk of HIV infection during cutting ceremonies.

In Yoweri Museveni's Uganda (referenced at the beginning of the chapter), *Imams* (Muslim religious leaders) incorporate accurate information about HIV/AIDS in Islamic teachings, promoting messages of mutual fidelity and moral responsibility in congregational prayers. When participating in sacred family birth and death rituals, they advise community members about the risks of contracting HIV through male circumcision (when an unsterilized razor may be used for several infants), and in the ablution of the dead (when body orifices may be cleaned without wearing protective gloves).

In Uganda and in Kenya, several HIV/AIDS interventions have replaced the biomedical metaphor of safe sex as "negotiation" with the metaphor of safe-sex as "play" (Adelman, 1992). Negotiating safe sex is a sterile, rational, and non-emotional strategy, devoid of sensuality and sexuality (Metts and Fitzpatrick, 1992). It denotes "time out," an abrupt pausing of a sexual script. Instead, playful

approaches focus on "healthy passions" i.e. teaching people how to have "good sex" that is "safe sex", as opposed to prevention messages promoting sexual abstinence (Singhal and Rogers, 2003).

Consistent with the sentiment of "healthy passions", Bolton (1995) asked whether HIV prevention programs with gay communities can recruit attractive gay men to educate their partner about the joys of safer sex. Bolton's question is relevant at many levels. First, it extends the discussion of cultural representations beyond heterosexual relationships to also include same sex relationships. Second, Bolton is asking if, contrary to present-day biomedical approaches, is it possible to liberate sexuality (as opposed to denying or repressing it), increase the sum of sexual gratification (as opposed to reducing it), and adopt healthy sexualities (as opposed to continuing with unhealthy ones)?

Conclusions

At a UNAIDS meeting in Geneva (in which the present author participated), a representative from Kenya talked about how young schoolgirls in Kenya rendered sexual favors to urban middle-class and affluent men, commonly known as 'Sugar Daddies', in exchange for the 3Cs: cash, cell phones, and cars. Sugar Daddies seduce by asking young girls: "Can I buy you chicken and chips?" or "Can I give you a lift in my car?" Such seductive offers put these schoolgirls at risk of contracting HIV. Ethnographic research with schoolgirls in Kenya showed that they were well aware of the high risks of their liaison with Sugar Daddies, but they were willing to take their chances (Singhal and Rogers, 2003). Why say no to such glamorous offers, when the alternative is to struggle through school and college, find a job, get married, and then to attend to one's husband, domestic chores, and raising children.

In Kenya as elsewhere, strong cultural undercurrents about masculine sexuality – beliefs in virility associated with bedding young girls, and power and prestige associated with such symbols of modernity as cash, cell phones, and cars – complicate the design of HIV interventions directed at young girls and Sugar Daddies. Messages directed at individuals such as "Stay away from Sugar Daddies" or "Stay away from schoolgirls" miss their point (Singhal and Rogers, 2003: 214) for they mistakenly believe that individuals make preventive health decisions rationally, irrespective of power and prestige considerations.

While an understanding of cultural factors is highly important in effectively responding to the AIDS epidemic, insufficient attention has been paid to them. Because they are focused on biomedical concerns, most HIV/AIDS intervention programs rarely take into account how sexuality is socially and culturally constructed in a society. Invariably, expert-driven knowledge trumps localized, culture-specific potentialities, and as long as the epidemic is represented as a biomedical problem, cultural factors will be shortchanged.

Behavioral interventions will continue to be the mainstay of HIV prevention programs, and for them to succeed, interventions must ultimately respond to the nuances of cultural representations, particularity, and detail (Parker, 1991). They must be based on an understanding of sexual experience as rooted in cultural meanings and social systems (Parker, 1989). Otherwise, HIV/AIDS intervention programs for the most part will be flying blind and be culturally rudderless.

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