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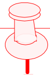

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AARG Anthropologists Debate Paradigm Shift in AIDS Prevention

Karen Kroeger

The AARG list serve has been the hottest spot in town in recent weeks. A stimulating and important debate has been taking place among anthropologists who work on AIDS prevention in Africa as well as other places in the world. The debate centers on the question of how to adequately
account for Uganda's apparent success in dramatically reducing HIV seroprevalence in recent years. Was it using faith-based programs to promote sexual behavior change, as Ed Green suggests, or was it other factors, as Doug Feldman and other anthropologists insist? Prompted by Edward Green's editorial in the New York Times, entitled, *The New AIDS Fight: A Plan as Simple as ABC* (NYT: March 1, 2003), and his March 20 testimony before Congress (http://energycommerce.house.gov/108/hearings/03202003Hearing832/hearing.htm) in which he suggests that, in some contexts, faith-based approaches that promote abstinence and marital fidelity may be more effective than Western-dominated approaches to AIDS prevention that focus on promoting condoms, the discussion has attracted many anthropologists and activists who have been involved in initiatives to prevent AIDS in Africa and other places in the world over the past 20 years. The list of those who have weighed in on the topic over the past month, such as Doug Feldman, Elizabeth Onjoro, Brooke Schoepf, Bill Weintraub, Pieter Remes, Lori Broomhall, Lawrence Hammar, Robert Bailey, Jim Stansbury, Daniel Halperin, Merrill Singer, and others, represents the extraordinary depth and breadth of experience among anthropologists working on AIDS issues.

Green's basic thesis is that we need to "move from consensus-based to evidence-based AIDS prevention" and that "AIDS prevention programs designed by Western experts have been largely ineffective in Africa *(from recent list serve postings)*." Green suggests that Uganda's recent success in reducing HIV seroprevalence from 21% to 6% since 1991, was based on a strong ABC campaign (Abstinence, Be Faithful, Use Condoms) in which A and B were heavily promoted. Green also suggests that Western donors have relied too heavily on technological and medical approaches such as condoms and drugs, at the expense of behavioral campaigns that can
encourage people to reduce the number of partners they have or to be

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monogamous.
Other anthropologists have been quick to argue that Uganda's success may have been due in large part to other factors, for instance, the Ugandan government's proactive stance on dealing with HIV as early as 1986, when they rolled out a national campaign to break down denial about AIDS. The campaign, based on the ABC approach, encouraged Ugandans to speak openly and frankly about sex, discouraged discrimination of people with HIV, and destigmatized the disease. In addition, the government took steps to empower Ugandan women, which contributed to their ability to refuse sex.

Some anthropologists have expressed concern that Green's conclusions will signify a green light to religious conservatives in the Bush administration who wish to promote sex-negative, abstinence-only campaigns at the expense of more comprehensive approaches. At stake is the $15 billion allocation that President Bush has pledged to mostly African countries over the next five years and how that money will be spent.

The question of how to account for Uganda's apparent success in reducing AIDS constitutes the core of the debate, with much attention being given to discussions of condom effectiveness and methodological issues in establishing the efficacy of one approach over another, but it has also raised numerous other questions of interest to anthropologists, such as: Are Western models of AIDS prevention that are predominantly based on condoms always appropriate for African and other nations? Have Western donors and researchers been guilty of imposing a one-size fits all western model of AIDS prevention on African nations at the expense of other approaches that might be just as, if not more, effective? Are faith-based approaches to AIDS prevention inherently sex-negative? And how has the recent polarization around religious issues in the United States helped to shape the ways that researchers view the influence of religious organizations in Africa? In addition to exploring the potential for a paradigm shift in AIDS prevention, participants have also raised important questions about the role of anthropologists in carrying out prevention initiatives. Some are encouraging anthropologists to "study up" (in the words of Laura Nader) by exploring the implications that funding decisions and donor priorities have for prevention efforts on the ground in local communities. Others have asked how we, as anthropologists, can play a more substantial role in developing prevention models that are both effective in and that emerge from the local context. And finally some are asking a question that is as relevant now as it was during the 1960's: What responsibility do we, as anthropologists, have with regard to the political uses and abuses of our data?

The debate has prompted the organization of a panel to discuss these issues at this November's AAA meeting in Chicago. We urge all of you to attend, and to check out the debate at http://puffin.creighton.edu/aarg/prevention.html and on the AARG list serve.

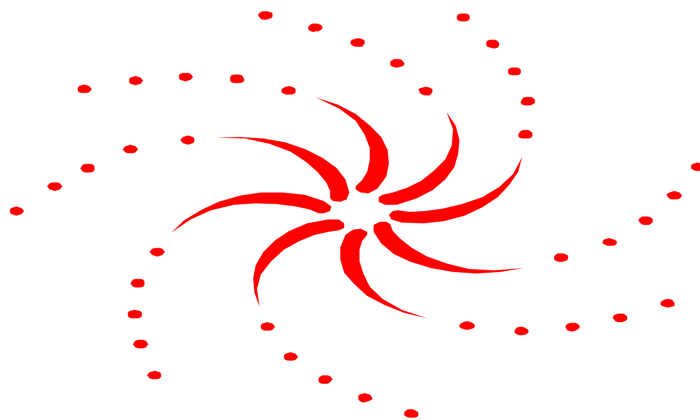
The discussion has generated numerous references to background material, some of which are listed below.

References:

Green, Edward The New AIDS Fight; A Plan as Simple as ABC. New York Times, March 1, 2003.

Green, Edward. Congressional testimony of March 20, 2003 http://energycommerce.house.gov/108/hearings/03202003Hearing832/hearing.htm

The Alan Guttmacher Institute. The Role of



Letter from the Chair

As Goes the Drug Trade, So Goes the Drug-related AIDS Epidemic: Breaking the Link

Any AARG member who has time to open her/his email knows that our listserv has witnessed an intense and impassioned debate on AIDS prevention in Africa over the last several weeks. This discussion, which has involved many AARG members and others who are not YET AARG members, is reviewed in this international theme issue of the AIDS & Anthropology Bulletin. Given the specific focus of this exchange on sexual transmission, I decided to reserve this space for a review of injection-related HIV trends around the world.

Over the last decade, there have been dramatic and consequential changes in the global picture of drug injection. Primarily, the drug picture has changed because the traditional notion that drug injection is primarily a feature of developed countries is no longer true. Drug injection is spreading rapidly in developing countries on every continent. Notably, drug injection has now spread to countries that just a few years ago were assumed to be at very low risk for developing an injection-related AIDS epidemic (because of long-standing non-injection drug use patterns, cultural or religious barriers, or low levels of technological development), and it has spread to diverse urban and rural populations.

Between 1992 and 1995 the number of countries reporting illicit drug injection jumped from 80 to 121 and has continued to climb thereafter, making drug injection a truly global health risk.

For example, it is now estimated that there are 10,000-15,000 illicit drug injectors in the northeastern Indian city of Chennai (Madras). But injection was not a traditional local pattern of drug consumption. Observations and interviews by Saresh Kumar and others have shown that a rapid four-step shift occurred in recent years, from little interest in heroin, to “chasing the dragon” (inhaling heroin smoke), to injecting heroin, to injecting buprenorphine (a pharmaceutical derivative of the opiate thebaine). Use of multi-drug cocktails containing pharmaceutical drugs like diazepam, promethazine, and avil has become common in Chennai as well. Further, there appear to be definite increases in the number of IDUs in the city in recent years. Both direct (actual syringe sharing) and indirect sharing (syringe transfer and drug paraphernalia sharing) have been found to be common. Similarly, in Southeast Asia, there has been a three-step transition in drug use, beginning with opium smoking, moving to heroin (anopiate derivative) smoking, and leading eventually to widespread heroin injection. Vietnam, for example, now has major heroin injection and injection-related AIDS epidemics. The Southeast Asian injection trend began in Thailand and spread to adjacent countries. Injection is now found widely in Southeast Asian cities, rural areas and even tribal communities. Injection has spread west to Bangladesh and Nepal. In Burma (Myanmar), injection has spread from those involved in heroin production and trafficking to fishermen, miners, and even upper socioeconomic groups. In China, injection began in the south and has continued to spread throughout the country. In the remote western Xinjiang province, for example, injection drug use markedly increased in 1996, and by 1997, 50-80% of all drug users were injecting. The consequences are predictable. In Yili Prefecture, HIV among injection drug users who have been tested jumped from 9% to 76% between January and August of 1996.

Less well known is that drug injection is now spreading in Africa as well. While opiate or cocaine use were not traditional to Africa, changing drug shipment patterns have resulted in a number of African countries becoming transshipment sites for drugs moving from Asia to Western Europe and North America and from South America to Europe. There are now reports of drug injection emerging in Nigeria, Gabon, Liberia, Cote d’Ivorie, Senegal, Chad, Zambia, Ghana, Kenya, South Africa, and Mauritius. In Nigeria, the local heroin consumption scene is now over 20 years old. While injection drug use has probably not yet had much impact on the AIDS epidemics of Africa, the potential is clear. Similar patterns could be described for Russia and Russian Federation countries (both of which now

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have major drug injection and AIDS epidemics), South America, and the Caribbean. The further spread of injection drug use and resulting health consequences is likely. It is expected, for example, that the supply of heroin from Afghanistan will go up significantly this year. While there was a noticeable drop in opium poppy acreage in Afghanistan following the imposition of a ban by the Taliban, there has been a reversion to old patterns of cultivation as a result of the U.S. intervention. It has become increasingly clear that the U.S. imposed government in Kabul has little control over most of the country, allowing (and, because it is the only way for farmers to survive, pushing for) a rapid return to high levels of production. As this opium is converted into heroin and shipped through other countries on its way to European and North American markets, drug trafficking routes soon become corridors of drug use, including injection drug use.

As this brief summary suggests, injection drug use continues as a major component of the global AIDS epidemic. Consequently, as Gerry Stimson and his colleagues argued at the Sixth International Conference on the Reduction of Drug Related Harm, there is a critical need for rapid assessment of changing drug use patterns relative to the spread of AIDS, a strategy well-known to anthropological researchers. In Hartford, our research team at the Hispanic Health Council has recently implemented such a project with funding from the Centers for Disease Control and Prevention. Its goal is to monitor and respond to the health consequences of emergent drug use trends based on rapid assessment of new ethnographically identified drug-related risks. More generally, the CDC has grown increasingly interested in drug-related behavioral monitoring, and is establishing a national network for this purpose. The NIDA-supported Community Epidemiological Work Group provides another such vehicle. What is needed now to break the link between shifting drug production and trafficking routes and the spread of drug-related HIV (and other diseases) is the global diffusion of similar monitoring programs, namely the development of HIV prevention systems that include rapid assessment of emergent drug-injection and other risky drug use patterns, transfer of research findings in an accessible format to prevention/

Letter from the Editor

This edition of the newsletter pays tribute to the huge outpouring of interest over the question of AIDS prevention in Uganda. For a compilation of this discussion from the AARG list serve, see http://puffin.creighton.edu/aarg/prevention.html as well as the Congressional Hearing transcripts http://energycommerce.house.gov/108/hearings/03202003Hearing832/hearing.htm

In addition to Ted Green's testimony, you may also want to read Sophia Mukasa-Monico's and Donna Barry's testimonies. Ms. Mukasa-Monico is the Director of the AIDS Program at the Global Health Council. Ms. Donna Barry is a representative from Partners in Health (Boston). In this edition of the Bulletin, Karen Kroeger has summarized the list serve discussion briefly; and two of the three main contributors, Doug Feldman and Brooke Grundfest Schoepf, submitted more substantive essays generated from their respective postings on the listserve. These two distinct perspectives serve to provide both context and content for further discussion of this important issue. In addition, you will be interested in reading personal insights from Ugandan Gerry Matovu Kiwanuka. Ted Green declined to participate in this forum, but his views are accessible on the list serve and in his Congressional hearing transcript.

Our Chair, Merrill Singer, provides a review of HIV/AIDS worldwide in relation to the increasing prevalence of injection drug use. Member David Beine has also submitted ad material for his new book, Cultural Contexts of HIV/AIDS in Nepal.

Our July edition will focus on student submissions. PLEASE encourage students to submit HIV/AIDS related essays, literature reviews, conference, paper or thesis summaries, or any other HIV/AIDS related submissions by July 15th. Students outside of the U.S are also encouraged to submit (of course)!

Many thanks to all the contributors.

Comment: A Ugandan Perspective

Gerry Wiwanuka, Cambridge, MA.

Perhaps Uganda is doing better because it had to. Uganda's politicians realized that hiding behind the cassocks, collars and pontifications of clergy would do nothing to slow the country's destruction. The problem was too big to hide or to waste time with endless debate. Action was needed immediately, and so it was taken. Sometimes, high-ranking clergy and religious conservatives had to be annoyed or bullied—and this was no small risk because those who cloak themselves in religion can make deadly enemies, especially in countries where religious leaders have great political sway.

From my perspective it seems that here in the US, HIV/AIDS is not viewed with the same urgency as it is by politicians and policy makers in Uganda. Politicians in Uganda have no such luxury. Everyone has been touched by AIDS. In my case, I have lost more than 30 cousins. These were all people in their prime. Unfortunately, they became infected early in the AIDS pandemic. In those days, information about HIV/AIDS was sketchy for ordinary folk and those in authority had other priorities. Even those who actively sought information on AIDS prevention found it difficult to get good answers. Eventually, through the considerable efforts of many people and organizations, more of the masses became aware of the dangers and how to avoid them. On a national level, the story goes that in the early days of AIDS, presidential advisors showed Museveni a report that compared Uganda's projected population levels if HIV infection continued unabated. They say he was staggered by the implications: his army, the police force, the teachers—all institutions—would be decimated. The cost in human life could not be ignored; despite his own religious conservatism, he went on national media shortly afterwards to say that we had a serious problem and to endorse condom use—a step unprecedented in Uganda's history.

In the US the severity of the problem is "not seen" by those people who are rewriting Uganda's successes in the struggle to contain AIDS. To them, AIDS is a threat only to "others": Africans, homosexuals, junkies. Since Bush is now willing to fund international AIDS, the religious right has identified a perfect vehicle on which to advance their own agenda. But attempting to control the spread of AIDS without acknowledging why Uganda's anti-AIDS efforts have been effective is folly. These gentlepeople have forgotten human nature, it seems. I wonder if our leaders here in the US might take a less dogmatic approach to public health if, as in Uganda, the ranks of the country's armed forces, teachers and civil servants were at risk.

Reassessing AIDS Priorities And Strategies For Africa: ABC vs. ACCDGLMT

Douglas A. Feldman,
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It has been 20 years since the medical literature first reported AIDS in Africa, and now¯two decades later¯there is still no full consensus in regard to the appropriateness of effective HIV prevention, care and treatment strategies on the continent. I will discuss here policy issues surrounding the question of how should President Bush's proposal to spend $15 billion on HIV/AIDS in 12 African, one Caribbean, and one South American nation over the next five years be spent on HIV prevention. How should we most effectively spend the billions of dollars? How exactly do we reduce sexual risk for HIV in Africa?

Last September, US AID held a special meeting in Washington, DC where they discussed changing the current approach of aggressively social marketing male and female condoms in Africa, to instead refocus prevention efforts on abstinence and marital fidelity using what has become known as the Ugandan model. The Bush Administration has favored abstinence-only HIV programs and faith-based initiatives in the United States, and some conservative

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analysts and policy makers would like to extend this to Africa as well.

I am very pleased to learn that the House International Relations Committee on April 2, 2003 thwarted an effort by conservative Republican Congress members to add an amendment stating that, while condoms could be a part of AIDS strategies, abstinence and monogamy should have priority. But the vote was nervously close, 24-20, with an amendment, by Rep. Barbara Lee that does not give preference to any one preventive method, passing instead.

In a report prepared for the September meeting by Synergy for US AID, *"What Happened in Uganda?,"* edited by Janice Hogle and significantly contributed to by Edward C. Green (both anthropologists), it is maintained that the "ABC Campaign" (A for abstinence, B for be faithful, and C for condoms) in Uganda dramatically reduced HIV prevalence rates, through promoting complete abstinence and strict faithfulness, years before condom promotion took hold in that country. The Ugandan government worked with fundamentalist churches and mosques to spread their campaign. The report contrasts this with other African nations where condoms are promoted but the HIV rates remain high.

Based upon my own research experience on AIDS in Rwanda in 1985, in Uganda in 1988, in Senegal in 1992, and in Zambia in 1989, 92-93, and 97-99, I believe that a commitment to abstinence or faithfulness, and the growth of fundamentalist religion did not turn around the AIDS epidemic in Uganda.

What really happened in Uganda beginning in 1986, and which did not happen in other African nations, was a total commitment on the part of the government from President Museveni on down to tackle the epidemic head-on, to destigmatize the disease, to saturate the media with information about AIDS, to bring discussions about AIDS into every home, every workplace, every school, to open the door to aggressively working with WHO on the problem, and to welcome European and North American research. Most other African governments at that time put up a wall of denial, even declining WHO funding. When that wall of denial collapsed in Uganda, the immediate reaction on the part of most multipartnering Ugandans was to reduce their number of partners. Partner reduction, out of concern for their personal safety, not religiously indoctrinated abstinence and monogamy, was the prime mover for HIV seroprevalence decline in Uganda during the late 1980's and early 1990's. By the mid-1990's, condom promotion significantly grew, and this has allowed the lowered seroprevalence rates to remain sustained in Uganda.

A broader concern of mine is what such a sex-negative approach, of spending billions of dollars in promoting religious-based abstinence or monogamy throughout Africa, would do to the diverse cultures of sub-Saharan Africa. We as anthropologists have the enormous advantage of extensive ethnographic and cross-cultural data which allows us to deeply understand social and sexual behavior and beliefs from both an emic and etic perspective. An analysis of pre-colonial sexuality, using the Human Relations Area Files, reveals an immense sexual diversity in many traditional African cultures, including post-partum sex taboos, ritualized homosexuality, strict rules governing polygyny (which was the ideal thoughout most of Africa), celebrations where multipartnering was encouraged, rules governing dry sex, ritualized stretching of the labia, sexual education and ceremonies during puberty initiations led by
elders, and so on. I have not come across any African culture which traditionally followed the American fundamenst Christian model of strict monogamy and pre-marital abstinence as both ideal and practice.

Missionary, colonial, and post-colonial influences have considerably narrowed this diversity and fostered a sexually repressive social climate. Fundamentalist churches and mosques have dramatically grown in their social and political influence during the past decade, casting a pall over sexual freedom and expression across the African continent. The last thing that Africa needs now is an ineffective, culturally inappropriate HIV prevention program based upon a misinterpretation of the data that will further embolden these regressive religious

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organizations.

Some, including Edward C. Green and Kenyan anthropologist Elizabeth Onjoro, have even questioned whether condoms are safe and effective. Condom slippage and breakage occurs only about 2.6% of the time. Research also shows that there is an 85% reduction in HIV/AIDS transmission risk when infection rates were compared in always vs. never users, and these data provide strong evidence for the effectiveness of condoms for reducing sexually transmitted HIV. What this means is that, when HIV statuses are not known, a faithful monogamous couple in Kampala, Uganda who do not use a condom are at slightly greater risk of HIV infection than a multipartnering male in the same city who has six partners but uses a condom properly each time. Condoms in bulk at cost are also one of the cheapest technical interventions available.

What then do I see as the solution to effectively promoting sex risk reduction in Africa? 1) Develop culturally appropriate targeted peer-led and community-based HIV interventions, which emphasizes those values, beliefs and norms that support safer sex practices; 2) Conduct more anthropological research to develop and evaluate these interventions; 3) Strongly promote and social market male and female condoms; 4) Work with traditional healers on HIV prevention and treatment; 5) Evaluate the efficacy of traditional healer herbal treatments for HIV-related opportunistic infections; 6) Work with the elderly who often conduct ritual initiations to incorporate HIV prevention in their initiations; 7) Encourage masturbation among youth as a substitute for unprotected intercourse; 8) Encourage forms of nonpenetrative sex; 9) Work with those progressive churches and mosques in Africa that do not condemn persons with HIV; 10) Promote social acceptance of same-sex sexual behavior and the newly emerging gay communities in urban Africa; 11) Develop national media campaigns that break down the wall of denial about AIDS; and 12) Work with top levels of government and NGOs to effectively coordinate national HIV prevention, and AIDS care and treatment campaigns.

We should not be dictating HIV policy for Africa from the West without an understanding of cultural factors. And far too few anthropologists have been involved (or hired by the "beltway" organizations) so far, and this has resulted, I believe, in such poor results as only 4.6 condoms available per person per year in Africa. Applied cultural anthropologists need to take the lead in finding out how to design culturally appropriate interventions that would make proper condom use routine among all sexually active multipartnering males in sub-Saharan Africa. We need to make our interventions targeted to specific cultures and ethnic groups, male/female, age cohorts, and income/social class differences. Rather than imposing a Western format, we need to do the qualitative research to find out what would actually work in the local population. We need to learn which of their values, norms, and beliefs could be effectively used to reduce their sexual risk in a successful multi-dimensional (meaning not just condoms) intervention. My concern is that the first and loudest voices we hear are those who advocate abstinence and fidelity and condemn the sinners who multipartner. We need to seek out those (especially the men) who are neither abstinent nor faithful, and perhaps not that religious, and "RAP (rapid assessment procedures) them" until we learn exactly what it would take to get them to practice safer sex. Then you will see routine and proper condom use go up and HIV rates go down.

After breaking down the impenetrable wall of denial kept in place by most African governments, their national media, and several local fundamentalist religious organizations that has prevented the destigmatization of AIDS, condoms are the single most important thing Africans can do to reduce HIV transmission on the continent. The fact that so few condoms are available per person per year in Africa tells me that it hasn't actually been tried. We also desperately need an effective

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microbicide for women now that nonoxynol-9, the only microbicide approved by the FDA, is no longer recommended.

The whole ABC debate (ABC, ABc, or abC), however, avoids the focus of what needs to be done in Africa. Rather than an ABC Campaign, I would promote an ACCDGLMT Campaign: A (Anti-discrimination), C (Condoms, and lots of them), C (Culturally appropriate and ethnographically researched [maybe by an actual anthropologist!] interventions), D (Destigmatization of the disease), G (Government involvement and commitment to a secular and humanitarian solution to the health crisis), L (Less risky sex - encouraging self-masturbation among youth, perhaps oral sex, and non-penetrative sex [interfemoral, mutual masturbation, etc.] as substitutes for vaginal or anal sex), M (media campaigns directed to both the general public and targeting specific at-risk populations, providing unambiguous information and promoting understanding of persons with HIV/AIDS), and T (Traditional healers, since they are the primary health providers in most of Africa).

Now, in the face of a lethal sexually transmitted infection, it might be expected that many in Africa would find the solution offered to them by the Pat Robertsons and the Sammy Tippits of the world quite appealing. Indeed, in my own research among gay men in 1982-83 in New York City, I learned that the immediate reaction among gay men to learning about the threat of AIDS back then was rapid partner reduction (from a mean of 6.8 per month to 3.6 per month). And it is not surprising that this has happened in Uganda, as well. It did not happen in most other African countries, I believe, because the wall of denial was kept intact, maintained by blinded or nervous governments, national media, and religious organizations, and the

What Happened in Uganda?

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Uganda is widely recognized as the first and most dramatic success story from sub-Saharan Africa. HIV prevalence has declined markedly, from a high of about 15% to 5% nationwide according to UNAIDS (2002)[1] estimates, and incidence is demonstrated to have declined in a few areas. News of
declining prevalence and incidence is truly good news and to be fostered 'by any means necessary,' to use a phrase from a bygone era. As the AIDS epidemic proceeds through its third decade on the sub-continent, lessons learned are important for prevention policy. But what are those lessons and on what data are they based? A current debate among anthropologists revolves around "What Really Happened in Uganda?" At stake is policy that will affect the lives of millions of Africans and others in the developing world.

The NRM victory ended nearly a decade of violence, during which many men were killed and women and girls were raped by soldiers with high HIV prevalence. President Museveni's government made rape an offense punishable by death. Peace brought new hope and economic renewal to southwestern Uganda (Bond and Vincent 1991, 1997). Changes in sexual behavior include delayed sexual debut among youth, reductions in partner numbers, increased marital fidelity and condom use in what are defined as high-risk encounters. Green (2003) has mentioned some of the steps taken by the government of President Museveni to raise the status of women, and reports that condoms are disliked by Ugandans, and little used. He also believes that religious leaders' teachings with respect to abstinence and marital fidelity are the major cause of declining prevalence and constitute a distinctive "Ugandan
solution."

However, Ugandan social scientists and lay

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informants stress the terrible numbers of deaths that generated widespread fear. This fear fostered discussion and determined efforts to change risky situations and behaviors (Mukiza-Gapere and Ntozi 1997, 1999). Churches were not the only players in the field. Many organizations took on the task of educating youth, including local government, women's organizations and anti-AIDS clubs, popular musicians and drama groups. Moreover, some Protestant churches, and even Catholic religious and lay leaders used the ABC approach in outreach to youth. Limited space does not allow me to address the many changes that took place in Ugandan society and culture, and in the political economy. Sources for the situation of poor women include exemplary ethnographic research by Obbo (1991, 1993, 1995).

In the early years many Ugandans continued to engage in risky behaviors, not always from choice (due to power differentials). Many also lacked awareness of personal and family risks. Although the Uganda government was open about AIDS, and the campaign slogan "love carefully" might be interpreted to refer to condoms, most people did *not* read it that way (Furley and Foster 1989). Condom promotion got off to a slow start due to moralist objections and bureaucratic obduracy. Seidel (1993) and Lyons (1997) analyze discursive struggles between moralists and biomedical advice, struggles still being waged in the United States around reproductive health issues, including abortion rights and stem-cell research, as well as AIDS prevention.

Reluctance to use condoms has abated in many areas across the continent in population segments generally recognized to be at very high risk (for Kampala, see Kamya, Mcfarland, Hudes and colleagues, 1997). At the same time, many men reported reduced partners numbers since 1989, and some foreswore them entirely, although decline was not significant in men aged 20-24. Women of that age group reported *more* partners. A more recent study of sex workers in Kampala reported nearly 100 percent condom use with clients, while use reported by truckers, traders and the military was found significant (for rural Masaka, see Kamali, Carpenter, Grover and colleagues 2000).

Targeting condoms to "core transmitters" early in an epidemic is technically correct on a population basis¯or would have been had high status men with multiple partners also been targeted¯at the outset of the epidemic. Socioculturally, however, condom promotion as "protection for men against infected women" is counter-productive; it increases stigma and gives others false reassurance (Schoepf 1988; Lyons 1997; reviewed in Schoepf 2001). In any event, public health campaigns did not begin until several years after people were recognized to be sick with full-blown AIDS in 1982-83 (van de Perre, Rouvoy, Lepage et al 1994; Serwadda, Sewankambo, Mugerwa et al 1995). By that time, the HIV epidemic was well-established in Central and East Africa. In Rakai in 1989, district-wide adult prevalence was 12.6 percent (Serwadda, Wawer, Musgrave et al 1992), and in 1990, incidence was calculated at 2.1 percent, with 3.2 percent in people aged 15 to 39 years, and highest levels in those 20 to 24 years, with 9.2 percent of women of that age infected each year (Wawer, Sewankambo, Berkley et al 1994). Thus everyone who had had multiple sex partners needed to make personal risk assessments and use condoms until they and their partners could be tested. Nearly 3 percent of people reporting a single partner in the past year became infected. In this context of high background prevalence, there were no special risk groups. Researchers in Uganda eventually made this observation explicit, albeit without mention of the C-word. *"Prevention education should emphasize that any unprotected intercourse, except for mutually monogamous couples with known seronegative status should be considered high risk, particularly in the trading centers"* (Serwadda, Wawer, Musgrave et al 1992: 989).

Cultural sensitivity, meaning capitulation to moralists' perspectives, or to dislike of the latex barrier, would have condemned even more people. Requiring women to remain married to abusive, exploitative or domineering partners out of concern for "morality" or "tradition" is also a violation of their human rights. Put another way, *not* to have empowered people at high risk to use condoms and

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enable them to convince partners of the need for them, is not "culturally sensitive," but politically expedient. Culture change is precisely what Uganda needed, and much has been accomplished by Ugandans in that regard. More is needed, however, including interactive communication that can enable people to abstain, to stay faithful in marriage, *and to use condoms with all partners, including those whom they define as "regular," whose serostatus they do not know*.

The sexual diaries of women who sold sex in a Masaka trading town in 1998-1999 indicated low and inconsistent condom use (Gysels, Pool and Nnalusiba 2002). Their stories included histories of rape, marital instability and lack of partner support for children. Not all women were powerless, however. Some successful businesswomen who owned bars along the highway refused marriage. They could select their clients, charge higher prices and successfully negotiate condoms. Very poor women could not, partly because they needed each and every fee no matter the circumstances. Many went in and out of unsatisfactory marriages in an effort to garner support and to avoid abuse. Differences were found among clients. Truckers, who had been targeted with condom campaigns all along the Trans-African Highway (Nyamwaya 1991; Haour-Knipe, Leshabari and Lwihula 1999), were likely to carry their own. With money to spend, they were preferred clients of the entrepreneurial women, and some became "regular partners." Poorer local men, who frequented the poor back-street women, were notably reluctant to use protection. Nevertheless, despite differences in negotiating strength with casual partners, none of the women negotiated protection with those whom they defined as regular partners. These men and women all had other partners. It is not clear whether these economically empowered women believed that they were not at risk, whether they felt unable to negotiate condoms due to the question of "trust" in regular partnerships, or a combination of the two which left them in denial. In any event, women's economic empowerment often does not result in empowerment in sexual relationships that they wish to maintain (Schoepf 1992; Mbilinyi and Kaibula 2000). Gysels and colleagues comment that condoms were "acceptable only for family planning," but apparently did not make use of this opportunity in their interventions.

The biggest risk to most women is from steady partners. Moralist discourse about fidelity ignores risk of infection by spouses, and incorrectly assures faithful women that they would be protected (Schoepf 1988,1993). Not all churches did this, either in Kinshasa or in Uganda. But many religious and lay leaders *did* maintain this position (Schoepf 1993; Seidel 1993; Lyons 1997). The Masaka project began five-year prevention experiments in 1995. Although outreach workers "felt that the religious leaders had a waning influence" over the years, Catholic, Muslin and Pentacostal leaders were nevertheless vocal in their opposition to condoms "because they 'send people down deep into adultery' and prevent procreation" (Mitchell, Nakamanya, Kamali et al 2002:212).

Marriage Risk

Data from Discordant Couples Longitudinal cohort studies in Rakai and Masaka indicate that as time went on, incidence in regular partnerships was very high. In Rakai, nearly 19 percent of couples in the trading towns had at least one seropositive member in 1990, and nearly half of all men reported two or more sexual partners in the preceding year (Serwadda, Gray, Wawer et al 1995). Sixty-six percent of married women whose husbands absented themselves trading or working were seropositive; similar to the rate among single women. Forty percent of widowed, divorced and separated women were infected. In both trading towns and agricultural villages, husbands tended to die first, indicating that they were likely to have been infected first by other partners and to have transmitted HIV to their wives. In the late 1990s, towns in Rakai District registered 12 percent yearly incidence in HIV negative partners of HIV positive people, even as overall prevalence fell. Not surprisingly, risk of transmission increased with viral load (Quinn, Wawer, Sewankambo et al 2000). This means that marriage leads to greater risk over time.

Gender power relations are significant. In

Masaka, "men are twice as likely as women to bring HIV infection into a marriage, presumably through extra-marital sexual behaviour" (Carpenter, Kamali, Ruberantwari et al 1999:1083). Over a seven-year period, married women with HIV positive spouses, especially women age 13 to 24 years, were 70 times more likely than male spouses to seroconvert. Discordant couples showed more than twice as much widowhood, separation and divorce as seronegative couples, because seronegative men were likely to repudiate seropositive wives when their infection became known. Early separation might have protected spouses, but considerable family pressures were brought to bear on women to remain married, especially when bridewealth was involved. That is changing as awareness of risk grows.

Although they were offered free counseling, only 10-20 percent of seropositive persons in discordant relationships came to the project offices to learn their test results. All those couples needed to use condoms, yet neither project at the time conducted interactive community-based interventions that addressed the question of condom protection within marriage. I was told that there was no money for this in the Masaka project budget. Neither was partner notification a priority.

In April 1992 the newly constituted Ethics Committee of the Uganda National AIDS Commission requested a review of these and other research projects' proposals for renewed funding. I raised questions about the ethical and human rights issues involved in cohort research that provides less than state-of-the-art prevention, including STI treatment (Schoepf 1995). Similar questions are raised by Marcia Angell (2000), who notes that from 1998, U. S. guidelines advise medical practitioners to see that seronegative partners are informed of their special risk. But since in Uganda and elsewhere in Africa (eg. Vidal 1995), most seropositive persons are not told of their status, a Tuskegee-like situation prevails.

Fear of stigma and knowledge that they will not have access to life-prolonging treatment also keeps people from seeking to learn their serostatus. The demonstrated relationship between treatment and prevention underscores the need to provide wide access to anti-virals (Farmer 2001). In Uganda, cost has been reduced to $350 per year, but half of those to whom it was offered on a trial basis dropped out as a result of inability to pay. Free treatment is another way to protect seronegative partners.

Contrary to common belief, a 1989-90 survey in Kampala and Jinja found that polygynous marriage does not protect women from infection (Carael, Ali and Cleland 2001). About one-third of marriages in Uganda were polygynous according to the 1988-89 DHS survey.

Epidemiologists now advise that prevention of transmission to young women will stem the HIV epidemic in Africa (Laga, Schwartlander, Pisani et al 2001). While delayed sexual debut protects young women in the years that they abstain, in areas of high background prevalence, many who marry may be at risk at first intercourse with their older husbands, especially as second wives. If husbands are infected subsequently by wives or outside partners, young wives are progressively more at risk each year. Thus falling prevalence or even incidence in adolescent women is no cause for complacency.

Culture Change

Multi-faceted, multi-sectoral social mobilization took place once the danger became known to Uganda's leaders. Some other countries followed, albeit more slowly, and less completely. Zambia, for example, has registered declines in prevalence. The critical factor in Uganda's behavior change is the openness that came with broader political economic change and culture change. It is possible for people to talk about sex, including protecting girls from coercion and sexual violence, about marital fidelity, and about condoms in ways they could not even imagine fifteen, or even ten, years ago. This humongous cultural change took place in response to critical reflection by people variously situated in a society faced with mounting deaths from AIDS. Some undoubtedly responded to religious preachments, but such preachments, which began in the late 1800s, have had only modest effects until

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recently.

Many rural communities have formed committees to support orphan care. Churches have been active in such support. Some communities have eliminated traditional widow inheritance on the assumption that husbands who died must have had AIDS and, therefore, their widows are infected. Widows, who then lose their homes and access to land, must find ways to fend for themselves and any children they are allowed to retain. Many migrate to towns where sex work is their only recourse. Funerals have been shortened and fewer people attend, to lessen the expense. They are held during daylight hours, and disco dances are prohibited, as ways of reducing casual sex. In other words, some changes are positive, while others may have unforeseen negative consequences.

Not surprisingly, culture has changed most markedly among urban, educated people. Recent interviews with Ugandan professionals and small business people who travel between Boston and Kampala indicate that high awareness of risk has prompted high levels of condom use among casual partners, and abstinence or condom use among young engaged couples until they take an HIV test prior to marriage. "*It has become acceptable to discuss such issues. Men use condoms with girlfriends and casual partners, and some even use them with their wives…. Girls use them with steady boyfriends. They tell them it's healthier for contraception…. It's now considered obscene not to use a condom,"* said a 38-year old man in a committed relationship. The couple have two children, and *"two is enough, especially since I have to send money home to my family."* Talk about contraception removes the trust issue (Schoepf 1993).

Conclusion

Uganda's good news is remarkable. Nevertheless, 5 percent national adult HIV prevalence means that more and better condom promotion is needed. Religious leaders who refuse to allow condom promotion as *part* of the solution contribute to the likelihood of infection within marriage, as well as among "core transmitters." This comes to the crux of my argument. It is not simply a matter of some groups stressing A and B, while others propose A, B and C. That would be fine if C could be promoted without hindrance. However, some religious leaders and FBOs in Uganda and elsewhere *actively oppose* condoms, and use AIDS to advance a politico-moral agenda. This is to the detriment of many people whose life situations place them at risk because social structures create limits to their agency. That is why I am opposed to funding such groups for *prevention* activities, as opposed to patient care and orphan support.

Green (2003) criticizes the share of prevention funds allocated to condoms, while acknowledging their spotty distribution and intermittent supply. In my view, more not less money needs to be allocated to condoms, quite apart from other funds for treatment and family support. Anthropologists need to be clear about this. Condom logistics are difficult. Supplies must be constant and reach into rural areas not yet covered. The programming and management skills needed to do this are not cheap; they are extremely demanding in resources and labor. Moreover, they must be promoted by creative campaigns using multiple channels that speak to the realities of people's lives so that they can make the best of less-than-optimal situations. Making the different parts of a prevention program compete for insufficient funds is a way to see incidence and prevalence rise. There is too much at stake in Uganda and elsewhere to let this happen once again and anthropologists need to make their voices clear on this issue.

CONNAISSIDA's action-research in Congo/ Zaire showed how unequal power relations and poverty determined by the structure of the wider society, limited the possibilities of many highly motivated poor women and men to alter their behavior. Uganda is not yet out of the woods. Without widespread implementation of interactive and non-prescriptive community-based prevention, coupled with access to treatment and continuing broader cultural change, we can expect differences in the incidence of new HIV infections to follow

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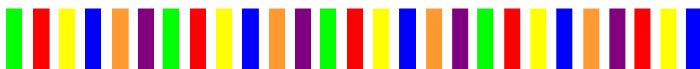
existing differences in power and access to information.

Since paradigms used to promote prevention influence policy and funding, it is essential to attend, not just to ABC, but to wider issues of patriarchy, inequality, job creation and broadly based development. Ethnographic action-research is a means of understanding these issues from below and within in ways that KABP surveys, focus groups and rapid
appraisals cannot.

Before we go all out in attributing Uganda's declining prevalence to behavior change, which many believe to be the most likely cause, we need to remember first, that this is a rapidly changing virus and many biological processes in virus-host interactions are not well understood. Second, WHO



Ensnared By AIDS:
Cultural Contexts of HIV/AIDS In Nepal
David K. Beine

About the book:

The way people make sense of illness is, in part, culturally determined. Existing beliefs and presuppositions shared by a community (cultural knowledge) regarding illness play a significant role in shaping an understanding of newly emerging illnesses in any given culture. This cultural knowledge is organized as cultural models, which are utilized to "make meaning" of new situations such as the HIV/AIDS epidemic. These cultural constructions (cultural models) of illness can also contribute to the spread of the epidemic. *Ensnared By AIDS: The Cultural Contexts of HIV/AIDS in Nepal*
examines the meaning and cultural contexts of HIV/AIDS in Nepal where AIDS is a relatively new and rapidly growing problem. Until now little had been known about how Nepalis understand the illness locally known only as AIDS rog. This book presents the results of a long-term study that examines the process by which the development of Nepalese cultural models of HIV/AIDS is occurring. It also introduces various illness schemata that underlie and inform these cultural models.

This book is based on the findings of two distinct studies conducted over a sixteen-month period in two locations of Nepal. The first study, employing traditional ethnoscience methods, explores illness beliefs and practices in rural Gorkha District of central Nepal. The findings suggest an emerging cultural model of HIV/AIDS that is based on an
integration of 1) indigenous concepts (placing HIV/AIDS into a existing illness classification paradigm), 2) Western-based HIV/AIDS prevention education messages, and 3) public discourses of HIV/AIDS. The second study, based on the linguistic analysis of thirty texts collected from persons with AIDS (PWAs) living in the capital city of Kathmandu, illuminates emotional and contextual aspects of the contested cultural models. It also discriminates between meanings of HIV/AIDS shared by those who suffer with it and members of the wider culture. Both studies are used to examine the cultural contexts and underlying schemata (universal and local, cultural and biological) which are involved in the construction of cultural models of HIV/AIDS in Nepal.

This book represents the first long-term field study of the cultural dimensions of HIV/AIDS in South Asia. It is also one of the few ethnographies of HIV/AIDS to emphasize the depth and diversity of the people's view and construction of the emerging illness. And it is the only HIV/AIDS ethnography to utilize a discourse analysis (linguistic)
approach.

Although this book is written primarily for scholars of Nepal, other scholars such as anthropologists (especially medical anthropologists), social epidemiologists and public health professionals (especially health educators

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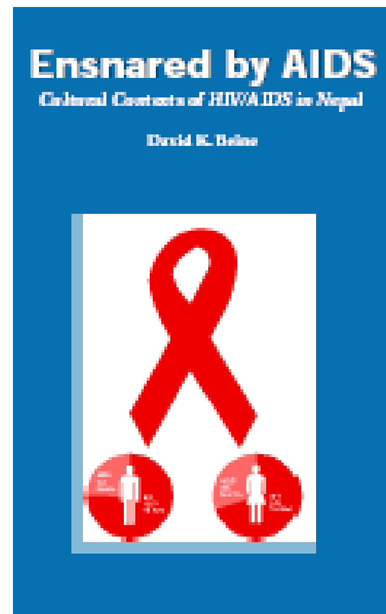
working with international NGOs) would also enjoy the topics covered. It may also be of theoretical and methodological interest more widely to cognitive anthropologists, cognitive linguists and psychological anthropologists because it explores the relationship between cognitive schemata and the creation of cultural models of meaning and provides a better understanding of how people incorporate new ideas into established cognitive systems. Cognitive linguists would also be
interested because the successful use of the narrative analysis method provides cross-linguistic validity to the discourse analysis model, a relatively new model of linguistic research.

About the author…

David Beine holds a Ph.D. in anthropology from Washington State University (2000) and was affiliated as a research scholar with Tribhuvan University, Department of Sociology/Anthropology, Kathmandu, Nepal during the tenure of his doctoral research (1998-2000). The findings of this research serve as the basis for this book.

Dr. Beine's interest in South Asia first began in 1988 when he traveled to India and Nepal to live for three years to conduct linguistic research that would later culminate in the publication of his linguistic anthropology Master's thesis, "A Sociolinguistic Survey of the Gondi-Speaking Communities of Central India" (San Diego State University, 1994). Following that he and his family again lived and worked in Nepal during 1995, 1998-1999 and 2000-2001. He currently resides with his family in Spokane, Washington and teaches summer courses in cultural anthropology in Eugene, Oregon. Dr. Beine also spends significant time in Nepal yearly and continues his involvement in applied anthropology and



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Encourage student submissions!

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