AIDS and cultural practices in Africa: the case of the Tonga (Zambia)

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Abstract

The fight against AIDS in Africa is often presented as a fight against “cultural barriers” that are seen as promoting the spread of the HIV virus. This attitude is based on a long history of Western prejudices about sexuality in Africa, which focus on its exotic aspects only (polygamy, adultery, wife-exchange, circumcision, dry sex, levirate, sexual pollution, sexual cleansing, various beliefs and taboos, etc.). The article argues that those cultural aspects are a wrong target of AIDS prevention programs because they are not incompatible with a safer behavior, and because their eradication would not ensure the protection of people. To fight against them might alienate the people whose cooperation is necessary if one wants to prevent the spread of AIDS. The major problems of AIDS prevention in Africa are not specifically African, but are similar to the problems existing in Europe or America. Therefore, anti-AIDS projects should not fight against one local African culture in order to impose another (Western), but should rather try to make behavior and practices safer in a way that is culturally acceptable to people.

Keywords: Africa; AIDS; Culture; Sexuality; Tonga

1. Introduction

Five years ago, while doing research in relation to an anti-AIDS campaign among the Tonga of Zambia, the researchers were interviewed about their work by a Danish journalist. Several weeks later, his article was published in a major Danish newspaper with the title: “The fight against AIDS is a fight against culture” (Vinding, 1993). This came as a shock to me, not only because the journalist had transformed what we had said to make it fit what he (and readers) expected the situation to be in Africa regarding AIDS and sexuality, but also because, as an anthropologist, I was supposed to study cultures without judging them, and was certainly not supposed to fight against them. Yet, after reading the scientific literature on AIDS in Africa, which includes articles written by anthropologists, it appears that placing the blame for the spread of AIDS on “African cultural practices” is part of a widespread discourse. This idea is commonly expressed, both in newspapers (for example Damkjær, 1998; Muurholm, 1999), and in some scientific articles. This article sets out to question this assumption.

The arguments used in this paper are based on 10 months of intensive fieldwork among the Tonga of Zambia. The village we stayed in for the greater duration of our research is inhabited by 700–800 people, and situated a 5-hour walk from the main paved road leading to the town of Choma. Our research aimed to examine the relative impact of training Community Health Workers (CHW) and a drama group in AIDS prevention in rural areas (no work was carried out in an urban context). We lived mainly in one Tonga village that was part of the CHW program and which was visited twice by the drama group. We also lived for

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AIDS and the study of “African sexuality”

During the 19th and the early part of the 20th century, studies of African sexuality written by missionaries or ‘armchair anthropologists’ espoused an ethnocentric and evolutionist point of view. These studies tended to describe all local customs as primitive and immoral, and were based on a morbid curiosity for exoticism. It was a time when physical anthropologists could take erotic pictures under the cover of scientific study. Books such as “History of Human Marriages” (Westermarck, 1921) or “Neger Eros” (Bryk, 1964) are representative of the above-mentioned interests and prejudices of the time on the exotic sexuality of the “lower races”. They are compilations of anecdotes, rumors and de-contextualized data gathered mainly from travellers, missionaries or colonial administrators, and they focus on polygamy, sexuality outside marriage (adultery, sharing of sexual partners, pre-marital sexuality — including masturbation and sexual intercourse), inheritance of widows and levirate, sexual mutilations (penis circumcision, clitoridectomy, vaginal infibulation), practices such as the elongation of the vaginal labia or dry sex, etc. These practices were ethnocentrically described either as irrational (lacking any cultural or social explanation) or as immoral. African men were described as sexually wild and insatiable. The authors, moreover, focused on various beliefs, such as those linked to sexual taboos, witchcraft and its effect on impotency or infertility, the use of love magic, the role of ancestors and spirits in the conception of children, etc. These taboos and beliefs were described as irrational, and little effort was made to understand the broader socio-cultural context in which they were embedded.

In general, African sexuality was studied only in as far as it was different from our own. It has been from the beginning, described as wild, animal-like, exotic, irrational and immoral. One should remember that the colonization of continental Africa began seriously only at the end of the 19th century, during the Victorian period, and that colonization was legitimized by “the white man’s burden” — the European’s moral obligation to bring their “higher civilization” to others. Africans were presented as the exact opposite of idealized Europeans, also in their sexuality, in order to give an ideological legitimization to the colonization.

Studies focusing on African sexuality became rare after the 1950s. Any research on sexuality was strongly influenced by feminist or family planning studies. These focused on gender and on the negotiation of sex-roles rather than on sexual practices. For decades, Africanist anthropologists avoided the subject of sexuality, to the extent that when AIDS was identified and brought about a renewed interest in African sexuality, recent data on the sexual behavior of the local populations was lacking.

AIDS made it legitimate again to study sexuality in Africa. As lives were at stake, anthropological research on sexuality could no longer be accused of being motivated by exoticism or an interest in “ethnopedomanography”. And yet, many of the same cultural prejudices resurfaced.

First came the theory that the virus originated from green apes, with the implication that it could have been transmitted to man through sexual relations between man and ape, or through some “exotic” cultural practice (blood drinking in love-magic, injection of monkey...
blood into human pubic parts, etc.) (Schoepf, 1991; Hunt, 1996; Harrison-Chirimuuta & Chirimuuta, 1997). There was, therefore, a renewed interest in all exotic rituals and sexual practices which were again described as “irrational” and “wild” or “animal-like”. This, as well as some racial deterministic theories (Hunt, 1996, p. 1285), and the association between AIDS and homosexuality or drug consumption in the West, induced a strong reaction from many African governments, who denied the seriousness of AIDS in their countries (Fassin, 1999, p. 51). Previous years during which prevention measures could have been implemented were wasted, mainly due to Western prejudices, reminiscent of a shameful colonial past.

Second, anthropologists were asked to explain why the prevalence of HIV in Africa was so high, and why the sex-ratio of the victims was almost 1:1 (while in Europe the victims were mostly male). Anthropologists then searched the existing literature or were sent to the field looking for ritual sexual practices involving exchange or mixing of blood (Packard & Epstein, 1991, p. 774). When asked to identify which aspects of African culture and sexuality were to be held responsible for the different profile of the epidemics, anthropologists complied without properly reflecting upon the prejudices on which these demands were based. The state of “anthropological emergency”, and the desire to save lives lowered the level of ethical, theoretical and methodological self-control of the researchers (Fassin, 1999, p. 49). Many failed to reflect upon what was being asked of them and reinforced the dominant clichés. The following were all used to explain the widespread nature of AIDS: polygamy (if one person is infected, he or she infects all the legal partners within the nuclear family), the unchecked practice of adultery, premarital sex, wife-sharing (ensuring that the virus spreads across different families and age groups), inheriting a widow (if a man dies of AIDS, and if his widow is purified sexually and inherited by his brother, the widow will infect him and his other wives), circumcision and scarification rituals practised on a large scale with the same knife, dry sex (seen as responsible for vaginal lesions that lower natural defenses, or make the use of condoms less safe), beliefs in witchcraft (seen as an obstacle to a good understanding of the nature of a virus, and therefore as an obstacle to the change of behavior based on informed and “rational” choices), etc. (Hrdy, 1987; Caldwell, Caldwell & Quiggin, 1989; Deniaud et al., 1991; Brown, Ayowa & Brown, 1993; Macdonald, 1996; Bawa Yamba, 1997, pp. 219, 220; Gresenguet et al., 1997).

Like the first studies of African sexuality, it was once again the “exotic, traditional, irrational and immoral practices” that were the focus of the research. If the pattern of AIDS epidemics was different in Africa than in Europe, the explanation obviously had to be the difference between African and European culture and sexualities. Some used the “Human Relation Files Area” in order to find significant relations, or to try to establish an ethnic cartography of the risk of infection according to the sexual and ritual practices (Fassin, 1999, p. 52). Early researchers were looking for things to blame, and identified African cultural practices as culprits. The logical consequence of this was to fight against African cultures and sexualities. Since then, many anthropologists have reacted against this viewpoint by stressing the important role of socioeconomic conditions, as well as the danger of infection within the modern medical system itself (Schoepf, 1991; Parker, 1995; Hunt, 1996; Farmer, 1996). Yet, the idea that African culture is to blame for the spread of AIDS is still widespread.

The double discourse on prevention

It is important to note that when the fight against AIDS is presented as a fight against “cultural barriers”, this is always in an African context and seldom involves European or Western practices. For example, on one side, some statistical studies argue that women using sexual drying agents have a higher seroprevalence than other women, and that the higher the number of sexual partners, the higher the risk of infection (see for example Gresenguet, 1997; Quigley et al., 1997). The implied solution is then to fight against dry sex and polygamy in order to fight against AIDS. On the other side, studies that show that people who live in towns, or people who have been hospitalized and who have received blood transfusions or injections in recent years are also more at risk than others (see for example Packard & Epstein, 1991, pp. 777, 778), never result in the suggestion that we should discourage people from living in towns, going to hospital, or prevent them from receiving blood transfusions or injections. There is a double discourse: when a correlation is found between HIV and the use of modern facilities, the facilities have to be improved and made safer; but when some correlation between HIV and an African cultural practice is found, it is to be eradicated.

The philosophy of the campaigns conducted in Europe is totally different from that of interventions in Africa. Although prevention campaigns in the West focused initially on homosexuals and drug addicts and were tainted by a moralistic discourse, they soon began to address the broader population and to promote safe sex and the use of condoms. Today, in the West, AIDS prevention campaigns do not suggest that homosexuals or drug-addicts (both groups being associated with a higher risk of seropositivity) have to stop being homosexuals or drug-addicts; rather, they advise them to make their practices safer — to use condoms and
clean needles. One understands well that homosexuals cannot just decide to become heterosexuals, or drug addict to stop using drugs. One understands that these practices are embedded in a complex cultural, social, economic and biophysical context, linked to the very identity of individuals. Yet, the same understanding is lacking in Africa; the cultural practices which are seen as barriers to AIDS prevention are completely decontextualized and their importance for people's identities is overlooked. AIDS prevention campaigns tell people that they should be monogamous, stop inheriting widows, stop practising dry sex, witchcraft, etc., without reflecting upon both the ethics and the feasibility of such changes. In the West, one respects different cultural and sexual behaviors and one tries to make them safer without fighting against them; in Africa, one adopts the opposite attitude and one tries to eradicate what are identified as "cultural barriers" to AIDS prevention.

Interestingly, the discourse of most rural Tonga is exactly the opposite of our own. For them, the spread of AIDS is seen as a result of Western practices; people go to town, visit prostitutes and no longer follow traditions and the old moral code (partly because of modern education). AIDS is associated with prostitution and with Western and urban life (Mogensen, 1995; Gausset & Mogensen, 1996; Gausset, 1998). The Tonga living in rural areas say that we should promote and restore African traditions and culture in order to fight against AIDS. The discourse is the exact opposite of the Western one that implies that we should fight against those very traditions. Both discourses have in common that they blame "the other" for being responsible for the spread of AIDS; in this respect, there is not much difference between "scientific" and "lay" thinking. As Hélène Joffe (1997) showed, the "facts" which one displays to explain the origin and the spread of a new fatal disease are imbedded in a broader psychosocial context, and often stigmatize "the other" as an identity-protective process against the new threat (see also Fay, 1999).

Both discourses make sense. On the one hand, some cultural practices may hasten the spread of AIDS. On the other side, disruptions of traditions associated with urban and Western life (prostitution, the breakdown of social and moral control) might also be seen as increasing the speed with which the epidemic spreads. Yet, to think that restoring cultural traditions or, on the contrary, fighting traditions, will solve the problem of AIDS is equally naive. Both discourses focus on wrong targets. Whether people live an idealized "traditional Tonga" way of life or, on the contrary, behave and think like Europeans, AIDS will still be there and continue to spread unless people practice safe sex and safe blood contacts. Traditional or Western behavior and ways of thinking are not what prevents the spread of AIDS. Safe sex and safe practices achieve this aim. To present AIDS prevention in terms of culturally defined "risk groups" may divert attention from these most fundamental problems. Firstly, it may transform the fight against AIDS into a fight between cultures, one culture trying to impose its own conditions on the others (what is at stake then becomes cultural practices instead of AIDS). Secondly, it is likely to have the counterproductive effects of first, creating an imagined immunity for those who are not members of the perceived "risk group", and second, alienating the members of the risk group who could refuse to be stigmatized on the ground of their behavior and practices.

Cultural and other barriers to AIDS prevention among the Tonga

In the following pages, I will argue that the cultural barriers to AIDS prevention are not really important compared to other more fundamental problems which are similar to those found in Europe and America. Polygamy, sexual cleansing, dry sex, circumcision and beliefs in witchcraft are not incompatible with safe sexual behavior, and their disappearance would not mean that people would adopt a safe behavior. They might play a role in the speed with which the infection spreads, but their disappearance would not be following by the eradication of the epidemic. Let me develop the argument by discussing, one by one, each cultural or sexual practice which can be thought to be responsible for the spread of AIDS among the Tonga.

Polygamy might be responsible for accelerating the spread of infection. If one partner is infected within a polygamous family, the number of persons at risk becomes higher than in a monogamous family. But polygamy in itself is not what spreads the HIV, and the absence of polygamy would only slow the epidemic down, not stop it. A polygamous family in which all partners practice safe sex in their extramarital affairs, is no more at risk than a monogamous family which has the same practices. What is important is not monogamy or polygamy, but fidelity or the practice of safe sex in extra-marital relationships. And the negotiation of safe sex (to which we will come back later) is as problematic for monogamous partners as it is for polygamous partners. To fight against polygamy will not make people behave more responsibly and practice safer sex. Moreover, polygamy is deeply ingrained in a great number of African cultures, and part of a complex set of social and economic relations, which makes it unlikely that one could eradicate this practice in the near future.

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This is not to say that the construction of risk groups has been unproblematic; see for example (Crawford, 1994; Clatts, 1995; Schiller & Schiller, 1994).
Sexual cleansing and the inheritance of widows are often mentioned when talking about the cultural barriers to AIDS prevention. If a man dies of AIDS, his wives are likely to be infected, and to infect others if they are sexually cleansed or are inherited by a brother of the deceased. Yet, this practice is part of a deeper set of socioeconomic conditions which entail that a woman often needs the support of a man to raise her children and have access to land. Even in a matrilineal society such as the Tonga, where women can rely on the support of their matrilineage to get land and pay for the education of their children, widows are still expected to remarry within their former husband’s matrilineage. It is therefore a practice that is deeply embedded in a complex layer of social and economic aspects, and is unlikely to disappear soon. This said, levirate and sexual cleansing are only problematic if they are systematically practised without condoms or testing the blood of the widow (and of the brother of the deceased) before the man inherits her. Yet, my own experience from Zambia shows that people are usually aware of the problem. When they suspect that a man has died of AIDS, people either cleanse the widows with herbal remedies instead of a sexual cleansing, or test the blood of the widow before cleansing her sexually. In the case of the alternative cleansing, culture has shown to be flexible enough to adapt to the new threat. But this new cleansing is shameful for the widow, as it brings into question her health and rights to a traditional cleansing. Blood tests are beset by logistical problems: the clinic is often far away; travel costs are expensive; one runs the risk that the test is not available that day; one has to come back after two weeks to get the result, etc. Another serious problem is the shame and stigma that the widow experiences while her blood is being tested and her health questioned, especially since the brother of the deceased is often reluctant to have his own blood tested. The reluctance of people to have their blood tested is linked to the stress that they experience when they have been tested and are waiting to hear the result, as well as the stigma associated with seropositivity. Few people want to be told that they are infected or want the community to know about it (see also Deschaux, 1996). In short, when analyzing the risk of infection linked to levirate or sexual cleansing, the problem does not come from the cultural practice, which has been adapted to the new situation, but it is rather due to the poor infrastructure of the country, the poor economic conditions of the population, the psychological stress linked to the test procedure, and the social stigma associated with the victims.

Scarifications and collective healing rituals might spread the virus if the same knife or razor blade is used collectively. Yet they are not problematic as long as each person is cut with a different razor blade, or as long as the cutting instrument is disinfected before being used on a new person. In Zambia, razor blades are available everywhere, and everybody can afford them. And among the Tonga, most people are aware of the problem and usually bring their own razor blade when they visit a traditional healer.3

Beliefs if witchcraft might appear as an obstacle to a good understanding of how the virus spreads, which is necessary if people are to change their behavior. However, Evans-Pritchard (1937) showed clearly that those beliefs, instead of being incompatible with natural causes, are rather complementary. The Zande (as well as any other group believing in witchcraft) know very well that diseases or accidents have natural causes or work according to natural processes, but this does not explain why only some people are affected, at a specific moment, etc. Natural causes explain how somebody can experience misfortune, while witchcraft explains why. In the context of AIDS, explanations in terms of virus can explain how somebody got the virus by sleeping with a prostitute, but witchcraft will explain why only he is infected, and not his friend who was exposed to the same woman (Bawa Yamba, 1997, p. 202). Western doctors would explain this in terms of chance and statistics; African villagers might resort to witchcraft or another system of belief. In short, belief in witchcraft helps people to make sense of misfortune and does not prevent them from making their behavior safer; it is not by fighting against belief in witchcraft that we will stop the spread of AIDS. Similarly, beliefs about purity and boundary-crossing are not incompatible with a biomedical explanation of HIV infection; they are complementary, as they are used to explain the origin of the virus rather than its actual working. Both Western science and local people try to find an explanation for the origin of the virus. The Tonga explanation that AIDS comes from a traditional disease — previously acquired through sleeping with an impure woman — is neither more irrational nor more exotic than our stories based on green apes and lost tribes (Gausset & Mogensen, 1996; Mogensen, 1995, 1997).

The practice of dry sex may cause vaginal lesions during intercourse, which may in turn facilitate infection by the HIV virus (Brown, Ayowa & Brown, 1993; Gresenguet, 1997). This practice is partly based on the idea that women are not supposed to be sexually excited before meeting their partner. Moreover, if a woman has a moist vagina before intercourse, this could be interpreted as the sign that she has just had sexual intercourse with another man; it is therefore associated with “loose” behavior. Far from being irrational, this practice is thus morally grounded. In our village, dry sex was especially practised by women who had given birth, and who wanted to have a “normal” and tighter vagina.

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3The Tonga do not engage in male or female circumcision.
again. Yet, in our discussions with both men and women after the drama group's performance, it appeared that this practice was not very widespread, and was not considered very important, neither for the men nor for the women. Its importance has been overemphasized. Other studies show that, in Zaire or Malawi, only a minority of women use drying agents or that the most commonly used drying agent is warm water (Brown, Ayowa & Brown, 1993; McNamara, 1997). To practise "dry sex" involves, in many cases, nothing more than practising minimal personal hygiene before having intercourse. In the discussions that followed the performance of the drama groups, the men asked many questions about the compatibility of dry sex and the use of condoms. Some men had experienced condoms breaking during intercourse, and wondered if it was due to the practice of dry sex. When we said that it was a possibility, the men discussed the topic and claimed a willingness either not to practice dry sex while using condoms, or to prolong foreplay before having intercourse. As in the case of sexual cleansing, traditional practices proved to be flexible. Far from being static, culture is dynamic and capable of adapting to new conditions.

It is often said that Africans are unwilling to use condoms because of different prejudices and beliefs. Among the Tonga too, people claim that it is better for a foetus if its mother has regular sexual intercourse, because the semen gives strength to the baby. They also think that a woman can only reach orgasm when she receives the man's semen in her womb. The Tonga also associate different unpleasant metaphors with the use of condoms ("it is like eating a sweet with the paper on", etc.). They have also heard rumors that condoms remaining in the vagina make women sterile, or that using condoms makes the men sterile. This is probably the sad result of decades of maladapted and unpopular family planning policy (Schoepf, 1995, p. 34). Yet, I doubt that this explains why people do not use condoms. Even if these rumours are told jokingly among the Tonga (most often by people who never tried condoms etc.), this does not prevent people from using condoms. In the Choma district, for example, the survey conducted our research, the socio-economic aspects of sexual relationships are of much less importance than they might be elsewhere. Women are more independent from men; they are still part of a lineage and have the right to get land and support from their matrilineage when they need it — in case of divorce or loss of support from their husband, for example.

Each sex nourished a lot of prejudices about the other's sexual needs, and men and women accused each other of refusing to use condoms. It is as if everybody wanted to use them but feared to propose it to the partner because they believed that they would refuse. In this case, it is rather the lack of communication between the two sexes that is the barrier to condom use; this problem was addressed during the second play performed by the drama group.

The lack of confidentiality in access to condoms is another serious problem. The CHW is usually a male member of the village, and it is difficult for a married woman to ask him for condoms. This is even more true of young teenagers, as it is difficult to talk about sexual matters with somebody of another generation, and as they are not supposed to have sex before marriage. Anonymity is a real problem, both in Africa and in the West. In Western countries, we have solved it by putting machines in public toilets; in African villages, this is not possible and we have to find other solutions. The quality of condoms might also be a problem, and studies are needed on the tastes of local people relating to lubrication, size, wrapping, etc. (Civic & Wilson, 1996).

Another major problem is that condom use is associated with casual sex, and therefore with a lack of trust or with suspicion between the two partners. When somebody proposes to use condoms, it is often taken as a sign that he or she does not trust the partner, or suspects that the partner is unfaithful or infected. The partner (whether male or female) will then feel obliged to refuse condoms in order to prove his or her integrity, faithfulness and righteous behavior. People want to appear as serious, responsible, faithful, and they want to be trusted. To propose using condoms is interpreted as a sign of mistrust, and this is most unwelcome when negotiating a sexual relationship (Schoepf, 1995, p. 34). This problem is not specific to Africa: it is significant in Europe and the US (Lear, 1995; Fay, 1999, p. 296). Unfortunately, the association of condoms with casual sex is often reinforced by anti-AIDS campaigns. When one advises people either to be faithful or to use condoms, condoms become associated with unfaithfulness. Not to use condoms is seen as a proof that one is

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4 The price was not a problem among the people that we studied because condoms were distributed in the villages free of charge. CHW each received, every two months, a kit of primary care medicines, which included 144 condoms. If the stock ran out, condoms were still available, free of charge, at the nearest primary health center.

5 In a matrilineal rural society such as the one in which we conducted our research, the socio-economic aspects of sexual relationships are of much less importance than they might be elsewhere. Women are more independent from men; they are still part of a lineage and have the right to get land and support from their matrilineage when they need it — in case of divorce or loss of support from their husband, for example.
faithful and that one trusts that one’s partner is faithful as well (Taverne, 1999, pp. 520–521). One possible way of avoiding this could be to insist as much on the contraceptive as on the protective aspect of condoms during the interventions. In this way, the use of condoms would not only be associated with sex outside marriage, but equally within marriages, for child spacing, for example. One last problem is the fact that women are not supposed to take the initiative in the negotiation of sexual relationship, and are therefore not supposed to ask their partner to use condoms (see also Schoepf, 1995, p. 31; Obbo, 1995; Heise & Elias, 1995; McNamara, 1997, pp. 125, 129). Yet, despite the dominance of men in the negotiation of sexual relationships, it is also difficult for them to propose using condoms, as the suggestion is often refused by women who feel offended because they interpret it as a sign of mistrust. At least five of our Tonga male informants (4 teenagers and one adult) had even tried to hide the fact that they were using condoms with their girlfriend. When they met with their lover, they excused themselves just before the act, went out, put a condom on, and came back to make love. This worked for sometime, until one of the girls discovered what had happened and had reacted against the attempt to deceive her by refusing to use condoms. The notion of deception added to women’s dislike of condoms, although what was really at stake was, again, a question of trust, faith, responsibility and communication. Despite the male dominance in the negotiation of intercourse, it is naive to think that they can decide to use condoms without asking their female partner, just as it is naive to think that to empower women is sufficient to enable them to negotiate safer sex. It takes two to have a relationship and, in Africa as elsewhere, communication is crucial when it comes to the negotiation about the use of condoms and the removal of the stigma attached to it (Campbell, 1995; Cohen & Reid, 1999, p. 378).

Confidentiality, the association of condoms with mistrust and infidelity and the lack of communication between the sexes are much bigger problems than the “cultural barriers” presented earlier. These problems are not specifically “African” since they are basically the same as those found in Europe and in America (Lear, 1995; Ingham & Kirkland, 1997; Fay, 1999, p. 296).

The impact of drama groups

An interesting and promising way of addressing these problems is through the use of a drama group. One of the objectives of our research program was to estimate the possible impact of CHW training and the use of a drama group to disseminate information about HIV, sexual behavior and condom use. The research was conducted in the Choma district, which for the purpose of the project, was divided into three zones. In the first, no specific campaign — other than the official state campaigns — was organized; this zone was used as a control for comparing the effect of the specific campaigns in the two other areas. In the second zone, CHW were trained to provide AIDS education to the population. In the third zone, CHW were trained as well, but in addition, a drama group toured the area twice to show plays relating to AIDS education.

The results of the survey (conducted by Henrik Trykker, Project Director7) revealed that the area in which CHW only were trained showed a limited behavioral change, and by contrast, better knowledge of AIDS and condom use were associated with exposure to the drama group (Trykker, 1999, p. 96). The survey also showed that prior to the drama group’s tour from village to village, women had a better knowledge of AIDS but men were more ready to change their behavior. The better knowledge of the women might be due to the fact that AIDS education is usually provided at rural health clinics, i.e. primarily to women (ibid., p. 90). The greater readiness of men to change their behavior might be explained by the fact that cultural and social barriers are less important for them; freedom of action for men is more important than it is for women, who are not expected to take the initiative in the negotiation of a sexual relationship (ibid., p. 72).

After the drama group toured the village, the survey showed that the men’s level of knowledge had improved more than that of the women, but that there was a higher connection between females and behavior change, which can be partly explained by the fact that the drama group’s use of role models succeeded in breaking down the usual barriers among females (ibid., p. 90).

Here, it is important to be aware of the content differences between the two plays. The first one was about a man who used to drink and visit prostitutes, did not listen to the warnings of his friends about AIDS and other STDs, and got AIDS as a result. Basic information about AIDS, condom use, counselling and care of AIDS patients was given during the play. The play introduced some discussion regarding the similarities and differences between AIDS and Kahungo, a disease which is acquired when a man has sex with a woman who has miscarried and has not yet been purified, and which was

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6 Among the Tonga, there is a long post-partum taboo that forbids parents to have a second child while the first is still breast-feeding.

7 The complete survey, with a full description and discussion of methods, has been published in Trykker (1999). My aim is not to discuss all the findings, but only those which are applicable here and those which can be complemented by findings coming from the qualitative anthropological research.
The questions and concerns of people were taken into consideration during the creation of the second play, in which one of the characters was a young female (in the first play, all the characters were male), who refused to have sex unless her lover used a condom. There then followed a discussion on the agency of women, and on the prejudices that each sex has relating to the other. The setting of the second play was more rural (contrary to the first play), and therefore closer to the preoccupations of people. All the villagers could feel involved, contrary to the first play that singled out drunkards and urbanites visiting prostitutes as the risk group for AIDS. The play was again followed by a group discussion and condom distribution.

The survey reported a significant increase in the use of condoms in the area which had been toured by the drama group: 15.3% of informants declared using condoms “more or less regularly” (compared to 10.8% before the intervention), and 17.5% declared that they had tried them at least once (compared to 12.9% before the intervention) (Trykker, 1999, pp. 67, 85). This change did not happen in the two other areas, where normal state intervention or the training of CHW had taken place. Information gathered through qualitative methods showed that several of our key informants did change their behavior, discuss the topic of condoms with their lovers, and begin to use them on a regular basis. We have the impression that this change of behavior was easier for teenagers than for adults. The major problem was the reluctance of some long-term adult partners, who did not want to begin to use condoms since they had not done so for so many years. In one case, a woman proposed using condoms to her long-term lover, but he refused. This was followed by an argument and the relationship ended. In another case, following the performance of the drama group, a man proposed to his lover — a divorced woman — to use condoms but she was reluctant because she hoped to become the second wife of this man and therefore wanted to become pregnant. Such responses reveal the limits of condoms as a means of prevention. They work only when partners want to avoid children, which is usually the case with an extramarital affair (it is considered shameful and irresponsible to have children from an adulterous relationship) or in the case of schoolgirls who do not want to be expelled out of school because of pregnancy.

Two explanations can be given for the success of the drama group. Firstly, it can be argued that the drama group provided information which was better adapted culturally, or acceptable to, its audience. The plays’ use of vernacular speech, a popular and more interactive form of education (theater play, discussions at the end), role models and settings with which people could identify. Secondly, and more importantly, the simple fact that both men and women, older and younger people saw the same play and discussed the topic afterwards made it possible for people to reach a new consensus on the acceptance and use of condoms, thus opening the way for a change in the rules of social behavior and in the negotiation of sexual relationships (to propose condoms became seen as a responsible attitude, for women and young people alike). I believe that the greatest impact of the drama group was the fact that it brought the whole village together, made people discuss their common problems, prejudices, fears and helped them to reach a consensus about the solutions. Such occasions do not happen by themselves; they have to be created.

Conclusions

The focus on exotic aspects of African cultural and sexual practices has a long and shameful history, the latest episode of which has just been explored in research aimed at preventing AIDS. What are usually presented as “cultural barriers” to AIDS prevention (rituals of purification, rites of passages, polygamy, systems of beliefs, dry sex, etc.) are the wrong targets for AIDS education. In the context of AIDS prevention, the problem is not polygamy or dry sex as such but rather infidelity or unsafe sex which may transmit the virus from one sexual network to another. Beliefs in witchcraft or in the association of AIDS with diseases caused by sexual impurity are not incompatible with a biological or medical explanation of the epidemic. Such beliefs allow people to give meaning to a frightening and strange new disease, and to reappropriate it through understandable terms. Therefore, we should not fight against systems of beliefs and narratives which do not fit into the Western biomedical discourse, but rather adapt our discourse so that it can be understood in local terms. Fighting against levirate or sexual cleansing might be a waste of resources, as widows can be expected to remarry or resume sexual relations anyway, whether within or outside their husband’s family. What is important is to make these new sexual relations safe, either through the use of condoms or through blood testing of the partners. The main problems with blood testing are linked to denial, stress, confidentiality and access. Those regarding condoms are linked to confidentiality, association with lack of trust and faithfulness, and the lack of communication between the partners. These problems are not specifically African and are present in Europe as well as in the US, for
instance. Therefore, the so-called “cultural barriers” to AIDS prevention should not be the main target of AIDS prevention programs.

Anthropologists studying AIDS have relied on culture-relative theories too much and too little. Too little, because they have studied cultural practices in a decontextualized and ethnocentric way, and because they have encouraged a fight against these practices. Too much, in that they have come to believe that everything (including the spread of AIDS) can be explained by cultural differences. They have overlooked the universality of the major problems linked to AIDS prevention. Today, one of the challenges faced by anthropologists is to stop being exclusively cultural relativistic and to study sexuality in its universal aspects. To limit one’s own study to a specific ethnic group (the Tonga, for example) is already to imply that the problem of AIDS among this population is different from the same problem among the neighboring group, as if different risks were attached to different ethnic identities because of their different cultures. In other words, it is dangerous to limit one’s study to a single ethnic group because it may imply that cultural practices are to be blamed for the spread of AIDS. We should stop looking only for what is “exotic”. What is common across cultures is more important to AIDS prevention than what is different, even if it is still important to adapt our message to the local cultures with which we engage in a dialogue. Anthropologists are not supposed to be social engineers, remodelling or fighting against the culture of the people they study, but rather they should engage in a constructive dialogue, in which they learn how to adapt the discourse of prevention to the local realities (Preston-Whyte, 1995, p. 318; Mogensen, 1995, 1997). They can, for example, play an important role in the creation of theater plays, which address the problems of relevance to the local population. The performance of drama groups has the advantage that it allows the message to reach most villagers in a culturally acceptable manner and allows them to discuss collectively the topics that they judge important in order to reach a consensus about what should be done.

One might disagree with levirate, polygamy, dry sex, as well as clitoridectomy or infibulation practices. One might also disapprove of homosexuality or drug addition. Yet, it is unethical to use AIDS prevention as an excuse to fight against those practices, which are only indirectly responsible for the transmission of the virus. In Western countries, the official campaigns choose not to blame homosexuals or drug addicts for their behavior, but rather to make their practices safer by encouraging the use of condoms or clean needles. So should the AIDS prevention campaigns in Africa try to make cultural practices safer, rather than to eradicate them. This attitude should be adopted not only for ethical reasons, but also on the grounds that blaming cultural practices for the spread of AIDS might create an imagined immunity for those who are not concerned with such practices. It could also alienate the local populations whose cooperation is crucial if we are to prevent the further spread of AIDS.

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