Part One

Introduction

The HIV/AIDS Epidemic in Sub-Saharan Africa
in a Historical Perspective
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Towards a Social History of HIV/AIDS in Sub-Saharan Africa

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The aim of this volume is to initiate a dialogue between historians and experts in other disciplines such as economics, sociology, epidemiology and the science of development on the history of AIDS in sub-Saharan Africa[1]. The articles published here retrace, in overviews of the situation or in case studies, the spacio-temporal origin of the epidemic. Many of them make use of oral history techniques.

Particular attention has been paid to issues of chronology and periodisation. The intention is to approach AIDS in sub-Saharan Africa as an historical fact. The epidemic is not a recent as supposed, but, in many aspects, it is an unrecognized event. The question of the recentness of AIDS lies at the heart of the historical problem which this book aims at developing.

Another challenge is to view AIDS as a multidimensional event rather than as a purely biomedical one. The epidemic has unfolded in a socio-economic, political and cultural context which explains and situates it at the same time. The articles published in this volume reconstruct, sometimes in great detail, the framework of events and the perceptions and beliefs concerning the epidemic. Reference is made to the epidemiological history of AIDS but greater emphasis is placed on its social and cultural history.

The fifteen contributors come from sub-Saharan Africa, Europe and North America. Half wrote in French, the other half in English. A third are professional historians. The remainder, from disciplines such as anthropology, sociology, economy, epidemiology, medicine or development sciences, are not historians but have agreed to review the subjects of study with which they are familiar from an historical point of view. Eleven of these authors participated in the conference "The HIV-AIDS epidemic in sub-Saharan African in a historical perspective" held in Louvain-la-Neuve in Belgium, from the 11 to 13 March 2004. The remainder contacted the editors in the months following the conference.

This book covers the four large regions of sub-Saharan Africa: West Africa, Central Africa, East Africa and Southern Africa. Coverage by country is, on the other hand, somewhat unequal. It was not possible to include works on Portuguese speaking Africa or on that done in the Horn of Africa. On the other hand, greater proportional weighting is given to South Africa. In absolute figures, this country has the highest number of HIV positive people in the world. Thanks to its universities, its centres of research and its medical infrastructures it is also the African country which, for the past ten years, has generated the most work on AIDS, often in collaboration with European or North American partners.

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[1] The countries of North Africa where the level of those who are seropositive is comparable to that in France have been excluded from the field of study. For an idea of the AIDS epidemic in North Africa, see Jeanne-Marie Amat-Roze, *L'infection à VIH/sida en Afrique subsaharienne, propos géographiques,* Hérodote, 111 (4e trimester 2003), 121-125.

The past in the present

In 1989, the medical historian Mirko Grmek asked the question, in a pioneering work, whether AIDS, whose clinical symptoms had been described eight years earlier, was a new disease. Yes, he answered, for it was the first time in history that a disease without specific symptoms and with no trace of organic lesions, certainly at first sight, had made its appearance. The speed with which it spread was also without precedent. On the other hand, he added, AIDS was not new for it had been present, even if people were not aware of the fact, in humankind for several generations.[2]

Significantly, *L'Histoire du sida* devoted very little space to Africa[3]. It was only with reference to the origin of AIDS, hotly discussed at the time, that the African continent was mentioned. At the end of the 1980s, epidemiologists certainly acknowledged the existence of a second type of epidemic, which had its origin in central Africa and whose form of transmission was mainly heterosexual. But for Grmek as for the majority of AIDS historians of the time, what was important was to understand an epidemic threatening the very foundations of their own society, that is to say European and North American societies. The notion that AIDS was an even greater threat to developing countries had apparently not crossed their minds. Likewise, the collective work by Elizabeth Fee and Daniel Fox entitled *AIDS: The Burden of History*[4], the article by the historian Charles Rosenberg in the journal *Daedalus* the following year on "AIDS in historical perspective"[5] and the articles collected and published by Virginia Berridge and Philip Strong in Cambridge in 1993 under the title *AIDS and contemporary history*[6] all allocate a small part to Africa. At the turn of the decade, studies such as that of Marc Dawson on the comparative history of syphilis and AIDS in East Africa[7] or that of Randall Packard and Paul Epstein on the evolution of interpretative models for AIDS in Africa[8] remain relatively exceptional.

Fifteen years later the importance of historical reflection on AIDS in Africa has become more evident. The first, most obvious, reason is the lightning speed with which the epidemic has spread throughout the world in general and Africa in particular. Some forty-five million people are HIV-positive, as I write these lines, 70% of whom are in sub-Saharan Africa, a region in which, I must emphasize, a mere 10% of the world's population resides. Since the beginning of this century, AIDS in Africa has become a global challenge, a fact which is borne out by the vast sums of money which have been invested by international organizations and pharmaceutical. The awareness of the existence of an AIDS epidemic in sub-Saharan Africa goes back to 1983. Without mentioning the proto-history of AIDS which began

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[2] Mirko D. Grmek, *Histoire du Sida. Début et origine d'une pandémie actuelle* (Paris, Payot, 3rd ed. 1995), 18. In the postscript of the third edition of his book, Grmek suggests that diseases such as AIDS which exist in the population before they are conceptualized as nosological entities be called "emergent" rather than "new".

[3] This is true also of the second and third editions which were reviewed and updated. The remark can also be applied to *l'Histoire de la recherche sur le sida* by Bernard Seytre (Collection "Que sais-je" N° 3024, Paris, PUF, 1995).

[4] Elizabeth Fee and Daniel Fox (eds) *AIDS: the Burden of History* (Berkeley, University of California Press, 1988).

[5] Charles E. Rosenberg, "What is an Epidemic? AIDS in Historical Perspective" in "Living with AIDS", special issue, *Daedalus*, 118 (1989), 1-17, reprinted in C E Rosenberg, *Explaining Epidemics and other Studies in the History of Medicine* (Cambridge, Cambridge University Press, 1993), 278-292.

[6] Virginia Berridge and Philip Strong eds, *AIDS and contemporary history*, (Cambridge History of Medicine). Cambridge, Cambridge University Press, 1993.

[7] Marc A. Dawson "AIDS in Africa: Historical roots", in Norman Miller and Richard C Rockwell, *AIDS in Africa. The Social and Policy Impact* (Lewiston/Queenston, Edwin Mellen Press, 1988), 57-69.

[8] Randall M. Packard and Paul Epstein, "Epidemiologists, Social Scientists and the Structure of Social Research on AIDS in Africa", *Social Science and Medicine*, 33/7 (1991), 771-794; "Medical research on AIDS in Africa: A historical perspective", in Elizabeth Fee and Daniel M. Fox (eds) *AIDS. The Making of a Chronic Disease* (Berkeley, University of California Press, 1992), 346-376.

towards the end of the 1950s, if not earlier, the epidemic has been in existence for more than twenty years in Africa and its history needs to be documented and studied. In 1989, Mirko Grmek stunned his readers by daring to write the history of an epidemic which had just been declared[9]. Today, the historical dimension of the phenomenon is indisputable even though the political, economic and social stakes involved in a history of the epidemic are far from being agreed upon by the various groups involved in the fight against AIDS.

At the end of the 1980s and the beginning of the 1990s "a new consensus" (Charles Rosenberg) emerged amongst researchers on the necessity of combining biomedical and social points of view in the study of AIDS[10]. Once the mechanisms for the transmission of infectious agents are identified, the forms of social organization and the cultural practices which favour their diffusion need to be understood. It would be useless to try and ignore the social dimension of epidemics whether they be old diseases such as syphilis or tuberculosis or new ones such as AIDS, Ebola or SARS. International conferences on AIDS, which have taken place at regular intervals since 1985, demonstrate the growing importance of human sciences in the study of AIDS, a topic that virologists and medical doctors tended to monopolize during the early stages of the epidemic. During the past decade there has been a growth in anthropological, sociological, geographical, economical and political science studies on AIDS in Africa, as has been shown, along with others, by the collective conference proceedings from Sali Portudal (Senegal) "AIDS and social sciences in Africa" in 1996[11] and the volume published following the conference at Champaign-Urbana (United States) on "HIV and AIDS in Africa: beyond epidemiology" in 1999.[12]

Nevertheless, it is true, as Ezekiel Kalipeni and his colleagues have remarked,[13] that the biomedical paradigm continues to dominate research into AIDS. Since the end of the 1980s, authors such as Jean-Pierre Dozon, Didier Fassin, Gill Seidel and Laurent Vidal have gone through ordinary epidemiological discourse with a fine tooth comb.[14] Under the pen of doctors, epidemiologists and sometimes even experts in the human sciences, the so-called sexual promiscuity of Africans – to which I shall return – has been presented as the main cause for the spread of AIDS in Africa, as if HIV spreads in direct proportion to the number of sexual partners of its carriers. The majority of prevention programmes are based on models which judge the spread of HIV to be the result of at risk behaviour and the refusal on the part of the individuals in question to adopt supposedly rational sexual behaviour. Certainly there are many doctors and epidemiologists who take the epidemic's social context into account

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[9] Grmek, *Histoire du sida*, Preface to the second edition, 3rd ed., 1995, p. 7.

[10] Charles E. Rosenberg *Explaining Epidemics and other Studies in the History of Medicine* (Cambridge, Cambridge University Press, 1992) p. 260, quoted in Alan Jeeves, Histories of Reproductive Health and the Control of Sexually Transmitted Disease in Southern Africa: a Century of Controversy – Introduction", *South African Historical Journal*, 45 (November 2001), p. 2.

[11] Charles Becker, Jean-Pierre Dozon, Christine Obo and Moriba Touré, *Vivre et penser le sida en Afrique. Experiencing and understanding AIDS in Africa,* Dakar, Codesria – Paris, Karthala – Paris, IRD, 1999. AIDS in Africa is mentioned several times in the proceedings following the conference organized by the anthropology laboratory of the University of Aix-Marseille III in 1994: Jean Benoist and Alice Desclaux, *Anthropologie et sida. Bilan et perspectives* (Paris, Karthala, 1996).

[12] Ezekiel Kalipeni, Susan Craddock, Joseph R. Oppong and Jayati Gosh, *HIV & AIDS in Africa: Beyond Epidemiology* (Oxford, Blackwell Publishing, 2004).

[13] *Ibid*., 4.

[14] Didier Fassin and Jean-Pierre Dozon, "Les États africains à l'épreuve du Sida", *Politique africaine,* 32 (December 1988, 79-85 ; Jean-Pierre Dozon et Didier Fassin, "Raison épidémiologique et raisons d'État. Les enjeux socio-politiques du Sida en Afrique », *Sciences Sociales et Santé*, 7/1 (1989), 21-36 ; Gill Seidel, "The discourses of HIV/AIDS in sub-Saharan Africa : discourses of rights/empowerment vs the discourses of control/exclusion", *Social Science and Medicine*, 26/3 (1993), 175-194 ; Jean-Pierre Dozon, "Des appropriations sociales et culturelles du Sida à sa nécessaire appropriation politique ; quelques éléments de synthèse", in Becker et al., *Vivre et penser le sida en Afrique*, 679-688 ; Laurent Vidal, "Anthropologie d'une distance : le sida, de réalités multiples en discours uniformes", *Autrepart*, 12 (1999), 19-36.

and, as a result, adopt a more flexible view towards sexual practices and social change. But it is not their work nor that of their human science colleagues which head the list of priorities of organizations which fund research. It should be noted that research into AIDS is overwhelmingly western. The voice of African researchers who denounce the ethnocentrism of specialist discourse battles to make itself heard.[15]

It is in this situation that the importance of inaugurating a history of AIDS is measured. In effect, AIDS lies within the scope of a social, political and cultural history which precede and include it. In this context, Didier Fassin denounces a "decontextualized" reading of AIDS which limits itself to a description of the sexual practices of the potential carriers of the virus or to the identification of the cultural phenomena which favour the spread of the infection[16]. The social practices which prevention and treatment policies consider are not static. They bear the weight of history. AIDS develops in a territory which, for generations, has been marked by gender questions, political relations, class conflicts and racial tensions which determine or, at the very least, explain the particular paths which the epidemic follows. As Helen Schneider has suggested, in order to get into the epidemic's mind one must read "the past in the present"[17]. This remark is applied to South Africa but it can be used for the whole of the African continent. How, for example, can the high level of sexual violence in Southern Africa, an important factor in the transmission of HIV, be explained without taking into account the history of migrant labour which, under colonial rule and later under apartheid, broke up traditional family life and drove men, humiliated by their loss of social and economic power, to exert their domination over women's bodies? In this context, Didier Fassin speaks of the "social condition" of AIDS. He distinguishes three aspects of this reality with reference to South Africa: socio-economic inequality, violence and migration.[18]

Another new perspective is offered by the history of epidemics and of sexually transmitted diseases, a topic to which Mirko Grmek returns in the third edition of his work which appeared in 1995. "One can never say often enough", he writes, "to what extent AIDS is different from all the other previously known illnesses and this as much by reason of its pathogenic mechanisms and certain epidemiological characteristics as by its medical conceptualization". As is the case in the first edition of his book, Grmek speaks as a doctor but nevertheless, he does not neglect the social and cultural aspects of the disease. "The historian still has his say concerning psychological reactions and the effectiveness of social measures", he adds. "Historical studies teach us, for example, that collective actions against scourges can only have lasting results if there is simultaneous recourse to medical intervention and social measures.[19]"The comparison with other epidemics which have struck humankind, writes Gilles Bibeau, shows that "the prejudices and the research of the scapegoats reappear as soon as silence is no longer possible, as soon as the balance between individual and collective rights is threatened, as soon as human reactions to the threat of infection show what appears to be a limited repertoire.[20]"The 1999 work of Philip Setel and

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[15] See for instance Collins Airhihenbuwa, *Health and culture: Beyond the western paradigm (*Thousand Oaks, CA, Sage Publications, 1995); "Of Culture and Multiverse: Renouncing the 'Universal Truth'" *Health. Journal of Health Education*, 30 (1999), 267-273.

[16] Didier Fassin, "Crise épidémiologique et crise sociale", in D. Fassin (ed), *Afflictions. L'Afrique du Sud de l'apartheid du sida* (Paris, Karthala, 2004), 11.

[17] Helen Schneider, "Le passé dans le présent. Épidémiologie de l'inégalité face au sida et politiques de justice sociale", in Fassin (ed), *Afflictions*, 75-110. This expression is also to be found in the writing of Hansjörg Dilger, « Sexuality, AIDS, and the Lures of Modernity : Reflexivity and Morality among Young People in Rural Tanzania", *Medical Anthropology*, 22 (2003), 32.

[18] Didier Fassin, "L'incorporation de l'inégalité. Condition sociale et expérience historique dans le post-apartheid », in Fassin (ed), *Afflictions*, 30-37.

[19] Grmek, *Histoire du sida,* 3e edition*,* 1995, 353-354.

[20] Gilles Bibeau and Ruth Murbach, "Déconstruire l'univers du sida", *Anthropologie et Sociétés*, 15/2-3 (1991), 8.

his colleagues which was devoted to the history of sexually transmitted diseases and to AIDS in nine sub-Saharan African countries[21] continues along the same lines. "For the most part, the novelty of AIDS is illusionary", writes Setel. "Its roots go as far back as the processes of cultural change which the colonial experience deeply carved over a long time.[22]" Along the same lines are the studies of Howard Phillips, an expert on the history of Spanish flu[23] and Shula Marks, another South African historian,[24] which were presented at the conference "AIDS in Context" in Johannesburg in April 2001. Both disclose important continuities between the colonial and contemporary eras in the development of the social management of epidemics. It is therefore necessary to clarify Grmek reply concerning the novelty of AIDS. From the standpoint of the vulnerability of populations to the disease and social responses to the epidemics, AIDS is nothing new. But, adds Phillips, despite this, it consists of several distinctive traits: its slow development (due to the long incubation period of the virus) and, as a result, its greater diffusion, the globalization of the fight against the disease and, finally, in South Africa but probably elsewhere as well, the effect of the rights of humankind on the response to the disease.[25] The articles by Myron Echenberg and Benedict Carton which are contained in this volume continue this discussion of the specificity of AIDS in the history of epidemics. The study by Elizabeth Colson, an anthropologist who has spent fifty years observing and describing the way of life of inhabitants of the Gwembe Valley in Zambia, also makes an important contribution to the history of AIDS by demonstrating how traditional modes of solidarity and resistance in this region were maintained when the new epidemic appeared.

Interdisciplinary work

The aim of this book is to encourage, by means of a resolutely interdisciplinary and multinational approach, the thought that AIDS is an historical fact in sub-Saharan Africa. North African countries, where levels of HIV prevalence comparable to those in Europe are seen[26], have been excluded from the field of study. The fifteen contributors come from sub-Saharan Africa, Europe and North America. A third are professional historians. The remainder, from disciplines such as anthropology, sociology, economy, epidemiology, medicine or development sciences, are not historians but have agreed to review the subjects of study with which they are familiar from an historical point of view. Eleven of these authors participated in the conference "The HIV-AIDS epidemic in sub-Saharan African in a historical perspective" held in Louvain-la-Neuve in Belgium, from the 11 to 13 March 2004. The remainder contacted the editors in the months following the conference.

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[21] Philip W Setel, Milton Lewis, Maryinez Lyons, *Histories of Sexually Transmitted Diseases and HIV/AIDS in sub-Saharan Africa* (Westport, Connecticut - London, Greenwood Press, 1999). The work deals with the following countries: South Africa, Ivory Coast, Ghana, Malawi, Uganda, Senegal, Tanzania, Zambia, Zimbabwe.

[22] Ibid., 6.

[23] Howard Phillips, "AIDS in the context of South Africa's Epidemic History: Preliminary Historical Thoughts", *South African Historical Journal* 45, (November 2001), 11-26.

[24] Shula Marks, "An epidemic Waiting to Happen? The Spread of HIV/AIDS in South Africa in Social and Historical Perspective", *African Studies*, 61/1 (2002), 13-26.

[25] Phillips, "AIDS in the context of South Africa's Epidemic History", 21.

[26] For a first glance of the AIDS epidemic in North Africa see Jeanne-Marie Amat-Roze "L'infection de VIH/sida en Afrique sub-saharienne, propos géographiques", *Hérodote*, III (4e trimester 2003), 121-125.

South Africa. In absolute figures, this country has the highest number of HIV positive people in the world. Thanks to its universities, its centres of research and its medical infrastructures it is also the African country which, for the past ten years, has generated the most work on AIDS, often in collaboration with European or North American partners.

The works mentioned above, particularly that of Philip Setel and his colleagues, of the historians who participated in the conference "AIDS in context" in Johannesburg and of the Franco-South African working group coordinated by Didier Fassin, are decided forerunners in the field of research into the history of AIDS in sub-Saharan Africa. The articles which have been included in this book make frequent reference to them. But many questions relating to the origin and the spatiotemporal development of the epidemic remain without answers. We hope that, because of its comparative and interdisciplinary nature, this book will throw new light on these subjects.

An African epidemic

Why is it that the African continent is marked, and so extensively, by AIDS? This burning question must be asked. It is true that the global epidemiological situation is undergoing changes. The distance which separates Asia from Africa will perhaps narrow in future decades. Meanwhile, the problem remains. Why is it that, by a cruel stroke of irony, the African continent which is already in a disadvantaged position, sees its chances of development compromised even more by an epidemic which is decimating its active forces and puts its fragile medical and social infrastructures under unbearable strains? A similar question can be asked concerning South Africa: having barely escaped apartheid, this young democracy now finds itself confronting another evil, even more insidious, as if it didn't need all its strength to overcome the three centuries of colonization and discrimination[27].

In their contribution to this volume, Alex de Waal and Alan Whiteside do not hesitate to state that the AIDS epidemic, when compared to others which have struck humanity in past centuries, is an historic event without precedent. Historians, amongst whom we include Myron Echenberg and Benedict Carton, arrive at conclusions which are less clear cut. If one concentrates on the infectious agent's modes of transmissions and on medical, political and cultural responses an impression of continuity prevails. De Waal and Whiteside rely on statistical evidence: life expectancy, mortality, number of orphans. According to them the demographic impact of AIDS exceeds that of other epidemics, less from the number of deaths at any given moment – from this aspect, the Great Plague or the Spanish flu epidemic are comparable to AIDS when it comes to the percentage of the population affected – than in terms of the death rate in a given age group. In years to come, the effect of the disease on the most affected populations will be debilitating. In the seven countries where the average rate of HIV prevalence in adults who are sexually active exceeds 20%, the projections for the 2010-2015 period are terrifying: number of deaths multiplied by three, life expectancy reduced to the age of thirty, level of infant mortality almost doubled. All these countries, namely South Africa, Botswana, Lesotho, Namibia, Zimbabwe, Zambia and Kenya are in Africa. According to de Waal and Whiteside, more extensive use of anti-retroviral treatments will alleviate certain sufferings, but will not alter the course of the epidemic.

The question of the origins of AIDS, although independent of the seriousness of the epidemic in Africa, is ideologically and politically linked to it. In her contribution to the present volume, Anne Buvé states that the hypothesis most commonly accepted by virologists is that of a zoonosis, where a simian immunodeficient virus would have been transmitted from non-human primates to humans, thereby becoming one of the now famous sub-types of

[27] See Fassin, "Crise épidémiologique et drame social" in Fassin (ed), *Afflictions*, 9-11.

HIV. The crossing of the barrier between species probably occurred in Central Africa. The circumstances in which this "jump" occurred[28] are purely conjectural[29] but have nevertheless given rise to the most fanciful hypotheses. The phylogenetic analysis of the different variants of the virus leads one to believe that their common ancestor goes back no later than the 1930s. Thanks to test carried out at a later date on blood samples which had been conserved, it is known that at least one male patient was HIV positive in Leopoldville, present day Kinshasa, in 1959.[30]

In his study on the reactions to the epidemic in Congo, published in this collection, César Nkuku Khonde reveals the extent to which the idea of an African origin for AIDS was (and still is) inadmissible to that country's inhabitants, be they literate or not. As Deborah Posel has shown, the vehement refusal of the South African President, Thabo Mbeki, to believe that an African virus could kill so many of the continent's citizens is made against a background dominated by racist theories concerning the African sexual body which has been common currency since the beginning of colonization.[31] These passions and emotions are as much an historical subject as the theme which has inspired them. No discourse, even though there may be consensus amongst the experts in a discipline, is neutral. Referring to an article in the prestigious American review *Social Science and Medicine*, Gilles Bibeau has shown that some academic research has perpetuated clichés and stereotypes and has "invented" an Africa which exists only in the fantasy world of Western experts.[32] One of the aims of this book is to historicise the academic discourse on AIDS whether one is dealing with the African origin of AIDS or with the discovery, described by Guillaume Lachenal, of atypical serologies in Cameroon.

Periodisation of AIDS

In order to be able to think of AIDS historically, one must resort to periodisation. This exercise, it is well known, is as artificial and arbitrary as it is indispensable[33]. Several contributors to this volume have suggested a periodisation. Given the important regional variations, to which I shall return, the most difficult task is to establish a periodisation for the history of AIDS that holds good for the entire African continent. This is what Michel Caraël has tried to do basing his attempt on his experience as a researcher in Rwanda then as a senior member of the WHO Global Programme on AIDS and the United Nations Joint Programme for the Fight against AIDS (UNAIDS).

The periodisation thus proposed refers to the responses by national and international authorities to the AIDS epidemic. Caraël defines three periods: the first which he calls denial

[28] R. Chirimuuta and R. Chirimuuta, *AIDS, Africa and Racism* (London, Free Association Books/Trenton, New Jersey, Africa World Press, 1989); Gilles Bibeau, "L'Afrique, terre imaginaire du sida. La subversion du discours scientifique par le jeu des fantasmes", *Anthropologies et Sociétés*, 15/2-3 (1991), 129.

[29] See Kevin M. de Cock, "Epidemiology and the emergence of human immunodeficiency virus and acquired immune deficiency syndrome", *Philosophical Transactions of the Royal Society of London*, Series B, 356 (2001), 795-798; Kalipeni et al., *HIV and AIDS in Africa. Beyond Epidemiology,* 14.

[30] T. Zhu et al., "An African HIV-1 sequence from 1959 and implications for the origin of the epidemic",*Nature,* 391, (1998), 594-97. See also, in this volume, the contribution of Michel Caraël.

[31] Deborah Posel, "Politiques de la vie et politisation de la sexualité. Lectures de la controverse sur le sida », in Fassin (ed) *Afflictions*, 47-74, On the same theme see Philippe Denis, "La croisade du président Mbeki contre l'orthodoxie du sida", *Esprit*, 271 (January 2001), 81-97.

[32] Bibeau, "L'Afrique, terre imaginaire du sida" 126. The Canadian anthropologist refers to J. P. Rushton and A. G. Bogaert, « Population differences and Susceptibility to AIDS: an Evolutionary Analysis", *Social Science and Medicine*, 28/12 (1989), 1211-1220. According to these authors, Africans are genetically and socially programmed to be less sexually inhibited than others, thus making them more susceptible to becoming victims of sexually transmissible diseases.

[33] See Catherine Coquery-Vidrovitch, "De la périodisation en histoire africaine", *Afrique et histoire 2* (2004), 31-65.

(1984-1988), the second characterized by a belated and vertical global response (1989-1994) and the third, still in operation (1995-) marked by a broadened reaction at international level. This last period is distinguished by a massive injection of funding from the Global Fund for the fight against AIDS and by the American agency Pepfar as well as by patient access to anti-retroviral treatment which is certainly slow and administered erratically.

This periodisation recalls that suggested by Charles Rosenberg in the article mentioned above.[34] As a social phenomenon, says this medical historian, an epidemic unfolds like a play. AIDS – which he studies in the United States but his remarks can be applied to Africa – is not an exception. The gradual acceptance of the epidemic, whose existence was originally denied by the principal social players, constitutes the theme of the first act. The second act highlights the inconsistent and disorganised efforts of the authorities to conquer the disease. Act three sees the galvanisation of collective action which is better informed and more effective. The fourth and last act – here the analogy with the history of AIDS is no longer pertinent – shows the slow withdrawal of the epidemic. The survivors count their dead and reflect on ways of avoiding a similar catastrophe in the future.

Linked to the way in which the different social agents have attempted to respond to the challenge of the epidemic is the way in which they have interpreted and situated it. This is the aim of a story of the history of AIDS which has yet to be written and for which we provide a few facts in the first part of this introduction. Here, too, it is a matter of periodisation.

Another type of periodisation, apparently more "objective" (if one does not take into account the problems caused by methods used for collecting of data) is that based on figures for HIV prevalence.

In 1989 Grmek could still write that "the United States remains the part of the world most infected [by AIDS]"[35]. The Atlanta CDC reported 86,000 cases at that time, compared to 23,000 cases reported by the WHO in Africa at the same date. For the entire world, the WHO reported 145,000 cases.[36] In fifteen years the situation has considerably changed, as much from the point of view of monitoring methods, henceforth routine in many African countries, as from that of the figures themselves. The most accurate data and the most easily comparable are the levels of HIV prevalence obtained from samples taken from pregnant women at surveillance sites. These are the most commonly used figures even if, it must be mentioned, some analysts dispute their value mainly because of the differences shown in data collected during surveys in homes.[37] Let us recall that in the eyes of UNAIDS and WHO a country or a region is in a state of generalised epidemic when the level of HIV prevalence amongst pregnant women is more than one per cent.

As far as I know, the only author who has suggested a periodisation of AIDS based on official figures for HIV prevalence[38] is Jeanne-Marie Amat-Roze, a French geographer who, in 2002, devoted a thesis to the geography of the HIV/AIDS infection.[39] At the end of the 1980s, she explains, the epidemic was firmly entrenched in the "pioneer" territories of the epidemic (Ivory Coast, Central African Republic, Rwanda, Burundi, Uganda, Tanzania, Zambia, Zimbabwe). Beyond these territories, the virus was more unobtrusive amongst the

[34] Rosenberg, "What is an epidemic?" (see footnote 4).
[35] Grmek, *Histoire du sida*, 316. This remark obviously changes in the third edition of his book (1995) when Africa is presented as "the continent which is the most affected [by AIDS]" (373).
[36] *Ibid*.
[37] See Fassin, "Crise épidémiologique et drame social", in Fassin (ed), *Afflictions*. 12.
[38] Those provided by the WHO and UNAIDS in their annual reports.
[39] Jeanne-Marie Amat-Roze, *Géographie de l'Infection du VIH/sida, emergence, conquête et enracinement,* mémoire d'habilitation à diriger des recherches, University Paris IV, 2 vols, November 2002. For a summary of the section pertaining to Africa, see Jeanne-Marie Amat-Roze, "L'Infection du VIH/sida en Afrique subsaharienne, propos géographiques", *Hérodote* 111 (4e trimestre 2003), 117-154.

general population. The decade of the 1990s saw Southern Africa set on fire. Whilst the number of new cases seemed to reach a ceiling in several regions of Central, East and West Africa, it exploded in the south where unequalled levels were reached. The figures for HIV prevalence continued to mount in Zambia, Zimbabwe and Malawi as if these countries, after having followed the movement of the first decade, were henceforth moved by that of the second.[40]

In the study which he presents in this volume on the training of health workers in the Eastern Cape in South Africa, Stephen van Houten suggests a third type of periodisation, restricted to a more limited territory and based on the experience of those engaged in the fight against AIDS. This more "subjective" form of periodisation corrects and complements the preceding forms.

In South Africa, as has just been mentioned, the epidemic arrived a decade later than in Central and Eastern Africa, and even later in the Eastern Cape, with KwaZulu-Natal and neighbouring provinces having been the first to show high levels of HIV prevalence. It is not surprising, therefore, that van Houten chose the year 1990 as *terminus a quo*. The first period, which he dates from 1990-1994, is characterised by a poor knowledge of AIDS on the part of the health workers, slight involvement on the part of governmental and professional bodies in the fight against AIDS and priority given by the NGO sector to awareness campaigns. The second period, the so-called growth of the epidemic period, which stretched from 1995 to 1998, is marked by higher HIV positive figures and hence a greater demand by HIV positive people on associations fighting against AIDS. The third period, that of generalised epidemic, is characterised by a general acceptance by the health workers in training centres, of the gravity of the problem and by the feeling, in the NGO world, of being overtaken by needs.

Such periodisations can be multiplied. Each context calls for its own special one. In her contribution on the Tonga in the Gwembe Valley, Elizabeth Colson shows how AIDS could initially be ignored because of its resemblance to other chronic, already existing, diseases. When – towards 1990 – it became clear that its transmission was of a sexual nature, those affected and their families adopted a position of denial so as to avoid stigmatisation. A new stage began in the last years of the 20th century when the massive growth in the number of AIDS related deaths made denial useless. The advent of retrovirals, to which only the wealthiest have access, in its turn, signalled a new period marked, as noted by Colson, by new moral dilemmas.

The history of AIDS in Africa demands a fine chronology which is based not only on official levels of HIV prevalence but also on the experience of those involved whilst account must be taken of local and regional differences. No less necessary are thematic chronologies. Each category of person involved experiences AIDS according to his/her own periodisation. This book calls to mind the time of the doctor (Kocheleff), that of health workers (Bayer and Oppenheimer), of virologists (Lachenal) and of ethics committees (Becker). Similar studies could be undertaken involving political decision makers, ministers of religion, traditional healers, businessmen and women or teachers.

Explaining regional variations

Another unresolved question is that of regional variations. Here, too, a combination of biomedical, anthropological and historical approaches allows one to understand better the dynamics of the epidemic.

As the diachronic study of maps charting HIV prevalence illustrates, the spread of AIDS in sub-Saharan Africa is heterogeneous. Three facts clearly appear. The first is the "lateness"

[40] *Ibid.*, 125-127.

of Southern Africa or, more precisely, the southern most part of Southern Africa (South Africa, Lesotho, Swaziland, Botswana, Namibia). During the 1990s these countries were relatively unscathed. In South Africa where the first two cases of HIV/AIDS were diagnosed in 1982, the level of HIV prevalence in adults was estimated at 0,73% in 1990, the date of the establishment of monitoring sites in the country. In 1995 it had climbed to 10,44% and today is above 20%.[41] Originally restricted to white homosexual milieus, the epidemic subsequently affected the entire population with the highest levels being observed in Africans of average socio-economic status living in urban and peri-urban areas.[42]

The second remarkable fact is the heterogeneousness of the epidemiological situation in sub-Saharan Africa. Generally speaking, West Africa is the sub region which is the least affected with, however, peaks in Ivory Coast, Burkina-Faso and Nigeria. In Central and East Africa where the highest levels were shown during the first decade of the epidemic, there has been a relative stabilisation during the past few years, with a level ranging between 5 and 15%. It is in Southern Africa, as we have seen, that the situations is the most catastrophic with Botswana and, recently, Swaziland holding the sad record of the highest HIV level in the world.

To the variations which exist between countries must be added those which affect regions within one country, variations, it must be added, which evolve with time. Rural areas are not necessarily those least affected. In Kenya, for example, it is in Kisumu and not, as one would expect, in Nairobi or Mombassa, the two largest built-up areas in the country, that the highest HIV levels were first observed. The reason is the proximity to Uganda where the epidemic had reached a peak in the middle of the 1980s. In South Africa, KwaZulu-Natal was the most affected province for the most part of the 1990s before being joined by other parts of the country, including the Western Cape which appeared to have been relatively immune initially. Let us end by citing the case of Tanzania, studied by Philip Setel, where, between 1987 and 1993, simultaneous levels of HIV prevalence were given that differed from 10% in the region of Kagera in the extreme west of the country to 2% in the region of Kilimanjaro in the North-East.[43]

The third fact which demands an explanation is the withdrawal of the epidemic in Uganda as well as, it would seem, certain regions bordering on Tanzania. This topic is discussed in the present volume by James Putzel. From 30% in 1992/3 the level of those who are HIV positive in the adult population of Kampala progressively declined to stabilise at 6% in 2004. Putzel also queries the related question of the (relative) non-development of the epidemic in Senegal. In this country, the rate of those who are HIV positive has, in effect, remained at a very low level compared with that of other sub-Saharan African countries.

The paths of the epidemic

How can the variations in the spatiotemporal distribution of the epidemic be explained? Recent studies, some of which are included in this book, propose that one distinguish between

[41] Karen Jochelson, “Sexually Transmitted Diseases in Nineteenth- and Twentieth-Century South Africa”, in Setel et al., *Histories*, 233.

[42] Helen Schneider, “Le passé dans le présent”, 89-90.

[43] Philip Setel, “Local Histories of Sexaully Transmitted Diseases and AIDS in Western and Northern Tanzania”, in Setel et al. (eds), *Histories*, 119-142. On HIV/AIDS in Tanzania, see also Philip Setel, *A Plague of Paradoxes. AIDS, Culture, and Demography in Northern Tanzania* (Chicago, University of Chicago Press, 1999).

two types of variables, those linked to exposure to the virus and those linked to its transmission.[44]

Exposure to the virus depends on the age at which one has one's first sexual contact, the frequency of sexual contact, the type of sexual contact, the number of sexual partners and, in the case of multi sexual partners, its concomitant or sequential nature.
Studies on the history and the anthropology of sexuality, which have multiplied in the past ten years, throw a new light on reasons which encourage Africans to adopt, according to an expression which today seems ambiguous, "at risk behaviour". Poverty and even more the gap between the rich and the poor greatly influence sexual behaviour as can be seen by the young South African girls who offer their favours to sugar daddies in exchange for food (survival sexuality) or consumer goods (commercial sexuality).[45] To this can be added the effects of migration, either internal or external. Yves Zoa, in the article included in this volume, points out the role played by movements of cattle breeders (mainly men) in the spread of the HIV virus in the Lake Chad basin. The sexual behaviour of these men is a reaction to specific reasons. Similarly, a migrant woman, without any social ties, who accepts sharing the bed of a single man so as not to have to sleep in the streets, knows what she is doing, even if she runs the risk of contracting AIDS. The wife of a migrant labourer who engages in sex in different places at the same time is not ignorant of the fact that she could contract the virus but rules of "respect" forbid her asking her husband any questions concerning his sexual activity. We are far from the analyses undertaken during the early stages of the epidemic according to which prostitutes, truck drivers and soldiers were seen as the main carriers of the epidemic. Rather than at "risk behaviour", an expression which has moral connotations or is paternalistic, the expression "dangerous environments"[46] is used.

The study of sexual behaviour in Africa must be undertaken with precaution because of the force of cultural prejudices which often, unconsciously, skew the results. Many writers do not resist the temptation of blaming the African people for the disaster which they are experiencing. An example is found in the study by two Australian demographers, John and Pat Caldwell[47] who claim, with no empirical basis, that the high levels of HIV in Africa are due to sexual behaviour on the continent, behaviour which, according to them, is caused by weak marriage ties, the frequency of polygamy, the exclusive role of the mother in the education of children and the refusal by women to indulge in sexual contact after birth. These different features allegedly form a coherent system which, according to the authors, explains the AIDS explosion in Africa.[48]

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[44] My ideas have been prompted by an article by Benoît Ferry (« Systèmes d'échanges sexuels et transmission du VIH/sida », in Becker et al., *Vivre et penser le sida en Afrique*, p.237-255). See also Mburano Rwenge « Facteurs contextuels de la transmission sexuelle du sida en Afrique subsaharienne : une synthèse », *ibid*, 217-236. I have avoided the expression "vulnerability" which is often employed in writings on AIDS because of it being too general. In fact it covers two very different realities: physiological vulnerability and social vulnerability. Cf Laurent Vidal, "Anthropologie d'une distance", 21-23.

[45] See Mark Hunter, "The Materiality of Everyday Sex: thinking beyond 'prostitution'", *African Studies,* 1/1 (July 2002), p.99-120. For a study on the multiply meanings of prostitutions in Zaire during the 1980s, see Brooke Grundfest Schoepf, "AIDS in Africa: Structure, Agency and Risk. In Kalipeni et al (eds) *HIV and AIDS in Africa: Beyond Epidemiology,* 121-132.

[46] My point of view coincides with that of Didier Fassin and Helen Schneider ("Crise épidémiologique et drame social", p. 15).

[47] John Caldwell, Pat Caldwell and Pat Quiggin, *Disaster in an Alternative Civilization. The Social Dimensions of AIDS in Sub-Saharan Africa,* Health Transitions Centre, The Australian National University, 1989. See also J. and P. Caldwell, "The nature and limits of the sub-saharan African AIDS epidemic", *Population and development Review* 19/4 (1993), 817-848.

[48] For a criticism of cultural prejudices in the study of sexual behaviour and AIDS in Africa, see Jean-Pierre Dozon and Didier Fassin, "Raisons épidémiologiques et raisons d'État. Les enjeux socio-politiques du SIDA en Afrique", *Sciences Sociales et Santé,* 7/1 (1989), 22-28; Gilles Bibeau, "L'Afrique, terre imaginaire du sida",

Significantly, studies into sexual behaviours which have been undertaken since the beginning of the 1980s in several African countries with high HIV positive levels have not shown significantly different results from those obtained in Western societies or in African countries with low HIV levels.[49] As far as Anne Buvé is concerned, the variations noted between the HIV levels in four African towns are due less to the frequency of so-called at risk behaviours than to factors which influence transmission such as lack of circumcision or the high rate of sexually transmitted diseases. Sexual behaviour certainly plays a role in the transmission of AIDS but in a way which is more complex than initially believed. It is not necessary to postulate intense sexual behaviour in order to explain the rapid transmission of the virus in the urban and peri-urban levels of the populace. It is the general instability which makes sexual behaviours dangerous, an instability which, sometimes for decades, has been nourished by urbanisation, migrant labour and poverty.

Let us now consider the variables linked to the transmission of the virus. There can be no transmission of the virus unless one has been exposed to it. But every sexual act – the most common form of exposure to HIV in sub-Saharan Africa – does not necessarily contaminate, far from it. Certain material circumstances increase, sometimes considerably, the probability of infection.

Firstly, it is advisable to consider those factors which hinder the transmission of the virus. The most well known is the condom. According to sources quoted by James Putzel, the use of the condom has probably contributed to the decline of AIDS in Uganda where the level of use has gone form 16% in 1995 to 40% in 2000. According to Anne Buvé, the good results obtained in Thailand in the fight against AIDS are due, partially at least, to the massive campaigns, launched at the beginning of the epidemic, promoting condoms amongst prostitutes. Conversely, it can be noted that cultural constraints on communication between spouses make the use of condoms difficult, thereby increasing the probability of infection.

There is now-a-days a consensus concerning the negative associations between male circumcision and the transmission of AIDS to which Anne Buvé alludes in her study. Non-circumcision increases the probability of lesions to the foreskin and therefore that of the transmission of the virus.

The same argument, but inverted, holds true for sexually transmitted diseases, sexual violence and dry sex.[50] All practices which cause irritation or lesions to the vaginal wall favour the transmission of the virus. Their spreading can explain high levels of HIV in certain regions. It is incontestable, for example, that the endemic presence of sexually transmitted diseases in the populace, due to the lack of medical infrastructures, has played a major role in the spread of AIDS in sub-Saharan Africa. The high rate of rape in South Africa – more than fifty thousand cases are annually reported to the police[51] – is certainly one of the contributory factors to the high rate of HIV in this country. As for dry sex, the fact that it is extensively practised in KwaZulu-Natal explains, at least partially, why this province is the most affected in South Africa.[52]

Another variable linked to the transmission of HIV is the type of virus. It is known that the second type of virus, HIV-2, which is wide-spread in West Africa, is less virulent than the first, HIV-1 which is found in the rest of the world. However, as Putzel notes with reference to Senegal, HIV-1 tends to impose itself on HIV-2. The two types are not mutually exclusive.

125-147 ; Jean-Pierre Dozon, "Des appropriations sociales et culturelles du sida à sa nécessaire appropriation politique : quelques éléments de synthèse », dans Becker et al., *Vivre et penser le sida en Afrique*, 679-680.

[49] Schneider, "Le passé dans le présent", 87.

[50] Insertion of substances into the vagina so as to dry it or to contract it, thereby increasing sexual pleasure.

[51] Charlene Smith, *Proud of me. Speaking out against Sexual violence and HIV* (London, Penguin Books, 2001), 73-74.

[52] Information kindly supplied by Dr Paul Kocheleff. Regarding Zimbabwe, see Diane Civic and David Wilson, "Dry sex in Zimbabwe and implications for condom use", *Social Science and Medicine,* 42/1 (1996), 91-98.

The higher rate of resistance to the virus in West Africa seems be abating.[53] It has also been noted that HIV-1 has eight or nine sub-types. However, according to Anne Buvé, it has not been proved that differences in the sub-types have had an impact on the spread of AIDS.

The human factor

Let us return to the questions which were raised earlier. Why are certain regions of sub-Saharan Africa more affected by AIDS than others? How can the decline of the disease in countries like Uganda be explained? These questions, which are of interest mainly to those involved in the fight against AIDS, human science experts and particularly historians have answers, albeit partial. In the light of recent work, including that published here, I would like to suggest three avenues of reflection.

The first involves the silence and shame which surround AIDS. The stigmatisation of the disease, a veritable "epidemic within an epidemic" hinders prevention efforts, undermines patients' moral and physical health and obstruct care and treatment possibilities. As Benedict Carton has demonstrated, the feeling of shame which accompanies AIDS has its roots in history and culture. Only an in-depth study of the way in which traditional societies and their colonial archetypes have experienced sexual behaviour, disease and death will allow one to understand why, twenty years after the beginning of the epidemic, AIDS continues to be indefinable and, to paraphrase Didier Fassin,[54] unbelievable.

Secondly, in order to be fruitful, this critical work must include some reflection on the knowledgeable or pseudo-knowledgeable discourse on AIDS. Studies such as those by Charles Becker on the history of ethics and law in Senegal or by Guillaume Lachenal on the methodologies of European researchers in Cameroon are indispensable. The language of medical doctors, researchers, international experts, journalists and literary writers needs to be understood as much as does that of the sick and their families. From this aspect, the work undertaken by Ronald Bayer and Gerald Oppenheimer amongst a group of South African doctors is priceless.

Finally, the case of Uganda suggests a reflection on the role of politicians and religion figures in the fight against AIDS. The preceding paragraphs have alluded to social and cultural determinisms which affect the evolution of the epidemic. Are we condemned to impotence? Is our only hope that of seeing the AIDS growth curve level out, as has been the case in several Central and Western African countries, because of a phenomenon of "natural" saturation with the number of new cases of infection being equivalent to that of those who have died? The Ugandan example illustrates, by contrast, the positive role which the State can play if there is synergy with religious groups and NGOs. Methods exists for slowing down the progress of the epidemic, first of which is the use of condoms, assuming responsibility for sexually transmissible diseases and therapy using antiretrovirals. But in order for these means to be implemented, a medical and social infrastructure is necessary. This is where the State has a role to play. In Senegal, for example, the fact that infrastructures set in place during the colonial period have been maintained after independence, meant that a relatively effective policy of prevention and treatment could be adopted at the outset of the epidemic. *A contrario,* the critical attitude adopted by the Burundian government during the 1980s and the procrastinations of the South African government in the following decade have contributed, as Paul Kocheleff has shown, to the lack of success of preventative policies in these two

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[53] Tony Barnett and Alan Whiteside, *AIDS in the Twenty-first Century. Disease and Globalization* (New York, Palgrave MacMillan, 2002), 125.
[54] Fassin, "L'incorporation de l'inégalité", 27.

countries. The lack of cooperation in prevention of AIDS programmes on the part of religious authorities in Burundi also explains, according to him, the rapid spread of the epidemic in this country.

Let us not, however, make a scapegoat of political and religious authorities. AIDS is a disease which concerns the entire society and not only those in power. The South African example shows how, in this area as in many others, the present depends on the past. It is incumbent upon historians and specialists in human sciences to explain how the epidemic becomes entrenched in the society which it affects. This will be their contribution to the fight against AIDS.

(*translated from the French by Carole Beckett*)