

The Deadly Pandemic, Quarter a Century After: The Katanga Province (D.R. Congo), and the Northwestern Province (Zambia) Women in a World of HIV-AIDS

Felix Ulombe Kaputu *

I. Introduction

Despite more and more widespread feminist sentiments and activities in both the Democratic Republic of Congo and in Zambia, women, in the Katanga Province (D.R. Congo), with a total population of 9,000,000, and the Zambian Northwestern Province Zambia, with a total population of 6,000, remain largely silent on killing pandemics. An interview of twenty questions oriented on sexual habits, sex commercialization, and dangerous sexual activities in both provinces has led to the writing of this article articulated on general observations of daily habits. A second one will go deeper in the details of all decoded results. The interview considered a total of 200 people aged 14-35 for each province with half men, half women.

We noticed that sexually active young women are increasingly suffering from catastrophic levels of HIV-AIDS. Sexually transmissible diseases (STDs) are expanding rapidly and, whereas this public health crisis caused by HIV-AIDS has attracted attention in both countries, the survey of these neighboring provinces studied is still largely alarming.

In 2000, some 189 nations came together under the UN to pledge support for “Millennium Development Goals” of eradicating poverty and hunger, reducing child mortality, and, most urgent of all, controlling HIV-AIDS (Epstein and Kim 2007: 39). This global awareness has motivated powerful countries to help developing countries more than ever before. Amid all the challenges and changes, it has become increasingly obvious that no major improvement can

* Professor, Massachusetts College of Art and Design.

be achieved without a strong concern with women's rights. The United Nations Millennium Declaration, also known as General Assembly Resolution 55/2, of September 8, 2000, insists on improving the status of women so that they become independent, healthier, and more educated beings. (www.ohchr.org/english/law/millennium.htm, May 20, 2007).

The situation in the Katanga Province (D.R. Congo) and the Northwestern Province (Zambia) is bleak. Living in extreme poverty, many people, especially in rural areas suffering from HIV-AIDS can still not afford any treatment or find their way to appropriate centers. Orphans wander in search of charity as physically weakened HIV-AIDS widows survive through commercial sex in spite of awareness of their contagious state. Despite the financial flow from the North especially through international NGOs, horror and death await at many doors. But what is to be done? Though the North has helped "weak states"⁽¹⁾ since the early 1980s, Sub-Saharan Africa in general, and both these provinces in particular, have not reached any agreement on the best ways of empowering women against HIV-AIDS. In vain, several methods have been tried: radio campaigns, pushing governments to enroll more girls in schools, and launching contraceptive programs here and there. However, experts are unanimous in asserting that churches, among other institutions, could do better, and that chieftains could be more involved.

A threefold approach to the HIV-AIDS pandemic focusing on education, religion, and gender offers a chance to stimulate a new vision and better chances to monitor the disease. Many HIV-AIDS victims in both studied provinces move from one church to another, then from one witch doctor to another, before meeting the same sad death. The HIV prevalence has gone from 2.7% to 6.6% in Katanga.⁽²⁾ HIV prevalence in the Zambian Northwestern Province has increased

(1) The concept "weak state" is borrowed from Kristina Persson. Weak states are unable to tackle the basic elements of a country's development: health care, food, security, education, and nation building.

(2) S. Wembonyama, S. Mpaka, L. Tshilolo, "Medicine and Health in the Democratic Republic of Congo: from Independence to the Third Republic", *Médecine Tropicale* 2007, 67: 447-457, page 455.

especially because of the new mines - Kansanshi and Lumwana mines - from 8 % to 12%.

II. The weight of the past

Congolese and Zambian political leaders have taken any opportunity to put as many actors as possible into the battle against HIV-AIDS. In fact, however, their will to fight the pandemic is very weak, as shown by the share of their total budget allocated to health issues (10% for Zambia and 4.3% for the D.R. Congo). Congolese and Zambian interpretations of the disease and use of witchcraft to combat it are still commonplace. In the Democratic Republic of the Congo, anxiety was alleviated through Lwambo's songs. Unfortunately, Lwambo himself died of AIDS, thus increasing the population's fear; the plague was not to be mentioned in daily conversations. Lwambo had sung of how many people were isolated because of HIV-AIDS, and how family relations were interrupted due to fear. Only some isolated parents, quite often very old ones, agreed to watch over their dying offspring. In 2006, Nkuku Khonde interviewed Katangans and Zambians from the Northwestern Province still linking HIV-AIDS to the same first beliefs.

In the same song, Lwambo lamented how all other diseases are ignored because all attention is focused on the strange disease HIV-AIDS: "We have forgotten all illnesses. When someone is sick it is said that he has AIDS even if he has only high fever. And when he dies, it is because of AIDS."⁽³⁾ All other

(3) This part of the song, "Attention Sida," has been borrowed from Cesar Nkuku Khonde's article "An Oral History of HIV/AIDS in Congo," published in Philippe Denis and Charles Becker (eds.), *The HIV/AIDS Epidemic in Sub-Saharan Africa in a Historical Perspective*, online edition, October 2006. Nkuku Khonde interviewed people in different cities of the Democratic Republic of the Congo to get their memories of the pandemic even before it was named HIV-AIDS. Many remembered how neighbors and friends passed away under mysterious conditions, some after they noticed that they were losing weight and suffering from diarrhea and had decided to go back to their villages to seek the assistance of their closest relatives. The author also noticed that many cases were linked to migration, trade, and the involvement of prostitutes with rich foreign travelers. He also mentions the role played by different armies, including raping women as a strategy of occupation.

known diseases seem to have disappeared, leaving only HIV-AIDS. Pagan strategies and witchcraft are revived to cope with this mysterious development.

It has taken years for some Congolese intellectuals to understand that Lwambo sang the truth. Many others remain attached to theories that describe the pandemic in one way or another as God's punishment or a product of magical forces. People still believe they may be bewitched and that HIV-AIDS can be sent from another territory to kill them. Its transmission is presumed to be closely connected with sins, condemnations, and spells, quite often cast between the Congolese and the Zambian provinces through active awareness campaigns.⁽⁴⁾ Such ideas have persisted for years, in spite of efforts to counter them here and there. Cesar Nkuku Khonde (2006) documents how some Katangan women still prefer to remain single, detest regular matrimonial arrangements in order to move easily from one place to another, from one man to another. To maintain their living standards, some of these prostitutes live with members of their families. The latter take care of the house and the women's visitors and eventually their children. They also play the role of facilitators and are paid with food and their stay in the city.

As for contamination through rapes by armies, a colleague of Cesar Nkuku Khonde, Joseph Yav, has researched the recent conflict between the Democratic Republic of the Congo and Uganda. He found that the main source of the conflict—not to mention of former ones— was the discovery of oil in Lake Albert at the border between the two countries. Human lives were unnecessarily lost and women ravaged because of this mineral resource.⁽⁵⁾ Jeffrey Gettleman, in a piece in the *New York Times*, wrote of fighters entering villages and raping

(4) http://www.cceba.at/croy/croy_populaires_sida.htm. On this site Robert Mbu Mputu depicts common people's understanding of HIV-AIDS in Sub-Saharan Africa. On top of seeing it as a disease sent by the Almighty God to punish people who disobey Him, or as a plague sent by witches, some also look at it as an outcome of Americans traveling to the moon. In this view, Americans brought the virus from there and freed it in Africa. Merely mentioning or singing about it is considered very dangerous; it allegedly leads to death, as with Lwambo Makiadi.

(5) "Central Africa: The Curse of Oil in the Great Lakes of Africa," *New York Times*, October 3, 2007.

young women in the presence of their husbands and children. Up to ten soldiers or militiamen would rape a woman in succession and abuse her at will. In Panzi hospital, in Bukavu (D.R. Congo), Dr. Denis Mukwege strives either to sew back inside organs in raped women or to teach them how to live with the pandemic for the rest of their life.⁽⁶⁾

Mass rapes are, of course, a serious source of HIV-AIDS propagation and include today victims among men and women. Combined with the disease's many other sources, especially internally displaced people in the Katangan Province and getting through the porous Zambian borders, they make this part of the world highly dangerous. The following tables show some figures for the Congo and Zambia:

Adults age 15-49 with HIV/AIDS, 2005	100,000
New HIV infections, 2006	nd
Adult HIV prevalence (%), 2005	5.3
Women age 15-49 with HIV/AIDS, 2005	61, 000
Children with HIV/AIDS, 2005	15, 000
AIDS orphans (ages 0-17), 2005	110, 000
AIDS deaths, 2005	11, 000

nd = No data

Source: UNAIDS

(6) http://www.nytimes.com/2007/10/07/world/africa/07congo.html?_r=1&th=&oref=slogin&emc=th&pagewanted=print.

Zambia	Yr 2006
Population total (millions)	11.7
Population growth (annual %)	1.9
Surface area (sq. km) (Thousands)	752.6
Life expectancy at birth, total (years)	41.7
Mortality rate, infant (per 1,00 live births)	105.1
Literacy rate, youth female (% of females ages 15-24)	66.3
GNI(Current US\$) (billions)	9.7
GNI per capita, Atlas method (current US\$)	630.0
Prevalence of HIV, total (% of population ages 15-49)	15.0

Source: World Development Indicators

III. Alternative Health Care Possibilities

The local population has desperately tried to develop alternative cures to HIV-AIDS, in part because of confusion between HIV-AIDS and many opportunistic diseases. Those would-be cures largely depend on illicit parallel markets and inexperienced human practitioners. The Zambian and Congolese district sanitary facilities are subdivided under the supervision of a major center, with decentralization at the bottom. Thus, a doctor serves on the top, controls all health care centers in the periphery and often reduces already insufficient means in order to cover his personal financial charges to cover centers' visits and monitoring.⁽⁷⁾ Consequently, the periphery is seriously neglected and lacks the basic resources needed to face everyday medical challenges.

Both in Katanga and in the Zambian Northwestern Province, church health-care centers often complain of the looting of supplies by the government centers and avoid any kind of cooperation with them. Many church health-care centers maintain detailed documentation of their actions on local health issues, unlike

(7) The web site <http://www.preventgenocide.org/prevent/news-monitor/2002nov.htm> discusses such cases, especially in cities which have been exposed to war, extreme poverty, and starvation. The Centre for International Cooperation and Security's report in the bibliography concurs with this web site.

the government centers. Unfortunately, they are often only in contact with their donors and benefactors from western countries, with whom they share details about their work, pandemics, and local projects (Elwo Mandjale et al.: APAD 29). These health-care centers are also very selective about who they treat. They may limit their patients either to the adherents of their churches or to those needing treatment in a very small medical area for the sake of efficiency. Nevertheless, people like them because they are affordable. In addition, their personnel take good care of people, act ethically, and avoid any kind of sexual harassment of patients. These church health-care centers maintain supplies of medical products and use them exclusively for their patients at affordable prices. Government hospitals, on the contrary, are often criticized and mocked in popular songs.⁽⁸⁾

Many people, especially in the rural areas of Katanga and the Zambian Northwestern Province have never been aware of any serious medical treatments, and have quite often practiced auto-medication without receiving any diagnosis, advice on dosages, or monitoring of their disease. Quite often, they easily move from taking modern medication to ingesting roots of plants. If their state worsens, they turn to witchcraft doctors in search both of healing and the person they believe is trying to harm them. Medical personnel from big centers easily operate in such places. Incomplete and unclear diagnoses are often the results of the speed at which they treat patients in order to see as many as possible. Once they see that the end is near, they will point out failures of modern medicine and advise their patients to spend more time with traditional

(8) In Lubumbashi, Kinshasa, Kitwe, Ndola and Lusaka, when coffins are escorted to the graveyard, funeral songs are sung in free verses and free imagination is used to fill in new words. People have plenty to sing about. They often know about the kinds of relationships that existed between the medical personnel from the government centers and the deceased. Some of those medical personnel ignore the dangers of HIV-AIDS propagation and have unprotected sex with their patients, who tell relatives that they have normal “opportunistic” diseases and will certainly be healed. When they pass away, their relatives have access to their secrets and the names of people who died later from the pandemic. Doctors from government hospitals and their nurses are, of course, among the victims. There are literary works about such matters.

healers who will offer the right sacrifices to ancestors (Yanick Jaffré, APAD 17). To solve their financial problems, such health-care dealers quite often steal or smuggle medicines and other instruments to treat private customers. Most of the time, their practice includes abortion, which is expensive. If, during the abortion, there is a problem leading to the death of the patient, these medical personnel often escape punishment owing to corruption. Such health centers also propagate HIV-AIDS because they are short of time and means to sterilize their instruments.

Yanick Jaffré (APAD 17) describes the chain of medicine smugglers. It is comprised of very young people whose main job is smuggling medicines from one country to another and advertising them. They are visible both in Katanga (D.R. C) and the Zambian Northwestern Province markets, where medicines coming from Tanzania and South Africa are used extensively and presented as the best. The smugglers deal in medical products without any respect of hygienic conditions; their products are often generic and largely bought and used by hospitals, though they do not follow normal importation requirements. Fake medicines are sold everywhere.

In these illegal medical markets, medical prescriptions are not issued by doctors but by sellers calling themselves pharmacists. According to Eliwo Mandjale Akoto et al. (APAD, 21), their drugs are sold alongside vehicle spare parts or anything else in the market. To attract more and more customers, these self-described pharmacists boast that their consultations are free, that time is spared by buying from them, and that their customers can deal with different issues at one time. And then there is the advantage of secrecy. These alternative health care facilities do not prevent or protect against HIV-AIDS propagation.

IV. Traditional Healers, Sexual Culture, and Travel

In Zambia, we noticed around the capital city, Lusaka, in the Copperbelt, and in the Northwestern Province that most HIV-AIDS patients were so desperate for treatment that they went to the outskirts of cities and submitted themselves to the Ngangas, or witchcraft doctors. Such “doctors” are generally

dressed like a Roman Catholic priest but in strong red and yellow colors. Their patients are secluded in a kind of dormitory where visitors are prohibited, except for one close family member who has to bring food. This seclusion is presented as a way of avoiding any contact with evil spirits. The patients participate in rituals throughout a week. Early in the mornings, the Nganga or one of his adjuvants will come for morning prayers shouting, singing, and getting in a trance to welcome ancestors' health spirits. They then confess all their sins and agree to undergo self mortification and punishment through denial of food, sex, and human joy. They agree to give most of their household goods to the Nganga, who is supposed to use these items to clean them and call for pure spirits. After this long repentance, they will drink different concoctions, both boiled and cold, which will provoke diarrhea and thirst. They are not allowed to drink water, only the several beverages given them by the Nganga. The third ritual consists of scarifications. The Nganga has many small wooden bowls full of different powders made of tree barks dried under the sun, then pounded, and mixed with unknown ingredients and smelly, incense-like plants.

In the largest bowl, the Nganga has razors; he washes them with hot water and adds some colorful liquid in order to purify them. These razors are then used on the patients—on their anus, vertebral column, cheeks, nose, neck, arms, legs, and groin. Over time, the patients form a kind of community and share their stories built on their fears and feelings of punishment by some family members under the pretext that they must be HIV-AIDS victims. They tell each other how their Nganga is very strong and how they will be healed quite soon. They also say that they will work hard afterwards to get more goods for their family. And they decide on different treatments for those relatives who they believe have bewitched them. They have some hope that they will survive, but when a well-informed visitor is allowed to see them, he or she will come out crying, as they are so thin and most of their conversations can be attributed to delirium. After their deaths, the Nganga will move to another place, where singers will have advertised his capacities.

The customers of traditional healers are, of course, influenced by African

traditions and customs. In the cleansing ceremony practiced in the Zambian Northwestern Province and in Katanga (Rachel Marcus 1993), a widow is provided a partner for one night before official recognition is given to either this new marriage or her “divorce” from her late partner (giving her permission to marry someone else). Such practices spread the HIV-AIDS virus, but also bring the inflicted to the traditional healers.⁽⁹⁾

The Democratic Republic of Congo and Zambia concentrate on heterosexuality as the main route of HIV-AIDS transmission.⁽¹⁰⁾ And, indeed, heterosexuality is the main route for 90 percent of HIV-AIDS transmission cases. Girls are often married around twelve in some rural areas. Before their marriage, they are expected to engage in training to prepare themselves for sexual relations, sometimes using plants and sharp unclean instruments to widen their vaginas. At the same time, girls spend much time pulling on their vaginal lips to get them as long as possible. They are expected to excite men easily and give them as much pleasure as possible. However, their lengthened vaginal lips eventually become very fragile and easily wounded, thus offering ideal tissues for contamination. In local traditions, village women dry up their vaginas using medicinal plants. In this way, they can always look virginal even if they have been spending time with many men, as blood on bed sheets is considered a sign

(9) Quite often, people selected for such rituals, whether men or women, are very young. They have no control over their selection, nor are they tied to the future of their partner if the palaver agrees on one night of intercourse only. There are even cases where a married man is asked to undertake the one-night cleaning ceremony.

(10) In Katanga and the Zambian Northwestern Province, it is believed that homosexuality does not exist in any form. However, recent texts such as Epprecht (2005) discuss homosexuality going back to the ancient world, where there were some cases related to religious achievements, revelations and epiphanies, and women or men possessed by a spirit of the opposite sex. Epprecht also discusses cases in southern Africa where women forsaken for a long time by their husbands who had gone into the mines would develop a given kind of female relationship accepted by their society. However, the most important cases are due to the isolation of men in mining. They start relations that can lead even to anal penetration. Epprecht also mentions cases in some places that are linked to western civilization. Other studies in this area include Shepherd (1987), Standing and Kiseka (1989), and Pillow (1990).

of virginity. After such violent contacts, bleeding and fistulas are hidden by young ladies so as to avoid being mocked or accused of anything immoral by the community. They have to show that they can face marriage without complaining about anything and can hide domestic problems. There are also abuses of young girls. Some men prefer young girls under the pretext that they may not be infected, as most of the time they are assumed to be virgins. And there are areas where young virgins are believed to cure HIV-AIDS through intercourse. But, of course, rather than curing the disease, they get infected themselves.

Trade also spreads the HIV-AIDS virus. From southern countries, including South Africa, Zimbabwe, Malawi, and Botswana, trucks export food to Zambia, the Congo, and Tanzania. The truck drivers are well known for forming relationships with female partners all along their way. They spend considerable time at the borders because immigration officers take many hours, if not days, to free a group of vehicles before moving on to the next group. Meanwhile the drivers change female partners and leave these commercial sex workers (CSWs) contaminated. There are roads extending from the port of Dar es Salaam, where many used vehicles from Japan arrive, and drivers have relations with female partners along these roads too. Some of the roads intersect and CSWs consort with drivers from many different caravans.

V. Religion, Customs and HIV-AIDS

Literature on the influence of religion on the behavior of people in Sub-Saharan Africa is scarce. The most important observation that has been made is on faith instability, documented by Victor Agadjanian (2005) in Mozambique. Zambians and Congolese people move from one church to another as their social conditions worsen or simply change. This suggests that most new churches attract people with problems. Agadjanian (2005: 1531) describes the emphasis of healing churches on miraculous cures through direct interaction with the Holy Spirit. Their stress on miraculous cures not only provides their *raison d'être* but shapes many of their organizational, procedural, and social activities. Baffour (2003: 1222) goes a bit further and posits Ghanaians motivations for faith and

church wandering that may be applied to the area under study: “Christian groups reflect the growing disenchantment with monotony of old denomination and the fact that these new churches often involve the use of ‘healing’ and ‘salvation,’ something which seems to appeal to needs of an impoverished population dissatisfied with their current socioeconomic conditions.”

In our investigation in the Zambia Northwestern Province, we noticed that apart from poverty, suffering due to diseases such as HIV-AIDS was pushing people back to the past, i.e. to traditional religious beliefs. At hospitals, we found, doctors would not tell people the truth about HIV-AIDS but would spend much time discussing opportunistic diseases that would keep recurring and enfeeble them. The main church leaders would advise them to put everything in God’s hands and to let his will act in incomprehensible ways: “Nothing happens randomly. God knows everything and wants you to go through this suffering in order to understand Him and the power of his name.” After losing everything—household goods, health, wealth, and job—the sick person, church leaders say, can expect to be rewarded like Job in the Bible. They speak of a reward in heaven. In the meantime, family members, especially children, are exposed to suffering, and parents question what the sufferer might have done—stolen something, had sex with a married woman or a widow, trampled on fetishes, or incited jealousy.

In Zambia, panoply of rituals, roots, and imported plants are used to stop such apparent transgressions. Stealing from the company can be covered and protected by bathing in special plants, drinking some concoction, and getting some scarifications from the witchcraft doctor. Prostitution with an unmarried woman is in most cases considered normal for a man, so he only needs aphrodisiac roots to behave properly with the prostitute, without his wife noticing anything. In the case of a love affair with a married woman, he will need a lot of protection to avoid getting caught by the husband’s witches. He will also need to schedule their encounters well, though there will be no danger if the woman is involved in business and has to spend much time in another area. He may simply behave there as if she is married to him. However, if she is

a widow and has not declared her status in advance, the situation will be viewed very differently. Their relationship will be considered dangerous, for the widow is living with the phantom of her late husband, it is believed, and the phantom resides in the body of whoever has sex with her. Rituals are needed early, before the phantom has settled down completely and started destroying the concubine of his wife. A lot of money will be required, and quite often the man who had sex with the widow will move from one witchcraft doctor to another.

And in spite of the importance of education, mainline churches such as the Roman Catholic Church in many places leave to secular associations and nongovernmental health agencies the task of informing their church members about HIV-AIDS. But, unfortunately, in most cases education sessions are limited to people considered sexually active, meaning youth, leaving out adults and families. Thus, the use of condoms is less likely among people in mainline churches. They find irrelevant information that should be helpful and which is accepted in the healing churches if pastors convey the same message.

In both mainline and healing churches, however, V. Agadjanian (2005: 1535) found a big gender gap. Whereas women are more likely to report prevention measures, men are more likely to be the only ones to decide their possible use. Even if women are informed on measures that should be taken against HIV-AIDS propagation, they are not usually likely to take them, as they are completely dependent on their husbands' attitudes.

Many men in Zambia feel that having sex with a condom on is like eating a sweet with a cover on it. Women are not allowed to argue about that or even allude to any kind of protection. V. Agadjanian (2005: 1536) observes: "Gender ideology therefore is recreated in the church as women and men are held to different standards and expectations. Being faithful or having outside relationships is really men's dilemma. In contrast, women's main role in HIV prevention is reduced to pleasing their husbands sexually and otherwise so as to discourage them from seeking relationships outside marriage." Many women concentrate on their personal hygiene to make sure that they please their husbands. But they may be so willing to please that they engage in

dangerous traditional practices, including, as we've seen, drying their vaginas to ensure bleeding at penetration or extending their vaginal lips. With the alleged miracles produced through healing churches, stress is put on biblical passages which allude to God's omniscience and power to stop or heal HIV-AIDS. Unfortunately, in many cases it is obvious that religion, churches and customs do not help their adherents to consciously take positions protecting them against their exposure to HIV-AIDS propagation.

VI. Culture and HIV-AIDS Propagation

Many cultural features of the Katanga Province (Democratic Republic of Congo) and the Zambian Northwestern Province are very much alike. Besides the religious elements already discussed, they largely contribute to HIV-AIDS propagation. There are forms of love that should not be confused with marriage. These expressions of love do not include penetration (Mark Hunter: 7), though there is also unprotected sex, mainly among young people. And there are places, especially where circumcision rites are not observed (e.g., most of Northwestern Zambian Province and in the southeastern Katanga border with Zambia), where young males are encouraged especially in rural areas - to test their masculinity by having sex on occasion with females of their social groups. At the same time, females are still encouraged to train themselves sexually with men in order to get ready for marriage.

These relationships usually bound women to men and create hidden friendships which might continue even after their marriage to other people. In the Zambian Northwestern Province, women would speak about a "Mukolwe," meaning a rooster, referring to the first man they knew in childhood and with whom sex is still possible. In many places, men would dole out gifts to many partners according to their needs. Sometimes married men in mining cities would benefit from the presence of women who need money.

Mark Hunter (2005: 2) notes that the commoditization of sex in its multiple forms, poverty, and the construction of very large suburban apartment buildings where people live closely together have not helped the situation.

Our observations lead us to add other factors linked to poverty: starvation, promiscuity, loneliness, isolation, drugs, child labor, child soldiers, and ruthless internationalization. A survey conducted over the last three years found that the breadwinning role is more and more assumed by females, with an increase in female-headed households. Some women become CSWs, while others participate in the informal trade and informal economy that have grown with the closing of mines in Zambia and the Democratic Republic of the Congo. These women travel to different locations in the subregion, with many stop-overs in cities as well as villages. Some fill the roles once assumed by their husbands when they were the working breadwinners. Unfortunately, some also tend to adopt the same behaviors as men.⁽¹¹⁾

In the areas of the studied provinces, women are victimized by virtually all social institutions. Their health care and indeed their destinies are considered unimportant. They face dangers that risk ending their lives earlier than men's. Parochial institutions led by men do not allow them to rise in social status, or even to rethink and deconstruct their relationships with men. Many customs force them to endure considerable suffering. And when they become the breadwinners in their families, their husbands often refuse to look for work again; some of those husbands even claim that their sole responsibility is to ensure progeny.

VII. General Conclusion

With HIV-AIDS threatening countless lives in Katanga, the Democratic Republic of Congo and the Northwestern Zambian Province ravaging the

(11) In the Congo, Zambia, Tanzania, Kenya, Botswana, Malawi, Zimbabwe, and South Africa, there are more and more examples of women acting as breadwinners but whose lives in the areas where they travel for business are completely free of any engagement back home. They lead love affairs with other men, especially those working on their convoys. Sometimes, their convoys help them connect with interested men and arrange their meetings depending on their travel schedules. Other times, such women simply spend one half of the year with their lovers while sending from time to time goods to help their families. We had the opportunity to discuss these issues with our interlocutors.

population, it is imperative to critically assess the situation and suggest possible solutions. Women can contribute to those solutions at many levels if they are empowered and have equal rights in all fields.

As women continue to die of HIV-AIDS at higher rates than men, neither churches or health-care centers have provided solutions to the pandemic. Decentralized responses have failed; weak states (and weak provinces) have proven unable to develop appropriate strategies for countries already victimized by wars, mass rapes, widespread commercial sex, and extreme poverty. Weak states also lack the moral will to consider the real impact of HIV-AIDS on their societies. They are unable to devote the necessary financial resources to combating the pandemic. Or they simply ignore it.

International interventions have also failed due to the absence of serious local support—most PWAs are focused on their daily suffering and hunger—and a lack of understanding of the necessary priorities. International agencies have failed to establish sufficient links to traditional leaders too. Those segments of the international community still willing to assist weak states and the mainly poor PWAs should change strategies and attack the pandemic at its roots. The structures fighting HIV-AIDS have focused too much on its consequences rather than its causes. There is a real need to concentrate on girls' education curricula oriented towards developing immediate and practical improvements in hygiene and public health, home budget management, microfinance and small enterprises, office work, farming techniques and technologies, and employment opportunities.

More and more women would question superstitions and traditional healers. A lack of education and poverty are key contributors to the HIV-AIDS pandemic. Provincial leaders and international bodies must work to alleviate poverty and expand educational opportunities. Weak states should build schools everywhere in their countries, while nurturing connections with traditional chieftains. Those chieftains can play important roles in reconstructing traditions and customs, which must be adapted to fit new times.

There should be sustained efforts to reduce gender inequalities in all

areas, including social rights and responsibilities, political access, the law, and employment. Women must become more visible in society, though their domestic work should be valued. Women's workshops must continue, and use of loans and micro finance to support women's work should spread. National leaders should pursue policies that reduce inequalities. Examples of accomplishments in other countries could help guide their work. Leaders should also coordinate the work of national and international NGOs in their countries. In the field of HIV-AIDS, governments should work with NGOs on setting short- and long-term priorities, avoiding the waste of time, energies, and resources of the last twenty-five years.

Women should also be encouraged to be self-reliant and become entrepreneurs as well as mothers. Women working in business should have the same benefits as men and be able to challenge men in all sectors. Through such competition, the subregion can participate in globalization and better face other challenges. Women in business could also shape new strategies for stopping the spread of HIV-AIDS. At all levels—villages, cities, countries, and regions—they can contribute to halting the disease. Women's economic participation will also change how they are viewed by men.

Of course, to make sustainable progress in Katanga (DRC) and in the Zambian northwestern province, grassroots work is needed. If women are accepted as equal partners in that work, the future will be much brighter. Equal opportunities are only possible if men and women share responsibilities both at home and in society as a whole. It is important that men avoid hiding behind concepts such as dual society, traditions, or patriarchal social obligations. But, to be realistic, women should not expect much support from men, who have been spoiled by an urban tradition which has given them power over women and children.

Globalization has made for a world of quick exchanges, virtual proximity, and the sharing of almost everything, especially information. It alone requires new attitudes. Ignoring globalization or imposing a model on society which does not take it into account would condemn both neighboring provinces on the

border of the Democratic of Congo and Zambia, Katanga and the Northwestern provinces, to simply a continuation of the past.

People have turned to old traditions and outdated methods in vain to counteract HIV-AIDS. Medically sound treatments would be better understood if their impacts on communities were shown through objective indicators, such as their success rates. Beliefs in witchcraft would then decline. People would also notice that HIV-AIDS contamination can be traced back to particular behaviors.

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**The Deadly Pandemic, Quarter a century After:
The Katanga Province (D.R. Congo), and the Northwestern Province
(Zambia) Women in a World of HIV-AIDS**

<Summary>

Felix Ulombe Kaputu

More than a quarter of a century after HIV-AIDS was recognized and located in Africa, 70 percent of its worldwide propagation still takes place in Sub-Saharan Africa in general, and in places like the Katanga Province (D.R. Congo) and the Northwestern Province (Zambia). The disease threatens to spread further despite international interventions. In the meanwhile, the population has scarcely changed its behavior; old traditions and customs still prevail and lead to poverty, commercial sex, dangerous sexual practices, and a return to the reign of gods and witchcraft doctors. A possible way out of the infernal circle linking poverty, sex, and HIV-AIDS involves education and redefining gender issues. Adaptation to globalization has the potential to engender new economic standards, religious organizations, and male-female relationships. Poverty reduction, good governance, and proper management of northern financial support will reduce, if not stop, HIV-AIDS. A case study of the Katanga province in the Democratic Republic of Congo and the Northwestern province in Zambia gives an excellent illustration of how the past quarter of century has not brought much change in popular sexual habits and HIV-AIDS propagation routes.