disClosure Interviews Ida Susser. Women's Autonomy and the Political Contours of HIV/AIDS in Southern Africa

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Dr. Ida Susser received her PhD from Columbia University. She teaches anthropology at Hunter College and the Graduate Center for the City University of New York. A medical anthropologist, Dr. Susser in her research focuses on HIV/AIDS, especially as it relates to changing patterns of inequality and poverty, gender, and social movements in the Caribbean, southern Africa, and New York City. In pursuit of understanding these issues, she has been and continues to be involved in extensive fieldwork in Puerto Rico, South Africa, and among the Ju/'huuans (San) people of the Kalahari. She is active in community concerns in New York City.

Dr. Susser visited the University of Kentucky in February 2005 to participate in the Spring Seminar and Lecture Series on Intimacy sponsored by the UK Committee on Social Theory. She delivered a talk entitled "From the Cosmopolitan to the Personal: The Politics of HIV/AIDS," a discussion of the work she did with the support of both the National Endowment for the Humanities and the National Institutes of Health. During her visit, she sat down with J. Michael Tilley and Larry Erickson, members of the disClosure editorial collective, to discuss some of the issues surrounding her work. In the interview, Dr. Susser focuses on the historical and social context of the AIDS pandemic, particularly as it has developed in South Africa, as well as the prospects for constructive ways of dealing with it.

disClosure: What are the structural obstacles in southern Africa to fighting the spread of HIV/AIDS?

Ida Susser: A lot of what I talk about is basically structure. The major one is that there has been very little or no
investment in public health in the rural areas. This was a major scandal under the apartheid regime, and the first thing that the ANC did was to legislate an effort toward primary health care, even before 1994. But there is a shortage of nurses and doctors. More than 40 percent of the population live in the rural areas, not just in South Africa but also in Namibia and Botswana. Botswana is the best in terms of public health facilities, since they’ve been independent the longest, and because they’ve had the wealth from their diamonds, there’s been more investment in public health than in South Africa or Namibia. So they’re on top of AIDS, and AIDS isn’t as high in Botswana as in South Africa or Namibia. So that’s number one, structure.

But I don’t think that public services are really where health comes from. This is an argument to be made about the West. We don’t think TB was cured because of sanitariums. It has to do with nutrition and with the empowerment of the population. The main issue around AIDS is the empowerment of women—the empowerment of women through work. Something like 29 percent of black men in South Africa are unemployed, and when you look at women, it’s much higher. The fault lines of inequality begin with black women at the bottom, and then black men, and so on. Of course, the color lines have shifted a bit since ’94, and the government has built housing and roads. The places where I started working in ’92 had no roads, no running water, no schools, and no health clinics. When I went back in ’95, there were roads, a community hall, and running water in the houses, small brick houses. They built the houses where the shanties used to be. The roads are built where the footpaths used to be. But the housing still isn’t enough, and the water has been problematic. But there has been quite a bit put into this early on by the new regime. So structure has been important, but there have been any number of disputes about how the water should be organized.

What has happened is that the structure is there but they don’t have very good implementation. It’s like the nurses I met in Namibia. They get letters telling them that there are only so many supplies of such and such pills, so don’t give too many of them out. The structure—the actual physical building—is there, and there’s somebody occupying it, but the implementation just isn’t there. And there’s only one doctor for three hundred miles. So structure is all of that, race, gender, class, etc.

dC: One central issue is that of colonialism. What is the receptivity to U.S. interventions and public health measures, given that some people think that AIDS was created by colonial powers?

IS: The whole tradition of the West and the protectiveness of the issues of AIDS and sexuality arguably reflect the old missionary Western approach of stereotyping Africans. It definitely comes out of that history. Mbeki, when he talks about AIDS, talks with reference to the colonial era and how black people were stigmatized and how they were blamed for everything.

So, if we go to colonialism, it’s a long story, beginning with the fact that, prior to colonialism, we find that women had autonomy in many of these societies—not just the Kalahari San, which has been called egalitarian, and I’ve written about that and I’m writing more—but also even among the Zulu, even though it was a warring society. Among many of the groups, women had a place, and autonomy; even though there were menstruation taboos and postpartum taboos, there was tremendous power—not that they weren’t patriarchal, they were definitely patriarchal. Patriarchy is a vague term and anthropology doesn’t really accept it. That’s going into the early eighties and the late seventies, with the second-wave feminists. Following that, most of the women who did research in southern Africa were documenting the autonomy of women in many different groups. The Ibo, the San—this is one of the important things that women documented, and I can give you hundreds of references. They documented how it was that women had their own separate councils, that the older women had places at the elders’ councils, that once a woman had kids, she had power. The history of that is very well documented. In South Africa, there are wonderful historians who use the old anthropological literature to document this. In this book that I’m writing, I devote whole chapters to reiterating what we know about women before HIV and before colonialism, but also after colonialism.

What colonialism did was change all that, although there was much more contestation of colonialism than is often granted in the literature. Anyway, it’s always been international. One of the founders of the ANC went to college in Oberlin, Ohio, and then he was funded by Booker T. Washington and went back to South Africa and founded the ANC. But he was originally trained in a missionary school in South Africa. So the missionaries were a hegemonic influence and this guy was very patriarchal, but he was also very revolutionary. So colonialism was a very contested field.

Anyway, prior to colonialism there were lineage, and when the woman got married, for example among the Zulu, there wasn’t just a marriage; there would be a cattle of betrothal and there would be a feast, and then there would be three more cattle and another feast and she would go live with the man, and then if she had a child there would be more cattle, and if she didn’t have children, they would send her back in exchange for the cattle. So she always had this other place which was her original lineage which had received the cattle, and she could go back there and they would give back the cattle. We think of marriage as a one-time thing: you’re mar-
ried and it's done. What they had in Africa was a grading: you're just living
together, give one cow; have a baby, give two cows; if it's a son, give three
cows. So the whole community recognized each stage. But if she was mis-
erable, she could go back. Well, women had those kinds of backups. And
her brother, or her father's brother, depending on the society, would look
after her and she could take a new man. It was a very negotiable, flexible
kind of compromise. Even in the most warring societies, where the chief
had lots of wives, they weren't really his. It wasn't sex; it was ritual owner-
ship of children that was important. And the more children a woman had,
the more power she had. Women had a kind of autonomy over their sexual
behavior. Often women were highly regarded if they had children before
marriage, because it meant they were fertile, and so men would often pay
more for women like that in some societies. Another thing is that if a hus-
bond died, the next guy, maybe his brother, would marry her, depending on
the society. So there were those kinds of rules. It was a very negotiable
situation, depending on the resources in the village, or the resources of the
patrilineage, and depending on the relationship between the man and the
woman. So there weren't rigid rules like you read in the missionary texts.

Well, then you get colonialism and those rules get somehow concre-
tized in colonial law. In KwaZulu, when the British colonial government
took over, they did codify the bride price. However, they codified for only
one kind of thing. So the woman was trapped. She was sold and then she
was trapped. It wasn't the flexible negotiation that it was before. Now when
you hear how tradition is used, and that there's a re-creation of traditions,
it's really not. So I have to say that, with colonialism, this is what you got.
The reason, of course, was for setting up the copper mines, the diamond
mines, etc.—everything that made Britain rich—and in all of the towns that
were set up around the mines, men were used to build the roads, and for day
labor. Chiefs were appointed and were turned into delegates for the colonial
government. It was the same for the French. The chiefs who were appointed
were men, though there were certainly women chiefs, but with the colonial
government, it was the men who were supported. It was men who were
taught English, men who were brought into the missionary schools, men
who earned the cash, men who were brought to the mines to work. If there
was some form of patrilineage, with a warrior society that included some
form of patriarchy before colonialism, then under colonialism, that is what
was codified, concretized, exacerbated, and accelerated. And then you have
the migrant labor. People from all over were moving around, and it was the
men. The women stayed home and engaged in agriculture. So that's the
setup for the separation of men and women.

When the women did come to the towns, they weren't allowed to settle
in the towns, so they built shanties around the towns, and they became the
beer makers and sex workers. So that was the picture created by colonialis-
m. And clearly it's a haven for AIDS. But what is important is that AIDS
came into South Africa through the white male population, like in Europe.
In the eighties, it had the European pattern, because South Africa still had
the apartheid system. So the level of AIDS among the black population was
quite low. Kenya had a very high rate, and Uganda. So the apartheid gov-
ernment did nothing. Benign neglect. But what it did do was implement
birth control in order to reduce the black population. In the archives, ma-
terial has been found showing that they did nothing about AIDS because why
not let the people die? But they did implement birth control, because the
black population vastly outnumbered the white population. The apartheid
government moved the black population out of the towns, and they set up
the pass system for the men. But the pass system was only for men. The
women organized against it and won.

It's a very interesting, very different gender gap. Nothing is the same
for men and for women. There's a different history for men and for women
in every country. There's a different relationship to the needs of production
and a different relationship to history. So the women won with the pass
laws. They had to live in the backs of white people's houses, do the laundry,
take care of the children. They had a different way of finding work. They
were never threatening. There's a different history. But women had no right
to live in the locations; they could only live in white people's backyards.
But black men were in these migrant labor camps.

However, when you really look at what was happening in those migrant
men's dormitories, set up by the mines, you find around each bed at least
one woman and some children. The bed then becomes the home—like the
homeless shelters in New York. The women come in. Nobody blocks them
at the door. And they have to establish a dependent relation with the man to
be allowed to use his bed. They cook for him and wash for him and have his
children. And the man probably has a wife at home. But this woman is then
established in the town, and during the day she probably goes around town
does other people's laundry. But the only way she could live in town
was by sharing his bed. So it's an incredible story. We think of these mine
workers as being male, but in fact every mine worker has one of these
women. And then around the town there are these sex workers, which is
another group. Around the sex workers are the men who often control these
women, so the women don't always get all the money they make. These
men who are unemployed control the scene around the mines. So it's a very
complicated setup.

This is the heritage of colonialism. With the end of apartheid, the mine
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workers’ situation really changed. Everyone moved into the towns. The pass system went away. There were labor movements, social action movements, and so on.

So colonialism and apartheid set up the migrant system. And then, after apartheid ended, they opened the roads to the rest of Africa. There was incredible highway construction during the early nineties. And that’s when AIDS really came in to the black population. It accompanied freedom. The quickest way to spread AIDS, it’s been documented, is along the truck routes. So they opened the borders. During apartheid, the borders were militarized. The apartheid government was afraid that neighboring African countries would be home to guerrilla movements. So, with freedom, the border restrictions were reduced, and that was part of this shocking influx of HIV. And it led to tremendous xenophobia, as well as anti-Western rhetoric.

dC: What would you say have been the effects of HIV/AIDS on the way men and women interact in southern Africa? Have there been any positive effects—for example, are women becoming more politicized because of it?

IS: I don’t think we can thank AIDS for that. As I said, women were already organizing against the pass laws; they organized for food for their children. This was, of course, long after the early period I outlined before, and they’ve been active all through. There’s a lot of history in that. When I was in South Africa in ’92, there was already a women’s legislative assembly set up by women in the ANC to try to get women’s recognition. And when the constitution was set up is probably the most liberated at the time it was written. One-third of the parliament has to be women. It gives sexual-orientation rights, women’s rights, the right to health care. It’s a wonderful piece of paper. It really is. It reflects the struggles against the apartheid government and the coalitions that were formed at that time, which included the unions, the feminists, the Communist Party, the judicial activists, and the churches. There were people in every field. There were all kinds of people in that United Front that helped the ANC come to power and their wishes and their pursuit of happiness was recognized in the constitution.

However, there is realpolitik since ’94. But there is still a strong feminist movement, and a strong union movement, a strong church movement, and a strong environmental movement. I would not credit AIDS. I know some people do, looking for some kind of silver lining. Some people, when they write about AIDS, like to end it hopefully. And I would like to end hopefully. Because I don’t want to say that AIDS led women to be more active than otherwise. But I think they could have put their energies into things like basic income rights, which they have fought for and won, or better education. The fact that they have to put so much time and energy into this doesn’t, to me, suggest that they are getting more liberated. I would say thank God they are active and it is growing, but I wish they could have been fighting for justice in other areas where they need justice.

dC: Some of the literature refers to the differences and disagreements between Western feminism and African feminism in formulating approaches to these health issues. Could you comment?

IS: That’s an age-old dilemma. The feminist movement has been dealing with this at least since second-wave feminism in the seventies. I always feel it’s a class issue, especially in the United States: who do we represent? Especially now, with Laura Bush saying that we went into Iraq to save those women, or Afghanistan. So I think we have to be very careful about what the feminist movement represents and who it represents, and how its rhetoric is used. That was really addressed in ’85 in Nairobi, and that’s where there was a strong contingent of African women who said that their issues weren’t being addressed, especially the issue of female circumcision. Western women were coming across as not understanding what female circumcision was like for women on the ground, or at least not taking over the issues that women in the Sudan or Egypt would have had as an issue and framed differently from the grass roots. I think this is an ongoing issue.

But I think there is a lot of empty talk that is used today by governments that don’t want to do anything. I have one article that says there are various needs of women on a local level and then a second article which says you can’t use culture as an excuse not to do something. So it’s an ongoing dilemma. The issue is that Mbeki and leaders all over the world are saying, “Well, you can’t tell our women what to do,” when in fact it turns out that they want to tell their women what to do, and they want to shut the women up. It’s not just about HIV. For example, the UN put out its declaration on group rights. Group rights tend to reflect what I said about colonialism, where the men originally were recognized. When you look at group rights in the U.S., they’re actually baffled when they look at some native peoples. I edited a book with an interesting article, which shows how group rights don’t recognize women’s empowerment, because they go back and call on “culture.” It’s the same in South Africa, so people will use these virginity rituals which are supposed to prevent AIDS, and it’s very much supported by the government. You know, go back to our “African history.” What they do is punish young girls about these issues and blame women for AIDS, and for not being virgins, and claim that their history was a virginal history. So you have to be careful about this issue of local culture.

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**dc:** To follow up on your comments about culture, many people point to Uganda as an example of the success of the ABC [abstinence, being faithful, condom use] model. What’s your assessment of their analysis? Has it been successful? Why is it or isn’t it a good model for other countries?

**IS:** All right, this is a big question, and I’m very happy to answer it. First of all, let’s look at Uganda. Uganda started out dealing with AIDS long before anybody ever heard of ABC, and it was one of the first countries with a high rate of AIDS. It had war and it was a very difficult place in which to work. After Museveni came to power, it became more accessible. Let’s remember that it still had a war going on, and there’s still war going on in the northern areas. Many people argue that it is very much soldiers going through separation in such crisis situations who are transmitting much of the AIDS virus. Such situations are incubators for all kinds of disease. So there were the truck stops from Uganda to Kenya, and then there was the war that had been going on for years and years.

There was tremendous pressure on Museveni from the churches, and from women’s organizations. TASO (The AIDS Support Organization) was formed by women whose husbands, family members, and/or themselves were HIV positive, mainly professional women, in the late eighties, long before the current Bush administration came in. So one of the basic things to understand about Uganda was that the women and the churches took a big role, and Museveni paid attention to them. One of the biggest things they did was distribute free condoms, paid for by USAID. This was back in the eighties. They also distributed millions of female condoms. They were very much oriented to talking about sex explicitly, to addressing things from men’s and women’s points of view. They had community approaches. The attitude about how you deal with AIDS was that you work with the women who come to the hospital, and then you go back to their families and work with the people who are their primary caregivers, to educate them. There is a whole process of education; there are films and dramas in the villages to educate the children and other people in the villages. And it’s all very explicit. And it involves the distribution of condoms, and female condoms when they became available, throughout the society, for free.

This idea of abstinence-only is what the Bush administration is calling for, and condoms have dropped out of the picture. All of the money from the Bush administration is being given out preferentially to organizations like faith-based groups, groups that weren’t going to talk about reproductive health, and aren’t discussing sex education. It’s kind of that missionary image that came with the colonial era. So Uganda is benefiting by that money being spent there by talking just about abstinence. We’re not sure how much this has impacted the rate of AIDS. Maybe it wasn’t altogether reduced, but the rate was halted from growing—because of early interventions in the eighties, from the government and other institutions in society and the churches—together. That was very powerful, and very important. It wasn’t just this formulaic thing. The other thing is that HIV is distributed differently in different areas. But definitely, in Uganda, ABC has had some impact, by raising by one year the age of first sexual experience of intercourse. But that’s in the context of extensive sex education, and the availability and knowledge of free condoms at the point when they do have sex. That’s a very big part of it.

So now when we talk about abstinence-only programs, with the Bush administration, first of all they don’t include sex education; our federal money is going to programs with abstinence-only programs without any sex education. All the data coming in, even in the United States, shows that yes, it does delay the debut of vaginal intercourse by one year. Maybe they’re having sex but no vaginal penetration. But, on the other hand, women and men are pretending they’re not having sex, so they have no condoms available and they have no information, and it seems to be actually increasing in some sections of the population, because as a result there’s more unprotected sex. Plus the fact that eleven of those programs that they did a study of in the federal government give misinformation, like that you can get AIDS from tongue-kissing. All the misinformation that we spent the first twenty years of AIDS trying to get rid of, and trying to educate people about, are being spread by these abstinence-only programs funded by the federal government.

The idea that Uganda somehow shows us something that we should copy—yes, it does, but the way it’s being described in the ABC program is just complete misinformation. The shocking, shocking effect of all this is that Museveni, who’s getting these millions and millions of dollars, is now turning around and making speeches about how condoms are not really masculine. It’s a whole different approach, and it’s sad to see this reversal is going on at the highest levels. What can a government do which is poor and is being given so much money? And so no money is going to Swaziland, or not going to Namibia, but going to Uganda because it’s held up as something which it isn’t anyway. It’s a very sad situation.

I think it shouldn’t be a hierarchical approach. It should be a set of "archies." Everyone should be able to make their own decisions. How can you talk about abstinence when the highest rate of AIDS is among married women? Who are we talking to? Anyway, most young girls don’t have choices; most of their first sexual experiences are rape. Where’s the abstinence? These are girls ten, eleven, and twelve, because men are looking for thresholds.
virgins. The whole story cannot be told with ABC. It papers over the complex human reality of the relationships between men and women in a gender-hierarchy world. It just doesn’t tell any story. It’s a way of destroying the kinds of options that might otherwise be available, and bringing up images of sin, and of women who should have made one decision when they made another, when the real story is so different. Even putting it into terms of ABC is confusing and destructive, because it doesn’t fit with what women are going through. Young girls aren’t choosing to have sex. There’s rape, and they’re being married off at ten, eleven, and twelve, and they have no access to information or condoms. ABC is a farce; it’s a misrepresentation.

dC: After your talk, the question came up about the inequalities of risk in the United States. There are certain groups, especially African American women, who are at a higher risk of HIV infection. How does public knowledge of this deepen the risk of stigmatization, thus exacerbating the inequalities and further marginalizing them? Does it?

IS: I think we have to have ways of talking about reality. I think that examples like ACT UP [AIDS Coalition to Unleash Power] point to how people need to be treated like adults. They have to be able to talk about it. Epidemiological data has to be made available. People have to know the story. Then, if you have respect for people, and people stand up and demand respect, if you provide the information, people themselves will stand up, like they did with AIDS, and demand treatment, demand dignity in health care. I think how the information is presented obviously is important. It’s more important that the population themselves recognize it and own it, and fight it in their own dignified and respective ways. It’s like black power movements: you have to know inequality and recognize all of its sides. There’s no point in pretending that inequality doesn’t exist. In some countries—even in Europe, where race is not counted, or in the U.S., where class isn’t statistically added up—it doesn’t do those groups any good. I think it is extremely important. In South Africa, the data on AIDS was not that public, who had it and how it spread. I think it’s extremely important that, in South Africa, statistically more Africans have AIDS than the white population, and that it’s stigmatizing is one of the things that Mbeki is willing to talk about. But I feel that knowledge is important, numbers are important. But how you use those numbers and present those numbers is also important. There has to be some context. Numbers are part of the political battle, always. Certainly you don’t want to keep the numbers quiet. So that’s what I think.