
Original Article

Stigmatised African Sexuality and Social Construction of AIDS in the Context of Uganda:

An Anthropological Discussion from the Perspective of Colonial Representation of African Sexuality

Yuko EGAWA

ウガンダにおけるスティグマを帯びたセクシュアリティに基づくエイズの社会的構築
—植民地主義に由来するセクシュアリティの表象という視点からの人類学的考察—

江川 優子

[Abstract]

Some diseases carry specific meanings in a particular social context. AIDS is among such diseases, where associated meanings have been discussed since the disease was first recognised. Taking the example of Uganda, which was the first country in Africa to experience a decline in HIV infection rate due to strong government leadership and commitment, the study presents the following research questions. Firstly, how does medical science influence the meaning associated with a disease with special attention on discrediting and discriminatory meanings or stigmatisation? Secondly, how can a stigmatised disease be used as a tool for social control and as an extension of a racist and imperialist project through cooperation between medical science and a government's goal for national development? The study focuses specifically on syphilis in Buganda, an old kingdom in Uganda, and the spread of AIDS in Uganda. The discussion is based on the literature published before the free dispersion of anti-retroviral drugs became widely accessible in low-income countries, including Uganda. This initiative transformed AIDS from a lethal disease to a manageable chronic condition and changed the popular perception of AIDS. The study concludes that the 'reality' of 'African AIDS' was constructed around colonial representations of 'African sexuality' as 'promiscuous' and 'unusual'. In this context, medicine as a science could be a powerful tool of social control and used as an extension of a racist and imperialist project in the era of the AIDS epidemic to pursue national development.

[Key words] AIDS, stigma, Uganda, Social construction, Medical Anthropology

[要 旨]

エイズは社会的意味を帯びる疾病であると言われ、エイズ患者の発見以来、その意味について議論されてきた。本研究では、2000年代初頭にエイズの制圧に一定の効果を上げたと評価されるウガンダを例に取り、第一に、科学としての医学がいかに疾病の意味、特に偏見や差別といった意味の構築に影響してきたのか、第二に、科学としての医学と国家の発展を切望する政府によって、スティグマを帯びた病がいかに社会統制の手段として用いられたかを論じる。議論は、ウガンダを含む発展途上国において抗レトロウイルス薬の無料提供が普及する以前のエイズが致死的な病であった時期の文献に基づいて展開される。本研究は、「アフリカのエイズ」が、植民地主義下で作りに上げられた「異常なアフリカ人の性」という表象に

基づき構築されたことを示すと共に、科学としての医学が、人種差別と帝国主義を帯びた国家開発のプロセスにおいて、強力な社会統制の手段となり得ると結論づけている。

〔キーワード〕 エイズ、スティグマ、ウガンダ、社会的構築、医療人類学

I. Introduction

Conrad and Barker¹⁾ proposed that certain diseases carry cultural meanings that are not reducible to biology. Acquired immune deficiency syndrome (AIDS) is defined as 'the epidemic of signification or meaning'²⁻⁴⁾. AIDS carries a complex array of cultural anxieties and morally charged meanings and is invested with stigma⁴⁾. Scholars argued that the stigmatising meaning of AIDS is a product of a specific historical context and socially constructed reaction to the epidemic⁵⁾. Specifically, the discourses of medicine and science are influential in shaping the meaning of AIDS, that is, the reality of AIDS²⁾.

As Goffman⁶⁾ noted, stigma is an 'undesirable difference from what we had anticipated' (p. 15). In a sense, medical science as the authority that defines 'health' is the arbiter of the line between norm and deviance with respect to not only the 'physical body' but also the 'social body'.

Medicine is one of the means of controlling deviance in society⁷⁾. In the case of infectious diseases, which are medically defined as deriving from deviant behaviour, people tend to believe that such behaviours have been epidemiologically estimated and validated as the cause of disease. Thus, those viewed as behaving in deviant ways are considered a danger to the public and provoke fear. In turn, this fear leads to rejection and accusations against those suffering from the disease and can result in the deprivation of civic status or social exclusion⁸⁾. Oftentimes, medicine is a powerful means of stigmatisation and social exclusion. In other words, it may be a means of exerting social control.

Uganda is the first country in Africa that experienced a decline in HIV infection rate due to strong government leadership and commitment⁹⁾. Although the incidence increased in 2013⁹⁾ and the decline in incidence has been stagnant despite the enthusiastic efforts¹⁰⁾, the country was viewed as one of the first in the early 2000s to successfully control HIV/AIDS⁹⁾. In Uganda, AIDS carries discrediting and discriminatory meanings and is a socially constructed representation to a large extent^{3, 11)}. From the western perspective,

AIDS in Africa has been associated with sexual promiscuity within the population despite many other factors connected with the epidemic from the beginning. This perception has resulted in the construction of specific ideas pertaining to 'African AIDS' that are distinct from AIDS in other parts of the world^{3, 12)}. More importantly, the correlation between 'African AIDS' and 'promiscuity' was deemed scientifically and medically proved.

According to UNAIDS¹³⁾, AIDS and its association with promiscuity and sexual wrongdoing is closely related to lay and popular 'beliefs'. Coupled with the lack of knowledge about HIV/AIDS, such beliefs have become the major determinant of stigmatisation. However, this explanation could be significantly influenced by western assumptions about 'Africans/blacks', specifically 'African/black sexuality' and sexually transmitted diseases (STDs). The assumptions have been reified through the medical interventions intended to control STDs in colonial times, which later continued in HIV/AIDS control programmes conducted in cooperation with western organisations as a result of the objective for national development of the government of Uganda.

The study examines the literature published before free anti-retroviral drugs became widely accessible in low-income countries, such as Uganda. Anti-retroviral drugs transformed AIDS from a lethal disease to a manageable chronic condition and changed public perception towards AIDS⁴⁾. Based on the investigation, the study presents the following research questions. Firstly, how does medical science influence the meaning associated with a disease with special attention on discrediting and discriminatory meanings or stigmatisation. Secondly, how can a stigmatised disease be used as a tool for social control and as an extension of a racist and imperialist project. Emphasis is placed on syphilis in Buganda, an old kingdom in Uganda, before the colonial rule and AIDS in Uganda.

II. Stigmatisation and medicine

1. Stigma as a meaning of disease

Disease is often employed as a metaphor that serves

to mystify things that are considered socially or morally wrong¹⁴⁾. Any disease viewed as a mystery is frequently considered morally contagious regardless of its biological fact¹⁴⁾. Furthermore, diseases that provoke the idea of contagion and insidious harm are heavily burdened by metaphoric trappings¹⁵⁾.

The stigmatisation of individuals who display its symptoms is contained within the social meaning of the disease¹⁶⁾. As Freidson¹⁷⁾ noted, 'biological deviance' is converted into 'social deviance' through the effects of the social context. When discrediting and discriminatory meanings are attached to a disease, then the disease is constructed as a stigmatising attribute, that is, the disease is constructed as a stigma.

2. Stigma: definition and conceptualisation

'Stigma is a broad and multidimensional concept whose essence centres on the issue of deviance'⁷⁾ (p. 303). According to Goffman⁶⁾, stigma is 'an attribute that is deeply discrediting within a particular social interaction' (p. 13). Moreover, stigma is conceptualised through social interaction, where one's actual social identity – attributes of a person – fails to satisfy the normative expectations of individuals considered ideal. This discrepancy leads to the conceptualisation of stigma especially when the discrediting effects of such attributes are extensive. The discrepancy 'spoils the social identity, isolating the individual from self, as well as, societal acceptance'⁷⁾ (p. 304). Stigma is a powerful social label that discredits and taints individuals⁶⁾ and defines the bearer rather than the sign it carries. Thus, the bearer of the sign is identified with the stigma and known by the discrediting attributes. Through social interaction, stigma represents a construction of deviation from certain ideals or expectations⁶⁾.

Stigma is not inherent in the attribute itself. In other words, the attribute that stigmatises the possessor is neither creditable nor discreditable. A particular attribute that is conceptualised as deviant may not be pathological, immoral, or deviant. In fact, deviance is stigmatised 'in the context of a particular historic period and social context'⁷⁾ (p. 304). Individuals are not devalued because they possess attributes that deviate from accepted standards, but because a certain society opts to define particular attributes as deviant.

An attribute that categorises the possessor as deviant and stigmatises the possessor can serve to confirm the normality of 'others'⁶⁾. The 'normals', who do not

depart from social norms, tend to assume that one with a stigmatised attribute is not relatively human⁶⁾. Based on this assumption, the 'normals' exercise discrimination and deprive the 'deviants' of chances at through 'a stigma theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalising an animosity based on other differences, such as social class'⁶⁾ (p. 15) as well as possibly race, ethnicity and religion. Stigma plays a key role in producing and reproducing relations of power and control¹⁷⁾. Thus, stigma is a powerful means for social control, which is applicable by marginalising, excluding, and exercising power over individuals or groups of people who possess certain stigmatised attributes. Thus, stigmatisation can reorganise society in a manner that is favourable to the 'normals'.

3. Infectious diseases and medicine as the means of social control

As previously discussed, medicine is a means for controlling deviance in society⁷⁾. Although medicine is deemed to be understood as a discipline that deals with actual bodily pathology in a manner that is free from social context, it seems to have a substantial influence on the social construction of deviance, that is, stigmatisation of certain attributes.

The development of the germ theory of disease exerted a massive influence on the popular conception of a disease. To a large extent, the association with the concept of contagion appears to have been transformed by the said theory. Contagion is mostly associated with actual threats to 'health' or 'life' in essence. In addition, the germ theory of disease revealed that a person who is carrying an infection and is infectious does not necessarily display it. This characteristic of infectious disease indicates that it is conceptualised as an insidious cause of damage⁸⁾. Medical diagnosis of infectious diseases is synonymous with 'accusation' and is ultimately tied to a 'crime'¹⁵⁾. Thus, the diagnosis of infectious disease can be a very effective and efficient means of attaching discrediting and discriminatory meanings to a disease and to construct it as a stigmatising attribute.

The germ theory of disease is of great importance to public health¹⁵⁾. In terms of the relationship between stigmatisation and social control, public health can be an efficient and effective discipline. This aspect offers various means for systematically operating the strategies for exclusion and thus contributes to the reorganisation

of society. With public health as a scientific discipline of intervention that aims to protect and promote the health of the population¹⁹⁾, controlling infectious diseases as a prevention and a cure is a highly significant issue. In this perspective, infectious agents, specifically, the carriers of micro-organisms, are interpreted as a threat to the social order that should be disciplined into health through medical intervention²⁰⁾.

By employing epidemiology, public health defines 'risk groups' as the target of intervention. Initially, the idea of 'risk groups' was used to indicate categories of persons with statistically high levels of propensity to suffer from certain diseases. However, the idea has expanded in the public perception and taken on a meaning that 'all persons within a group are, because of association with that group, considered to be contaminated and dangerous'²¹⁾ (p. 1364). Individuals who carry certain diseases can be categorised as a 'risk group' and construed as a 'public nuisance', which is the target of social exclusion. Individuals recognised as members of a risk group and possessing characteristics of the group (i.e. race, ethnicity, gender or social class) are 'discredited' and subjected to notable stigma. Thus, public health can be used to attach discrediting and discriminatory meanings to individuals, the community, and even to entire countries. With its authoritative power, public health as a part of medicine and the science of 'health' and ultimately 'life' can facilitate the stigmatisation of certain groups and become a driving force of social exclusion.

III. Stigmatised 'African sexuality' in colonial Uganda as the path to the construction of 'African AIDS'

As Bond and Vincent²²⁾ pointed out, the AIDS propaganda reflected and disseminated a moral discourse derivative in and is heavily influenced by eighteenth and nineteenth-century English utilitarian and Christian missionary values. Reviewing the AIDS epidemic in Africa, examining the manner in which the image of 'promiscuous African sexuality' is constructed through efforts to control STDs in colonial Africa is deemed essential.

In Uganda, colonial medical departments and Church Missionary Societies initiated the efforts to control STDs, especially syphilis. Such an initiative is considered to have profoundly influenced the representation

of African sexuality as 'unusual'^{23, 24)}. The 'uniqueness' of sexuality in the African context appears to be the key determinant of the methods for addressing the AIDS epidemic later in Uganda and the rest of Africa.

1. Sexualised and pathologised blackness

As Vaughan²³⁾ pointed out that female sexuality was pathologised and connoted as dangerous in the European mindset, whereas uncontrolled female sexuality indicated degeneration into primitivism. In Europe, a deep-rooted presupposition that control over the dangerous female sexuality was a token of civilisation was observed.

Moreover, as Fanon²⁶⁾ argued, colonial discourse on blackness was highly sexualised: blacks are constructed as a sexualised 'other'. Gilman²⁷⁾ concurred that in the late nineteenth-century Europe, black women were symbolised and interpreted as displaying uncontrolled sexuality and being black connoted that an individual was 'promiscuous' and 'backward'. The image of a particular African sexuality that differs from that in other parts of the world probably has been and remains central to the argument about the cause of many diseases in Africa²³⁾.

This European presupposition about African sexuality was deemed to have been crystallised as a discourse in the manner that medicine was used in colonial times to control STDs in general and syphilis in particular. The meaning given to African sexuality, that is, 'the myth of black sexuality'²⁶⁾ as constructed by the Europeans, were considered validated by the biomedical, specifically epidemiological, authority.

2. Syphilis in colonial Buganda

According to Davies²⁸⁾, the existence of STDs in Buganda was first recorded in 1863. From the time Buganda became a British Protectorate in 1894, syphilis was frequently cited as the main cause of infertility, morbidity and mortality, which posed a great threat to colonial development²³⁾. In 1907, Lambkin, a venereologist of the Royal Army Medical Corps, alarmed the medical audience with the prognosis that a widespread incidence of syphilis, which involved up to 80% of the population, would lead to an infant mortality rate of 50–60%²⁹⁾. Following this prediction, the colonial medical department and Church Missionary Society initiated the investigation of the cause and research to formulate control strategies^{23, 24)}.

3. Medicine and construction of Bugandan syphilis

Colonial and missionary medicine focused on 'promiscuous African sexuality' particularly female sexuality as the pathology in the society²³⁾. Colonial secular medicine viewed the high prevalence of syphilis as proof of their assumption about the uniqueness of sexuality in Africa from a problematic context²³⁾. Furthermore, it concluded that the syphilis epidemic was largely attributable to modernity and the disintegration of traditional societies as a result of colonial rule especially with the introduction of Christianity, which unleashed primitive and uncontrollable female sexuality²³⁾. Missionary medicine insisted on the inherent immorality of the lay society represented by polygyny and paganism, which only could be saved through the penetration of Christianity. Their perspectives seemed to be heavily influenced by European preconceptions or even 'myths of the African'.

Through medical intervention from the secular and missionary sides, the European preoccupation with African sexuality and imagery of syphilis became crystallised in the Uganda Protectorate. The statistics about the prevalence of syphilis indicated that syphilis, as a venereal disease, was excessively widespread in Buganda. Furthermore, the statistics exerted a significant influence on the construction of syphilis as the disease of the Baganda (people in Buganda) in particular, and African sexuality as excessive and evil in general.

Vaughan²⁵⁾ noted that for colonial rulers and missionaries, the syphilis epidemic symbolised the dangers and difficulties of colonial rule and extension of civilisation. Through enthusiastic control strategies for syphilis, the idea of 'African sexuality' was reinforced and maintained an enduring and powerful influence over a wide area of Africa. Importantly, the discourse was deeply rooted in the western concept of 'Africa' and has been extended to the AIDS epidemic in Africa.

IV. AIDS and social control in the era of national development

Through medicine, particularly epidemiology, 'the myth of African sexuality' has been rendered a 'reality'. African sexuality eventually acquired a shameful meaning, which had a significant influence on the Bugandan society. The control and treatment of STDs and meanings given to 'African sexuality' during the colonial period seem to have significantly influenced the con-

struction of the AIDS discourse in the late twentieth century. The emergence of AIDS probably affirmed the meanings given to 'African sexuality' through research and control based on the western scientific model of the disease and the long-term western representation of 'Africa'.

At this point, the study examines the manner in which the AIDS discourse in Africa, which was constructed around the stigmatised 'African sexuality' and in turn ultimately stigmatised 'Africans' as a whole, has again been 'scientifically' shaped. Previous discussions that tackled AIDS involved a similar form of stigma that is shaped around 'promiscuity' and viewed as an obstacle to effective AIDS control programmes, which can also be a means of social control in the form of the extension of western imperialism.

1. Construction of AIDS in Africa

In Uganda the first cases of AIDS were recognised in 1982. Epidemiological research was initiated for the discovery of transmission patterns, risk factors, and prevalence of HIV infection in Uganda²²⁾.

AIDS in Africa was defined as a disease that significantly differed from that in developed countries^{3, 12, 24, 30, 31)}. Such a differentiation between AIDS is based on transmission patterns, such as homosexual or heterosexual relations or contaminated blood supplies. The World Health Organization (WHO) conducted an epidemiological research and produced categories of HIV infections based on transmission patterns³¹⁾. The countries that belong to Pattern I are the United States and Europe (the so-called west) and present the transmission mainly through homosexual activities, injection drug use and prostitution. Countries in Africa are part of Pattern II, where HIV is transmitted primarily through heterosexual contact.

Seidel³¹⁾ argued that the construction of Pattern II resulted in the invention of 'African AIDS' as if it were an entirely distinct disease. Although a clear definition of risk groups is observed for countries in Pattern I, the distinction between risk groups and non-risk groups seems to be obscure for African countries in Pattern II. Consequently, the entire population is considered high risk³²⁾. In contrast to Pattern I, HIV/AIDS for Pattern II is shared nearly evenly by men and women³⁾. In response to the high prevalence of HIV/AIDS through heterosexual contact, it was concluded that 'risk behaviour' related to African sexual activities was

caused by multiple partners and polygyny^{3, 24)}.

The west seemed to conceptualise African AIDS as a distinct form of AIDS by emphasising statistically interpreted or proved difference. The interpretation of the statistics and meanings attached to AIDS were developed in light of the specific social, economic and political contexts of the west and simply transferred to a different social context³⁾. However, a deep-rooted western preoccupation about STDs and the association between 'sexual deviation' and 'immorality' appeared to prejudice the construction and discussion of AIDS in Africa. Thus, 'African sexuality' received a substantial amount of attention and is attributed as the cause of the high prevalence of HIV. Importantly, 'African sexuality' was eventually defined as 'deviant' and 'promiscuous'. Thus, AIDS in Africa was constructed as a disease resulting from 'deviant sexuality'.

Such a 'promiscuous African sexuality' seems medically and scientifically 'proved' and has become the centrepiece of the AIDS discourse in Africa. Promiscuity is the most important keyword in the discussion of AIDS in the African context regardless of the country in which discussions occur³³⁾.

2. AIDS as synonymous with Africa: racism and accusation

Chirimuuta and Chirimuuta^{12, 30)} asserted that the objectivity of medical science is an illusion and that science is significantly influenced by preoccupations (in this case, the western mind-set), which take the form of racism. The theories that purported that AIDS originated in Africa have strongly influenced the construction of its discourse³⁰⁾. Previous studies hypothesised that AIDS occurred within a 'tribe' in the forests of Central Africa and reached the west. However, previous studies did not hypothesise and investigated in-depth the probability that the west introduced AIDS to Africa^{30, 34)}. Therefore, AIDS appeared to be constructed as an African disease by a science invested in unconscious racism.

The problem of diagnosis is considered to be the cause of the interpretation of Africa as a continent devastated by AIDS. The number of reported cases of AIDS in Africa is overwhelming and devastating, which is medically proved. However, the differences in the criteria of diagnosis between developed countries and Africa are ignored³⁰⁾. In developed countries, those with symptomatic HIV are not reported as official statistics.

However, in African countries, the criteria used do not differentiate symptomatic HIV infection from AIDS as both are reported as AIDS because of the expense of laboratory tests for HIV infection. Furthermore, such countries do not differentiate AIDS from other clinically similar wasting diseases. Between 26% and 50% of individuals who meet the criteria are seronegative for HIV infection^{35, 36)}.

Science and medicine that are biased by western presuppositions, which Chirimuuta and Chirimuuta^{11, 30)} referred to as racism, constructed AIDS as an 'African disease'. AIDS originated in Africa and is extremely prevalent in the continent, which leads to the creation of an illusory perception that each African is HIV-ridden. In this regard, AIDS has become nearly synonymous with Africa.

Identifying Africa with AIDS through scientific and medical investigation seems to have resulted in a fear of Africans as dangerous and the accusation that Africa was the source of the infection³⁷⁾. The factor that caused the devastating epidemic and that possibly placed other areas of the world in danger of infection appears to be central to the accusation: African sexual behaviour shaped by 'unusual', 'corrupt' and 'uncontrolled' sexuality^{3, 24, 30, 33)}. Controlling African sexuality became a serious issue on the global agenda that should be tackled with intense intervention to protect 'global health'. African sexuality was globally stigmatised. In turn, Africans became recognised globally as the target of accusation and intervention.

3. AIDS as a critical national development issue

In response to the accusation of African sexuality and Africa as the source of danger to the planet, African governments opposed and strongly refuted the theories^{12, 39)}. However, African governments seem to have accepted the political rhetoric surrounding the African AIDS discourse constructed by the west around 'unusual African sexuality'³⁾.

This acceptance of the AIDS discourse seems related to the recognition of AIDS as primarily a development and national crisis. Development is the most significant issue in developing countries³⁸⁾. As such, countries address the socio-economic determinants of health and health care as a significant development agenda³¹⁾. AIDS, although primarily a public health issue, has been stated to be a serious development issue in the hardest-hit countries because it affects the most productive

age group⁴⁰⁾.

In Uganda, AIDS is an issue that is impossible to ignore and is a part of the national agenda. AIDS was addressed at the national level with the implementation of the National AIDS Control Programme (NACP). In Africa, such programmes are mainly implemented through collaboration between the government and western international organisations, such as the WHO, UNAIDS and World Bank. The collaboration is based on the agenda of organisations and the accountability of the governments to these organisations⁴¹⁾.

4. Internalised Western gaze at African sexuality: NACP in Uganda

Uganda is one of the first counties in Sub-Saharan Africa to acknowledge the extent of the prevalence of HIV/AIDS and welcome discourse and research^{3, 41, 42)}. Uganda attracted international attention and gained massive international support. In 1986, NACP was launched in cooperation with the WHO.

Without effective treatment, prevention was the main measure for controlling the transmission of HIV⁴³⁾. The programme focused on prevention through sex education and changes in sexual behaviour⁴²⁾. The educational intervention was filled with moralistic language against promiscuity and slogans conveying abstinence and faithfulness. Notably, at the beginning of NACP and following modernisation, the government's philosophy of the programme was significantly different. Initially, it denied tradition and other aspects associated with tradition as being the source of promiscuity and promoted the use of condoms³⁾. Subsequently, however, the explanation of promiscuity shifted to blaming the influence of contact with foreign institutions that resulted in moral decay or promiscuity in urban areas and promoted the spread of AIDS^{3, 21)}. Moreover, President Museveni denied condom use and placed further emphasis on abstinence and faithfulness⁴⁴⁾.

The Ugandan government itself centred the AIDS discourse in Uganda on 'promiscuous African sexuality'. Thus, the debate over the origin of such promiscuity is deeply rooted in 'African AIDS': inherently or non-inherently, African sexuality is assumed promiscuous. In other words, the government has internalised the western gaze on 'African sexuality', which is evident in the implementation of the NACP and motivated by the craving for national development and international recognition.

The control policy of Ugandan for AIDS was characterised with a strong emphasis on the moralistic aspects of sexual behaviour and can be considered a unique case. However, the focus on moralistic aspects can be interpreted as the expression of nationalism to create Uganda as one nation under the same sense of value after the devastating civil war⁴⁴⁾: President Museveni criticised condom use as 'non-Ugandan'³²⁾.

Following Uganda, other African nations acknowledged the existence of AIDS within the territory and adopted a donor-driven AIDS control programme called Information, Education and Communication (IEC) as the NACP framework. Kenya, where politicians denied the existence of AIDS in the country and left the issue to religious organisations, acknowledged and adopted the international donor-driven IEC under the pressure of donors⁴⁵⁾. In addition, Tanzania and Zambia adopted the donor-driven IEC and strongly implemented the programme under the supervision of donors⁴⁶⁾.

The underlying perspective of IEC is the alteration of 'risky sexual behaviour' derived from promiscuity⁴⁷⁾. In the aftermath of colonialism, African governments were left without a choice in achieving their aspiration for national development and international recognition as independent nations. The only choice left was to accept donor-driven AIDS control programmes based on the western representation of African sexuality, that is, the internalisation of the western view of Africa.

5. AIDS and 'belief' in the discourse of science and medicine

AIDS-related stigma is considered the major hindrance to an effective AIDS programme¹³⁾. In Uganda, the major determinant of AIDS-related stigma is lack of knowledge coupled with the persistence of the lay or popular 'beliefs' about HIV/AIDS, such as the association between promiscuity and sexual wrongdoing¹³⁾. However, this idea of 'promiscuity' seems unrelated to lay or popular beliefs about HIV/AIDS in Uganda²¹⁾. In fact, the western-biased discourse may have influenced the people's perception of the disease, that is, the meaning given to the disease, through enthusiastic national AIDS control programmes supported by western organisations.

Here, the focus is not on the analysis of the way 'African sexuality' is constructed as 'promiscuous' and 'stigmatised' through social context with the support of a medical science that is strongly biased to the western

preoccupations about Africa and African sexuality. The focus is on 'African sexuality' as necessarily being associated with 'promiscuity' and 'stigmatised' through lay 'beliefs'. Such 'beliefs' shared by the people of Uganda are considered an obstacle to effective HIV/AIDS intervention. 'Long-held beliefs make it [stigmatisation and discrimination] seem logical'¹³⁾ (p. 31) and 'pre-existing local cultural practices and beliefs are both determinants and legitimators for HIV/AIDS-related stigmatisation' (p. 35). UNAIDS¹³⁾ states that intervention should aim at 'countering popular beliefs about HIV/AIDS that seemingly justify stigmatisation and discrimination' (p. 37) by legislation and human and civil rights intervention.

Focusing on the language of 'belief', another discourse constructed by science seems to strengthen the African AIDS discourse. The discourse could legitimate the perception that lay 'belief' is an obstacle that should be tackled. 'Belief' is contrasted with 'knowledge' derived from the worship of rationality⁴⁸⁾. Moreover, 'belief' is 'an acceptance that something exists or is true, especially one without proof' (The Concise Oxford English Dictionary). In contrast to 'knowledge', 'belief' is constructed as 'irrationality' and 'error' that should be corrected or removed through the intervention of scientifically validated 'knowledge'. Importantly, 'knowledge' portrays people who hold 'belief' as ignorant and waiting to be enlightened. 'Knowledge' creates the appearance of ignorance of 'others'⁴⁹⁾, thus enabling the west to represent itself as the source of knowledge and order. Furthermore, it serves as the reason for intervening to correct the 'belief' of the ignorant in the name of science and judge the other as an inferior to be saved by science.

Using 'belief' could construct the idea of a certain population as ignorant and legitimise intervention to be favourable to those who intervene through scientific discourse. In this manner, a discredited meaning is attached to 'belief', which is thus stigmatised. In the case of AIDS in Africa, intervention is legitimised in the name of worldwide health and security. The conceptualisation of 'belief' may create a firm basis for intervention. Lastly, the conceptualisation of a correlation between AIDS and stigmatised promiscuity and 'belief' can be viewed as a reaction from the west or even desire, as a form of 'unconscious racism', to remain in power.

V. Conclusion

The image of AIDS in Africa as a disease related to 'promiscuous sexuality' is a product of centuries of western representation of Africa. The role that medical science played in the intervention for infectious diseases in Africa in general and STDs in particular has contributed to the development of this image by emphasising 'scientific objectivity and neutrality'. However, scientific objectivity and neutrality may have been largely biased by the western preoccupation with black people as a 'highly sexualised primitive other', which has significantly influenced the meaning attached to AIDS. Epidemiologically collected data could be interpreted and transformed into 'reality' to be favourable to the west by examining data through the filter of such preoccupations.

The biases in medical science applied to AIDS have developed a firm image of AIDS as an African disease and legitimised the accusation of 'promiscuous African sexuality' through 'scientific' hypotheses and analysis. Importantly, the image of AIDS as an African disease legitimises the passionate intervention to control 'African sexuality' as a 'danger' to the global population. Combined with western preoccupations about black people, African sexuality has been constructed as a 'deviation' that should be controlled, corrected, disciplined and saved.

In the context of African countries as developing countries, AIDS in Africa is considered a part of a serious developmental crisis. 'African sexuality' is considered the great hindrance to the national development of African countries. In the case of Uganda, the statement about AIDS as a national development crisis persuaded the government to welcome international or western intervention through collaboration in national AIDS control programmes designed to mitigate 'uncontrolled African sexuality'. This perception is deemed to substantially influence the image of AIDS, that is, the meaning implied by AIDS, in Uganda. AIDS is linked to discrediting and discriminatory meanings, particularly 'promiscuity', among the population. Promiscuity as an AIDS-related stigma is considered a large hindrance to effective AIDS control programmes.

UNAIDS¹³⁾ concludes that promiscuity is associated with lay and popular 'beliefs'. Importantly, further intervention supported by biased medical science is legitimised by employing the term 'belief' in contrast to

'knowledge' as science. Within the scientific perspective, the cause of the high prevalence of AIDS can always be found in Africa, in African backwardness, and inherent African promiscuity.

In the 'reality' of 'African AIDS', which is constructed around 'promiscuous African sexuality' by Western pre-occupation, medicine as a science can be a powerful tool of social control as an extension of a racist and imperialist project in the era of the AIDS epidemic and national development.

ACKNOWLEDGEMENTS

I would like to express my deepest gratitude to Dr John R Campbell of the School of Oriental and African Studies, University of London for guiding me in this study.

This paper is a revision of the MA dissertation in Medical Anthropology submitted to the School of Oriental and African Studies, University of London.

The author declares no conflict of interests.

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