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Little more than five years after Hutu extremists tried to exterminate the country’s minority Tutsis, disease—rather than machetes and guns—is cutting a deadly swath through Rwanda. One in 10 Rwandans is now infected with the HIV virus, and 10 years of bloody upheaval have bred an apathy and fatalism that ensures the number of victims will grow. (Hranjski 2000; 1)
Introduction:

The global HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) pandemic has taken the world by storm relatively recently, arguably seizing the title as the most pressing crisis of our time. The HIV virus has been relentless in its transmission and propagation since the early 1980s when it was co-discovered by Dr. Luc Montagnier and Dr. Robert Gallo (Grmek 1990). It has since been dramatically amplified and spread throughout the world—leaving every continent plagued. Its biological basis for transmission has tempted many scholars to write off the HIV pandemic as a mere scientific fact rather than having a major role in real social and political contexts. As the fight against AIDS continues, however, cultural behaviors, knowledge, practice, and beliefs that lead to the spread of this deadly virus are being unveiled as important implications for its propagation; these factors are crucial for understanding in depth how the transmission of HIV has continued to the extent it has. They are the core issues for modern anti-AIDS campaigns and are central to reversing the damage that has been instigated by the AIDS dilemma. One could argue that this worldwide epidemic has provoked social, economic, and cultural issues that might have never received such focus to come to the forefront, in the attempt to eradicate this crisis. Philip W. Setel highlights this point: “applied researchers have been pressed to remove their gaze from the immediacy of the epidemic and reflect in more abstract terms upon the ways in which AIDS must be comprehended, analyzed, and combated,” (Setel 1999; 1). Among these issues is the topic of gender relations and how political and cultural beliefs often result in the trend for higher probability of HIV infection among women, directly and indirectly.
There is now extensive evidence that the disease AIDS, or acquired immune deficiency syndrome, is caused by the virus HIV (human immunodeficiency virus). How HIV was first introduced into the human race remains a mystery, although there are theories that attempt to explain the phenomenon. The most accepted hypothesis in scientific literature is that HIV or a virus similar to HIV “jumped species” via zoonosis, to humans from a closely related primate. According to recent findings, HIV is most likely a descendant virus of another virus found in monkeys—SIV, or Simian Immunodeficiency Virus. There are currently different strains of HIV in human populations, HIV-1 and HIV-2; the latter bears a close resemblance to a type of SIV (SIVsm, specifically) found in the sooty mangabey monkey, a specious indigenous to West Africa (Kanabus and Allen 2000). The other strain, HIV-1, is more virulent; until recently there were no plausible explanations for its appearance in the human species. It had previously been linked to another SIV found in chimpanzees, but there were too many differences between the two viruses that were unaccounted for. In February of 1999, researchers from the University of Alabama discovered that a certain SIV (SIVcpz) found in frozen chimpanzee tissue was almost identical to HIV-1 (Kanabus and Allen 2000). This particular type of chimpanzee was from a sub-group known as Pan troglodytes troglodytes—a species also once common in West Africa. This finding had serious implications for the theories regarding the place of origin of HIV. Because there were two arrows pointing to the direction of West Africa, it was agreed upon that this discovery isolated the birthplace of the virus. It is important to note, however, that chimpanzees are only rarely infected with SIVcpz; this could indicate that there is a third,
unidentified, primate species that was the primary host of the simian immunodeficiency virus (Kanabus and Allen, 2000).

Speculations regarding the transfer of a type of SIV to humans include the “cut hunter theory,” a scenario in which humans killed and ate contaminated chimpanzees for food (perhaps preparing them with cut hands), thereby acquiring the virus. This is still a popular belief, as there have not been many contestations to this argument. A controversial hypothesis that has arisen relatively recently, however, is one that focuses on the transmission of the virus through medicinal vaccinations, notably the polio vaccine that was administered to humans between 1957 and 1960 (e.g. Hooper 2000). These vaccinations were cultured in the United States (at the Wistar Institute in Philadelphia), using cells from monkey kidneys and possibly chimpanzee cells; they were then iatrogenically transferred to humans living in the Belgian Congo. If this proposition is valid, what has now become a worldwide epidemic may have begun from a simple vaccine that was intended for medicinal purposes. This postulation is striking; if it upholds the scrutiny of further testing, the methodology of scientific research and the future administration of vaccines and other medicine will undoubtedly need to be completely reexamined—especially now, as we prepare to test the newly developed HIV vaccine on certain African populations.

These are just two promising explanations for the emergence of HIV in the human species; there are many other reasonable scenarios that have not yet been researched thoroughly. There is a chance that HIV (or its related virus) passed over into the human species more than one time. According to Annabel Kanabus and Sarah Allen: “it is quite possible that HIV emerged at the same time say in both South America and Africa, or that
it even emerged in the Americas before it emerged in Africa,” (Kanabus and Allen 2000; 3). Another suggestion has been made that the first case of HIV arose in West Africa around 1930; this estimation is based on a complex computer program that has mapped the possible mutations and evolution of this virus. The authors do make a point, however, that this date carries with it a margin of error of 20 years (Kanabus and Allen 2000; 3). Although we can continue to speculate, we will probably never ascertain the exact origin of this virus that has resulted in the disease known as AIDS that is currently plaguing the world.

HIV belongs to the lentivirus subfamily, which is a member of the virus class known as the retroviruses (literally “backwards” viruses). There are certain glycoproteins on the envelope of the HIV virus that allows it to bind to specific receptors (CD4 receptors) on Helper T cells of the host’s immune system. After binding, “the viral enzyme, reverse transcriptase, catalyzes the synthesis of a haploid, double-stranded DNA provirus, which becomes inserted into chromosomal DNA of the host cell,” (Clapham and Weiss 1999; 13). Reverse transcriptase is an enzyme that can transcribe DNA from an RNA template, resulting in the backwards flow of genetic material—from RNA to DNA (Campbell 1993). It is this mechanism that makes HIV so deadly in humans; it can integrate into a chromosome in the host cell, operating as a provirus. The viral DNA can then serve as a template on which the host’s RNA transcriptase creates RNA copies, subsequently generating viral proteins that can infect the entire human organism (Campbell 1993). New viruses bud from the surface of the infected host cell, continuing on their way to infect other cells. This is a highly efficient mechanism, as the virus does not need to possess its own enzymes in order to proliferate—it requires only a simple
RNA genome. The most important aspect of this virus’ mode of attack, however, is that the provirus in a host cell is “invisible to the immune system” (Campbell 1993; 871) because it encodes itself into the host’s DNA. It can, thus, remain latent for many years, rendering the immune system unable to eliminate the disease.

Infection with HIV results in the loss of immune system function over time, ultimately resulting in the syndrome AIDS. Individuals with AIDS are more susceptible to “opportunistic infections,” those that take advantage of the weakness of the human immune system and cause damage when they otherwise might not have under the siege of a strong immune system. The most common of these are tuberculosis, pneumonia, a protozoan-induced respiratory infection, and Kaposi’s Sarcoma, a cancer of the skin and blood vessels (Campbell 1993). In healthy individuals, the protozoan *Pneumocystis carinii* normally does not cause a problem: “it is one of tens of thousands of creatures that are easily held in check by people’s immune systems,” (Shilts 1987; 34). Its effect on an AIDS patient, however, often proves fatal. The rate of disease progression has been shown to be variable in individuals; yet, the average length of time between initial exposure to HIV and to the development of AIDS is estimated to be 10 years (Kilby and Saag 1999; 49). The stage of progression can be quantified in a CD4 T-cell count; the number of Helper T-cells gradually declines as the virus proliferates, thus advancing the stage of illness. During the ten-year period between the initial infection of HIV, leading up to the debilitating effects on the immune system resulting in AIDS, “the patient exhibits only moderate hints of illness, such as swollen lymph glands and, later, yeast infections of the mucous membranes,” (Campbell 1993; 872). It is during this phase that
many individuals are unaware of their infection with HIV and are most likely to infect another person.

Biologically, women are more susceptible to HIV infection than men. Through vaginal intercourse, the possibility of transmission of HIV is higher from men to women than vice versa. This fact can be explained by the higher sensitivity of the epithelium of the vaginal tract than penile tissue, allowing the virus to enter microlesions more readily in females (Cotton 1999; 151). Because there is a larger surface area of the vaginal mucosa than of penile tissue, transmission from males to females is significantly higher (UNAIDS 1999). Furthermore, semen infected with HIV contains a higher concentration of the virus than do vaginal secretions. Recent studies have shown that genital ulcerations, usually accompanying STDs, also increase the likelihood of transmission (in both males and females). Other factors that may damage the epithelium of the vaginal tract and thus increase susceptibility to infection are “tampon use or reaction to intravaginal spermicides,” (Cotton 1999; 151). Genital mutilation, a practice common to many African societies, also dramatically increases physiological susceptibility to HIV transmission due to the trauma inflicted upon vaginal tissue. Anal intercourse often results in the higher transmission of HIV as well due to the “fragility of the anal mucosa,” (Cotton 1999; 151) resulting in more frequent tearing of anal tissue. This mode of transmission is most prevalent in homosexual and bisexual male populations, though this pattern is also seen in the heterosexual female population.

In the early years of AIDS discovery and research, scientists continually modified the list of manifestations of this disease, as new cases arose. Originally, women were relatively absent from the AIDS population because the list of AIDS-defining
characteristics did not include gender-specific symptoms such as “chronic *Candida* vaginitis or distinctively aggressive cervical neoplasia,” (Osborn 1999; 123). The most recent update of these symptoms took place in 1993 with the addition of pulmonary tuberculosis, rapidly invasive cervical carcinoma, and recurrent bacterial pneumonias; these indicators of immune deficiency were seen most commonly in females, as well as in the intravenous drug user population (Osborn 1999; 123). Thus, the statistics of women infected with AIDS has been more accounted for since the beginning of the epidemic.

The first AIDS cases were uncovered in the United States in 1981 (though, as speculated above, HIV may have been present in the human species much earlier than this date). Because the collection of symptoms associated with AIDS was discovered (in the United States) to be more prevalent in the gay community, notably in gay men, AIDS became popularly known as a gay disease. “When AIDS was first recognized as a discrete medical entity, the initial cases were primarily found among homosexual men; this led to the stereotype of it as a ‘gay disease,’” (de Bruyn 1992; 250). At one point early in its emergence, the syndrome was dubbed “GRID,” or Gay-Related Immune Deficiency. However, in 1982, there began a series of discoveries that the symptoms associated with AIDS were sprouting up in other groups, such as hemophiliacs and heterosexual male and female drug users. Haitian refugees in the southeastern part of the United States were also a targeted population. It was, thus, generally accepted in the early years of this pandemic that there were easily definable “risk groups,” subpopulations that were more likely to acquire the virus than others. This notion perhaps created a rationale that, if one was not a member of these so-called “risk groups,” then he or she was not in danger of contracting the virus. This naïveté towards the virus’
transmission was soon changed when cases of HIV/AIDS in individuals not easily categorized in high-risk groups began to emerge. According to June Osborn: "the sense of invulnerability that characterized many cultures and countries in the first years of the epidemic has given way to an awareness that the pandemic is indeed universal," (Osborn 1999; 124).

The modes of transmission of HIV were somewhat apparent even at the onset of the epidemic. It was generally recognized that the virus could be transmitted via sexual intercourse and injection. What was not known for certain until 1984, three years after the first discovery of AIDS, was that HIV transmission was highly amplified under conditions of blood-blood contact. By this time, diagnostic techniques (serologic tests for the presence of the HIV antibody) were sufficiently advanced that scientists were able to confirm that transmission was restricted to contacts between hosts either by sexual contact, through blood, or from an infected mother to her child during birth (Osborn 1999; 125). This finding made preventative measures possible, the most important of which was the "securing of safety of blood supplies... [This] was effectively accomplished in the United States by mid-1985. That success opened the way for reliance on education as a primary weapon of prevention, inasmuch as avoidance of risky behavior could ensure safety from HIV," (Osborn 1999; 128).

Described by Randy Shilts recalling the public impression about the emergence of AIDS in the United States, "in those early years, the federal government viewed AIDS as a budget problem, local public health officials saw it as a political problem, gay leaders considered AIDS a public relations problem, and the news media regarded it as a homosexual problem that wouldn't interest anybody else," (Shilts 1987; xxiii). AIDS,
perhaps, did not get the attention it deserved at the onset of the epidemic, as many brushed it off as a disease only afflicting the gay community. However, the general population became vividly aware of AIDS as it began creeping into the heterosexual populations as well. According to June E. Osborn: “what was vividly clear by the end of the first decade was that HIV/AIDS was a new, deadly disease to which the whole human race was approximately equally susceptible, and that no corner of the earth would escape,” (Osborn 1999; 124).

Mirko D. Grmek describes three different categories regarding the HIV transmission pattern according to global region. The first, prevalent in the United States, Canada, Western Europe, and urban areas in Latin America, can be categorized as having roots in homosexual male populations, then transferring to heterosexual individuals. According to Grmek, “in these geographical loci, homosexual contacts and needle sharing among addicts remain the predominant route of transmission, while heterosexual contacts and perinatal transmission are both gaining in relative importance. Men are more often affected than women in this schema,” (Grmek 1990; 171-2). In the second pattern, HIV is spread mainly through heterosexual contacts; this model is found predominantly in Africa, yet it is starting to include parts of Latin America and the Caribbean. This case results in infection rates relatively equal for women and men; prostitutes play a large role in transmission. The third prototype describes regions in which the percentage of the population infected with the virus is relatively low, depicting Eastern Europe, Australia, Oceania, and some Asian countries. Grmek notes: “even among prostitutes the disease prevalence here is low,” (Grmek, p.172, 1990). Although
contrived roughly ten years ago, the schemas described above hold up, more or less, against current statistics.

To give context to the emergency of the existing epidemic, it was estimated at the end of the year 2000 that there are 36.1 million people—adults and children—currently living with AIDS. Of this number, 5.8 million are found in South and South East Asia. The most dramatic of these statistics of any continent, however, is found in Africa, with a total of roughly 25 million individuals dying of AIDS. Sub-Saharan Africa, alone, accounts for 25.3 million of these (UNAIDS 2000). The HIV/AIDS epidemic is scheduled to reduce the life expectancy in southern Africa from 64 to 47 years by the year 2015 (Satcher 1999; 1).

According to recent reports, there are 12 African women infected with the virus for every 10 African men. The discrepancies in infection rates between adolescent girls and boys are astounding; with the contraction of HIV for adolescent girls five times that for adolescent boys in the same age group (Garbus 2000; 5). Furthermore, it is estimated that, in eight Sub-Saharan African countries, one in three fifteen-year-olds will die of AIDS in coming years (UNAIDS 2000).

Example 1: RWANDA

The assassination of the Rwandan president Juvenal Habyarimana on April 6, 1994 opened the floodgates for what would be roughly one hundred days of merciless massacre in an attempt at the annihilation of an ethnic minority in Rwanda. Machete-wielding Hutu soldiers were instructed to wipe out Tutsis and moderate Hutus; they succeeded in slaughtering between five hundred thousand and one million individuals,
including women and children of the Tutsi minority. Women that survived were often left to witness the massacre of their families and were subjected to repeated rape and sexual mutilation by Hutu soldiers—an act that was condoned and encouraged by Hutu officials to humiliate Tutsi women and destroy what was left of the Tutsi identity. Sadly, social stigma and devastating emotional trauma was not all that these women and girls were forced to endure. Many suffer from medical complications due to the severe mutilation of their genitalia and/or self-induced abortions of unwanted pregnancies by their rapists. In addition, several are now testing positive for HIV, the “silent killer that knows no ethnic differences,” (Hranjski 2000; 1)—also a planned outcome by the Hutu militia that allegedly advocated the spread of this deadly virus as part of the genocide strategy. The prevalence of this virus has been dramatically amplified as an outcome of the 1994 tragedy in Rwanda, a genocide that has not yet finished claiming its victims.

Situated in central Africa, Rwanda is a landlocked country, bordered to the west by the Democratic Republic of Congo (formerly Zaire), the east by Tanzania, the north by Uganda, and the south by Burundi. Its population before the genocide of 1994 (estimated mid-year, 1993) was roughly: 5,740,000. This number plummeted in 1994 to 5,370,000, only to be reduced even further by mid-1995 to 5,260,000 (UNAIDS 2000). These drastic reductions in population are due to murder and human displacement (refugee movement) in concert with low birth rates for the country during this time. Rwanda's population now is estimated to be between 7,229,129 (EndAidsinAfrica.com 2001) and 7,235,000 (UNAIDS 2000). Because its size is roughly equivalent to that of the state of Maryland, Rwanda's large population makes it one of the most densely inhabited African countries—perhaps an added factor for the potential of violent outbreak. The population
in Rwanda is comprised of two main so-called "ethnic" groups, the Hutu forming the majority with eighty percent, and the Tutsi, a mere fifteen to seventeen percent (depending on the consulted source). There is also a pygmy minority, the Twa, which makes up between one and five percent of the Rwandan population.

Rwanda is a country that has rarely enjoyed stable, long-term periods of peace. The conflict between the Hutu and Tutsi tribes has often been described as one based on differences in ethnicity leading to hostility between the two groups. Describing the relationship between the Hutu and Tutsi tribes is more complex than one might gather at first glance, however. These two groups share a common cultural heritage, speak the same Bantu language, and—in southern Rwanda, especially—have engaged in extensive intermarrying. Many scholars argue that this claim of pure ethnic divide is a myth, supporting the idea of tension more based on power and social class stratification. It must also be pointed out that the leader of the Interahamwe (Hutu led) militia, Robert Kajuga, was a Tutsi before his father successfully changed the family's identity to Hutu. Thus, the lines separating these two groups are not as clearly drawn as one might suppose or like to imagine.

Historically, the group that ultimately formed the Tutsi tribe was comprised of cattle herders who had migrated into Rwanda and other parts of central Africa from the north, while the hunter-gatherer indigenous peoples were known as the Twa, or pygmies. The Hutu had migrated into Rwanda before the Tutsi arrival and had dominated the indigenous Twa group in successive monarchies. Eventually, the Tutsi clan was successful in dominating the central region of what is now Rwanda, consolidating wealth and power over the centuries. According to historians, ownership of cattle was a major
marker in this stratification of wealth during pre-colonial Rwandan society, allowing the Tutsi to form armies and intensify the aristocracy while including Hutu members under their governance: “ownership of large herds of cattle allowed the Tutsi nobility to raise armies and to draw vast numbers of Hutus into the web of clientelism (for example, a Hutu peasant would be given a cow, in return for which he would make himself available for work on the land of his patron),” (Keane 1995; 12). Thus, the Tutsi cattle herders became established as the elite group, while farming Hutu and subsisting Twa groups became the peasant or serf class. After some time, there evolved a “dangerous sense of second-class citizenship among the Hutus,” (Keane 1995; 12).

Not only was wealth a contributing factor to the stratification between the Hutu and the Tutsi, however; certain physical features possessed by the Tutsi nobility were stressed as marks of superiority. Among these were physical stature and gracile facial features. Shorter, more robust individuals who were not associated with the Tutsi elite were automatically dumped into an inferior tier: “those who were short and stocky, who worked the land, and who had neither cattle nor ties to the nobility became a distinct second class in Rwandan society” (Keane 1995; 12). However, this distinction was not carved in stone; one did not have to necessarily possess “aquiline facial features” (Keane 1995; 12) or be slim and tall to gain entrance into the ruling class. Although not easily accomplished, due to economic actualities, with sufficient savings one could buy enough cattle to be considered amongst the ranks of the aristocracy. During that time, the qualifications for nobility mainly rested on materialistic values (Keane 1995).

However, with the onset of the colonial period, first under German, then Belgian control, stature and gracile facial features were solidified to have consequences on social
status. Tutsi characteristics were more common in resemblance to those of Europeans, and thus, were thought to have moral and social implications: "it suited early colonists to believe in and foster the myth of the Tutsis as black Aryans, men not too dissimilar to Europeans, more noble than savage, who could be trusted to carry out the orders of white men," (Keane 1995, 13). Much like ideology in Germany under Nazi control, so-called superior characteristics were, therefore, (arbitrarily) paired with personal character—a classification that did not go unnoticed by the second-class Hutu. According to Gérard Prunier: "racially-obsessed nineteenth-century Europeans started building a variety of hazardous hypotheses on their [the Tutsis'] 'possible', 'probable' or, as they soon became, 'indubitable' origins," (Prunier 1995; 6-7).

These stereotypes implemented by European colonists had a deleterious effect on social relations between the Hutu and the Tutsi groups. If there was already a festering "ethnic" (or class) divide, it was intensified by the theories and assumptions made first by the Germans, then by the Belgians. According to Keane: "the implication of Belgian policy and public utterance was clear enough: the Hutus were a peasant majority and in no way suitable partners in the exploitation of Rwanda. By contrast the Tutsis, with their elitist background were a minority who had every interest in keeping the country in its existing state. For the colonists it was a perfect partnership," (Keane 1995; 16). Thus, an alliance was formed between the Belgians and the Tutsi, eventually resulting in control over Hutu lives by the Tutsi elite. Affiliation with the Belgians allowed the Tutsi to further exploit the Hutus over which they had control, deepening the social divide between the Hutu and Tutsi groups.
Early social stratification between the two groups led to vastly different realities amongst Hutu and Tutsi individuals, the Hutu having been made undeniably inferior to their Tutsi counterparts. This truth had harsh effects on the cultural sensitivity of the Hutu. Prunier states:

The result of this heavy bombardment with highly value-laden stereotypes for some sixty years ended by inflating the Tutsi cultural ego inordinately and crushing Hutu feelings until they coalesced into an aggressively resentful inferiority complex. If we combine these subjective feelings with the objective political and administrative decisions of the colonial authorities favouring one group over the other, we can begin to see how a very dangerous social bomb was almost absent-mindedly manufactured throughout the peaceful years of abazungu [Tutsi] domination. (Prunier 1995; 9)

An identity card system implemented in 1933 further aggravated the steadily increasing social stratification. Every Rwandan citizen was required to carry proof of his identity—marked as either Hutu or Tutsi. The possibility for migration between the two social classes—even upon the accumulation of wealth—was, thus, eradicated; an individual born Hutu would remain Hutu and vice versa. According to Keane: “Hutus were in effect told that their mission in life was to toil (forced labour on the lands of Tutsi nobles was commonplace) and serve in perpetuity,” (Keane 1995; 17). With no ability to advance in the ranks of society, Hutu individuals were destined to remain in the lower social class.

As the possibility for an independent Rwanda drew nearer, however, the Belgians began to look toward the Hutu majority as being the favored resource in which to place stock, especially with increasing confrontation from the Tutsi-led National Rwandese Union (Union National Rwandaise, or UNAR), which was also looking toward post-independence power (Keane 1995). Because of the sheer number of Hutu individuals, the
inevitability of Hutu control steadily became apparent; the Belgians thus switched sides and began to favor the Hutu political party—The Party for the Emancipation of the Hutus (PARMEHUTU). The death of the Tutsi monarch, Mwaami Rudahigwa, in 1959 resulted in an overturn of power, as the Hutus staged a rebellion, killing between ten and one hundred thousand Tutsi (Keane 1995)—a massacre of which little attempt was made by the Belgians to stop. It has been argued, in fact, that the Belgians exacerbated the conflict by unfairly "cracking down on Tutsi," (Kamukama 1993; 31), often overlooking parallel crimes committed by the Hutu.

By 1960, thousands of Tutsis had been killed, swamping nearby rivers with bodies. In addition, more than 200,000 Tutsi were displaced internally, forced to flee to nearby countries (Kamukama 1993; 31) such as Tanzania, Burundi, Uganda, and Zaire between 1959 and 1964. In Uganda, children of these refugees joined the National Resistance Army of Rwanda (NRA) under Yoweri Museveni to fight against the regime of Milton Obote. They eventually staged a military comeback in the late 1980's and created the Rwandan Patriotic Front (Front Patriotique Rwandais, or RPF), plotting a violent return to Rwanda, (UN Higher Commissioner for Refugees 2000). According to Keane: "these 'children of '59' regrouped after the end of the Ugandan war and formed into the RPF, determined to return to the country of their forefathers," (Keane 1995; 20).

The period that followed the 1959 butchery was one fraught with disturbance. After the exodus of many Tutsi during the massacre of 1959, Hutu pride was rampant in Rwanda, which led to occasional violent outbursts targeting the Tutsi: "clientelism thrived, and discrimination against Tutsis was widespread and systematic. There were occasional violent pogroms throughout the sixties, which was a period of fear and
uncertainty in Rwanda," (Keane 1995; 20). Subsequently, Tutsis often staged attacks against the Hutus, and the Hutus frequently retaliated with mass killings. In 1963, the Interahamwe murdered roughly 10,000 Tutsis (Keane 1995; 20)--an event that was duplicated in 1967. There was trouble in 1973 as well, with widespread discrimination of Tutsis, resulting in the expulsion of Tutsis from major universities and the education system at large. President Juvénal Habyarimana was suspected to have been behind the organization of these events. "In power Habyarimana may not have murdered the Tutsis with the same fervour as his predecessors but he was relentless in the task of discriminating and scapegoating," (Keane 1995; 21).

The RPF's planned attack on Rwanda manifested on October 1, 1990. This invasion was an attempt at an "end to the misuse of public office, the establishment of social services, democratisation of the security forces and a progressive foreign policy," (Kamukama 1992; 44-5). Armed conflict ensued between the RPF and the Hutu militia; however, the Tutsi-led RPF gained some political control. This, along with international pressure for democratization, influenced Habyarimana to pursue political negotiations, resulting in the Arusha Peace Accords of August 1993. These negotiations culminated in a "series of protocols, the most significant of which were those on power-sharing, a dramatic reduction in the powers of the presidency and, crucially, the integration of the RPF into the armed forces," (Keane 1995; 26-7).

Despite these negotiations before his mysterious death, President Habyarimana has been criticized for much of the backwards politics in Rwanda leading up to the 1994 genocide, namely the propagation of ethnic hostilities and stereotypes: "the regime of President Habyarimana… is blamed for ignoring numerous appeals…and for fanning
ethnicity rather than trying to correct the distortions of the colonial era,” (Kamukama 1993; 7). It has also been widely documented that Habyarimana had a major part in the organization of the premeditated genocide, planning of which had been under way for quite some time before any actual bloodshed occurred in 1994. “For several years prior to the genocide Hutus were exposed to an ongoing and virulent campaign of anti-Tutsi brainwashing,” (Keane 1995; 8)… "It is not known whether Habyarimana intended the killing to reach the scale that it did after his death. What can be said is that he encouraged the most virulent anti-Tutsi propaganda and that, given Rwanda's history, he must have been aware of the potential consequences,” (Keane 1995; 24). This propaganda was, essentially, a way for the Hutu to retain control over Rwanda in the face of increasing Tutsi opposition. For this reason, the atmosphere in pre-genocide Rwanda has been compared extensively to that of Nazi Germany before World War II. Much like the Jews targeted in Nazi Germany, the Tutsis were outcast, denied privileges, and blamed for many facets of Rwandan society gone awry.

The assassination of Rwanda's president, Juvenal Habyarimana, on April 4, 1996 pushed the conflict between the Hutu and the Tutsi past the breaking point. While he was returning from the Arusha Peace negotiations, missiles were fired at the president's jet as it approached the Kigali airport. Originally, the RPF was accused of the assassination, though there are theories on both sides that support both the Tutsi and the Hutu motivations for purging their country of its president (the assassin is still unknown). Regardless of who was responsible, the sentiments that had been culminating for years—arguably decades—between the two groups suddenly arose, resulting in a killing spree instigated by the Interahamwe. The massacre lasted roughly one hundred days before the
RPF gained control. The killings that ensued were horrific; machete-wielding Hutu militiamen hacked away at any Tutsi and Hutu that attempted to conceal or protect their Tutsi friends and neighbors.

Although it will never be known exactly how many women were the victims of rape in Rwanda during the 1994 genocide, it is estimated that roughly 250,000 women and girls were subjected to either individual rape, gang-rape, or were held under terms of sexual slavery for repeated (mis)use of their bodies. Many women were forced to witness the murder of their family members after having been brutally raped. This sequence of events followed a prototype: “these crimes were frequently part of a pattern in which Tutsi women were raped after they had witnessed the torture and killings of their relatives and destruction and looting of their homes,” (Human Rights Watch 1996). In one reported case, a Tutsi woman hid in a tree during the genocide of her village, where she stayed for several days. During this time, she witnessed her father’s killing directly beneath the tree in which she was hiding; she came down that night to bury his body because dogs were eating his remains. Upon disembarking from the tree, she discovered the bodies of her mother, her brother, her sister, and her children—all butchered and thrown into a latrine pit. She was eventually reunited with her 6-year-old daughter who was still alive. While attempting to flee the area, however, the woman and her daughter were captured. The woman was then forced to witness something, perhaps, more terrible than the massacre of her other family members—her daughter was gang-raped by three militiamen, while she stood by—powerless to defend her little girl, (Goodwin 1997).

Gruesome stories accompany most of the rapes that occurred during the 1994 genocide. Included in these tales is the vast use of machetes and weapons used to attack
women, often destroying and disfiguring private parts. Many women’s breasts were hacked away by machetes in an attempt to rob them of their womanhood. Their pelvic regions were disfigured and destroyed most often, however. In many cases, sticks, spears, and other instruments were brutally forced into women’s vaginas, resulting in death of the victim, (Guardian Unlimited 1999). According to the Human Rights Watch (HRW) 1996 report: “rapes were sometimes followed by sexual mutilation, including mutilation of the vagina and pelvic area with machetes, knives, sticks, boiling water, and in one case, acid,” (HRW 1996).

Sadly, these crimes were not only committed once; usually women were forced to suffer the offense several times, resulting in irreparable damage to their genitalia:

The machetes were invariably aimed at breasts and genitalia, a savage postscript to days or weeks of repeated rapes by the women’s captors. It was not uncommon for battered and bleeding women to be passed from one group of armed men to another. And no matter how severe the women’s injuries, the sexual assaults would begin all over again. (Goodwin 1997; 4)

Not all women survived this kind of brutal debauchery. Many died from devastating wounds, bleeding to death.

Historically, violence against women, and sexual violence, in particular, has always been a variable entered into the equation of war. We see evidence of rape as a “spoil” of war even as far back as in ancient Greek societies with the abduction and rape of Helen of Troy. However prevalent in the past, the frequency of rape during war has not been given sufficient attention as being a crisis that needs addressing. It is only recently (arguably beginning with the mass rape cases during the civil war in Yugoslavia between 1991 and 1993) that light has been shed on this tragic offense and efforts have been taken to penalize the perpetrators. To give dimension to the frequency of this
horrific phenomenon during this century alone: it is estimated that roughly between
100,000 and 200,000 Asian women were abducted for sexual slavery by Japanese soldiers
during World War II in Korea; during the civil war in Bangladesh (1971), between
250,000 and 400,000 women were raped, resulting in 25,000 unwanted pregnancies;
Liberia’s civil war has resulted in an enormous number of women and girls raped and/or
forced into sexual coercion (statistics not yet available); and in Uganda, approximately
70% of women in the Luwero triangle area had been raped by Ugandan soldiers in the
early 1980’s. Many of these women were accosted by more than one soldier, either at the
same time or on different occurrences, (Swiss et al. 1993; 613). During World War I, it is
reported that German soldiers “used rape and other atrocities in a deliberate campaign to
instill terror in the local population,” in Belgium and France (Niarchos 1995; 663).

Rape has often been coined an “unfortunate byproduct of war,” demonstrating its
unfortunate inevitability during times of conflict. According to Susan Brownmiller:
“[r]ape flourishes in warfare irrespective of nationality or geographic location,”
(Brownmiller 1975; 32). It is only recently that rape has been given global attention as
being a crime against humanity—focus that has arisen through various other horrific mass
rape incidences in the late twentieth century. The sociology of violence against women
during wartime is complex but not hard to understand. According to Richard Hartigan:
“[t]he savage mind could be pictured as logically concluding that the most economic use
of his energies in war would be to guarantee that he would not have to face his enemy
again. One way to achieve this result was to eliminate the source of future supply,”
(Hartigan 1982; 17). Using this logic, women would be the easiest targets during war, as
they comprise the root of the society’s propagation. They are also, perhaps, weaker and more vulnerable to attack.

Rape, as a strategy of offense, is used to destroy a group’s pride; it is humiliating to any group in which there is a sense of humanness or compassion for “their own.” Thus, attackers view rape as a blow to the entire community rather than to the individual woman: “as well as an attempt to dominate, humiliate, and control behavior, rape in war can also be intenced to disable an enemy by destroying the bonds of family and society,” (Swiss et al. 1993; 614). According to the Human Rights Watch 1996 Report:

Rape in conflict is also used as a weapon to terrorize and degrade a particular community and to achieve a specific political end. In these situations, gender intersects with other aspects of a woman’s identity such as ethnicity, religion, social class or political affiliation. The humiliation, pain and terror inflicted by the rapist are meant to degrade not just the individual woman but also to strip the humanity from the larger group of which she is a part. The rape of one person is translated into an assault upon the community through the emphasis placed in every culture on women’s sexual virtue: the shame of the rape humiliates the family and all those associated with the survivor. (HRW 1996)

Brownmiller argues that rape of the women of a certain group damages the masculine ego of that group, signifying failure of those men to protect the women involved. This eats away at the fabric of the society, indicating success for the rapists whose intent is to destroy the group through women’s bodies. Thus, direct assault against a single woman is less meaningful in the context of war; it is the indirect assault on the population as a whole that is projected to be more detrimental to the society.

Men of a conquered nation traditionally view the rape of “their women” as the ultimate humiliation, a sexual coup de grace. Rape is considered by the people of a defeated nation to be part of the enemy’s conscious effort to destroy them… Apart from a genuine, human concern for wives and daughters near and dear to them, rape by a conqueror is compelling evidence of the conquered’s status of masculine impotence. (Brownmiller 1975; 38)
Furthermore, rape by the conquerors is a ghastly ritual of victory, flaunting their “ability” to abuse the women of the defeated group: “it is obvious that if there is any raping to be done, it will be done on the bodies of the defeated enemy’s women... [R]ape is the act of a conqueror. This is more than a truism. It helps explain why men continue to rape in war,” (Brownmiller 1975; 35).

According to Catherine Niarchos, rape during the war in former Yugoslavia between 1991 and 1993 followed five general patterns. A summary of the first is as follows: “rapes are being committed before fighting breaks out in a region,” (Niarchos 1995; 657). This can involve the incursion of the target group’s property, usually in attempt at terrorizing the inhabitants of the household, vandalizing and stealing property, and raping the women—usually in a gang atmosphere, whether or not the victim was actually gang-raped. The second pattern includes rape during invasion of a town or village; in these instances, a gang component is also common; rape is often public. The third pattern involves the detention of women in camps after the clearing of the village after invasion. In these cases, a woman is detached from the camp when needed, used, then either killed or returned to the camp, usually after having been severely beaten or tortured. The fourth pattern is much like the third, though in this scenario, women are held in “rape-camps,” which are generally large, well-ordered, and under specific control. The women in these camps are “raped frequently, perhaps numerous times each day. They are humiliated, beaten, and some are killed,” (Niarchos 1995; 657). In last method of rape during wartime, “women are forced into brothels to sexually entertain soldiers,”
(Niarchos 1995; 657). This pattern usually results in women being killed more often than released.

The incidences of rape during the 1994 genocide in Rwanda followed many of these patterns, almost to a tee. It was reported that Hutu militiamen were specifically instructed to rape Tutsi women, who were seen to be more tall and beautiful in comparison to women of the Hutu population, often described as being “tall and lithe, with Caucasian features,” (Goodwin 1997; 4). Tutsi women were, thus, considered unattainable by Hutu men and were thought a threat to the Hutu majority. Through propaganda, sexual aggression towards Tutsi women was exacerbated and condoned by the Hutu militia: “the propaganda that poured out of the government radio stations in the months leading up to the genocide taunted Hutus with the mythology of the Tutsi women: they were taller, more beautiful and arrogant. They had to be tasted and humiliated before they were killed,” (Guardian Unlimited 1999). Newspapers controlled by Government authorities also published cartoons depicting rape of Tutsi women (CBC Witness 2000), further provoking sexual violence. Thus, militiamen targeted Tutsi women’s sexuality as a means by which damage to the Tutsi population could occur and be devastating. Rape was a vehicle by which women and men of the Tutsi population would be destroyed—not just the women. “[Savage rape] is rape as torture, mutilation, femicide, and genocide. It is war fought on and through women’s bodies. It is rape as a military strategy,” (Niarchos 1995; 651). The mass rape of Tutsi women was a planned and vital feature in the Interahamwe strategy of genocide.

This type of humiliation proved successful for the Hutu militiamen. Because there is a strong social stigma in Rwanda against rape survivors even under less severe
conditions, the stigma against female survivors of the 1994 genocide was enormous and compounded. Survival under these conditions is seen as a choice: a woman can choose to live after she has been ravaged and has watched her family die, or she can choose her own death. Thus, a woman’s morality is in question if the choice is survival: “adding insult to injury, victims are admonished for having preferred survival through rape,” (USAID Evaluation 2000). According to one woman who lived to tell the tale, “there is shame among the survivors... Those who were not in Rwanda during the genocide look at those of us who were and they sometimes ask: ‘How did you survive?’ It [is] as though we have done something shameful to have survived,” (Guardian Unlimited 1999).

In these regards, the mass rape of (mainly) Tutsi women during the 1994 genocide is not a novel issue. However, not only was it premeditated to strip humanity from Tutsi women through humiliation in order to target the Tutsi population at large; some rapists were also reported to have “boasted of infecting the Tutsi women with the AIDS virus. They would be left to live, they were told, so that they would pass on the virus to returning Tutsi fighters,” (Hilton 1999; 1). According to several reports, it is now estimated that roughly 50% of the rape victims during the 1994 genocide in Rwanda are dying of AIDS—a figure approximately three times that of the national rate of infection. Thus, the death toll during the Rwandan genocide is not yet completely accounted for. The women that were raped and infected with HIV will invariably die of the lethal virus, an indirect result of war:

Millions of deaths have occurred since 1980 as a direct result or indirect consequence of war: more than a million in Sudan, perhaps the same high toll in Ethiopia, Mozambique and Rwanda. AIDS is uncontainable during conflicts like the Rwandan civil war when rape, coerced sex and forced prostitution are
common; in this context, advice to use condoms or ‘just say no’ appears ludicrous. (Turshen and Twagiramariya 1998; 19)

In addition to torture and brutal rape, many women accosted during this genocide became pregnant with children of their rapists. According to a survey conducted by UNICEF of 304 rape survivors, roughly 35% of rape victims during this genocide were impregnated by their rapists (UNICEF 2000). Because Rwanda is a country that is primarily Catholic, abortion is illegal. Thus, rather than bear the children conceived during rape, many women killed themselves or sought out clandestine abortions: “some pregnant women committed suicide rather than give birth to ‘a child of hate,’” (Goodwin 1997; 5). These abortions often resulted in further trauma to the woman’s pelvic region, irreparably damaging her genitalia. Further still, many of these women died: “an additional cause of death was the botched and primitive abortions Rwandan women resorted to when they learned they had been made pregnant by the enemy,” (Goodwin 1997; 5). Still other women chose to bear these “children of bad memories” (or enfants mauvais souvenir) and abandon them or commit infanticide. However, many women are now raising these children and are forced everyday to remember the nightmare they suffered in 1994—their children serve as a constant reminder of the rapist’s attack and the murder of their loved ones.

The negative effect of war on the behaviors and practices associated with STD transmission is enormous. When one witnesses horrifying manslaughter at a scale such as that which occurred during the 1994 Rwandan civil war—seeing family members butchered and perhaps tortured and raped—the threat of HIV, perhaps, goes by the wayside: “the government declared the fight against AIDS a national priority in 1997, but
official warnings about the disease’s dangers don’t easily scare people still traumatized by one of the 20th century’s worst bloodbaths,” (Hranjski 2000; 1). According to Pascal Crussard of the aid group CARE: “These people have lived through genocide. They’ve seen the worst. For many, AIDS has no meaning. Why care about AIDS when you’ve seen your family killed?” (qtd. in Hranjski 2000; 1). The genocide may have had a numbing effect on the Rwandan population, erasing all effort that has been made by aid groups in combating knowledge and beliefs that lead to the spread of the HIV virus.

Even though there is a serious social stigma against those with HIV in Rwanda, practices that prevent the spread of this virus will more than likely not become more prevalent in the near future. People that were the victims of this terrible tragedy are so scarred psychologically that knowledge about the mechanism of transmission of HIV and fear of its effect is, perhaps, no longer enough to promote their safe behavior. Individuals affected by the 1994 genocide may engage in specific behaviors known to be risky, such as lack of use of condoms, having casual sexual intercourse with multiple partners, and prostitution. The fear of contracting a lethal virus, such as HIV, becomes less prevailing in this case, resulting in widespread perilous conduct.

Another avenue by which lives will be claimed due to this genocide is the practice of husband-sharing that now exists in Rwanda. Because so many men were killed during the 1994 massacre or have now been imprisoned, Rwanda has become a country primarily of women. According to David Gough, women are now looking toward sharing their husbands in an effort to gain financial support and to start new families (Gough 2000). Since there are already a great number of individuals infected with HIV in Rwanda, this new occurrence puts women at a greater risk to contract the deadly virus
that leads to AIDS: "the practice of sharing men, known as 'kwinjira,' is widespread in rural Rwanda, where adult males compose only 20 percent of the population in some parts. Kwinjira is used by women to replace families lost during the genocide, but it is particularly dangerous when an estimated 11 percent of Rwandans are infected with HIV," (Gough 2000; 9A). Furthermore, it is postulated that the spread of this virus can be somewhat accounted for by the desire for older men to seek younger mates, thus increasing the HIV infection rates among adolescent and young women: "women are expected to have relations with or marry older men, who are more experienced, and more likely to be infected. Men are seeking younger and younger partners in order to avoid infection and in the belief that sex with a virgin cures AIDS and other diseases," (WHO 2000; Fact Sheet No. 242).

As it now stands, the 1994 genocide in Rwanda has not yet seized the lives of all of its victims. Because many of the women who were brutally raped during this horrendous event were also infected with HIV, they will most assuredly die in future years. Thus, murder was not the only avenue of genocide. Because of this atrocity, the 1994 genocide in Rwanda can be viewed not only as a crime against each victim that was involved; it can also be regarded as a crime against humankind in its purest form.

**Example 2: THAILAND**

Even if not directly forced into unwanted sexual acts, women are not always able to control their sexual relations, including when and with whom they engage in sexual intercourse. In cases where women have lost their husbands and family either in war or due to other circumstances (and thus have no means of financial support), prostitution is
potentially risky behaviors is deemed a choice one makes that is deleterious to his or her health, implying that these individuals have an alternative yet are simply choosing to be reckless with their bodies. According to Maria de Bruyn: “it is continually emphasized that the practice of preventative methods is an individual decision, ignoring the fact that decision-making also depends on social factors facilitating a particular course of action,” (de Bruyn 1992; 251). It is safe to argue that, with an opportunity for another lucrative form of income outside of prostitution, many of these women (if not all) would choose the rejection of the sex industry. In a study conducted by Marjorie A. Muecke in which she conducted interviews of current prostitutes, it was found that many disliked their occupations yet chose prostitution over a bleaker situation:

Although there are women who choose to undertake and remain in prostitution, there appear to be few... who deny having suffered as a result of their occupation. The suffering of a prostitute may take various forms, including loneliness physical abuse and pain, verbal abuse, deception, illness, exhaustion, rejection, uncaring, unsafe abortions, sexually transmitted disease, and the stigma and lethality of HIV infection. Typically the prostitute’s choice was to stay in the suffering of a difficult family or poverty, or to live in the suffering of loneliness, alienation, and personal abuse that goes with being a prostitute. (Muecke 1992; 893)

Thailand supports a population of roughly 55 million; in 1992, it was estimated that 80,000 to one million women were working as prostitutes, not including the 20,000 more that are girls under the age of 15 also in the industry (Muecke 1992; 892). Thailand is a country that is now experiencing great economic changes due to its modernization, resulting in a very stratified society with a wealthy class and a very poor class. Although the average per capita income has shown a steady increase over the last thirty years, the gap between the wealthy and poor classes has become even more extreme: “although in absolute terms poverty has been reduced over the past three decades the increasing
commodification/nonetization of Thai society has served to increase the financial pressures on poor people and possibly also to make them more conscious of their relative poverty,” (Ford and Koetsawang 1991; 408). Additionally, most of the individuals that make up the lower class are farmers or are involved in the agricultural sector of business. This vocation is one that often results in an unpredictable source of income, rendering workers constantly vulnerable to fluctuating crop prices and economic instability—frequently resulting in debt. Because of this factor, women of poor families are often forced into the sex trade or are encouraged by their family members to migrate to the cities to pursue a career in prostitution in order to generate income to support their relatives: “poverty—particularly rural poverty and landlessness—coupled with the rapid commodification and monetisation of Thai society, is undoubtedly the major underlying factor in promoting the large scale entry of young women from particular regions into commercial sex work,” (Baden 1992; 11). Furthermore, the assumed obligation to provide support for one’s family is deeply embedded in Thai culture—making it more difficult for young women to reject the possibility of making more money in the sex industry. It can even be argued that a woman’s choice is not her own in this matter. There is more pressure on female children than on male children of the rural poor to migrate to large cities in hopes of making money via this outlet:

It is important to recall that making a decision as to whether to work in the commercial sex industry is not solely based upon individual considerations, but is closely related to family and community issues. An oft-repeated reason for engaging in employment in the commercial sex establishments in Bangkok is to remit money back to parents and siblings. (Ford and Koetsawang 1991; 409)

Men are not bound by the same hardships as young women. Even lacking in education and raised in conditions of harsh poverty, there are opportunities for men to succeed
without needing to revert to trading sex for money or something equally demoralizing and harmful. According to Muecke: “men, in contrast [to women with minimal education], can escape poverty and achieve respectable social status and economic security through two honorable careers that are closed to women: the monkhood and the military,” (Muecke 1992; 895).

There is often a double standard when it comes to prostitution in Thailand and many other developing countries in South Eastern Asia. While commercial sex workers are blamed as being the vectors for STDs and HIV, the truth is that the sex trade is a lucrative industry. Although prostitution is officially illegal in Thailand, it is often argued that the Thai government covertly supports commercial sex work, as it is a means by which the country generates an ample amount of income. According to Muecke: “the government benefits economically from the contributions of sex entertainment to tourism income, while it maintains that prostitutes are primarily responsible for the scourge of AIDS,” (Muecke 1992; 896). Much of the money made by prostitutes and other tourist industries is brought into the country by foreigners—a fact that prevents the government from cracking down on prostitution altogether. According to Scott Bamber, Kevin Hewison, and Peter Underwood: “the government has earned revenue, either directly or indirectly, from prostitution, and this association has constrained any measures undertaken to control the sex industry and STDs,” (Bamber, Hewison, and Underwood 1997; 268). It is fair to say that the lure of prostitution is the main driving force behind tourism in this area; this argument is highlighted by the fact that, in 1985 and 1987, 70% of all tourists to Thailand were single men (Muecke 1992; 895). This figure has, presumably, gone down with the increasing awareness of the high prevalence of HIV and
other STDs among commercial sex workers; yet, it demonstrates the motivation of tourism in the past, before the realization of the AIDS era.

The vigor of the commercial sex industry cannot be blamed solely on the influx of tourists, however. There is, perhaps, motivation for the government of Thailand to duck accountability for the existence of prostitution and to place the blame on foreign tourists; prostitution goes against the ideals of honorable Thai society. In reality, the greatest percent of clients are Thailand natives. Blaming foreigners’ employment of commercial sex workers is a way for Thai society to allow the institution to exist without admitting its liability in the matter. According to Muecke: “since both prostitution and polygamy are illegal yet prevalent among men of elite social standing, the media’s selective targeting of foreigners who patronize prostitutes works to protect and conserve the same practices of the Thai.” (Muecke 1992; 895).

The existence of prostitution has also been a major part of Thailand’s history, having early origins: “Thai scholars ascribe the origins of prostitution in Thailand to the early Ayudthia period, which, in the 15th century, codified laws that structured society hierarchically and vested authority over women to men, and required men to leave home for extended periods to serve their lords,” (Muecke 1992; 892). It has been documented that, in the past, prostitutes were made available to men during their time of service when they were away from their wives. These women were sold into duty as prostitutes by their families or husbands—a fact that sheds light on the social status of women during that era. Muecke argues that this position of women has persisted into the current day, only under different guidelines and parameters: “although laws have changed, the historical practice of selling women provides important precedent for the current practice
whereby adults, predominantly men, sell family members, particularly daughters, for economic gain,” (Muecke 1992; 892).

Although much attention has been given to the spreading of HIV via the sex industry, it is important to note that the prevalence of HIV/AIDS in Thailand has been reported to be highest not among prostitutes, but among intravenous drug users. However, because commercial sex workers see a large number of clients, this statistic is often overlooked. The most frequent method of HIV transmission is thought to be through these women to their customers, resulting in a high prevalence of individuals affected by HIV:

The existence of large scale sex industries, especially in Thailand and the Philippines, such that small sections of the population—i.e. sex workers and their clients—have a large number of partners; high levels of STDs (an important cofactor in the spread of HIV infection); and low levels of condom use. (Baden 1992; 7)

Because of this amplification, the percentage of the population with HIV is rapidly increasing. Prostitutes are, thus, seen as the vector for this deadly virus. More often than in any other population, commercial sex workers are blamed for the transmission HIV and other STDs. “In Thailand… STDs are commonly known as ‘women’s diseases,’ and AIDS is literally called a ‘prostitute’s disease’,” (Baden 1992; 14). This stance puts focus on women for the transmission of HIV, disregarding the role that men play in frequenting brothels and massage parlors. There is also a significant sector of male prostitutes that cater to the homosexual population that should not be ignored. Thus, the denotation of AIDS as purely a women’s disease cannot be justified.

Ford and Koetsawang make the observation that there is a hierarchy between prostitutes and across the establishments in which they work. They argue that these
levels correlate to the prevalence of HIV transmission between prostitute and client. The type of establishment indicates the type of customer they serve—the brothels being at the bottom, serving all social strata. Perhaps due to a general lack of health care (of both prostitute and client) and lower levels of education, there seems to be a greater level of transmission of HIV and other STDs at the poorer end of the spectrum. There is evidence for “rising levels of HIV infection in particular in those establishments which cater for the cheaper end of the market,” (Ford and Koetsawang 1992: 407). Ford and Koetsawang also mention a more pronounced lack of compliance regarding condom use in addition to less control prostitutes have over their clients among the lower class establishments as another possible reason for this finding. Because there is, to a large extent, opportunity for upward mobility in this trade, there is a potential for a greater deal of transmission of HIV where there might normally not have been. Since prostitutes are more readily infected with HIV in lower class establishments, they are also more likely to carry the virus and bring it to their new position, enlarging the “pool” of the infected population. That is not to say that transmission of HIV is non-existent in upper scale establishments, but, according to statistics, men who are members of the higher social strata and who frequent more elite prostitution establishments are more likely to have a higher level of education. Hence, they may be more aware of the risks associated with HIV and other STDs and are more willing to wear condoms during sexual intercourse.

Until the political and social standing of women is changed in Thailand and there become available other options for lucrative employment, there may not be a significant reduction in the transmission of HIV. As mentioned by Bamber, Hewison, and Underwood, “those at greatest risk have lacked political power... These groups have had
little opportunity to have a say in the provision of services or other measures that would improve their position,” (Bamber, Hewison, and Underwood 1993; 60). Furthermore, it is not warranted to blame the spread of HIV on the commercial sex workers themselves. Men who visit them are partly responsible, as are long-established practices of Thai society. There are many other facets to this phenomenon that are too involved for this paper, but suffice it to say that other factors, such as the easy movement of people across the borders into Thailand, the widespread practice of polygamy, and intravenous drug use also play a role in the heavy transmission of this deadly virus. Anti-AIDS campaigns must also address these issues.

Example 3: KENYA

Sexual practice and behavior among adolescents is a substantial factor in the rate of transmission of HIV. Where access to information regarding STDs and sexual health is limiting, youths often do not perceive to be at a great risk for acquiring the virus or are generally uneducated about the methods of HIV transmission and ways to protect themselves. Knowledge and awareness of condoms and their uses are a factor involved in the determining patterns of sexual practice, as is access and the ability to acquire condoms from a known source. In a survey conducted on 13 developing countries in Africa and South East Asia, it was apparent that awareness of condoms was sufficiently lacking in the general population (Mehryar 1995). A trend showed that awareness and knowledge of condom use was generally lower for Sub-Saharan African countries than for those in South East Asia (however, there were some discrepancies, namely in the Philippines, where condom awareness was generally low; knowledge was substantially
high in Tanzania and Lusaka). In all cases, females showed a lower percentage of condom awareness than males, sometimes revealing astonishing differences between the men of the same country. For example, 52% of males in Cote D’Ivoire were aware of condoms as opposed to only 29% of females. In Kenya, the percentage of males who were aware of condoms was roughly 68%, whereas females aware of condoms represented 60% of the female population (Mehryar 1995).

Age was also a variable in the response to knowledge and awareness of condoms, with individuals between 15 and 19 years of age having the lowest awareness level. As noted by Amir Mehryar, this statistic is regrettable, as many youths indulge in their first sexual encounters during this time period: “with regard to age, one would hope for high levels of condom awareness among people aged 15 to 19 years who are beginning their sexual careers,” (Mehryar 1995; 130). General knowledge about the existence of condoms, however, is not indicative of condom use; nor does it imply that an individual will have access to condoms. It was also reported that, even if an individual was aware that condoms existed or even knew how a condom was used, and had knowledge regarding HIV/AIDS, he or she did not know that using a condom during sexual activity could prevent the spread of HIV (Mehryar 1995). These findings indicate that the need for education regarding condom use and the prevention of STDs is of utmost importance in developing countries.

Located in East Africa, Kenya is a country that is afflicted with a dramatic number of individuals living with AIDS. It is estimated that this number exceeds 2.1 million (UNAIDS 2000). This statistic becomes even more striking when most of the reported cases are youths between the ages of 15 and 19 years. Within this statistic, six
times as many girls are infected with HIV than boys; in Kisumu, 23 percent of all teenage girls are infected with this deadly virus (Muganda 2000).

Many youths in Kenya, although aware of AIDS and the consequences of unsafe sex, display a general feeling of invincibility toward HIV/AIDS. Many individuals believe AIDS to be an affliction that is a disease of the "other"—an illness that does not pertain to them, personally. Because notions of risk are central to decision-making in any context, this is a dangerous pattern as it applies to HIV transmission. According to John Cleland, "the concept of personal risk, or vulnerability, is central to many theories of behavior change. Indeed in some theories, the feeling of personal risk is held to be a precondition for adaptive change," (Cleland 1995). According to a survey conducted in Kenya during the early 1990s, the percentage of the population who had knowledge about HIV/AIDS and who considered themselves personally at risk for contracting HIV was found to be relatively small in comparison with those who considered themselves not at risk at all. Responses indicated that roughly 45% of males and females considered themselves "not likely" to catch AIDS, while only 15% considered themselves at high risk. Approximately 18% of Kenyan individuals thought themselves to be at a small risk; the rest were undecided about their likelihood of catching HIV/AIDS (Cleland 1995). Amongst the Kenya population who thought they were at no risk or not likely to contract HIV were those who had frequently engaged in risky behavior during the 12 months prior to the survey, such as visiting commercial sex workers and/or not frequently using condoms. However, it was in this population that the perception of high risk was most evident as well. It is important to note, also, that one can see a marked difference in the attitudes of personal risk between educated and non-educated groups, the more educated
population demonstrating a greater fear of contracting HIV, whether or not that sentiment corresponds to personal sexual behavior (Cleland 1995). Granted, there may be a greater awareness about HIV/AIDS leading to different behaviors among these individuals now that the AIDS situation has escalated to the heights it has in the past decade, but even so, these trends can be viewed as a precursor to the extent of HIV transmission that we have seen recently.

Hampering the progression of HIV/AIDS awareness and the widespread use of condoms during sexual activity may be due, in part, to the reluctance in Kenyan society to openly discuss issues relating to sex and sexual behaviors. Specifically, condom use is seen as a breach of religious belief; for this reason, religious leaders have discouraged condom use in the past. This aspect of Kenyan belief has had a deleterious effect on the rampant transmission of HIV in Kenyan society, especially among the young population, who are, perhaps, more vulnerable to the advice of adults in positions of authority. According to Family Health International: "many religious leaders are concerned that condoms are a form of birth control or that they contribute to promiscuity and youth sexual activity by reducing the risks associated with intercourse," (Family Health International 1999). It is safe to say that, in Kenya, at least, sex is a topic that is taboo, reserved for discussion only between intimate partners. The public, at large, seems to be somewhat cautious about advertising ways in which the AIDS epidemic can be eradicated for fear of promoting "immoral" or promiscuous behavior. Some schools may be unwilling to teach sex education or to advertise condom use as an effective means of protection against STD transmission (Family Health International 1999). If schools are the primary outlet for the transfer of knowledge, and they are unwilling to discuss such
issues as sexual health and education, young people may remain somewhat oblivious to the dangers of casual sex and irresponsible activities that can lead to the propagation of HIV and other STDs. According to one Kenyan youth: “the worst thing about [the] AIDS crisis in Kenya is that no one is even talking about it. It is still seen as a dirty disease that affects dirty people who use dirty needles and engage in dirty sex,” (Yakub 2001).

Conclusion:

There are several patterns of HIV transmission that exist between cultures. It is almost a universal truth that women are more susceptible than men to HIV infection due to several factors, including economic, biological, social and cultural dynamics.

According to the World Health Organization:

Women’s right to safe sexuality and to autonomy in all decisions relating to sexuality is respected almost nowhere. As it is intimately related to economic independence, this right is most violated in those places where women exchange sex for survival as a way of life. And we are not talking about prostitution but rather a basic social and economic arrangement between the sexes which results on the one hand from poverty affecting men and women, and on the other hand, from male control over women’s lives in a context of poverty. By and large, most men, however poor can choose when, with whom and with what protection if any, to have sex. Most women cannot. (WHO 2000; Fact Sheet No. 247)

It is necessary to examine gender relations and the political and social status of women in order to develop gender-appropriate methods for the prevention of HIV/AIDS, especially in countries where there are marked gender inequalities. It is not enough to simply look at the biological transmission of the HIV virus that leads to the disease AIDS in order to ascertain the possibilities for the reversal of its effect on the global population.
In the past decade, a trend has arisen: the average age of HIV infection in young women has dropped significantly. In some African countries, especially, this phenomenon can be partially attributed to affairs between a young woman and her "sugar-daddy," a term that implies a young woman's financial dependence upon an older male in exchange for sexual relations. Often, the men of these cultures believe that sex with younger women is less risky because younger women have not had extensive opportunity to engage in risky sexual behavior. The implication is that they are probably not yet infected with HIV. Younger women are, thus, seen as a commodity; in some cases, men believe that sex with a virgin can cure AIDS. According to Filgueiras: "older men in many countries, called 'sugar-daddies' in some cultures, are now seeking out young women for sex in the belief that these girls are less likely to be infected with HIV. This is happening all over the world, but especially where AIDS is having a visible impact," (Filgueiras 1995; 121).

Education is another universal factor involved in the frequency of HIV transmission. Individuals who are more highly educated are more likely to be aware of behaviors that are risky and tend to act accordingly (though not always). In areas where sexuality is a relatively unapproachable topic of discussion, such as in Kenya, the information regarding safe sex practices may not reach the general public. Young individuals, specifically, may be unaware about the importance of safe sex to avoid getting AIDS. In many cases, even if sex education is taught in schools, women are at a distinct disadvantage, because—especially in developing countries—women are taken out of school earlier than their male counterparts (UNAIDS 1999).
Although preaching abstinence may seem like a logical approach in some societies to prevent the further spread of HIV, this is not always a feasible option. As shown, it is not always a woman's decision under which circumstances she engages in sex. In cases of rape, this scheme is impossible. Furthermore, being faithful to one partner does not guarantee safety against HIV. According to the UNAIDS report on women and AIDS: "simply being married is a major risk factor of women who have little control over abstinence or condom use at home or their husband's sexual activity outside," (UNAIDS 1999). This factor is especially important in countries in which sex outside of marriage—often with prostitutes—is common and where condom use may not be frequent. Exacerbating the situation is the often negative portrayal of condom use in developing countries. Often, condoms are associated with the notion of distrust of the sexual partner or serves as a visual reminder that the transmission of HIV is possible. According to Amir Mehryar: “in many countries with the start of the AIDS epidemic, the word *condom* has become a morally and emotionally loaded term with connotations of illicit sex. As a result… their widespread use as a contraceptive has been hampered by their historical association with STD prevention,” (Mehryar 1995; 124).

In order for anti-AIDS campaigns to be successful, it is necessary to look at each factor determining behavior and knowledge in different societies as they relate to sexual practices. This often becomes a tangled web of cultural beliefs—playing off of tradition, politics, and morals. The differences in modes of transmission of HIV, globally, can be explained through these cultural phenomena and cannot be taken out of context. The weight of each mode of transmission is different in each society, reflecting myriad
cultural practices. Intravenous drug use, for example, continues to be a major form of HIV transmission in the United States.

Although the most widespread route of HIV transmission, globally, is via heterosexual contact, homosexual transmission of HIV cannot be ignored. This behavior—once thought to be the primary route of transmission of the virus—accounts for only a small number of the global AIDS population. However, homosexual contact continues to be a prevailing mode of transmission in the developed world.

As we forge through the 21st century, many more lives will be claimed by AIDS, almost completely decimating certain societies. The ultimate effect HIV/AIDS will have on the human species is left to speculation, as there is currently no cure to terminate the propagation of this virus.
Works Cited:


