

# Riding HIV's superhighway

This is not a disease of poverty, but a result of a culture of concurrent sexual relationships

## Comment

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**T**he differences in HIV prevalence between South Africa's racial groups are as large as those between countries with the highest and lowest prevalences in the world. It follows that examining the different sexual behaviours underpinning these differences would likely provide helpful clues about what is driving our ongoing high HIV transmission rates.

Why then has no such study been published in South Africa? The prevalence rates are 19.9%, 3.2% and 0.5% for 15- to 49-year-old Africans, coloureds and whites respectively. The dominant explanation for the racial differences in HIV prevalence is that these merely reflect the fact that HIV is a disease of poverty.

This is remarkable because there is now compelling evidence that HIV is not a disease of poverty. In all eight sub-Saharan countries where this has been looked at HIV prevalence is higher in the richer population categories — and this is true for both men and women.

In the South African literature the main piece of evidence quoted to back up the thesis that HIV is a disease of poverty is the Human Sciences Research Council's (HSRC's) finding in its 2005 HIV survey that HIV prevalence is higher in informal than formal settlements.

But this is more likely explained by the fact that Africans, who have a higher HIV prevalence, are more likely to constitute the informal than the formal populations. Certainly, when one breaks down HIV prevalence within Africans in various South African HIV surveys, there is no relationship between poverty and HIV status. Unfortunately, the HSRC has declined all requests to undertake a similar analysis.

In a recently completed analysis of a sexual behaviour survey in Cape Town we established that the likely cause of the difference in racial HIV rates is not the lifetime number of sexual partners (which was highest in whites) but that Africans were much more likely to have concurrent (overlapping) sexual relationships (30% versus 5% for whites).



Michele van Rooyen draws blood from Ivano Hendaicks in Worcester. To stop the spread of HIV, South Africa needs a prevention programme driven by evidence, not values. Photo: AP Photo/Schalk van Zuydam

For various reasons, concurrency creates interconnected sexual networks that act as superhighways for HIV transmission.

Our data showed no hint that this concurrency was patterned along socioeconomic lines. Instead it was more prevalent among Africans of all income categories. These findings are backed up by the (unpublished) Soul City "Ten Countries" study, which found that having a main and a side partner are regarded as normative throughout East and Southern Africa.

How then do we explain many South African academics' reluctance first to examine the sexual behaviour differences that explain the differential racial spread of HIV and second even to countenance the possibility that these may be determined by culturally sanctioned differences in sexual partnering?

We have experienced one reason first-hand. When presenting our data showing higher concurrency rates are the most plausible reason for higher HIV rates among Africans and that this is driven more by

cultural than socioeconomic factors, we have been accused of both "cultural essentialism" and racism.

The racism charge rests on two arguments. First, it is racist to assume there are significant sexual partnering differences between different groups of peoples. Second, it is racist to state that Southern and East African cultures tend to condone concurrency, as this implies a "tolerance of cheating".

What this line of reasoning ignores is that sexual norms are one of the most varied of all behavioural norms across place and time. Moreover, it is monogamy that is the statistical outlier. Of 1154 societies described in Yale University's Human Relations Area Files, for example, 93% condone a version of polygamy. In 70% of societies polygamy is the preferred choice.

Monogamy as a universal norm arose in Europe in the Middle Ages and came to be imposed by Europeans on the peoples they conquered and their religions. In the process the Christian-inspired practice of universal monogamy came to be regarded in secular Western thinking as the only acceptable form of sexual partnering.

But there is nothing unethical about consensual concurrency. Having concealed partners is clearly dishonest but the unethical conduct here is related to the concealment

and not the concurrency. If one accepts the empirical evidence of how varied sexual norms are, and that concurrency is not intrinsically immoral, one should have no problem accepting the cultural explanation that high contemporary concurrency rates among Africans are at least in part a continuation of a pre-colonial pattern.

There is good historical evidence of this. The spread of monogamy as a universal norm was least complete in Africa. Historians have documented that married African men who converted to Christianity were no less likely to take additional partners, but they were much more likely to conceal them.

HIV spreads along sexual networks and understanding the differences between low- and high-prevalence networks is a vital first step in exposing what drives the spread of HIV. But for the past two decades we have failed at this task. It seems as though the fear of being labelled racist, combined with an unquestioned commitment to universal monogamy, has conspired to blind us to the way that the culturally condoned practice of concurrency is driving our epidemic.

Two strategies have been suggested to deal with high concurrency rates in Southern Africa. First are the "be faithful" messages, which emphasise the immorality of

concurrent partnerships. The second strategy correctly argues that the first will fail and rather encourages "damage limitation" measures such as promoting condoms in the settings of high concurrency rates. But this second strategy fails because there is now extensive evidence that people in long-term relationships stop using condoms.

What we therefore propose is a third strategy — cultural change based on epidemiological evidence rather than ethics. Concurrency may not be unethical but what the HIV epidemic has brought into sharp relief is an extremely dangerous mismatch between environment and culture. Although sex networks characterised by considerable concurrency were relatively safe in the pre-HIV era, they now act as superhighways for HIV transmission.

South Africans need to embark on an urgent programme of cultural change. There is now good evidence that Uganda's rapid decline in HIV rates was because of precisely the kinds of cultural change necessary in South Africa. Of key importance in this process is that it needs to be informed and driven by evidence and not values.

A central component of this strategy will need to be "one partner at a time". This is a very different policy to the value-driven imperative to "be faithful" — with its implications of immorality if one has more than one partner. A piece of information that has been concealed from most HIV-prevention programmes is that there is no evidence at a population level and little at an individual level that more than one lifetime sexual partner increases one's risk of HIV infection — provided partnerships are arranged serially and both partners go for couple testing before commencing sexual relations (and after one month to allow for the HIV-tests window period).

A more evidence-based HIV-prevention message might therefore be "123" rather than ABC (abstain, be faithful, condomise): "1 partner at a time; 2 couple HIV counselling and testing before starting new sexual liaisons (and delaying sex for one month after ceasing sexual relations with others); and 3 using condoms if a third party may be involved".

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**"Africans are more likely to have overlapping sexual relationships than whites"**

