THE NEW ATLANTIS
A Journal of Technology & Society

AIDS Relief and Moral Myopia

Travis Kavulla

Public-health specialists working on AIDS in Africa are fond of invoking "ignorance." It is a term assigned to any local attitude that stands in their way—from the cool reception Africans have given condoms to the lingering doubt in many African societies that sexual activity is the essential cause of AIDS.

But while "ignorance" is one term to describe the psychology that has led to an epidemic of such proportions—with more than one million Africans dying of AIDS each year, and more than eleven million children orphaned by the disease—it is not a wholly apt one. "Ignorance" implies that there is an inevitably persuasive truth that, once revealed, will peel the scales from the eyes of the naïve.

The problem in Africa is not so much uneducated ignorance as it is willful ignorance. Few better exemplify this second kind than the leaders of South Africa, one of the countries most ravaged by AIDS. Thabo Mbeki, the former president, despite an otherwise mannerly and intellectual character, was a career-long conspiracy theorist when it came to AIDS. He believed that it was not caused by a virus, but was merely the result of "malnutrition" and "allergens"—well, except those times when Mbeki *did* believe it was a virus, but thought it was, in line with Soviet propaganda of the time, an invention of Western laboratories. Until recently, South Africa's Ministry of Health advocated "traditional" remedies for AIDS—encouraging sufferers to take beetroot soup instead of their anti-retrovirals (ARVs). Indeed, Health Minister Manto Tshabalala-Msimang at one point made her kooky remedy effectively mandatory by halting the importation of a number of perfectly safe, tested ARVs, thus consigning thousands to agonizing deaths.

And then there is Jacob Zuma, referred to in a number of bolder African media outlets as "Power Shower Jake." This epithet has its roots in Zuma's 2007 rape trial, where he admitted to having unprotected sex with a woman he knew to be HIV-positive (but denied coercing her). In the course of his testimony, he said that the woman had seduced him by wearing a *kanga*, a type of colorful wrap, and that any Zulu man was

Travis Kavulla *is a Phillips Foundation journalism fellow and was last year a Gates Scholar in African history at Cambridge. He writes from Kenya on issues of religion and politics.*

honor-bound to satisfy her. (Zuma is a self-styled traditionalist with four wives and over twenty children already.) To protect himself against HIV, he testified that he had taken a cold shower after intercourse. Zuma was acquitted and, this May, became president of South Africa.

We can call these people ignorant or backward. But there is something larger afoot in African society; there is a reason why the conspiracy theories are so many, the leadership so seemingly inept. Africans are not blindly resisting Western public-health beliefs. Their world is not a blank chalkboard where AIDS lacks an explanation that must be filled in by outsiders. Rather, they have a system of beliefs that makes perfect sense, in its own way, of the AIDS calamity.

A Tale of Two Causes

Not long ago, I was driving along a murram, dry-weather road to a large American-owned rice farm near the Kenya-Uganda border, accompanied by the farm's community-relations agent. I was working on a story on land and corruption, particularly relating to the hassles that the farm's management has faced. We drove silently for some time before coming upon a nondescript village of mud and thatch homes where most of the rice farm's workers reside. Many people were milling about outside one hut. "Could you stop please?" the dutiful P.R. flack asked, surveying the scene. "Someone must have died."

It was not a death. Instead, we were directed to an area behind the hut, where from a distance we could dimly make out a box. As we approached, it became clear: it was a miniature coffin, about the size of a shoebox. It had small openings in the front revealing an object inside, but the coffin was nailed shut. Disturbingly, a passport-sized photograph of a young woman was taped to the front. An upside-down cross, carved into the wood, gestured ominously to her photo.

The woman lived here, and had just the other day rejected a man's marriage proposal. He was the obvious culprit. The woman herself sat quietly, looking distant and saying nothing, while her mother stormed about, highly agitated.

"Pretending to the practice of witchcraft" has been, since colonial times, a criminal offense in Kenya and much of Africa—though when Africans talk about this crime, they usually just call it "witchcraft." The local chief, who had been interviewing witnesses when we arrived, got on his motorcycle and spun away to the district commissioner's office to report the incident.

As the flack and I drove on, I laughed. Witchcraft is common in Africa, but few commit it so openly. How could the man be so stupid to do such a thing, I wondered aloud, which would clearly implicate him? The community-relations flack looked at me gravely and said, "Oh, but you know, this is very bad. Maybe they put him in jail, but he can still hurt her. Maybe she will get AIDS, or she will have an accident."

This man is not a person I would call "ignorant." On the contrary, he's the smartest bean in the village—university-educated and a graduate of the respected Kenya Polytechnic. He knows that when the human immunodeficiency virus enters a person's body through another's bodily fluids, that person may eventually become ill with AIDS. But lots of people have sex—presumably including the woman whose face was on the coffin. Many people who have had sex with HIV-positive partners never become ill.

HIV is a mysterious virus, and even Western scientists consider there to be a fair degree of randomness in its behavior. A person may be infected with HIV, but never become ill with AIDS, while still infecting others along the way. People's chances in contracting HIV during intercourse depend on whether they are men or women, circumcised or not, and other factors. Even condoms have a failure rate, so that over time even a "cautious" sexually active African's exposure to infection is almost inevitable, just as a gambler shooting craps will eventually roll snake eyes. This is all to say that it appears to many Africans that who is stricken and who is spared is not simply governed by obvious physiological factors: always present is the matter we might call "chance."

It is natural for anyone facing a terminal disease to ask, *Why me?* This is an exasperated, unanswerable *cri de coeur* in the rational West—one of the steps of the grieving process, we are told, that we all just need to get through. But many Africans have their own kind of answer to that question.

African tribes are not a homogenous, undifferentiated mass, but the vast majority traditionally held in common a worldview of causation very different from our own. With reference to illness, it is called the personalistic theory of disease. Even today, most Africans believe that any major occurrence, good or bad, has two causes. The first might be called physical: for instance, that a retrovirus causes AIDS by destroying the cells of the immune system. The second is a spiritual, less tangible cause, but is perceived to be no less real. Edward Evans-Pritchard, whose ethnography of the Nuer people of Sudan is a foundational work of anthropology, put Africans' cosmological outlook this way: One might understand that a house collapsed because termites damaged it. But the more important question is, *Who sent the termites?*

Sniffing Out the Witch

This worldview is not so unusual. Across the globe and throughout history, the material and spiritual worlds were understood to be conflated in ways that seem alien to a twenty-first-century Westerner. In Europe before 1800, whether attributed to God or luck, supernatural factors were often reckoned to have a very real impact. The corpus of Shakespeare is heavy with "star-crossed" anti-heroes and events that were "fated" to happen. Another Renaissance man, the sculptor Benvenuto Cellini, complains throughout his autobiography about his treatment at the hands of "Fortuna"; at one point he even tries his hand at necromancy to acquire power. This outlook came to assume a Christian patina, with explanations of God and angels as well as Satan and his agents committing physical acts on earth, the worldly and the otherworldly fluidly intermingling. Most people did not believe in this concept in a vague and general way, the way Westerners today might call a particularly apropos occurrence "a miracle." Rather, the old West believed in what we might call "witchcraft": that an individual could control or summon the spirit-world to practical effect. From the peasants of Salem to Cotton Mather, the Harvard don and author of a treatise of witchcraft, it was agreed that a "psychic attack" was a real event—that "to think ill" of someone was literally that.

While these ideas faded in the West, in Africa it is still a commonplace belief that spiritual forces can be galvanized to cause harm (or to bring good). A famous curse in Swahili, still used today, is *Nitafikiria wewe*; it literally means "I will think about you," but carries an ominous tone, implying that one need not wield a dagger or poison to harm another.

Bruce Dahlman, a doctor who started his career in northern Minnesota, came to Kenya fifteen years ago to work at a field hospital in Masai tribal lands run by the Africa Inland Mission, a group that has evangelized and provided social services on the continent for more than a century. His experience has taught him (as he told me in an interview):

> Africans for the most part live in two worlds all the time. They have this Western veneer that's been brought onto them with globalization. But in our church hospital with 200 beds, we had one pastor come through and ask the patients, "If you don't get better right away and the medicine isn't helping, how many of you would visit the village shaman?" The vast majority raised their hands. That's the other world they live in.

Dahlman, now director of Nairobi's Institute of Family Medicine, adds that such a shaman, known as an *mganga* in Swahili, does have real powers

and talents. "They know the pharmacopia of their area—in that sense they are doctors. They also serve as a confidante and counselor who helps to sort out relational issues in a culture that is highly relational." And then of course there is the *mganga*'s other work, that which the name "witch doctor" implies. Throughout sub-Saharan Africa, where people are looking to determine the spiritual causes of their problems, the work of the village shaman is to discern who or what has made someone ill—"to sniff out the witch," as many societies throughout East Africa call the practice.

As an evangelical Christian, Dahlman believes that the witch doctor's powers may well be real but that Christ's are potent above all others. "There are powers for good and powers for harm," he says. "Our Western, Hellenistic view says that doesn't exist, so we can safely put it off the map. But I can bring you people who would tell you otherwise, for whom the spiritual world is a real, day-to-day concern." In his years in the field, Dahlman says he has seen an exorcism that reversed the curse of a *laibon*—a powerful spiritual figure in Masai culture—as well as a prayer session that healed a woman whose femur was fractured by a cape buffalo. She could not walk and, because night had fallen, could not be evacuated. But as daylight broke after an all-night vigil, "the American, board-certified doctor who had diagnosed the fracture came to the woman's house, and she walked out and greeted them," Dahlman says. "So you can say there never was any break, contrary to what this physician said and saw, with this lady unable to walk or bear any pressure on that leg. Do you mistrust that easy diagnosis, or do you believe that something else happened?"

Such stories abound in Africa—so common that every African (as well as many Westerners who have spent time in Africa) seems to have in his repertoire a story of a miraculous occurrence, regarded by the storyteller as perfectly credible. However, most Africans would not call these beliefs by their old names anymore. The term "witch doctor" conjures up distinctly unmodern images of wild-looking men with bone-pierced noses clad in bark-cloth and hides. Besides, witchcraft in both its beneficent and malevolent varieties, from rainmaking to curses, is frowned upon by Christians and Muslims alike.

Be that as it may, the basic premises of the old beliefs have found new form in these religions. This is the case, as Dahlman's stories of miracles and exorcisms suggest, with evangelical Christianity broadly, and in particular with Pentecostalism. Adhering to a theology that emphasizes the Book of Acts, which suggests regular divine intervention in the everyday world by the Holy Spirit (the Pentecost), they believe in the intermarriage

of natural and supernatural in a way that most Western Christians no longer do. For the past two decades, Pentecostalism has seemed an unstoppable phenomenon in much of Africa. In Kenya today, Pentecostals are not merely a majority of Christians, but a majority of the entire population, according to a recent Pew poll.

The witch doctor and the Pentecostal minister fill the same role in African society. Each of them completes an objective ritual—whether the reading of a sacrificed chicken's entrails or the laying-on of hands—to propitiate the spirit-world in the hope of a material reward. "In each case, healing is realized due to the intervention of the Supreme Being," argues Adam Chepkwony, a Catholic theologian who has tackled many of these issues. And it's not just healing—Pentecostals claim to bring parishioners love, wealth, and everything in between, including a better job and a U.S. visa. (At a prayer gathering of expatriate Zimbabweans in Dallas in 2008, I heard one woman testify that God had filled up her gas tank.) Such are the promised rewards of Pentecostalism's so-called "prosperity gospel," where God is said to return the favor of those who honor Him (or His agents) with tithes.

Among Pentecostalism's many claims to the supernatural in African society today is a supposed cure for AIDS. Family TV, which broadcasts church services around the clock in Kenya, shows the macabre scenes: Skeletal figures struggle down the aisle supported by ushers—if men, they have their shirts off to expose their bony frame—until they reach the rostrum of the chapel. The choir strikes up a raucous, jubilant hymn about the powers of the Holy Spirit, the pastor lays hands upon the afflicted, starts murmuring in tongues, then shouting, and—*presto*—the AIDS sufferer shakes and sometimes fall down, but gets up on his own and saunters away. This, supposedly, is what it looks like to be cured.

Illnesses That Hospitals Do Not Cure

The Pentecostal treatment of AIDS is spurious in the extreme; I do not mean to suggest otherwise. But it is mistaken to think, as Westerners so often do, that this treatment is the refuge of the desperate, the poor, the people who have nowhere else to turn. Relying on the Pentecost and other spiritual interveners is standard practice even for the upwardly mobile—stemming from the sensible position that when a problem has a spiritual cause, a spiritual solution is called for.

In Kenya, people make a distinction between illnesses quickly treated by a visit to the local dispensary and other "illnesses that hospitals do not

cure." This phrase looms large in Africans' conversations about healing and illness, a reminder not so much of their backwardness as of the lacunae in the West's own medical knowledge. Indeed, hospitals do not cure HIV. There is no biomedical cure. Were Western medicine able to produce one, perhaps it would burn away other viewpoints on the treatment and even the causation of HIV/AIDS. Until then, it is not at all surprising that the Western public-health community must contend with purported local remedies.

Let us state, for the record, the basic facts of the matter: A vaccine for HIV is not an impossibility, and as long as it isn't, it remains the greatest and in some ways the only hope in the battle against HIV/AIDS. It is also clear that current Western methods of preventing and treating AIDS are objectively, scientifically valid. Condoms, properly and universally used among an "at-risk community," would prevent the vast majority of HIV infections from occurring. ARVs, administered in a brightly lit and nonjudgmental setting, would give life to the unlucky few infected.

Yet short of a vaccine, the practical value of a scientifically proven implement, like a condom or an anti-retroviral drug, depends not on science alone but on whether it can be socially and culturally embedded. It is here where the West has faltered. Too often, policymakers take a device's or method's apparent scientific worth as a prospective indicator of how it will be valued in human society.

Take, for example, condoms. More than anything else, condom use is the gospel of the public-health community. And why should it not be? In the West's experience with AIDS, condoms were the saving grace. There, the pattern of infection centered on high-risk communities; even today a majority of HIV-positive people in the United States and throughout the West were engaged in prostitution, homosexual intercourse, or intravenous drug use at the time of infection. Targeting these discrete communities with a message of mechanical prevention was a highly effective strategy. The uptake of condoms in urban gay communities in America was staggeringly fast (though this practice has since fallen away as ARVs have made the threat of AIDS less imminent). The lesson the public-health community derived from this experience was that widespread sex and drug use is an immutable fact of life. In this light, the main task of the public-health community was and is to give risky behaviors an appliqué of safety, not to seek to alter behavior fundamentally, lest stigma and alienation result. This attitude is rigorously enforced today in such circles; at the 2007 worldwide conference on AIDS in Mexico City, a number of scientists emphasizing behavioral change over condom use were actually shouted down.

In Africa, the epidemiology of HIV is very different. Rather than affecting segments of the population that can easily be targeted, the African "at-risk population" comprises nearly every sexually active person. Moreover, HIV is spread in Africa through sexual conduct of a very different manner. In most African cultures, if a man has the means, he is almost guaranteed to practice polyamory: having multiple, routine partners in the same span of time. (Only a small percentage of these men are, like Jacob Zuma, acknowledged polygamists who—in a way—do the gentlemanly thing by making more of their relationships official.) Since HIV is more virulent and infectious when it is first contracted, the disease spreads easily throughout this polyamorous web. The Western practice of serial monogamy is a behavioral defense against this, even if Westerners may still be more promiscuous in the long run in their total number of sexual partners.

Most of these polyamorous men are unwilling to use condoms, even after learning of their benefits. Unlike the short-term dalliances of those at risk for AIDS in the West, where the anonymity of a one-night stand encourages the use of condoms, many risky African relationships are long-term. Condom use in these seemingly "trusting" relationships is low and, in any case, would rob them of one of their primary purposes: to produce children. It did not take injunctions from the Vatican, American evangelicals, or other outside sources for Africans to recognize in sex an intimacy and purpose that condoms diminish or altogether reverse.

One can advocate the science of condoms right up to the point where it becomes a cultural disagreement between the public-health lobby and Africans themselves over the intrinsic meaning of sex. Decades of witnessing AIDS stalk the land has not persuaded Africans to use devices understood to be "life-saving." Can we then expect them to be convinced by the harangues, the budgetary largesse, the snazzy ad campaigns of the West?

Parallel Systems

The Western treatment for those already infected, meanwhile, is an ever-mutating cocktail of anti-retroviral drugs—ludicrously beyond the reach of the average African were it not for the selective beneficence of the international community. An infected African lucky enough to be eligible for this lifelong battery of drugs—young people and mothers get first dibs—will live for a while, provided he has enough food to eat.

This is plainly not a "cure" for AIDS. Yet it *is* the best that Western medicine has to offer, and its use has been subsidized heavily in the part

of the Third World badly stricken by AIDS. The United States alone has spent $15 billion since 2003 under PEPFAR, the President's Emergency Plan for AIDS Relief. More than double that amount has been allocated for the next five years, and PEPFAR may prove to be one of the lasting components of George W. Bush's early "compassionate conservative" agenda. Some of these funds go to prevention and others to ARV treatments. Although some of these funds have been mismanaged and embezzled by host governments, let there be no mistake: This huge sum of money has had a breathtaking impact.

Go to any district hospital in Africa today, and you will find two clinics: one for AIDS—built, funded, and perhaps even staffed by the donor community—and the other for everything else, supported by whatever invariably cash-strapped and corrupt government presides. Bruce Dahlman notes, "Medical officers in either clinic will be seeing the same conditions, because those HIV patients come in with colds and flus and everything else, but they'll be treated as a separate category because of their status." So, in addition to the prospect of being medicated for life, Africans who develop AIDS and need intensive treatment become taboo figures—the lepers of this century, you might say, though exquisitely looked after by comparison, much to the resentment of those who must make do with regular health care.

More importantly, to seek Western treatment usually means leaving the home area where the patient has lived all his life, decamping somewhere near the foreign-funded clinic upon whose charity his life now depends. Helen Epstein, a microbiologist who has done AIDS work in Uganda, has written passionately in *The Invisible Cure* (2007) that taking Africans out of their home village when they are sick with AIDS is neither good for them nor for broader public-health purposes. Treatment would be easy to receive at home but for the imported bureaucracy and grant-making system that encourages big projects and centralization. Epstein argues that in African cultures where AIDS is too often out of sight and out of mind—in Kenya, for instance, four out of five people infected by HIV do not even know they have it, according to a 2007 survey conducted by the country's Ministry of Health—having people sick with AIDS stay in their home areas would be a potent reminder of the reality of the disease. When Uganda decentralized its AIDS treatment process, involving village-level home-care organizations (they could be classified as NGOs, though they bear little resemblance to the behemoths operating in African capitals and district headquarters), those areas posted a marked increase in visits to voluntary counseling and testing centers.

There is, beyond this practical appeal, a lingering cultural skepticism in most African societies about the wisdom of removing a sick person from his family and friends. These relationships not only offer the afflicted practical succor at the bedside; they are thought to help protect against the spiritual maladies that supposedly plague solitary persons. The loneliness of the hospital is seen as dangerous—as indeed it is, if considered from the viewpoint of the patient's morale and mental health.

If Africa is in some ways mired in its customs, the same might be said for the Western public-health community that directs much of the response to HIV/AIDS throughout the world. Rather than relying on local networks to implement its grand schemes, it sometimes seems as if the West has just plopped down across Africa eager to carve out a space of its own. That, certainly, is what the present structure of AIDS treatment suggests; instead of training and buffeting existing primary health-care systems, an entire parallel network for treating HIV/AIDS—"a silo," as Bruce Dahlman calls it—has suddenly sprung up from donor funds.

In the West's mechanical and systematic approach, what matters are the hard targets: how many condoms distributed, how many "HIV awareness" meetings convened, how many ARVs administered and in how many clinics. This insistence on concrete numbers is the only way, really, to run so enormous an aid operation. And whatever its inefficiencies, one cannot argue with the "Lazarus Effect" that a properly administered and sustained regime of ARVs can work on a human body suffering from AIDS. American and other Western states have heavily funded these treatments, saving millions of lives in the developing world and doing so on the cheap. A year's worth of ARVs for a dozen Africans can be provided for the annual cost of educating one child in an American public school.

The Challenge of Prevention

Yet Africa's AIDS crisis runs too deep and wide for a solution to be based solely on treatment. The ultimate goal is to prevent HIV's further transmission. Ironically, this is a task which ARVs may discourage by keeping HIV-positive Africans alive and sexually active. Treating AIDS, moreover, is accomplishable through the direct interventions of the West—all that's required of HIV-positive Africans is that they present themselves, take a free blood test, and consent to the ARV treatment, coming in regularly thereafter for check-ups. But preventing HIV from ever being transmitted in the first place is an ongoing effort that is squarely in the hands of the individual, informed by his cultural and religious beliefs.

A telling indication of Western thinking on HIV prevention is that one rarely hears the term "sexually transmitted disease" applied to HIV when it is being discussed by Western public-health workers in Africa. Despite the frankness about sex that one might think condom promotion would entail, this policy craftily avoids a more fundamental discussion. To hear an exquisitely mechanical account of a condom's proper usage by Western-trained presenters is to realize that there are certain assumptions made and things left unmentioned about the value and nature of sex. This reticence is, again, a product of the distinctively Western notion that it is some combination of futile and wrong even to attempt a widespread alteration of sexual behavior, rather than simply mediate it.

In contrast, a natural corollary of viewing the spirit-world as the source of human suffering is the belief that man is (or thinks he is) under the thumb of God. If a person genuinely believes this, he will work to propitiate and please the spirit-world through his actions. Morality has a practical emanation in this sense, since the goodness of a man's actions is tied to perceived material benefits. In March 2009, for instance, the long rainy season was worryingly delayed in Kenya, and so Kenyans attributed it to the recent political violence and venality that had marred their country in the wake of disputed presidential elections. In churches and taxis, bars and hair salons, people could be heard to say "there is a lot of sin in this country" by way of explanation for the missing rains.

Evangelical Christianity, following in the footsteps of the traditional beliefs, encourages Africans to view their problems in this spiritual-moral frame of reference. The language of African churches in desperate times resembles that of the Book of Job. Consider a recent pastoral letter from the Most Reverend Benjamin Nzimbi, head of the Anglican Church of Kenya, the largest Protestant denomination. "God has deserted us," Archbishop Nzimbi begins. "He has cut off the food supply and sent famine; he has withheld the rain and sent drought instead; he has sent the sword against Kenya to kill men and animals; he has sent plagues to destroy us." Not really an uplifting message from your religious leader, is it? But it ends with a telling exhortation: "God is calling all of us to return to Him. God promises to restore our nation back to the right path if we seek Him with all our hearts." The rhetorical pattern that emerges is a lamentation, but not self-pitying; it asks, "What have we done wrong?" and "How can we change to better please God?"

The public-health lobby answers these questions, vis-à-vis one of Africa's greatest calamities, by saying, essentially, "What's wrong with you is you haven't been using condoms." *This* is the narrow-minded

response, much more so than the call for behavioral change. As long as this attitude persists, Western policy will remain discordant with the realm of cause and effect within which Africans are operating. It is hardly news that sub-Saharan Africa is in the grips of a religious and social upheaval. Church attendance is soaring, and even those denominations, like Roman Catholicism, that are hemorrhaging members to evangelical sects are nonetheless still growing in absolute numbers. It is highly uncommon to attend a church service on a Sunday in Africa where the building is not filled to capacity. Christianity, as well as Islam, is a huge force whose day-to-day impact on African lives cannot be ignored. Any successful HIV/AIDS strategy will have to enlist churches, their moral authority, and their enormous memberships.

The Power to Change

The seemingly unique historical moment of the African AIDS crisis does have its precedents. After the First World War, thanks to burgeoning colonialism, countless Africans were alienated from their lands and pushed into the plantation or the city to provide labor. Families were split by the upheaval. Girls from the countryside moved to workers' areas to make bargains of their bodies for financial independence. Dislocated men started multiple, furtive relationships; many of the women who stayed behind in rural locations did as well. Syphilis spread rampantly during this time, radiating outwards from plantations and cities to those rural areas where laborers and *wasiwasi* (comfort women) originated.

One of the areas most impacted was the homeland of the BaHaya people, which straddles the Tanzania-Uganda border. Both men and women held freedom of mobility in traditional Haya society, and this well-educated tribe (beneficiaries of an early missionary presence) quickly became known for its shrewd and amoral businessmen throughout Britain's East Africa possessions. It was a serious insult to remark that someone's sister was a Haya, implying as it did a willingness to prostitute oneself if necessary. This business boomed. Luise White, author of *The Comforts of Home* (1990), a history of prostitution in colonial Nairobi, gives a telling example: When British officials blocked overland passage of some Haya women to Kenya, a leading Haya madam merely chartered a plane.

Syphilis came to Hayaland dramatically, ravaging villages and people who had never set foot outside their home areas. Throughout the colonial era, Haya leaders expressed alarm at almost hysterical levels about syphilis. The Haya Union told colonial officials that modernity had led

the Haya astray, that their people resembled "the poor Black fellows of Australia and the Red Indians of America who, under natural ignorance, could not realize their fate." The British colonial government's refusal to take prostitution seriously was simply incomprehensible in Haya moralists' eyes. As one petition, addressed to the Secretary of State for the Colonies, argued, "We fail to understand the reason why a Christian Government, as British Government is professing to be, since its King is Head of the English Church, does not regard prostitution as an offence and a grievous moral sin."*

Where government failed, religion stepped in. Beginning in the 1930s, a religious fervor known by many names but rather blandly dubbed by historians the Holy Spirit Movement swept across East and Central Africa. Pentecostal in its outlook, the Holy Spirit Movement was most interesting not because of its ascetic, spiritual quality, but because of its enormous projection into corridors of society not regarded at that time as set aside for religion's purview. Members of the movement railed against sex outside the prescribed bounds of marriage, and became the first Africans in the modern era to start and pursue a discussion of how venereal disease was destroying the African family. The Holy Spirit Movement linked moral concerns to public-health concerns, and did so to great effect. Colonial officers buzzed in internal correspondence about the spontaneous clean-up of scoundrels and prostitutes happening under the movement's blend of persuasion and ostracism for those who stepped outside its norms.

One often hears the public-health community decry "imposing our values" on Africa. This is meant as criticism of American evangelicals' efforts to make abstinence and monogamy centerpieces of HIV prevention policy. In fact, these critics should better calibrate their reality to Africa's. Radical individual behavioral change and collective moral clean-up have been integral parts of Africa's religious landscape for a long time—since the 1930s, as far as evangelical Christianity is concerned.

There are strong resemblances between that period and the present situation. The Haya have already gone through the cycle all over again: They and other tribes on the northern and westerly littorals of Lake Victoria were the first groups to be struck by the AIDS epidemic in the 1980s. Absent any pointers from a wider world which treated the disease then as a curious aberration, they were left to home-grown solutions. Most have since died, but a quarter-century ago there were still many Africans

* I am grateful to Derek Peterson, senior lecturer at the University of Cambridge, for pointing me to this fascinating chapter in Africa's colonial history.

who remembered the Holy Spirit Movement. The obvious approach to this new problem was, as in olden times, moral rejuvenation. Preachers scoured the Ugandan and Tanzanian countryside, professing that God was punishing His people for their misbehavior, and calling on them to take up the challenge to change their lifestyles, as their grandparents had in the colonial era. This approach soon received the imprimatur of the government of Uganda, which realized before any other African government that HIV needed to be regarded as a serious social—not just medical—ailment. AIDS was spoken about openly and in a moralizing tone. The government's official message became: You have the power to change your behavior and, if you do not, you may very well die. The approach, absent the message of facilitation that condom-promotion inherently transmits, proved to be startlingly effective. According to a 2004 review of the Ugandan government's approach published in *Science*, Uganda saw a "60 percent reduction in casual sex…equivalent to a vaccine of 80 percent effectiveness." In the wake of the policy's implementation, Uganda became one of the first African countries to post a decline in the HIV-infection rate.

Uganda's approach was the template for the policy we today call ABC: Abstain, Be Faithful (that is, monogamous), and Use a Condom as a last resort. The condom element was tacked on to placate the public-health lobby, though Edward C. Green, a Harvard researcher who has spent most of his career tracking AIDS in Africa, reports in his comprehensive 2003 book *Rethinking AIDS Prevention* that Uganda's decline in HIV prevalence was almost solely the result of "B" and "A," in that order.

It is simply disingenuous to pretend that advocating a Christian standard of sexual morality is any more of an imposition of values than the exclusive focus on condom distribution. Indeed, the greatest impetus for the ABC policy has come from Africans themselves. When Congressional Democrats were contemplating undoing the requirement that two-thirds of PEPFAR's HIV-prevention funding be spent on promoting abstinence and monogamy, Ugandan First Lady Janet Museveni flew to Washington to rally Republican senators against the change.

Nevertheless, the shrill cry persists that any other way than condoms is "unrealistic." What this actually suggests is that it is merely unrealistic for the average Westerner who, thinking of himself and his own society's libidinal incontinence, applies this lesson on the impossibility of self-restraint to the whole globe. But elements of Africa's recent history, like the Holy Spirit Movement of the 1930s and the evangelical-Pentecostal resurgence of today, gesture to a greater receptivity to moralizing messages about sexual behavior than the modern West would tolerate.

And while moral rejuvenation has a track record of success in places like Uganda, policies favoring condom distribution have much less to show for their enormous expenditures. Despite ubiquitous condom-usage training in urban areas and hundreds of millions of condoms distributed gratis, South Africa's HIV prevalence rate only worsened during the early 2000s when this policy was vigorously advocated by the donor community.

The only lasting solution to AIDS in Africa will come through behavioral change. In a society that associates ailments with individual and collective moral wrongdoing, an approach that re-moralizes sexual behavior and encourages Africans to take control of their bodies is the most promising path to tread. That is not to say that it is easy or can be accomplished quickly. Any successful AIDS policy will probably involve a degree of social coercion—ostracism of those who do not abide by the moral consensus, a public shaming of hypocrites who preach one thing and practice another. Such a policy allows an essentially religious movement to co-opt the government and the generous foreign aid it receives. To some extent, this is what ABC policies already do, though they are still hampered by the squeamishness of American grant-makers who wish to decouple abstinence and monogamy from the religious and moralizing message they are often embedded in, and instead treat them as sterile and scientific methods by which to avoid infection. Rather than promoting condoms and sending a mixed signal, it would be better to continue to make them freely available in places known to those people, mainly city-dwellers and sex workers in market or industrial towns, who are already using them or inclined to do so because of the anonymity and casualness of their sexual relations.

The Western public-health lobby, bred in a culture that preaches unconstrained freedom of the individual in the realm of sexual relations, is put off by talk of moralizing policies, or of any policy that de-emphasizes condoms. But it needs a dose of its own advice. It must stop imposing its own agenda on Africa. It must realize that HIV has a social dimension that must be addressed, that Africans are naturally wont to view this disease, which perversely inverts the life-giving act of sex, as a moral calamity. The sooner the donor community realizes this, and reorients its policies to fit African realities, the better.