REVIEW ESSAYS

Brooke G. Schoepf

ASSESSING AIDS RESEARCH IN AFRICA: TWENTY-FIVE YEARS LATER

Jane Arnott and Anna-Louise Crago. ***Rights Not Rescue: A Report on Female, Trans, and Male Sex Workers' Human Rights in Botswana, Namibia, and South Africa.*** New York: Open Society Institute, 2008. Public Health Program Report. 106 pp. Images. Abbreviations. Acronyms. Appendixes. Notes. www.soros.org/health.

Monica Karuhanga Beraho. ***Living with AIDS in Uganda: Impacts on Banana-Farming Households in Two Districts.*** Wageningen, The Netherlands: Wageningen Academic Publishers, 2008. African Women Leaders in Agriculture and the Environment (AWLAE), volume 6. 372 pp. Acronyms. Glossary. References. Appendixes. Tables. $52.00. Paper.

Musa Wenkosi Dube. ***The HIV and AIDS Bible: Selected Essays.*** Scranton, Penn.:, Scranton University Press, 2008. Distributed by The University of Chicago Press. x + 208 pp. Notes. Bibliography. $20.00. Paper.

Marc Epprecht. ***Heterosexual Africa? The History of an Idea from the Age of Exploration to the Age of AIDS.*** Athens: Ohio University Press, 2008. xiv + 231 pp. Notes. Works Cited. Index. $39.95. Cloth. $19.95. Paper.

Helen Epstein. ***The Invisible Cure: Why We Are Losing the Fight against Aids in Africa.*** New York: Picador, 2008. xvii + 324 pp. Map. Figures. Notes. Appendix. Index. $16.00. Paper.

Douglas A. Feldman, ed. ***AIDS, Culture, and Africa.*** Gainesville: University Press of Florida, 2008. xiv + 293 pp. Tables. References Cited. Index. $75.00. Cloth.

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Brooke G. Schoepf is a a medical and economic anthropologist and a lecturer in the Department of Global Health and Social Medicine, Harvard Medical School. She has taught and conducted research in fourteen African countries since joining the Rockefeller Foundation's field staff in Lubumbashi in 1974. Since 1985 she has designed and conducted participatory action-research on AIDS prevention with African colleagues and currently is conducting a review of social norm change with respect to sexual risk reduction for the Word Bank. E-mail: bgscs@netzero.net

Linda K. Fuller. ***African Women's Unique Vulnerabilities to HIV/AIDS: Communication Perspectives and Promises.*** New York: Palgrave Macmillan, 2008. xvii + 309 pp. References. Index. Appendixes. Notes. $95.00. Cloth.

Stephanie Nolen. ***Twenty-Eight Stories of AIDS in Africa.*** New York: Walker and Company, 2008. 376 pp. Maps. Glossary. Bibliography. Index. Photographs. $24.95. Cloth. $15.95. Paper.

Edith Mukudi, Stephen Commins, and Edmond J. Keller, eds. ***HIV/AIDS in Africa: Challenges and Impact.*** Trenton, N.J.: Africa World Press, 2008. 204 pp. Tables. Figures. Notes. Index. $24.95. Paper.

Jonny Steinberg. ***Sizwe's Test: A Young Man's Journey Through Africa's AIDS Epidemic.*** New York: Simon & Schuster, 2008. ix + 349 pp. Note on Terminology and Names. Illustrations. Notes. Further Reading. Index. $26.00. Cloth.

Ida Susser. ***AIDS, Sex, and Culture: Global Politics and Survival in Southern Africa.*** Malden, Mass.: Wiley-Blackwell, 2009. xxiii + 277 pp. Figures. Notes. Bibliography. Index. $84.95. Cloth. $34.95. Paper.

Robert J. Thornton. ***Unimagined Community: Sex, Networks, and AIDS in Uganda and South Africa.*** Berkeley: University of California Press, 2008. xxi + 282 pp. Illustrations. Figures. Notes. References. Index. $60.00. Cloth. $24.95. Paper.

UNAIDS. ***AIDS Epidemic Update.*** Geneva: United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO), December 2009. 100 pp. Tables. Charts. Images. Maps. Bibliography. http//data.unaids.org/pub/Report/2009_en.

Graziella Van den Bergh. "From Blessing to Burden: Coping with the Fertile Body in Times of Aids: Adolescent Girls in Western Tanzania at the Turn of the Millennium." Dr. Polit. diss., University of Bergen, 2008. 439 pp. Bibliography. No price listed.

Introduction

AIDS, the most devastating human disease pandemic known to date, continues its progress across the globe, despite some recent signs of diminishing rates of new infections. The drums of affliction beat nightly in many countries of sub-Saharan Africa, the epidemic's epicenter, where 71 percent of the world's HIV-infected people, numbering an estimated 22.4 million, live with the virus. In Africa, 1.4 million die annually of AIDS-related causes and nearly two million new infections are transmitted, mainly through heterosexual intercourse. Most countries in southern Africa still have adult prevalence rates of 15 to 25 percent, while in a large population even a 5 percent

rate of HIV infection creates tremendous suffering. Most people with HIV are unaware that they are infected, and so they continue to spread the virus. Slow to recognize the epidemic's catastrophic potential, the international community has yet to respond with adequate resources.[1]

The epidemic is neither uniform nor static, and efforts to contain the spread of HIV vary, as do responses to the affliction and suffering among the sick and their families. With neither cure nor vaccine in sight, prevention and biomedical treatment, including antiretroviral medications (ARVs), offer the only means of controlling the pandemic. Both approaches are exceedingly complex. The need to build long-neglected public health systems slows treatment expansion. About 30 percent of Africans who need life-extending treatment obtain it at present; many of those without treatment will die within five to ten years. Recent success in treating people with AIDS has not been matched by effective prevention interventions, which in most countries have received a declining share of funds, even as newly infected people exceed by far the numbers on ARV treatment. Wherever prevention efforts slacken or poverty deepens, transmission rates rise. The search for effective protective responses continues; some are documented in the books under review.

AIDS in Africa is about sex, the most personal and yet culturally molded of human activities. But AIDS is about much more than sex; it speaks to inequality in gender relations, access to resources and political power, and ideologies, both those deeply entrenched in local cultures and those imported with colonial power and religions. Studies of politics and fine-grained ethnographies show how women's poverty, gender inequality, ideologies of male dominance, and the political power of moralists preaching about sex all impede the prevention of HIV infection. The epidemic is exacerbated among the poor by inadequate biomedical health care, lack of economic opportunity, and low levels of formal education; all weigh most heavily on young women. In many countries adolescent women are three times as likely to be infected as young men of their age, while in young women ages 20 to 24, the figure is over five times in some surveillance sites. Overall, the sex ratio is 60:40, with women biologically more susceptible than men.

Many women confront severe social, cultural, economic, and legal disadvantages—often with roots in the colonial period and worsened by deepening economic crisis and Structural Adjustment programs. Labor migration, long-distance trade, and low-intensity warfare all contribute to the separation of spouses. Neoliberal economic policies have undermined many men's ability to provide for families. In these economic circumstances, many unemployed young men cannot hope to establish families and settle down to responsible adulthood (see Schoepf 1993a). Poverty and the dissolution of gender role norms have led to more brutal behavior. Many men's sense of entitlement to multiple partners continues to fuel their denial of HIV/AIDS risk, as does the secrecy with which they hide multiple concur-

rent partners, including extramarital relationships and secondary households. The ideology and practices of male dominance, including the threat of sexual and domestic violence, make it impossible for many women to avoid sex with partners who refuse condom protection; lack of resources obliges many women with children to depend on a man—or men—for support. Some young women enter the sex trade to contribute to parental households or to support children whose fathers do not. Others seek consumer luxuries and security that only older men, most with families, can provide. While these factors were all well understood by women whom I and my colleagues interviewed in Kinshasa in 1987 (Schoepf, Rukarangira, Payanzo, et al. 1988), new epidemiological research documents the continuing—and even enhanced—need to protect such socially marginalized people as sex workers, men who have sex with men, and injecting drug users. Recent studies also document the elevated risk among people in regular relationships, including those who have had only one partner but whose partner has had other relationships, or who carry on simultaneous relationships while professing monogamy. The agencies' descriptive acronym is MCPs, for "multiple concurrent partnerships," the latest target of prevention attention.

The greatest success story is that of Uganda, where by the time HIV was identified, median prevalence among urban pregnant women had reached 24 percent. It would climb to 30 percent by 1992. Then, until 2005, HIV prevalence fell to about 11 percent for that group, while the national average fell from 15 percent to just under 7 percent. Epidemiologists are divided on the nature of the changes that brought down HIV prevalence (Wawer et al. 2005; Nagelkerke et al. 2009). However, more recently Uganda's politics have changed, moving away from the nonjudgmental stance that defined the government's early multisectoral involvement and the broad NGO and grassroots response that involved more than a thousand organizations. Today, two of the four television stations in Uganda stream religious programs throughout the day, huge billboards promote abstinence for youth, and condom distribution is no longer widely accepted. The infection rate has begun to climb once again.[2] The largest share of new infections now occurs among older heterosexual couples, particularly among wives, who are half as likely as husbands to be the "sero-incident" partner (the first to be infected).

Other countries have also registered prevalence declines: among young antenatal clinic attendees in Botswana in 2007, in South Africa since 2005, and in eastern Zimbabwe since 1996, while incidence of new infections fell significantly in Tanzania and among Zambian women and youth in eastern Zimbabwe (figures from UNAIDS 2009). Some of the decline is due to reduced sexual risk, including delayed marriage; some may be due to reduced numbers of highly susceptible people. Nonetheless, the prevalence figures are still very high and in Swaziland, the most affected country, 42 percent of pregnant women attending clinics tested positive for HIV.

Female sex workers continue to experience very high rates of infection, despite the success of demonstration projects (see Ngugi 1988; see also Chandrasekaran et al. 2008).[3]

Many men refuse to wear condoms and in fact threaten partners with violence or with abandonment if they seek to protect themselves from infection. Young female partners of older men are especially vulnerable, especially if the man's former wives died of AIDS. Widows and divorced women are more likely to be living with the virus than are single women. And yet few prevention interventions are directed toward formally married or cohabiting couples. Formerly married individuals, sex workers, the growing numbers of injecting drug users, and men who have sex with men also receive short shrift in prevention and treatment programs. Rape and domestic violence also must be addressed, first at the community level, and then by national laws, effective enforcement, and the punishment of military and militia leaders who use rape as a weapon to render communities compliant. Anthropologists have not seen a great deal of lasting change brought about by Christians preaching abstinence and fidelity, except as recent campaigns against multiple partnerships have driven some of these relationships underground (Parikh 2007).

This review discusses several recent books and reports about HIV/AIDS in Africa that approach the subject from differing points of view and with different aims. Several are complex, multilayered, and informed by an ethnographic approach that allows affected people to express their concerns. The UNAIDS report combines the latest epidemiological survey and surveillance data with a bibliography of source materials. All examine key issues such as gender inequality, patterns of sexual relations, political responses, poverty, international policies, condom use, and behavior change. Two books are about the impact of AIDS; five are about prevention (from both the grassroots and policy perspectives); one tackles a major set of obstacles in Christian theology and the practices of religious leaders; three focus on policy issues at the same time that they examine community responses in detailed case studies; two edited collections, of disparate quality, address a variety of cultural and political issues; one book is about the historical silencing of same-sex relationships among men, and one is about what happens to adolescent females when youth transgress their elders' social norms. Most of the works convey the voices of people at risk or those suffering from AIDS, while embedding them in broader analytic frameworks. These often include the effects of structural violence, international and national political economies, policy programs, ideologies, and the process of implementation as factors affecting the epidemic and the individuals caught within it. I find such approaches the most interesting, informative, and effective; but then, I am an anthropologist.[4]

Monica Karuhanga Beraho is a lecturer at Makerere University, where she teaches agricultural extension, participatory research, and women's stud-

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ies. She is also active in several professional organizations in the field. Her detailed analysis of the ways that HIV and AIDS reconfigure the vulnerability of agriculture-based livelihoods (*Living with AIDS in Uganda: Impacts on Banana-Farming Households in Two Districts*) shows the severe impact of AIDS in a country where 70 percent of the population depends on smallholder farming. Although Janet Seeley and colleagues (Seeley, Grellier, & Barnett 2004) earlier covered many of the same issues, mounting deaths among adults have undermined formerly effective family coping strategies, especially among the poor (see also Rugalema 1999). From her field studies in Masaka and Kabarole Districts of Uganda in 2002–2005, Beraho shows how the effects of AIDS vary by income, education, gender, and farming systems. Farmers perceive that access to resources, including land, information, credit, and education, all accrue to those with higher incomes, who also enjoy better health (198). With careful attention to local and regional variations, Beraho's study confirms their view. Better-endowed households are able to diversify their income-generating activities and to profit from asset-depletion among the poor, who sell their animals, land, and crops to purchase food and medicines for the sick, withdraw their children from school, and reduce their food consumption—thus weakening both their short-term and long-term health.

Beraho documents higher levels of AIDS among the poor. In wealthier households affected by AIDS, the children tend to remain in school, whereas children in poorer households do not. Even when poor orphans are fostered in wealthy households, they may be treated as servants instead of being sent to school. AIDS exacerbates intrafamilial and lineage conflicts, and is associated with increased male violence, alcoholism, and abandoned orphans. Households headed by widows or single women have fewer assets than male-headed households; in turn, they experience greater resource depletion, with restricted social networks and less ability to access farm inputs or to hire labor. Because they assume care for surviving orphans, such households often have more dependents. With this cycle, agricultural devolution has set in; with less labor and fewer resources being applied to crops, yields and incomes are decreased because of insect pests, plant diseases, and lost working days.

Poor women's livelihood strategies reflect this lack of assets. Many are driven to pursue activities that yield low returns or are risky, such as casual labor or sex in exchange for food. In Masaka, the district with the highest HIV prevalence in this study, the effects are especially damaging to the social fabric; but the peripheral Kabarole District receives even less government and NGO support. In both areas, households that cannot reciprocate community support are likely to get little assistance.[5] Women find it difficult to maintain membership in rotating credit associations, orphaned children are unable to access the social support networks built earlier by their parents, while widows' insecurity is compounded by land-grabbing by their late husbands' male relatives. Beraho examines community-level effects as well.

For example, a Masaka health official recounts that in the decade 1990–2000, the district lost half of its staff to AIDS, while the government banned new recruitment. In other words, as need increased, resources dwindled, and they have not been fully replaced by NGO-supported activities and the often strenuous efforts of volunteers.

Beraho finds that the privatization of agricultural extension services—a policy currently promoted by the government under pressure from international institutions—is counterproductive for a multisectoral AIDS strategy. Instead, she recommends that government equip staff to conduct AIDS prevention as part of community mobilization in the small communities where other public servants do not go. Beyond the reach of extension, however, are the social practices, policies, and ideologies that continue to maintain and reproduce distinct forms of inequality. Unless these are redressed, Beraho concludes, they will continue to aggravate people's vulnerability to all manner of shocks, including AIDS. In itself, AIDS does not determine a household's livelihood strategy; its effects, however, especially household food scarcity, are most significant and damaging among the already vulnerable.

With its mix of quantitative and qualitative methods, its inclusion of case studies and the voices of small farmers, Beraho's research is unique in the recent literature. This thoughtful book, by a mature and dedicated scholar, is valuable for students of agricultural economics, agricultural extension, anthropology, and public policy, but it will also be of interest to general readers. Her final chapter is an essential guide for professionals in the field of AIDS; my hope is that once they have read that chapter, many of them will turn back and read the full study.

The explosive expansion of conservative evangelical Christian churches across sub-Saharan Africa in the past twenty years has increased blame, shame, stigma, and discrimination against HIV-positive people and those living with and dying from AIDS. Some sect leaders claim to "exorcise" evil intentions, sometimes by means of torture, or they promise a cure by recourse to the Holy Spirit. Along with some mainstream churches, they have linked sexual transmission to "immorality" and carried on successful campaigns to prevent widespread use of condoms to protect the sexual partners of HIV-infected people. Africa's fundamentalist churches, however, have not acted in a vacuum. The Bush administration, with support from PEPFAR funds (President's Emergency Plan for AIDS Relief) as well as from donations from conservative U.S. congregations and expatriate proselytizers, promoted the evangelicals' global reach, especially in Africa.[6] In such a context, the nascent "condom culture" developing among youth and others with multiple casual partners took a heavy hit, leaving many vulnerable to HIV/AIDS. The churches' political power and American support have prevented many national governments from carrying out realistic prevention education among young people, both in and out of school. Stigma

and shame, in turn, have prevented many from seeking HIV testing to learn of their health status and from gaining access to ARV treatment to prolong their lives.

Alongside these dismal, even vitriolic, moralist discourses, however, other Christian voices have from the outset preached a gospel of love, provided compassionate care for the sick, and organized realistic counseling on HIV/AIDS prevention. In various countries many Catholics have even promoted condom protection in defiance of their religious superiors. One indigenous organization that seeks to bolster solidarity among people affected by AIDS is the African Network of Religious Leaders Living with AIDS (ANERELA). Organized in 1992 by the Reverend Cannon Gideon Byamugisha of Uganda, the Anglican priest who disclosed his HIV-positive status, the network by 2005 included more than thirteen hundred members of various denominations dedicated to rational, caring responses. Another organization that has encouraged solidarity by mobilizing theological arguments of compassion and human rights is the World Council of Churches, where Musa Wenkosi Dube (also a professor of New Testament theology at the University of Botswana) is a scholar-activist. The title of her collection of writings is *The HIV and AIDS Bible.*

Amidst the din of the culture wars, we hear little about liberation theology from Africa. Dube, however, is clear about the continuing "retraditionalization" taking place under the aegis of religion, as "custom" is reshaped in the present, as in the past, with the effect of subordinating women. Calling for a cultural hermaneutics that decolonizes the mind, Dube steps into the middle of the controversy over the "ABC" strategy (Abstain, Be faithful and [*in extremis*] use Condoms) unleashed by religious conservatives from the U.S. "If we preach ABC," says Dube, "all the while ignoring the power of some cultures to sanction gender inequality, multiple partners for males, the feminization of poverty, violence against women, youth powerlessness, and taboos about discussing sexuality, then we are a long way from effective prevention of HIV/AIDS and the provision of quality care. African cultural feminists interrogate how the biblical texts work with culture to further legitimize the marginalization of African women and reinforce biblical patriarchy" (114–15).

With her critical reading of the sacred texts, Dube calls for an action-oriented theology of AIDS; hence, the refreshingly rights-based, closely argued, and compassionate *AIDS Bible.* Dube dedicates the collection to the Reverend Cannon Byamugisha, who tells his story to Stephanie Nolen in Nolen's *Twenty-Eight Stories* (discussed below). Dube's chapter endnotes and bibliography contain a goldmine for activists as well as scholars.

The ABC strategy's emphasis on fidelity leaves uninfected partners in monogamous couples without protection and helps explain the epidemiological shift described above. Many policymakers, governments, churches, and NGOs have much to account for as infections multiplied, death rates

soared, and orphans' misery was compounded as school systems and health services fell over the brink into ruin. The works by Stephanie Nolen, Jonny Steinberg, Helen Epstein, Ida Susser, and Robert Thornton all offer cogent critiques of South Africa's AIDS policy and provide case studies (from South Africa and elsewhere) showing how these interrelated elements have affected communities in various contexts.

In *Twenty-Eight Stories of AIDS in Africa,* Stephanie Nolen, a journalist, recounts the stories of people she came to know through repeated visits and in-depth interviews during the years that she was based in South Africa. Her deeply moving portraits put a human face on the suffering and struggles of people with AIDS and those they leave behind. In particular, their stories convey how difficult it is for many people to absorb the facts of HIV/AIDS—difficulties compounded by opaque, often euphemistic messages about risk and prevention—and how difficult it has been for ordinary people to obtain access to life-prolonging ARV treatment.

Nolen is especially critical of the slow roll-out of antiretroviral drugs for children, whom she watched dying painfully, their helpless mothers at wit's end. Even when the medical agencies demonstrated how to prevent AIDS in the vast majority of children by administering ARVs to HIV-infected mothers prior to their giving birth, the South African government refused to act on such a protocol until a court order forced it to comply. The Treatment Action Committee (TAC), an action-oriented group comprising people living with the virus (or with full-blown AIDS) and their supporters, has waged a campaign of nonviolent activism—first demanding that the pharmaceutical companies bring drugs to South Africa at reasonable prices, then demanding that the ANC government make treatment available. Nolen tells the story (chapter 14) of South African AIDS politics through interviews with Zachie Achmat, one of its principal spokespeople. An ANC organizer during the freedom struggle, Achmat became an iconic figure as a hero who refused to undergo treatment until the government agreed to adopt a policy.

In chapter 19 Nolen tells the story of Winston Zulu, the first Zambian man to announce his HIV-positive status publicly and to detail the ups and downs of his relationship with ARVs. He became a national, then an international, spokesman for Africa's tragedy and hope. In 1996 he fell ill and began to take drugs that were unavailable at the time in Zambia but sent to him by organizations abroad. In 1998 he encountered "AIDS dissidents" in Geneva; then his hero, then-President Thabo Mbeki, joined their ranks, claiming that AIDS was solely a disease of poverty, rather than a disease caused by the HIV virus. In February 2000 Zulu stopped taking the drugs and Mbeki invited him to join his panel of experts. One year later, however, Zulu fell sick again; covered in fungal infections and lesions that would not heal, and confined to a wheelchair, he acknowledged that the virus had taken over. Noticing that wealthy people were among those hardest hit in Zambia, he began to reconsider his position on the causes of AIDS, went

back on ARVs, and within a month he was out of the wheelchair. "What saved me is that I didn't feel too ashamed to go back and ask for real advice," he told Nolen (219). Zulu, who has lost five siblings, as well as cousins, nieces, nephews, and in-laws to AIDS and TB, mourns all that has been lost by the Zambian nation. Having moved to Kabwe, a Copperbelt town, where he and his wife have organized a support group for People Living with HIV/AIDS (PLWHA), he notes how "a once-vibrant economy has been choked by a World Bank–engineered privatization of the mines and railways that caused thousands of people to lose their jobs. Now young women [stand] on the trucking route . . . selling sex for as little as $1 per encounter" (221). "Death has lost its sacredness and its meaning," he adds.

In chapter 9 Nolen relates the story of Manuel Cossa, a Mozambican miner who worked for thirty-seven years in the South African gold mines, where thousands of men lived in crowded hostels from which families were barred and where many turned to sex workers or to "town wives" to stem their loneliness. Their infrequent visits to rural homes also left their wives starved for company and support, so the wives, too, often turned to other partners.[7] In chapter 18 Nolen takes up the argument about developing income-generating opportunities for sex workers that will allow them to leave the sex trade. She relates the story of Agnes Munyiva, who has been part of a research cohort in Nairobi since 1985; she is one of the long-term uninfected sex workers whose genetic makeup and physiology are the subject of intensive study by medical investigators. Nolen uses the example to trace the history of AIDS research and the discoveries made using blood donated by the sex workers. With Elisabeth Ngugi, a physician (see Ngugi 1988), Nolen goes beyond the importance of "pure research" to ask what the researchers have done for the women in return. Munyiva, who is aging, would like to leave sex work: "I can buy our daily food out of what I earn, but that's all. If I could find something else I would" (238). And indeed, in 2002 Ngugi obtained a grant to train 120 women in hair-dressing and dress-making; two-thirds have successfully made the transition out of sex work. While not a panacea, such projects need to be multiplied and supported across Nairobi, across Kenya, and across the subcontinent.

In January 2005 former President Nelson Mandela announced publicly what everyone knew: his last surviving son had died of AIDS. Even in 2005, when eight hundred people died of AIDS daily in South Africa, "no one liked to say the word" (315). Chapter 26 tells the story of Mandela's increasing involvement with the issue, despite his reluctance to engage in the minefield of AIDS politics following his departure from office. Nolen quotes from his address at the Barcelona AIDS Conference in 2002: This is a war, he said, that "has killed more people than has been the case in all previous wars . . . . We must not continue to be debating, to be arguing, when people are dying" (324). And he directly addressed his own successor's positions on this issue: "There is no doubt that strong leadership is the

key to any effective response.... When the top person is committed, the response is much more effective" (324).

Following, as it did, his plea to the ANC to begin work on preventing transmission to babies—for which Mandela was openly heckled—many people took these statements as a criticism of Mbeki. But it could just as well have been seen as a transformation in his own position, for Mandela's reticence during his presidency could be explained only partly by the press of other issues. Whatever his earlier postion, Mandela and Graça Machel subsequently became very much involved in the problem of AIDS, and the Mandela Foundation has provided direct support for ARV treatment and leadership in policy issues. In 2005 Mandela spoke out again: "We live in a world where the AIDS pandemic threatens the very fabric of our life, yet we spend more money on weapons than support for the millions affected" (327). Nolen recounts a lengthy interview she conducted with Machel, who expresses her astonishment at the heavy silences surrounding AIDS and sex in South Africa. The reluctance to talk about sex, gender relations, and the need to change culture may be what kept Mandela and the ANC tragically immobile for so long. As for Mbeki, his denial and foot-dragging on treatment need to be viewed in the light of his embrace of neoliberal cost-cutting, which simply abrogated the right to health, as enshrined in the South African Constitution. Propelled by the combined forces of TAC, Médecins Sans Frontières (MSF), and their many international supporters, the government finally began limited ARV treatment in 2003. We shall see if President Jacob Zuma will do better in more than words.

Sizwe's Test is a rare volume by a journalist who combines textured ethnography with sensitive psychological awareness and historical depth to shed light on the complex interweaving of culture, political economy, and socioeconomic change. Jonny Steinberg narrates the itinerary of Sizwe, a young, successful South African rural shop owner who thinks he probably should take the HIV test that has recently been made available along with ARV treatment at an MSF pilot project in Lusikisiki, the nearest rural town in Eastern Cape. Yet Sizwe hesitates over a period of eighteen months: he is afraid of a positive result, for he has "moved around." The message that "sex equals death" has given many people an exaggerated notion of HIV prevalence and what it takes to become infected, and the mass media do not explain. This feeds into a sense of fatalism: I can't know about my partner(s), so I can't do anything to avoid infection. And from there emerge attitudes that express not wanting to die alone: "All be die" and "Infect one, infect all" (see Leclerc-Madlala 1997).

Sizwe is aware that other people waiting at the clinic can tell who is positive by the length of time it takes for them to emerge from the post-test counseling session, and he is afraid of the stigma that would result if he should test positive. He is also afraid that, in the event, worry about AIDS

would bring on the disease. This psychosomatic interpretation is found in many countries. The "Lazarus effect"—the rapid restoration of AIDS sufferers to health by means of ARV treatment—does not overcome the lasting suspicion of "white man's medicine" generated by more than a century of medical apartheid.

Many of the stories recounted by Sizwe and his neighbors reveal the popular misconceptions and silences that surround HIV. Inaccurate rumors about the origins of AIDS origins swirl with the dust across the rural landscape, along with stories about connections between AIDS and ritual murder (see Niehaus & Jonsson 2005). Blood drawn from African bodies has never been seen as inert material in colonial Africa, as Luise White (2000) reminds us, and it has always been associated with a technology of power. Steinberg's book offers analogous examples from South Africa.

A familiar nosological dichotomy characterizes African medicine: if biomedicine can cure a disease, it must be of Western origin; otherwise other forces must be at work. But this leaves AIDS open to interpretation as "an old African disease." In Sizwe's community, the suspicion and hostility provoked by supernatural explanations of disease wax and wane as more and more people succumb, some even after they begin (too late) to take the pills. Accusations expressed in national politics are woven into the fabric of rural life. Many believe that AIDS is crafted in a Western laboratory and then spread by health workers' needles or by condoms. Taking pills is also suspect, a lifelong enterprise fraught with dangerous opportunities for people of ill will to intrude. Moreover, Sizwe tells Steinberg, as though trying out the idea, "people believe that whites are withholding a cure so Black people will die and they can elect DeKlerk president again" (138): not an illogical notion, in view of the fact that ARV treatment of demonstrated efficacy was available in the U.S. and Western Europe by 1996 but not in Africa until several years later, when MSF began a pilot clinic in Kayelitsha outside Cape Town in 1999 and wealthy Ugandans began to obtain drugs privately. Sizwe reiterates this suspicion as an absolute certainty in 2007: "The *umulungus* are so clever. It is not possible that they don't have a cure" (307). "Why did people start dying of this thing [only] after democracy came in 1994? . . . Why did Americans . . . get better when we didn't?" And most of all, "Africa's great question about AIDS: why has the epidemic been uniquely terrible here?" (308). Can it be that witches are at work? Steinberg interprets clues provided by Sizwe in the following manner: "Those who speak of the shame of the HIV-positive are a hair's breadth from speaking of the shame of witches. . . . As much as people try to strip AIDS of evil by giving it a strictly biomedical explanation, it nonetheless remains lodged in an old and poisonous well of fear, of suspicion and of misogyny" (133).

Steinberg makes effective use of Monica Hunter's 1930–32 ethnography of love, sex, and courtship among the Xhosa of Lusikisiki, Sizwe's home district, to understand the social changes that have taken place over the decades (Hunter 1936). Hunter described young people's open court-

ship at dancing parties, followed by strictly enforced nonpenetrative sex, either nearby other couples in the forest or in the girl's compound. Partner change, all without full intercourse, was frequent until young people were ready to marry, but monogamy was not valued after marriage, either.

Twenty years later, in 1950, Hunter led a survey team to an area some 250 miles distant. She found that while only 20 percent of women over 45 years of age had borne children out of wedlock, more than half of younger women 18 to 45 had done so. What had caused the change? Along with other authors whom he cites in the section titled "Further Reading," Steinberg looks to political economy: land expropriations had forced Africans into overcrowded and unproductive areas, inheritance foundered, and jobs at the mines had taken men away. Today in South Africa, as was the case in Congo in the 1980s, most young men cannot find steady jobs or establish families. Steinberg asks what future can the youth hope for? Meanwhile, the elder men attribute young people's "explosion of unbridled desire" (the *tama* of East Africa) to their inability to contain their sexual urges and their rebellious spirits, their insistence on "deciding they were men" (247), albeit without land and cattle—the economic foundation of marriage and the potential for the continuity of the peasant household and lineage. This condemnation of youthful sexuality by elder men (and sometimes by middle-class women) is familiar in studies throughout the region, from DRC on south.[8]

Sizwe struggles to create for himself a responsible "modern" masculinity that resonates with that of his grandfathers. He has abandoned his insouciant moving about between multiple girlfriends because he fears the disease that has taken many of his agemates. Fear of his past adventures is accompanied by the familiar denial and fatalism, a sense that nothing can be done. Yet Sizwe is ambivalent: he swings between fear and hope. He seeks to become a household head meeting the needs of his pregnant wife-to-be and their children, the lineage descendants he hopes to grow. He will employ few of the old patriarchal practices, however, for his wife is a modern, employed woman who prizes negotiation. Those who write about AIDS and gender note the common fate of widows and children despoiled of property by husbands' families. Sizwe offers a male perspective: AIDS would threaten his (nuclear) family with "the most primordial of rivals—fathers [or] brothers who would take [the] children's inheritance and spend it on themselves" (298).

Sizwe is unusual in another way: he struggles to provide transportation, medications, and encouragement for extended family members afflicted with AIDS—even those likely to die soon. In this he differs from those who write off the lives of the very sick whose deaths will render them unable to reciprocate, thus severing their connections to the living and condemning them to "social death." His experience accompanying Steinberg as he visits the sick with a community health worker inspires him to emulate the health worker within his own circle, and to find a woman in his village to take on

the role. Sizwe begins to have hope that he will survive the scourge.

Steinberg sets out to document the rural MSF experiment.[9] He follows it until several months after the departure in 2006 of Hermann Reuter, the dedicated, creative, and well-resourced physician, at which point the Lusikisiki clinic and outlying health posts returned to control by the routinized, rule-bound government health service. He fears that Reuter's community-based system will be steam-rollered under the health system's "business-as-usual" approach. However, the pressure of demands by local members of TAC and the training Reuter provided to community health workers continue to bear fruit in their willingness to break the rules to get sick people tested and on treatment, despite many bureaucratic hurdles.

Helen Epstein began her professional life as a microbiologist, worked in Uganda preparing for a vaccine trial, then earned a degree in public health. Her *Invisible Cure* is a tour de force, a collection of previously published articles, most from *The New York Review of Books.* The book first adumbrates HIV/AIDS biology for lay people in readable fashion, and then reviews policy and prevention projects with case studies from South Africa (and also from Uganda and countries in between). I have a few cavils with her biological information, which has become outdated in this fast-changing field. To cite just one error: women's bodies *are* more susceptible to infection than are those of uncircumcised men.[10] An omission is the failure to mention the special burden of disease in Africa in the context of Structural Adjustment and failed health systems, which are analyzed by many of the other authors. Without a grounding in international and national political economy, her discussion, even of Mbeki's apparently aberrant denialism, floats in psychological and cultural limbo.

Epstein does describe how African governments and intellectuals resisted the stigmatizing characterization of Africans as more promiscuous than peoples elsewhere. The "risk group" paradigm obscured many other people's vulnerability to infection, and stigma made open discourse about sex difficult. She also shows how Mbeki's defense of African personhood against racist discourses of hypersexed, lascivious men opened him to the charge of being an AIDS denier and fed into a nationalist project that rejected both realistic prevention programs and systematic treatment with ARV medications.

Epstein highlights the tragic confusion that contributed to delay in treatment and has cost at least three hundred thousand South African lives (see Chigwedere et al. 2008), and she tracks the dubious government-authorized drug trials that resulted from Mbeki's misplaced nationalism. Opposed by the country's biomedical experts, the quack preparations included an industrial solvent, in one case, and in other cases involved dangerous or inert substances. Epstein notes the irony of a policy that endangered many lives through the quest for an "authentically" African cure for AIDS while at the same time rejecting ARVs as "dangerous."[11] Even now,

the absence of "modernity" in many countries leaves the poor to rely on "traditional healers," many of whom claim to cure AIDS or a disease resembling AIDS, which they believe to be caused by witchcraft, sorcery, or sexual pollution. The presence of conflicting interpretations, hardly a new phenomenon, is exacerbated by many governments' neglect of health and education services. This cedes the field to self-interested charlatans as well as to well-meaning herbalists, all attempting to cope with AIDS and other infectious diseases that are exacerbated by HIV. Calls for collaboration with traditional healers continue, in both governments and development agencies, without controlled trials of the supposed "remedies," or investigation into the concurrent pharmacodynamic effects of their preparations on bodies dependent on ARVs for survival. For example, several herbals widely used in the U.S., such as St. John's wort, increase the likelihood of therapeutic failure (Lee, Andrade, & Flexner 2006). Epstein returned to the U.S. with one widely praised herbal preparation claimed to cure fungal infections that a Kew Gardens botanical laboratory found, upon analysis, to have no medicinal value whatsoever.

Epstein also criticizes several prevention projects, including "loveLife," an NGO in South Africa that targets its HIV/STI prevention campaign to youth (by incorporating sports and cultural activities and by means of billboards and other publicity vehicles), and an income generation project in Zimbabwe. She finds young Zimbabwean women unable to benefit from a microcredit project due to "environmental hazards" (government regulations, corrupt police who confiscate goods, etc.). Indeed, microfinance has been more successful with older, more experienced women. Nor can it be used as a pathway for "reforming" sex workers; for the most part, they can earn far more from the sale of sex. Hence the emphasis by sex workers in southern Africa on their human right to prevention services, and their search for freedom from harassment and violence from both the police and their own clients.

Epstein also looks at ways that the mining companies' policies have undermined the health of workers and their families. In Maputo she visited the TEBA recruiting company office that is supposed to disburse funds for Mozambican miners' pensions and disability claims. There, in 2002, she discovered that the major pension fund, accumulated from miners' payments, held some $40 million in unpaid compensation accounts; in addition, the companies owed nearly $2 billion to hundreds of thousands of miners who had developed silicosis. Although a company official cited the multiple bureaucracies through which the funds must pass, and claimed that many intended beneficiaries could not be found, Epstein witnessed a room full of widows still waiting for money that had never arrived.

Epstein's publications have helped popularize the understanding that sexual networking with multiple concurrent partners, some of whom have other partners, creates a fertile field for HIV transmission. Acknowledged since Africanist social scientists began writing about AIDS, the danger of

what is called "concurrency" is now widely accepted (Miller & Rockwell 1988). David Brokensha (1988) has pointed to the infidelities that often accompany polygyny; my CONNAISSIDA colleagues and I have pointed to several types of informal unions that may precede and accompany marriage in Kinshasa (Schoepf 1988; Schoepf, Rukarangira, Payanzo, et al. 1988).[12] Christine Obbo (1993a) has mapped out sexual networks among rural elites in Rakai District, Uganda. While Western public health advisors, not entirely incorrectly, focused on sex workers and their clients' "promiscuity" as the main drivers of the epidemic, they ignored the wealthy men and their partners (among whom AIDS had been discovered in Europe). But the networks of the wealthy also continued to spread the virus, and such approaches made it seem that AIDS is a problem only for stigmatized "others," while everyone else (the "general population") can continue with life as usual.

Now the funding agencies have shifted to "concurrency" as the target of behavior-change interventions. One problem is that surveys collect reported data; yet as Shanti Parikh (2007) found in rural Busoga, information campaigns that stress fidelity may inflate the numbers of people who provide what they perceive to be socially acceptable responses, while in their lives they carry on as before. Moreover, two new studies have rejected the focus on multiple concurrent partners as a major driver of HIV, pointing out that polygyny can also be protective if partners confine their sexual relationships to the designated triad, quartet, or quintet (Reniers & Watkins 2009; Kretzschmar, White, & Carael. 2009). Although low HIV infection rates in West Africa may seem to bear this out, the situation is confounded by virtually ubiquitous male circumcision there, which confers a protective effect. Moreover, the "if" is a big one. Muslim women whom I interviewed in Mbale district in 1992, and in the Comoros Islands in 2006, pointed out that many couple relationships within polygynous unions end in divorce, and that men, before they remarry, are likely to try out several partners (Schoepf, Andrianarisata, & Bedja, et al. 2006). In other words, there are no easy answers to preventing HIV/AIDS transmission.

Neverless, despite some omissions, and despite these caveats, this is a worthwhile book, full of critical case studies and provocative insights.

Ida Susser, South African–born into an ANC family and raised in exile, has made the journey to her early home several times to assess various aspects of HIV prevention. Her *AIDS, Sex, and Culture* provides an outstanding review of the policy contours in South Africa, and one that is more nuanced than that of other authors because of her position inside the liberation struggle. Charting the dilemmas of reconciliation and nation-building, and the tragedy of competing goals that interfered with an early response by the newly elected ANC government, she notes (but does not stress) the leadership's reluctance to address sexual relationships and to confront male dominance directly, despite significant constitutional guarantees of gender equity and

despite legislation to bring about structural changes favoring equality, at least for educated women. When it comes to sexuality, what emerged is what might be termed a "patriarchal coalition," with nationalist discourses of denial converging with religious, moralistic prudery.

With so many lives at stake and governmental action often seen as counterproductive, Susser is most interested in the social agency of ordinary people confronting the disease. By "agency," Susser (and I agree) means not merely the ability of an individual to act, but also the ability of the individual to join with others in a purposeful social group to struggle for change. As I found in Kinshasa in the late 1980s (Schoepf 1988a; Schoepf, Rukarangira, Payanzo, et al. 1988), despite devotion to their church, women in a poor urban community had sufficient counterhegemonic "practical" knowledge to resist their pastor's talk about sin and fidelity. Those who could not convince their husbands to use condoms sought nevertheless to protect their sons by redefining the maternal role and providing them with condoms. According to Susser's account, in South Africa pastors were divided in their response to the epidemic: some favored realism and attended the researchers' seminars to learn about protection; others promoted a hegemonic "commonsense" view, equating condoms with "promiscuity" and assuring women that their faith and their faithfulness (even to multipartnered husbands) was sufficient to protect them. Rural women were more prone to accept such hegemonic ideas about morality and to attribute AIDS to "sin" and "divine punishment." Yet workshops provided by the researcher and her collaborators strengthened women participants' critical consciousness and their capacity to act in their families and in public.

Susser documents grassroots agency among women's groups in peri-urban and rural areas of southern Africa, and also the protracted but successful struggle waged by national and international NGOs—with grassroots support—to obtain female condom distribution in Namibia. She traces the origins of rumors about the dangers or shortcomings of condoms to Namibian religious leaders, something that Christine Obbo and I had suspected elsewhere in the late 1980s (conversation, January 1988). Susser describes the objections: that condoms are difficult to use and expensive; that poor people can't afford them; that individuals don't know how to use them; and so on. At the same time, she notes that subsidized condoms were available in every shop and supermarket, and wealthy as well as poor people were spreading HIV. As a result of religious leaders' objections, condom education was unavailable at either Lutheran or government hospitals, and public distribution was delayed at both national and local levels. With pastors' wives often found in influential positions in rural women's organizations, the silence was complete. (In one community Susser found an ironic twist to conspiracy rumors: wishing to protect their children, some women alleged with resentment that the pastor's children secretly had access to condoms.)

Eventually, in 1999, the government of Namibia launched a "National Condom Use Day." With public advocacy for the female condom by a woman

with access to President Nujoma, and calls from women's groups, by 2001 a government promotion and distribution program had begun. Women who could afford the condoms began to try them, although Susser notes that poor women need free supplies. The failure of AIDS programs elsewhere to provide female condoms beyond research experiments is puzzling, especially since many women who cannot convince their male partners to use condoms are prepared to use them themselves to save their lives.

Susser's book also reports on research with Ju'hansi (San) women showing how their former sexual autonomy has changed with the encroaching threats to the group's self-reliance.[13] Roads connect the San world to urban centers in Namibia; the omnipresence of commercial shebeens and the presence of men employed from outside threaten young female adolescents, who are lured by their promises. Changes include in-migration of civil servants, road workers, school teachers, and secondary school students; the combined result brings a volatile mix of sexually active and materially deprived youth and migrants with cash living far form home. By 2003 AIDS deaths were becoming known. Although young women claimed awareness of the need for condoms and reported that they refused sex with men who would not use them, a high rate of unwanted pregnancies also indicates the prevalence of unsafe sex. The pursuit of transactional sex is bolstered by an urban disco culture and norms that accept transgenerational encounters and the "date-rape" of intoxicated girls, a situation exacerbated by the easy accessibility of the local home brew and nonenforcement of drinking hours at shebeens. The proportion of Ju girls involved in this risky culture is unknown, and Ju women may be able to obtain condom protection from Ju men. But men from outside, who may refuse or become violent, are another story altogether.

Susser identifies a concatentation of structural factors and bureaucratic procedures that create risky situations for the Ju, and makes it clear that HIV prevention will require much more than a few condom outreach projects. She reminds us that the knowledge of how to effect community mobilization exists; what is needed is the political will, bolstered by international resources, to avert tragedy. Susser's penultimate chapter deploys a Gramscian theory of social change in her assessment of the role of "organic intellectuals" in bringing it about—that is, professionals and bureaucrats who identify with the poor and promote critical or "practical" thinking rather than the received moralist ideas of churches and the state. The concluding chapter reflects on the role of neoliberal economic policies that have eroded both macro-level support for health services and micro-level independence and self-sufficiency of poor women and families throughout the region.

Susser is unique among the authors reviewed here in her adoption of an activist stance, both in the way she gathers data and in the production of critical knowledge. Guided by her longstanding commitment to medical anthropology and to public health as a collaborative enterprise between

researchers and the people whose lives are at stake, she emphasizes the importance of mobilizing local, professional, and international support for prevention interventions and for social change. She points to the Sonagachi project in Kolkata, India, begun in 1992, as a model. That project has held seroprevalence among sex workers (numbering some 18,000 women in the vast red-light district) to about 11 percent, in comparison to rates of 50 to 90 percent reported from Bombay, Delhi, and Chenai. Community-based programs in Africa have much to learn from the Songachi methodology and ethnographic evaluation showing how the interventions have proceeded. This project incorporates all of the major elements of a well-thought-out community-based program, bringing stakeholders on board by appealing to their self-interest, organizing and supporting paid peer outreach workers with education that has allowed them to manage the program, providing comprehensive health services, and much more (see Swendeman, Basu, & Das 2009; Evans, Catrin, & Lambert 2008). From the project emerged a grassroots organization that engaged in participatory social mobilization on behalf of sex workers. The women's self-concept changed from that of stigmatized people, with internalized feelings of low self-worth assigned by others, to that of workers providing a valued service and whose lives deserve respect and protection. Using various strategems, most were able to require condom use from their clients. Nonetheless, there were limitations as well: although the project was able to affect a range of conditions that had previously hampered condom use, overall structural changes remained beyond their influence.

Robert Thornton, a professor of anthropology at Witswatersrand University in Johannesburg, also traces South African policy. There are some weaknesses to his analysis. For example, although he notes the racist murmurings of whites at dinner tables and garden parties, he believes that Mbeki's defensive reaction to racist ideas was unnecessary (and without foundation). Yet he neglects the literature on mass media racism in South Africa with respect to Africans' sexuality. In other respects, however, his chapters on South Africa's struggle to come to terms with the HIV threat, the government's denial, its acceptance of bogus claims of cures, and its actions in the international arena to impede rational prevention—for example, at the 2006 UNGASS (U.N. General Assembly Special Session on AIDS)—are outstanding, thoroughly documented, and well written.

Thornton contrasts the South African context—with its wide-open sexual networks occasioned by the massive mobility of those in search of employment—with the situation in Uganda, where a more sedentary population makes its living on the land. Thornton's treatment of AIDS in Uganda—where he lived with his family as a youth, attended Makerere University, and subsequently taught school—is deeply grounded in empathic listening and participant-observation. Interviews conducted in 2003 with wide-ranging sets of informants, including old family friends, and casual

conversations, along with analysis of contemporary published texts from the Luganda-language newspaper *Munno*, provide the clearest picture to date of "what happened in Uganda" to dramatically reduce HIV prevalence in Kampala and other sites in the southwest from 1992, the peak year, until 2006, when prevalence began to rise again.

Thornton uses epidemiological research to show the variation in prevalence in different age groups and different regions at different times—all features essential to consider in moving beyond national-level statistics. He points out that awareness of *sliimu*, a new, deadly wasting disease, was widespread in Rakai as early as the early 1980s, and that the government response began under the Okellos, before the NRA carried Museveni to power in January 1986. Ugandans appear to have had a fairly straightforward response to talking about sex and risk, for by the time the government got involved, local people had already named and acknowledged the disease. Museveni's government brought peace, development, and hope, at least to the southern area of the country. Its early recognition of the disease, and its political response, fostered widespread mobilization and undermined conspiracy theories about the new and mysterious killer. This stands in stark contrast to the response in South Africa, where despite the fact that the disease became manifest a decade later, the government initially failed to respond, and later responded only with denial and confusion.[14]

Another important contrast lies in the different configurations of sexual networks. Thornton notes the strength of Ugandans' ties to the land, to lineages and property inheritance, not only among the 80 percent who live in rural areas, but among urban residents as well, who retain ties to rural families. Sexual networks among families were not hidden by shame, but were integral to the culture of many groups. Plural wives were common, as was wife-sharing among brothers in the southwest, and neither men nor women were necessarily faithful. Rural networks, however, tended to be of limited scope, "highly clustered with limited links between clusters"(71), and partner reduction could have had marked effect. The highest HIV prevalence occurs in cities and trading towns with more diffuse sexual networks.

In South Africa, by contrast, white expropriation of Africans' lands and the subsequent removal policies shattered lineages, while mine recruitment, the exclusion of women from towns, and rural poverty broke apart families. Today in South Africa, some 60 percent of household heads are unmarried. Land ownership is dramatically skewed: forty-six thousand among the total population of forty-five million people own 85 percent of the land. These realities have had far-reaching effects upon family life in both rural and urban areas, ultimately creating far-flung sexual networks with webs of risk that continue even after the deaths of several members. With virtually all persons linked to multiple parts of the network, Thornton argues, even quite large changes in sexual behavior will have scant effect on the whole.

Another difference in Uganda was that the government linked AIDS

control to development, with the government allowing many NGOs to become involved in prevention and permitting international donors to fund programs ranging from condom promotion to support for people living with the disease or caring for orphans. At the same time, as increasing deaths among families and neighbors became evident, many rural communities decided to eliminate sexual "cleansing" rituals and widow inheritance. Thornton agrees with those of us who have concluded that no single factor or behaviorial alteration can account for the many changes that took place. "Indeed, there are likely to be different causes for different age groups, regions, and genders," he says (89). Nevertheless, Thornton's analysis effectively undermines the claims of USAID in the Bush years that "ABC" was responsible for Uganda's declining HIV prevalence. Since moralistic approaches, especially the emphasis on abstinence, have only limited, temporary effects, he concludes that the money and effort spent on such policies have been wasted. I would go further and term them actually counterproductive, because they led to a rise in stigmatizing people. Thornton comments that aside from a limited number of people with strong religious beliefs, "sex is far too important to the majority of people to be controlled in this way" (227).

Thornton includes a chapter on indigenous concepts of sexual fluids, pollution, and disease as explored with *sangomas* (traditional healers)—mainly women in South Africa. He concludes with some proposals to limit the reach of sexual networks, although I find these unrealistic in the main, because they ignore the risk of infection within stable couples in a mature epidemic; they also ignore the cosmological concepts that he himself set out in the chapter on *sangomas*. By contrast, I find much more important Thornton's conclusions with respect to networks, including his reflections on struggles over knowledge and on local efforts to mobilize communities to protect their members. Curiously, in view of the excellent emerging literature on same-sex relationships among men in both South Africa and Uganda, Thornton gives the subject no attention.

This book is particularly useful for readers interested in the review of relevant epidemiological research showing the variability that has yet to be fully explained. It is also notable for Thornton's treatment of contrasting sexual networks, including his suggestions about socially and culturally determined differences. I found the sections in which he allows people to speak for themselves particularly interesting.

Doug Feldman was the first anthropologist to publish (in 1985) research findings on the social aspects of AIDS in Africa. Though he began as a medical anthropologist new to Africa, he has since then acquired first-hand ethnographic experience, led teams of researchers, read widely, and edited half a dozen anthologies on culture and AIDS. The most recent, *AIDS, Culture, and Africa* is by far the best of these works. Most of the fifteen chapters (some of which were published previously), deserve to be reviewed indi-

vidually; however, with limited space, I must choose just a few. Feldman's perspectives have changed over the years to incorporate considerations of political and economic contexts of risk and vulnerability. He reviews some recent literature and calls for structural changes to alter the contexts of sexual risk (see also Symonds & Schoepf 2000), although he provides no proposals on how even small steps might be taken toward the utopian goals he lists in his conclusion (a reason that the Susser volume is so important).[15] The book is directed toward non-anthropologists, but anthropology undergraduate and graduate students will find many chapters and bibliographies of interest.

In chapter 3, Ruth Kornfield and Stella Babalola explore the gendered dimensions of the high level of stigma and the low level of public support for people with AIDS, both of which increase HIV risk in Rwanda. They find that because of these factors, people often delay HIV testing—and that those who do test positive continue to practice unprotected sex. In addition, reliance on traditional medicine can retard entry into the biomedical health care system and discourage HIV testing. Men may continue to patronize sex workers so that their peers will not suspect their status, while some poor women, including AIDS widows, engage in sex work as their only recourse. Gender inequality contributes in various ways to women's poverty and subordination in relationships with men. Patriarchal practices persist in rural areas despite changes in land and inheritance laws; wife inheritance (and perhaps the sororate?) continue, despite the increase in female-headed households in the aftermath of the 1994 genocide and continued imprisonment of perpetrators.

Women's coping responses include participation in associations of PLWHA, which men are reluctant (and perhaps ashamed) to join, thus missing out on the food distribution and emotional support such groups provide. Because sick men are often dependent on their wives for care and for most of their economic needs, they are unable to meet masculine role expectations, causing shame and emotional distress. Alcohol abuse, a prevalent coping mechanism even among Rwandan men without AIDS, has increased among men with HIV. The authors find that the programs in place focus mainly on treatment and care, while neglecting prevention. Prevention programs, they point out, need to be strengthened and to recognize the roles that sexual relations play in the lives of women and men, even when they are infected, while avoiding the stereotyping that perpetuates inequities. The chapter's excellent descriptive case study materials and thoughtful analysis deserve to be expanded into a book. It would be interesting to see a study that compares the specific areas of this research with the area of southeastern Rwanda served by Partners in Health's comprehensive AIDS project, which includes care by paid community health workers, money for food and transportation to hospitals, and measures to reduce poverty through agricultural inputs and training.[16]

A novel study by Anthony Simpson (chapter 7) is titled "Harmful

Ideologies of Masculinity and Sexual Encounters in Zambia." Drawing on participant-observation, the author follows men whom he taught and interviewed in the 1980s (when they had completed their education at a mission secondary school) to explore how constructions of masculinity are embodied in their lives. These elite men have the information and power to protect their partners from exposure to HIV. "That some at times did not do so," he says, "must be understood within a context where harmful ideologies of masculinity and the vulnerability of men striving to appear as 'real' men put them and their partners at risk" (108). Simpson's informants invoke both African "tradition" and Christianity to justify their superiority and power over women, even when they cannot fulfill what they and others delineated as the male "provider" role. Most consider multiple sexual partners an entitlement of masculinity, while those who fail to measure up to this hegemonic ideal attribute their behavior to "shyness," not considered a positive trait among their peers. Although a few men have been able to maintain, or rekindle, positive relationships with their wives, in most households gender antagonism prevails. Simpson draws on the anthropological archive of Copperbelt studies to document both the historical continuity and the exacerbation of gender antagonism under the impact of AIDS. Adherence to the hegemonic meanings of manhood—emphasizing male power and sexual performance, despite the concept's fragility in this time of economic crisis—along with disinformation about condoms deliberately spread by the Catholic Church, has resulted in risk of HIV/AIDS. Nevertheless, Simpson finds that some men seek to construct a more responsible alternative. We need to know more about such men and the processes by which they arrive at their decisions and are able to resist peer pressure to follow the more conventional path.

Simpson wrestles with an issue that has preoccupied many anthropologists who seek to prevent the spread of HIV in Africa. Given the colonial and postcolonial fantasies of black men's "hypersexuality," it is crucial to avoid constructing an "African sexuality" in opposition to some supposed "white" or "European" sexuality. He hopes that involving men directly in confronting the dangers of hegemonic discourses and practices can save anthropological research from becoming merely another form of social control. This research, too, deserves book-length treatment.

In chapter 8, Douglas A. Feldman and seven associates examine the moral ideology adoped in regard to HIV and AIDS by elite Zambian youth in two Lusaka secondary schools. They reveal the impasse created by fundamentalist Christian religious leaders who currently dominate the cultural airwaves and whose uncompromising message leaves youth to become sexually active without protection from HIV or other STDs and also vulnerable to unwanted pregnancies. Most of those interviewed came from families with above-average incomes (both for Lusaka and for Zambia as a whole), and most expressed approval of government assistance and compassionate care for people living with the virus or AIDS. However, their choice of

terms denoting certain behaviors implied strong moral condemnation, and a sizeable fraction favored harsh punitive policy actions for these behaviors; nonmarital sex is termed an "evil sin," and AIDS is designated as a "punishment from God." Many expressed the belief that people with AIDS should be detained in hospitals to prevent transmission of HIV and should not be allowed to marry; some even said they should be killed. Although most students had a family member who was sick or dying from AIDS, roughly half said they did not view AIDS as a major health crisis in Zambia.

At the time of the study (1997–2000), Zambian government leadership was largely silent on the AIDS crisis, schools provided no formal HIV/AIDS curriculum, and pastors in the burgeoning fundamentalist churches thundered moralist condemnation of "sinners." Yet despite the dramatic growth of religious conservatism during the 1990s, the researchers found that the presence of "strong societal norms against extramarital sex have not substantially changed the sexual behavior of many Zambians.... The presence of AIDS has neither weakened those norms nor diminished the social stigma attached to these norms" (136). Indeed, although half the young men and one-third of young women surveyed reported that they had had at least one sexual experience by tenth grade (most often without condom protection), the students evidently rejected the notion that their own behavior was immoral. Minimizing the importance of HIV/AIDS in Zambia, many students view AIDS as affecting only an immoral "other," thus making effective government intervention more difficult. To use protection, young people must first believe that they are at risk, and then accept the efficacy of regular condom use as protection.

Government and church leaders, however, have stressed that condoms offer less than 100 percent protection, and this view was represented among the students as well. Asked to estimate what they believe to be the effectiveness of correct and consistent condom use, the students came up with a range of 50 to 75 percent, much lower than the result of actual trials conducted among couples in Lusaka, for whom regular condom use averted an estimated 85 to 87 percent of new infections. The students' responses reflected the wider social tendency to discuss AIDS in moralist terms; few people have been tested to learn their HIV status or to obtain free treatment and death notices rarely mention AIDS. In short, this study suggests that the moralism and stigma surrounding nonmarital sex leaves sexually active students confused, in denial, and unable to act collectively or individually to protect themselves against HIV or unwanted pregnancy.

Robert Lorway (chapter 9) addresses the marginalized, vilified, and persecuted African men who have sex with men (and perhaps women as well, either concurrently or later in their lives.[17] From the vantage-point of twenty months of fieldwork in Namibia in 2001–2002, he interrogates international health policymakers who for many years characterized Africa's HIV epidemic as exclusively heterosexual. Describing the daily lives of young men with same-sex partners, he investigates the ways that the young men experience

their sexuality and construct their identities as sexual subjects. They are particularly vulnerable because even knowledge of HIV risk does not protect "moffies" from the superior power of "straight" men, locals, and international tourists, who purchase sex and assume the insertive role. He finds them protesting the rampant homophobia of President Sam Nujoma, who like Robert Mugabe lambastes same-sex relations as "un-African." Such resistance to persecution connects these men to transnational queer rights' protest, and also links them to the rights' discourses and collective action discussed in the report by Arnott and Crago (see below). Lorway's research follows a pathway opened by Marc Epprecht (1998), whose "Unsaying of Indigenous Homosexualities in Zimbabwe" lifted the veil of silence in that country.[18]

In chapter 10, Elizabeth Onjoro Meassick constructs a defense of abstinence and fidelity on the grounds of cultural appropriateness for Africa based on traditional values—a seriously flawed reading of ethnography. While African societies made rules about sexuality, rarely was lifetime monogamy expected among them, and "rules-for-breaking-rules" abounded (Schoepf 1992). Meassick also favors local remedies over Western biomedical technology and claims, without evidence, that "developing strategies to address cultural behaviors . . . is much more cost efficient and logical than investing in the massive distribution of condoms" (190). She has nothing to say about Western-developed antibiotics or ARV treatment, which have saved millions of African lives. Meassick and others refer to ABC as though it were an African invention. In fact, early WHO advice, which was publicized in Kinshasa by the Zaire Department of Health in leaflets from 1987 on, included these guidelines as well as recommending the use of disposable injection needles.

Meassick's either/or arguments are so weak, and her appeals to an invented "tradition" of sexual abstinence and fidelity so patently ahistorical, that one wonders why Feldman—who, as a critic of what he calls "ABc" (with the lower-case *c* signaling the relative neglect of the role of condoms, which are widely thought to promote promiscuity), clearly disagrees with her—includes this chapter in his book. Was this in the interest of "fairness"? But what is "fair" about spreading misinformation? Was he simply eager to present an "authentic" black African woman's voice? If this was the reason, why not request a contribution or reprint from Christine Obbo, whose pioneering ethnographic work in Uganda and contributions to research epistemology tend to be forgotten? (See Obbo 1993a; see also Obbo 1993b, 1995, 1999.)

Susan McCombie and Ariela Eshel (chapter 11) address the language of survey instruments, pointing to the different meanings for sexual activities and sexual partners in African contexts, where "there has been little attention to issues of translating terms" (202). Meanings of what counts as sex (think of President Clinton!) may vary by acts, by place, and by types of partners, inter alia. They argue for a reinterpretation of the Uganda data, pointing out that condom use in fact rose among "nonregular" partners,

and they find that "many prevention specialists retain negative attitudes about condom use and have never used one with a regular partner. . . ." They also argue that "positioning condoms as a last resort for those who cannot abstain or be faithful does little to change prevailing misconceptions about partner selection as a primary strategy[,] . . . [while] reluctance to promote condom use for [committed couples] . . . has been an obstacle to HIV prevention since the mid-1980s (216). I agree entirely.[19] One exception has been the Aids Service Organisation (TASO), an NGO, did promote couples' dialogue for risk reduction. One of the stratagems advised by the TASO volunteers, many of whom were HIV-positive, was for people who were shy about talking about AIDS with their partners to introduce the subject of condoms as the preferred family planning method (Kaleeba 2002 [1991]).[20] However, this approach has not, to my knowledge been attempted on a larger scale.

Theresa Swezey and Michelle Teitelbaum (chapter 12) studied Muslim households in Busoga, Uganda. They observe that "little has been done to incorporate a realistic view of African marriage into policy, funding and interventions" (221). Instead, idealized, prescriptive concepts of Christian theology have hampered prevention, while surveys often have counted people in polygynous unions as one couple, without noting the other women in the ménage. In contrast, imams use sermons to convey the need to "stay within unions" and for men to support women's income generation. They recommend this approach without assessing its effectiveness.[21]

Charles Rwabukwali (chapter 13) argues that poverty is not necessarily a risk factor for Ugandan women, since many do not engage in sex with multiple partners. One of his informants received assistance from her father; another sold illegal liquor. He goes on to argue that rather than poverty, male dominance in the society is at issue, since men's use of resources to attract additional sex partners contributes to poverty. Indeed, the epidemiology shows that married women's biggest risk factor is husbands with multiple partners, and that the epidemic is shifting from wealthy men and their partners to the poor. While women with education and incomes can protect themselves by refusing sex, poor women without these advantages are obliged to "trust their partners" and are caught in a bind when men are unfaithful. I also would have hoped that Rwabukwali might have provided some insight into how multiple sex partners are used by many men to enhance their masculine identity in a situation in which poverty closes off other avenues, and how this might be changed.

Marc Epprecht's new book, *Heterosexual Africa?* interrogates the silences of anthropologists who have failed to dispel the myths denying that alternative forms of sexual expression among Africans, particularly men's same-sex relationships, formerly were tolerated in various societies. Epprecht argues that by ignoring the subject—including facts well known to historians of southern Africa—anthropologists have bolstered the problematic

stereotype of African heterosexuality and have contributed to an absence of public health campaigns to address the men's vulnerability to HIV.[22] He explores possible reasons for anthropologists' silences during the colonial period and in the present, and considers the homophobia of both Christian and Muslim fundamentalists that has fueled the gay-bashing of some African leaders. He proposes that the visible and vocal presence of the gay rights movement in southern Africa will have a transformational effect on scholarship, leading to a new ethnography of sexualities in Africa that is attentive to new subtleties. At a time when the Ugandan Parliament is considering making homosexuality punishable by imprisonment, and even by the death penalty, the international human rights community needs all the help it can get from engaged scholarship.[23]

Graziella Van den Bergh's dissertation, "From Blessing to Burden," combines analysis of adolescent women's attempts to manage their fertile bodies with her own efforts at providing sex education and instruction in HIV prevention at the local level in Kigoma Region, Tanzania, where little government activity was in evidence in the late 1990s. Her twenty years in the area as a health worker and her fluent command of Kiswahili were evident in the sensitivity and breadth with which she pursued her investigation.

Van den Bergh begins by tracing the violent history of the nineteenth and early twentieth centuries that cemented most women's and children's low position in the region. Despite the presence of defiant "wicked women," as portrayed so vividly by Sheryl McCurdy (2001)—that is, women brought in chains from Maniema during the upheavals of the slave trade who made new independent lives for themselves by selling sex—local village women found themselves newly disadvantaged. Van den Bergh's descriptions of villages left behind by male labor migration show similarities to the situation in South Africa. And while some women have gained independence through petty trade, the major enterprises are still owned by men. Today the region's general poverty, alongside the influx of refugees from DRC (Congo), Rwanda, and Burundi, create new contexts of sexual risk.

Another parallel with South Africa lies in the invocation of "tradition" by elders and civil servants, including teachers and nurses influenced by Christian and Muslim teachings that demand abstinence from adolescents and refuse them sex education and contraceptives, despite laws that are supposed to provide access. Providers in the provinces, including Kigoma (located more than 1,600 kilometres from Dar-es-Salaam), may not be aware that the law has changed. Even in the time of AIDS, many view pregnancy as a moral rather than a health issue, with both pregnancy and eviction from school seen as the deserved punishment for girls who engage (or "indulge") in "precocious" sex. Yet no comparable punishment falls upon men and youths who make the girls pregnant, often by enticing them or forcing them against their will. As numerous other studies from across the region have reported, Van den Berghe found that men who previously

would have admitted to, or perhaps would even have boasted of, causing the pregnancies, now (partly under the pressure of poverty and unemployment) are unwilling to acknowledge responsibility. This leads some pregnant adolescents to seek nonmedical abortions, which may result in serious complications and even death. Most of the young women who give birth lead hopeless lives, earning little in the lowest ranks of the informal economy; some rely on sex with multiple partners to support their children.

Eschewing the moralistic and judgmental tone of health workers (and even her research assistants), Van den Berghe examines the silencing of young people's voices, which Obbo (1993a, 1993b, 1995, 1999) noted a decade ago. She points to the operation of Foucault's "logic of censorship," which first prohibits an action, then prevents it from being discussed, and finally denies its existence. The study effectively documents the limited agency of many adolescent females, whose lack of control over their own bodies often traps them in dangerous choices. In response, Van den Berghe calls for the creation of "youth-friendly" health services and realistic instruction in the biology of sex and reproduction. She further notes the need for measures to create meaningful productive roles for young people of both sexes for whom peasant production is unrealistic—the need, that is, to give them hope for the future.

This dissertation joins other outstanding contributions on young people's sexuality and their place in contemporary society by anthropologists who worked in Tanzania in the 1990s, such as Liv Haram (1999), Philip Setel (1999) and Brad Weiss (1996), and the interdisciplinary volumes by members of the Women's Research and Documentation Program (WRDP) in Dar es Salaam (Tumbo-Masabo & Liljestrom 1994; Rwebangira & Liljestrom 1998). The single most interesting source on youth sexuality and vulnerability to HIV to appear in recent years, it will repay any careful reading of its deployment of theoretical constructs in anthropology and gender studies.

Most of the chapters in the volume *HIV/AIDS in Africa*, edited by Edith Mukudi, Stephen Commins, and Edmond Keller, contain more description than analysis. Many authors offer good advice with respect to policies and programs, but they fail to show why these have not been implemented, or how political and economic conditions have impeded their success. As part of this collection, Robert Ostergard Jr. continues the work he began with Ali Mazrui on the subject of HIV/AIDS and the military (Mazrui & Ostergard 2002). Here he notes the potential threat posed by AIDS to security issues if the health needs of military men who are HIV-positive go untended. However, his essay omits any analysis of the role of militaries in spreading HIV. A literature review on the extent of mass rape in the continuing violence in eastern DRC, perpetrated both by combatants (on all sides) and by civilians, would have been a valuable case study of the social effects of the convergence of militarization and masculinities.

Vivian Lowery Derryck writes about U.S. interest in Africa since 9/11, not merely as a site of terrorist recruitment, but also as the source of one-quarter of our oil supply by 2015 and as "a potential new frontier in globalization" (149). Already, private investment accounts for 80 percent of U.S. capital inflows to Africa, while another large portion consists of military support. Derryck exhorts U.S. industrial firms to mount effective prevention and treatment programs out of self-interest, and to this end he provides examples of partnerships between state agencies, private sector actors, and philanthropic institutions. Unfortunately, in this chapter the actual practices of multinational firms are left unexamined. From early in the last century, the presence of multinational firms has been synonymous with labor migration, low wages, brutal working conditions, and lack of health care and worker protection—a template that has contributed (and continues to contribute) to the spread of the virus. Also unexamined is the sentiment expressed by Mbeki and others that African labor is expendable, given the current "oversupply."

Some mines in South Africa have closed their single-sex hostels and now provide a "living out allowance" that is insufficient to fund decent family housing. The men live in rented shanties in nearby "informal settlements" bereft of amenities, to which unemployed women flock, seeking support from sex work. HIV prevalence is off the charts, at 50 to 80 percent. Prevention has been stymied by stakeholders' competing interests and a focus on individualized responses (see Campbell 2003). In companies such as De Beers, which now provides ARV treatment, "rollout has been less than optimal," primarily because workers do not trust health providers who do not speak local languages or *fangolo*, the lingua franca of the mines, and who tend to "disparage local health beliefs and practices" (IRIN Plus News 2008). Generally they are assumed not to maintain confidentiality, a holdover from earlier years, when miners were tested without their consent and those found to be HIV-positive were fired before they could claim disability benefits (interview with Shadrack Mothlung, Arusha, August 1991).

Other contributors to *HIV/AIDS in Africa* sketch the dire effects of AIDS sickness and death on other sectors of African societies, such as the civil service, education, and health; they also furnish general policy chapters on national and community mobilization. All of the chapters are helpful and contain many valuable suggestions, but since most lack a strong ethnographic grounding in the analysis of real cases, or the deep political and humanist engagement of the other works, I find that they make for dull reading.

In *Rights Not Rescue,* Jane Arnott and Anna-Louise Crago report on the results of a consultation with sex workers in Botswana, Namibia, and South Africa. Most of the interviews were with women, but the study includes some male and transgendered people as well, making this an unusual document. Their portrayal is grounded in a realistic assessment of the economic pos-

sibilities afforded by the crowded informal economy, especially for women. With so many sellers, and so many would-be buyers constrained by poverty, the prospects for inexperienced new entrants looking for jobs in the formal economy are grim. Sex work brings in greater and more predictable returns, while women find that "rehabilitation" programs perpetuate stigma and marginalization. For women in Cape Town with a primary education, sex work pays up to four times that of any other job—if, indeed, any other job were available.

Like the women of Sonagachi, in India, the women interviewed in southern Africa demand to be treated as workers, and demand rights to health and survival. The familiar rotating credit associations to which many African women with no access to bank accounts belong, called *stockvel* in South Africa, take on special significance as a social safety net for sex workers who frequently face robbery by *tsotsis* and the police. Theft of belongings is more than a financial loss alone; it may also mean loss of ARVs or other medications, which peers sometimes try to provide until the victim can obtain replacements.

Sex workers across the region call for governments to decriminalize sex work, end police harassment and corruption, and provide free condom supplies at work areas to ensure safer sex practices. Another important demand is free education for their children, who often are excluded from schools in Botswana, for example. The report also calls for sex worker–led training for health workers and police to ensure respectful, nondiscriminatory services and protection, and for projects to increase sex workers' capacities for organizing both formally and informally. To this end, international funders need to support sex worker organizing, proven safer sex interventions, and health and human rights initiatives. A collaborative endeavor between researchers and sex workers, the report is a new departure for HIV prevention and advocacy in Africa. The 2008 PEPFAR renewal continues to ban provision of U.S. funds to organizations that serve sex workers; moralism continues to trump science. The authors and the Open Society Institute, which published the book, are to be congratulated.

The title of Linda Fuller's book, *African Women's Unique Vulnerability to AIDS*, is misleading in two ways. African women's social, economic, and cultural (let alone biological) vulnerabilities are hardly unique. And vulnerability is not the end of the story. Fuller reviews the general literature on African women and AIDS, then describes some actions taken by women in groups and provides lists of organizations involved in prevention campaigns in both the mass media and community-based projects. Readers looking for addresses will find this useful, but Fuller fails to provide critical evaluations of the interventions, either from published literature or her own observations. The latter is not surprising; although the publishers' announcement lauds her "hands-on experience in Africa," Fuller, when pressed to expand on her qualifications, replied that she spent some three months in Senegal

on a Fulbright grant in 2002, "helping SWAA [the Society for Women and AIDS in Africa] with their programs" (phone conversation, October 2009). She places her hope in communication for development and concludes, "What happens next for African women, vulnerable to AIDS, depends on local communities, governments, civil society, human rights organizations, and you" (192). I have to acknowledge that this critique of the book may seem uncharitable, since Fuller asked me for advice before she departed for Senegal, and quotes liberally from reports of CONNAISSIDA's community-based work.

Conclusion: AIDS, Structure, and Agency

In sum, although some settings have seen declining prevalence and reduced death rates, the numbers of HIV-infected people in Africa have risen with the rise in population. HIV is still the leading killer of African adults and continues to infect young and old, with incidence rates climbing anew wherever prevention efforts falter or harsh conditions disempower populations. As global power relations have grown more unequal, the HIV epidemic in many countries has shifted from predominantly well-off population segments to threaten the poor and powerless. AIDS strikes with particular severity in communities struggling under the burdens of economic crisis, deepening poverty, and the effects of armed conflict.

The books reviewed document the interrelated contextual forces that drive the African epidemic, including the intertwining of meaning and materiality in sexual relationships. These forces have been known for more than two decades, since they were first analyzed by my colleagues and myself in Kinshasa and CONNAISSIDA called for community mobilization, socioeconomic change, and the empowerment of women to stem the spread of HIV, and pointed out ways to enable people at risk to envision cultural change that would be protective. In the interval, many researchers have found similar results in other countries, and their works testify to a paradigm shift: away from reliance on informational messages to alter individual behavior and toward social analysis and a search for transformational structural change.

Most of the authors discussed here participate in this call for change, beginning with poverty reduction, an end to gender inequality, the elimination of national debt obligations, and an end to policies imposed under Structural Adjustment and its later incarnations that restrict budgets for education, health services, and other forms of social protections. All of these reforms are critically important to Africa's future, but there is little evidence of political will at national and international levels to begin such transformations. AIDS is a metaphor for the impasse of development in Africa, and the body politic is inscribed on the bodies of women (see Schoepf 1988b). Researchers express uncertainty about which changes can reduce sexual risk and how to measure their impact (see Parker, Easton, & Klein 2000).

While the U.N. agencies (especially UNDP) recognize that the economic and social depredations wreaked by Structural Adjustment programs create vulnerability for African women and men, USAID and the World Bank do not (see Lurie, Hinton, & Lowe 1995; Schoepf, Schoepf & Millen 2000), and in general the structural and political changes that must undergird cultural change are not on the agenda. Instead, there is some tinkering around the edges, as with microlending, or informal economy projects for vulnerable women. Community mobilization efforts, which increasingly are acknowledged in international health and development agencies, have nevertheless failed to receive the resources that could expand their reach (or "bring them to scale"). With ample international support, the Sonagachi project, the most successful risk-reduction program, now is being "replicated" in many sites in other south Indian states. Critical lessons from this project appear to have been neglected elsewhere, however, perhaps not so much because the major actors are sex workers, but because of the progressive aspects of community mobilization in Sonagachi that have not been replicated elswhere: the involvement of "organic intellectuals," the development of critical consciousness, and mass social action for structural change—the same processes that Susser's analysis finds so helpful.

Few governments of wealthy countries have sought to stimulate widespread changes in the political economy that might redress the structures of inequality and social injustice. Indeed, the new century has accelerated the privatization of economies, as international owners move their factories in search of cheaper labor; as international land deals dispossess small cultivators, leaving them without livelihood resources; as vulnerability to drought and global warming increases over time; and as single-commodity economies become more dependent on the extraction of oil or a few other minerals (on the first factor, see Schoepf et al. 2006). All contribute to migration in search of work, to mass impoverishment (especially of women), and to the widening gap between the wealthy few and the poor majority in many countries. The extremely high HIV prevalence among pregnant women in Swaziland, for example, may be due to high unemployment rates of both women and men.

At present, international funding agencies advise government programs to "change social norms" in order to reduce multiple partner "concurrency" and other risk behaviors, albeit without a clear idea of how this might be done, or how to recognize such change if or when it occurs. The notion that changes in behavioral norms can take place without economic, political, and ideological change in society never ceases to amaze social scientists. The books reviewed here are in uniform agreement that a focus on prevention interventions to effect changes in the norms governing sexual behavior, without commensurate attention to the contexts and the life circumstances that create sexual risk, is of limited value, and indeed may be counterproductive.

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Notes

1. In 2001 world leaders at the U.N. General Assembly Special Session on AIDS (UNGASS) recognized AIDS in Africa as a social crisis. However, the Global Fund to Fight AIDS, Malaria and Tuberculosis in 2007 obtained pledges of $9.7 billion, about half the amount it hoped to raise. In 2009 the shortfall rose further and the U.S. flatlined its contribution under PEPFAR (the U.S. President's Emergency Plan for AIDS Relief).
2. Uganda's National AIDS Commission reported new infections on the rise in 2004–2005.
3. Ngugi's (1988) methodology is similar to that of CONNAISSIDA (see note 4).
4. When we learned of the presence of AIDS in Kinshasa in 1985, several Congolese colleagues and I began the CONNAISSIDA Project to conduct ethnographic research in support of HIV prevention. We focused on sets of social relations that included sex, and charted popular meanings of AIDS as they changed over time. By mid-1987, participant-observation and hundreds of depth interviews in diverse neighborhoods, as well as life history narratives, afforded a broad view of the multilayered relations among political, economic, social, cultural, and psychological dimensions of HIV risk and vulnerability. Situating research on AIDS within Zaire's history of colonialism, underdevelopment, worsening global inequality, and gender subordination, we proposed that what appeared to be individual behaviors are actually culturally constituted gender roles and relations produced from material conditions and enforced by institutional and social structures.

   We began to experiment with various community groups to explore the value of participatory problem-posing interventions. Psychosocial action–research is a form of interactive "performative ethnography" based on principles of social psychology that can make the knowledge acquired accessible to those who share in its production. Based on research by Kurt Lewin (1948) and others in the 1950s and 1960s, the method was popularized as a development strategy by the Brazilian educator, Paolo Freire (see Freire 1970, 1983). In contrast to the transfer of didactic information via messages, group problem dialogues can empower people to take action and to envision more general social change. The method can be used as a powerful research tool, a form of "performative ethnography." I trained in the methodology while I was a researcher in the community psychology department at New York University (1971–72). I led training workshops in Kinshasa for the Department of Agriculture in 1983 and 1985, and in Harare for the ZANU/PF Women's League in 1983.

   In a series of workshops on HIV prevention in 1987, I designed role-plays, stories, and other "experiential exercises" to convey biomedical information and to create situations that engage participants' emotions. These encourage people to consider their level of risk and explore their prevention options, both as individuals and as social groups. My colleagues and I began with university

colleagues, local officials, and informal women's groups. For a full description of the methodology, see Schoepf (1993b).

5. A study from Rwanda by Ruth Kornfield and Stella Babalola (chapter 3 in Douglas Feldman's *AIDS, Culture and Africa*, see below) offers similar findings, as one might expect from a culture in which, as the well-known Rwandan proverb says, "help from neighbors comes only after the rains."
6. The renewed "moralism" of the Bush years continues in vogue. PEPFAR provisions still prevent funding support for programs that include sex worker prevention and mandate reporting to Congress when abstinence-only program funding falls below 50% of prevention interventions.
7. The manner in which the whole subcontinent is connected by the movement of people is the basis of Robert Thornton's "unimagined community," discussed below.
8. For example, see Graziella Van den Bergh's study in Kigoma, Tanzania, discussed below. Ida Susser's study, however (also see below), found urban community women more realistic, as my colleagues and I did in Kinshasa (Schoepf, Rukarangira, Payanzo, et al. 1988).
9. For an analysis of developing "health citizenship" and the steps taken by MSF and TAC to bring about change, see Robins (2004).
10. For example, the constant shedding of cells in the convoluted lining of the vagina and cervix, including Langerhans cells (which are more numerous in women than they are in the male foreskin), leaves new epithelial cells as ready targets of the HIV virus. HIV is more concentrated in semen than in vaginal secretions. The result is that HIV is more readily transmitted from men to women than vice versa. Immature girls, in whom membranes of the lower reproductive tract are especially fragile, may be infected at first sex with an older man. See Schoepf (1992). Also, women are more susceptible to other sexually transmitted infections (STIs) that increase the risk of acquiring HIV by three to five times, and, due to stigma and cost, are less likely to obtain biomedical treatment. Bacterial vaginosis, a common multiplier for HIV acquisition, affects only females.
11. Although she fails to note earlier instances of this quest in DRC (then Zaire), Kenya, Malawi, and The Gambia.
12. See note 4 for an explanation of the CONNAISSIDA project; the acronym is derived from *connaitre* ("understand") and SIDA (the French acroynym for AIDS).
13. This research also appears in the Feldman volume (as chapter 2, with Richard B. Lee) and is updated here.
14. Even with the more open government responses in Uganda, however, my interviews with young Baganda in 1992 and 2003 found that many rejected the advice and others engaged in secret in practices that they denied in public—remaining in denial until the popular musician Philly Lutaya announced his illness in a 1997 concert, shortly before his death from AIDS (Schoepf 2003, 2004).
15. In 1987 Feldman attended a Medical Anthropology Roundtable hosted by Ruth Kornfield, where he discussed the political economy and culture perspective developed by myself and colleagues in CONNAISSIDA, along with our proposal for community-based action research for collective empowerment in prevention. He apparently was less than impressed at the time.

16. Interview with Paul Farmer by David Brancaccio, *NOW*, PBS, December 18, 2009.
17. Chris Lockhart (2002) addresses the temporal dimension. In 2005 Gabriel Essak (in research for the project reported on in Brooke et al. 2006) found that some "MSMs" (men who have sex with men) in the Seychelles are actually bisexual; they marry and sire children to meet normative expectations.
18. I unfortunately missed this and other important contributions in Schoepf (2001).
19. See Schoepf (2003, 2004).
20. Women in Kinshasa arrived at the same strategem in 1987. They decided it would be useful at home as a way to introduce the subject of condoms without arousing denial and accusations of blame. About half the women who believed their husbands were unfaithful reported that it worked: their husbands agreed to use condoms at home. In 1991 I took the idea to the UNICEF office in Dar, where I drew it as a cartoon for my draft HIV prevention strategy. My secretary laughed and pinned it up on office bulletin boards throughout the building. We returned the next day to find multiple pinholes in each. Women with whom she spoke (and perhaps some men) had taken the drawings down to photocopy, replaced them, and used them at home. The cartoon can be seen in Schoepf (2010).
21. But see Parikh, above. Also see Ngugi (1988).
22. I can attest to the avoidance of public discussion of male homosexuality by the leaders of the CONNAISSIDA Project in Kinshasa in the late 1980s, despite our awareness of two networks of men practicing sex with men. In 1987 we were already besieged by moralists among the faculty of our host, the Center for Social Research, who objected to our distributing condoms to journalists and female sex workers. Instead, my colleague, Rukarangira wa Nkera, contacted one group that frequented a certain café located at the edge of the downtown area (Gombe), while I spoke with a long-time acquaintance working in the U.S. Consulate, who immediately volunteered to conduct risk-reduction counseling with his peers on the Kinshasa University campus. Our interventions at international AIDS conferences about married women's risks were so harshly received that we "chickened out" with respect to public disclosure of stigmatized same-sex relationships among men.
23. See Refugee Law Project and Civil Society Coalition on Human Rights and Constitutional Law (international@list.refugeelawproject.org).