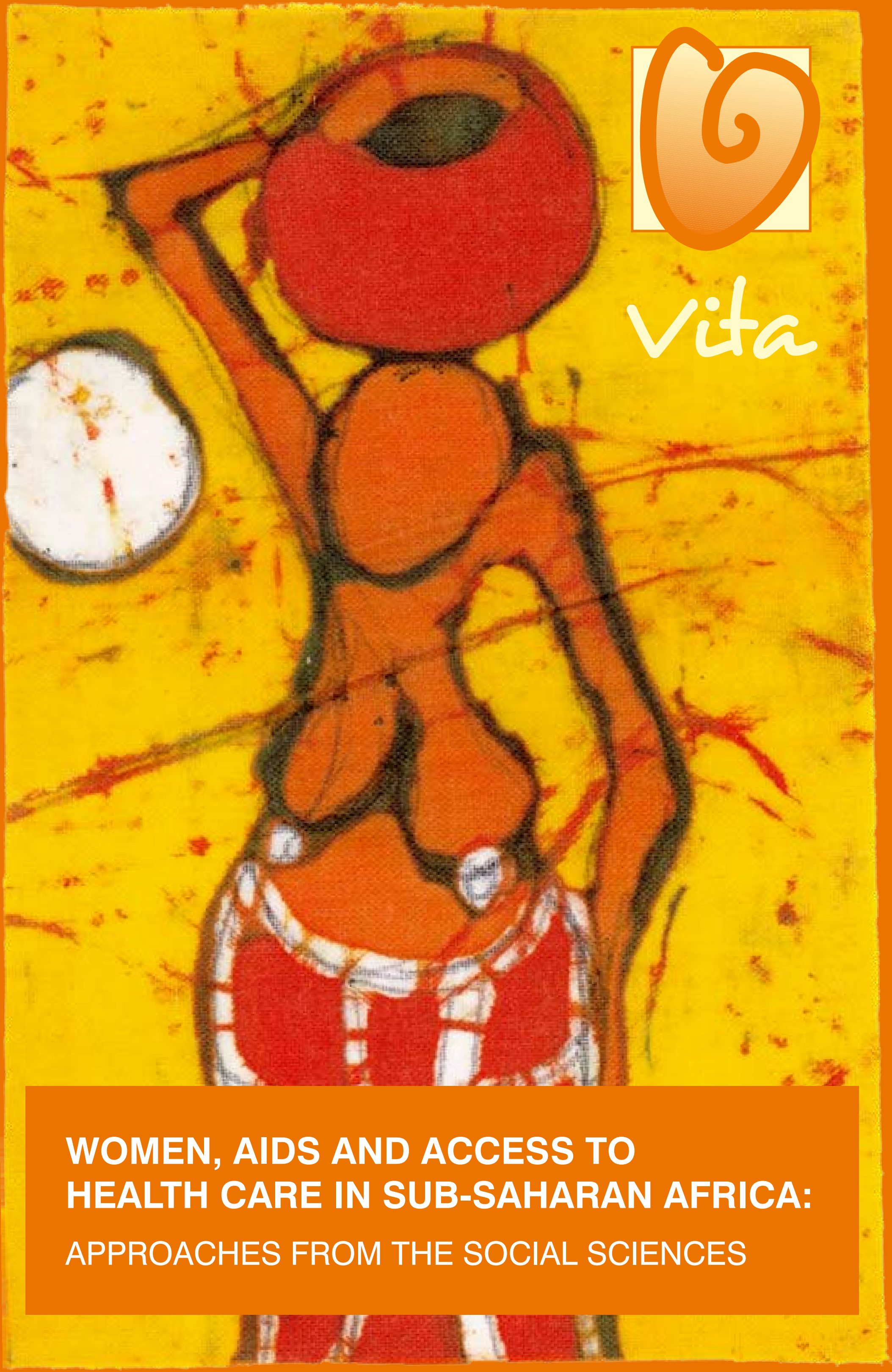

Vita

WOMEN, AIDS AND ACCESS TO HEALTH CARE IN SUB-SAHARAN AFRICA:

APPROACHES FROM THE SOCIAL SCIENCES

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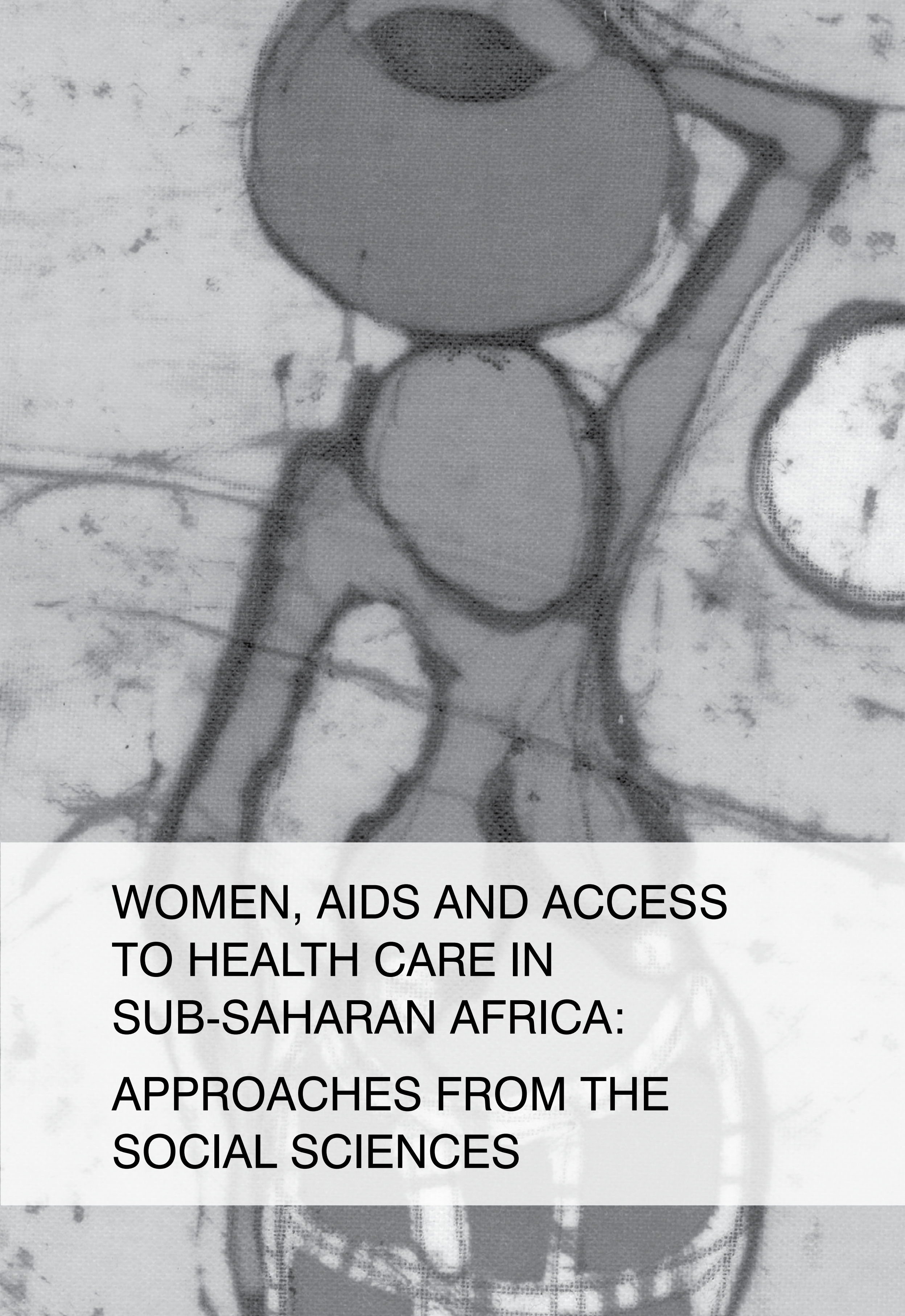

WOMEN, AIDS AND ACCESS TO HEALTH CARE IN SUB-SAHARAN AFRICA:

APPROACHES FROM THE SOCIAL SCIENCES

PROLOGUE

Leire Pajín Iraola
Office of the Secretary of State for International Cooperation
Ministry of Foreign Affairs and International Cooperation

On the occasion of International Women's Day 2006, representatives of various organizations as well as of the governments of Spain and several African countries attended the first Meeting of Women for a Better World, held in Maputo, Mozambique. At the initiative of our government and that of the host country, for the first time in the history of Spanish international cooperation we had the opportunity to lay the foundation for effective development work in Africa, premised on a gender perspective.

One of the fruits of the Maputo meeting was the "Mozambique Declaration", in which we find, among other commitments, to improve women's access to health resources and services in order to promote greater health and well-being, and to adopt measures to mitigate the impact of HIV/AIDS.

The 2005-2008 Master Plan for Spanish International Cooperation features the commitment to work from this perspective. It defines gender as one of the priorities in all areas, considering the enhancement of women's capacities and autonomy to be an essential element in all international cooperation activities.

Also worthy of note as a mechanism of coordination among the actors involved is the VITA[1] Program, which includes among its areas of endeavor the struggle against infectious disease, with special attention to HIV/AIDS. Thus it is that the executive secretary's office has given its support to this publication, which marks the beginning of the realization of the commitment made in the Maputo meeting.

In addition, the Africa 2006-2008 Plan highlights the political relevance given to the continent closest to our country. With the drafting and implementation of this plan, there is now a firm basis for a real commitment to the continent, and specifically to the region of sub-Saharan Africa. We should be aware of the "closeness" of African men and women in all senses of the word. Globalization, although it has in part accentuated international inequalities, has also brought the reality of the most impoverished countries closer to that of the richest countries.

These points of departure strengthen the commitment of the Spanish government to work toward the promotion of equality between men and women, with special emphasis on women's autonomy, access to resources, and decision-making ability.

The first stage in the realization of this commitment took place during the workshop held in November 2006 in Barcelona, entitled "The social sciences and African women's access to sexual and reproductive health and HIV/AIDS services". The participants in this workshop were international experts, mainly Africans, who presented and discussed efforts to reduce the impact of AIDS in Africa, with special emphasis on the type of social and community approaches that are necessary in order for this work to be effective.

It is necessary to recognize the relevance of structural factors that place certain populations at higher risk for certain diseases. The quality of health services and of public services in general, communication and transportation, support for human rights, the quality of educational systems, the concept of sexuality and the feminization of poverty, among others, are factors directly related to the likelihood of contracting AIDS or gaining access to treatment. It is also necessary to keep in mind the importance of the social construction of illness, and how essential it is to approach the problem from a broad, multicisciplinary perspective.

The fruit of the work originating in Maputo and initiated in Barcelona, the experiences of the participants in the workshop and the consensus and conclusions arrived at, are the results presented in this book. It is our hope that this document will reach institutions both public and private, Spanish and African, engaged in the struggle against AIDS, and that it will enrich their work. In this way we seek to improve the quality of development activities aimed at reducing the impact of AIDS so that together we may strive to achieve goal number 7 of the Millenium Development Goals, which are also the objective of Spanish international cooperation.

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[1] See www.aeci.es/vita

Acknowledgments

We wish to thank our colleagues who participated in the conference ***Contributions from the Social Sciences to Public Health and HIV/AIDS Programs in Sub-Saharan Africa,*** held in Barcelona in April 2006, but were not able to participate in the making of this book because its theme was more narrowly focused. Their contributions to the 2006 conference gave us the confidence and enthusiasm to move forward with this project: Anna Cirera, Josep Maria Comelles, Manuel Corachán, Helena Drobna, Silvia Ferazzi, Juan Garay, Asunción García, Emidio Gune, Sara MacKian, Ángel Martínez Hernáez, Cristina Larrea, Alphonse McDonald, Clément Mufuzi, Michael Muyonga, José-Antonio Nieto Piñeroba, Claudia Quiceno, Izabella Rohlfs, Oriol Romaní, Batuke Walusitu and Gustavo Wilches-Chaux.

We also wish to thank our invited guests who attended the conference and participated in the post-conference workshops: Nee Mensah Afiavi, Ngary Sylla Ba, Assumpta Lucienne Françoise Bella, Atte Diop, Joyce Dodoo, Margaret Kimoli, Gebre-Egzbiabher Kiros, Damen-Haile Mariam, Muluken Melese Aseresa, Marina Margarida Montenegro Agorostos Karagianis, Chiratidzo Ellen Ndhlovu, Elizabeth Mwikali Ngala, Etienne Nnomzo'o, Samson Hezron Winani, Tsegay Legesse Woldeyohannes and Justine Zue Essono.

Laura Mascarella's suggestions were very useful in developing the working methodology we used during the week of November 20-24, 2006, during which this book came together as a collective project through the exhilarating process of intensive discussion, debate and sharing of ideas.

The VITA Program team, and the AECI international cooperation branch offices and Spanish embassies in the participants' countries of origin, expedited visa applications for the participants and assisted with other logistical matters.

Finally, we are deeply grateful to the experts who responded positively and enthusiastically to our invitation to participate in this project despite the extremely short deadlines and the extraordinary effort required to meet them.

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INTRODUCTION

María Cristina Álvarez Degregori
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On the occasion of International Women's Day, during the Meeting of Women for a Better World held in Maputo, Mozambique on March 7 and 8, 2006, and organized by the governments of Mozambique and Spain, African and Spanish women came together to reflect on the rights of women and reaffirmed their commitment to the promotion of gender equality and women's autonomy. One of the central themes of the Mozambique Declaration that emerged from this gathering concerns improvement in women's access to health resources and health care services, and the development and implementation of measures to mitigate the impact of HIV/AIDS on women and children.

A month following the Mozambique Declaration, within the framework of the VITA projects[1], Medicus Mundi Catalunya[2] organized a conference in Barcelona on "The Contribution of the Social Sciences to Public Health and HIV/AIDS Programs in Sub-Saharan Africa"[3]. This conference started from the premise that many of the key indicators for measuring progress on the Millenium Development Goals are related to the health of populations. At the same time, however, it is evident that, in large measure, these indicators depend on several factors related to North-South inequalities, structural weaknesses in developing countries and in their health systems, and sociocultural factors whose interaction with biological determinants of disease shapes a complex scenario in which social determinants play an important and sometimes definitive role in the success or failure of health programs.

The aim of the conference was to sensitize the participants to the contribution and potential of the social sciences for a holistic, interdisciplinary and multisectorial approach to the HIV/AIDS pandemic, with a focus on public health in general and this case in particular, from a broad perspective in which the social sciences can contribute conceptual frameworks and useful instruments for planning, analysis, implementation and evaluation of health projects and/or health policies.

We used that opportunity to bring together experts in the social sciences, both Spanish and international, several from Africa including representatives of WHO and UNESCO-UNAIDS, to present, in a manner both conceptual and applied, an itinerary of the principal objectives for a social-scientific approach to public health programs. We also invited 14 health professionals – experts from health institutions in sub-Saharan Africa involved in local programs to combat HIV/AIDS – as well as representatives of NGOs, international cooperation agencies, international bodies, funding agencies, and other actors involved in analysis, research, or implementation of health programs, with special interest in those focused on the struggle against AIDS in Africa. In short, a cross-cultural as well as cross-disciplinary encounter took place.

The idea for this book was conceived during that conference, when the participants, working together towards developing a set of conclusions for the event, expressed a desire to continue deepening their understanding of the subject from the same perspective, but focusing on key themes for public health, and at the same time to maintain the spirit of exchange at many levels – interdisciplinary, interterritorial, intercontinental, interinstitutional and even interpersonal – which had so enriched their shared experience over the course of two very intense days. It was a process of exchange involving both knowledge and experience capable of transcending the encounter and being of use for all those who struggle with public health problems crosscut by social and cultural realities that the social sciences can bring into sharper focus in order to make them better understood.

The subject of this book arises out of the Mozambique Declaration's own language, an agreement to "improve women's access to health services and to fight tropical and infectious diseases, especially HIV/AIDS" (Mozambique Declaration on Women and Development 2006). It is also inspired by the experience of Medicus Mundi Catalunya in Mozambique, which is based on a sociomedical approach to improving women's access to health services. This approach is already yielding very positive results from an applied social science research project carried out by an interdisciplinary team of physicians,

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[1] http://www.medicusmundi.es/catalunya
[2] http://www.jornadaSidafrica.org
[3] http://www.aeci.es/vita/

anthropologists, social educators, and a social geographer.

In this context, **women** and a**ccess to sexual and reproducive health services** are the key ideas that move back and forth between two realities: one directly related to health indicators showing the vulnerability of women with respect to their sexual and reproductive health in countries with the lowest income levels; and the other related to structural imbalances in fundamental rights, where women represent the most fragile component. Unlike any other illness, **AIDS** and its development in **sub-Saharan Africa** has sharpened our awareness of the fact that public health is many-sided, and that in the planning of interventions, whether focused on prevention, treatment, and medical care or on evaluation of program results, both medical and nonmedical issues must be taken into consideration.

Starting with this perspective, a project was designed for the construction of this book, based on a common theme focusing, from a social science perspective, on key topics in women's access to health services in the context of AIDS in sub-Saharan Africa. These topics determined the list of invited experts who participated in the work, most of them also participants in the 2006 conference. Each participant was asked to prepare a chapter focusing on his or her area of expertise and professional experience, developing it in accordance with the guidelines established for contributions to the project. The core of the project was a five-day workshop bringing together all the participants, who brought with them their chapters in draft form.

During the first two days of the workshop, each author presented his or her chapter, and following each presentation there was general discussion among all the participants. In order to facilitate communication, there was simultaneous translation in three languages (English, Portuguese and Spanish). The third day of the workshop was reserved for individual work on chapters in response to the exchange of ideas from different disciplinary perspectives during the two previous days. Finally, during the two remaining days the participants re-presented their revised chapters to each other, and developed some general conclusions out of the week's collective work.

Elizabeth Maadra, the author of the prologue, was not able to be present for the workshop, but thanks to electronic communication, she remained in touch with the process and had available to her all the information it produced.

This book is the product of eight months of intense work that took shape over several stages: conception of the project and framing of its conceptual basis; selection of experts; definition of the working methodology to be followed; the planning and realization of the workshop; and finally, the editorial preparation of the volume.

Following is a brief overview of the book's contents, organized by chapter and author:

In **Chapter I**, *"Access to Sexual and Reproductive Health Services in Mozambique: An Analysis of Organizational Culture and Institutional Obstacles"*, **Cristiano Matsinhe** questions analyses of the accessibility of sexual and reproductive health services, including those for the prevention and treatment of HIV/AIDS, that emphasize "sociocultural aspects" and scarcity of material and human resources. In his own analysis he includes in the domain of culture the formal and institutional aspects of these services, arguing that access to and quality of health services are also socially constituted and characterized by practices, values and habits that are culturally and contextually established and must be constantly reevaluated, independently of the scarcity of material, financial and human resources.

In **Chapter II**, *"Inequalities and Values in Reproductive Health: Women's Vulnerability in the Context of the Feminization of AIDS,"* **Ana María Loforte** points out that reproductive choices and access to sexual and reproductive health services are conditioned by gender inequality, stigma and discrimination in a context of high HIV/AIDS prevalence. At the center of Loforte's analysis is the concept of gender understood as relational and transversal, in interaction with cultural capital, as the consequence of social processes and not as a condition that defines different levels of vulnerability. This analysis focuses on three dimensions of vulnerability – behavioral, cognitive and programmatic – that shape the difficulties women experience in gaining access to services and to adequate medical and preventive care for HIV/AIDS.

In **Chapter III,** *"Notions of Sexuality: Responding to the Dreams and Desires of Young People Perinatally Infected with HIV in Uganda"*, **Harriet Birungi** argues that AIDS programs must take into account the sexuality, dreams and desires of young people who are HIV-positive in order to offer them effective guidance on matters of sexuality that will enable them to make informed decisions and balance their sexual and reproductive rights and responsibilities. The author focuses on the need to involve program managers, political leaders, and beneficiaries in strengthening the link between research and health interventions, since a nearly exclusive focus on the negative health implications of sexual activity prevents the development of a broader approach to sexuality and its inclusion in HIV/AIDS programs.

In **Chapter IV,** *"The Multiple Dimensions of Vulnerability to HIV/AIDS in Africa: A Social Science Perspective",* **Ezekiel Kalipeni** and his colleagues develop a conceptual framework for identifying the main causes of vulnerability in the HIV/AIDS epidemic in Africa.. They take note of multiple dimensions of vulnerability that constitute an intricate assemblage of obstacles that limit access to medical care especially for women and children. The central argument of the chapter is grounded in the authors' conviction that the analysis of these multiple dimensions of vulnerability can offer useful knowledge for structuring interventions in a way that reduces the severity and impact of the disease.

In **Chapter V,** *"The Experience of Community Participation in Access to Sexual and Reproductive Health Services in Mozambique"*, **Elsa Jacinto** analyzes the experience of the Mozambique Ministry of Health, which adopted the strategy of integrating services at the level of primary health care. This permitted the optimization of scarce resources, and the empowerment and participation of communities in health-related activities in order to improve access to sexual and reproductive health services and HIV/AIDS-related services.

In **Chapter VI,** *"Overcoming Obstacles to the Provision of HIV/AIDS Care, Support and Treatment. Public, Private and Civil Society Partnership – The TASO Uganda Experience"*, **Noerine Kaleeba** analyzes Uganda's success in reducing HIV prevalence from 22 percent to 6 percent in less than 10 years. This success is attributable in large measure to The AIDS Support Organization (TASO), an association that began as a public, private, and civil society partnership with strong support from the country's president. TASO has been instrumental in the development of an extraordinary openness at different levels of society in the face of the pandemic, and this openness is a key factor in the results achieved. Through the TASO experience, the author builds an argument for a holistic approach in the social response to the epidemic, with special attention to the most vulnerable populations: women, children and the poorest of the poor.

In **Chapter VII,** *"Media as Medical Intervention: HIV/AIDS and the Struggle for Women's Reproductive Health Care in South Africa"*, **Susan Levine** describes her experience with women in the course of a research project with a mobile cinema unit that brought non-directive documentary films to audiences in communities marked by silence and the fear of AIDS. This chapter discusses the role of stigma and structural inequality as the principal obstacles preventing women's access to adequate health care. The study shows how it is possible to reduce or even eliminate these obstacles through media advocacy, whose aim is to initiate discussion about HIV/AIDS, breaking the silence that intensifies women's feeling of isolation, stopping them from seeking health care in both rural and urban areas of southern Africa.

In **Chapter VIII,** *"Sexuality and Gender Relations in HIV Transmission: Proposals for Research on Prevention"*, **Arachu Castro** advocates research as a way of anticipating obstacles that may be encountered in the distribution and use of barrier methods such as microbicides for the prevention of HIV infection.This study of the "economy of sex" refers to the complex personal and social space in which sexual relations take place. The principal idea of the chapter is that the study of the social function of sex is crucial in preventing transmission of HIV.

In **Chapter IX,** "*Rapprochement or Resistance? Utilising Traditional Healing Principles and Practice* *to Enhance HIV/AIDS Treatment in South Africa"*, **Joanne Wreford** explores difficulties in the relationship between biomedicine and systems of African traditional medicine that limit the benefits of a potential ally in the struggle against AIDS in South Africa. A combination of social, economic and cultural factors come together to make traditional healers a real alternative to biomedicine, and often the first resort. The author questions the unidirectional and educational approach often adopted in collaborative efforts between Western physicians and traditional healers, and proposes instead a broader approach to intersectorial cooperation involving appropriate use of the traditional pharmacopeia and ritual practices of amagqirha/izangoma in the design and practice of medical interventions for HIV/AIDS.

In **Chapter X,** *"Medical Pluralism in Africa"*, **Joan Muela** presents a conceptual framework for doing research on medical pluralism centered on its ethnographic dimension; that is, on the analysis of how different illness representations, practices, and medical institutions coexist and are used in a given community or region. From an applied perspective and with public health programs in mind, the author presents a series of domains that require study in order to understand the use of and access to different healing systems in a given population. These include the characteristics of different medical traditions, representations of illness, social proximity in the therapist-patient relationship, cultural proximity, and specialist charisma.

In **Chapter XI,** *"Addressing Sexual and Reproductive Health Needs: Appropriate and Timely Use of Qualitative Research Methods"*, **Iqbal H. Shah** describes the unique scientific potential offered by qualitative research methods for understanding and analyzing sociocultural and behavioral factors that cause people to be exposed to the risk of HIV infection or to sexually transmitted diseases (STDs), and limit their use of health services. At the same time, he offers a critical review of the application of qualitative research methods in public health, and points out the factors that either limit or facilitate their use and programmatic impact. He proposes triangulation of one or more qualitative methods with a quantitative method as the optimal approach on which to base health policy decisions.

In **Chapter IX,** *"Critical Medical Anthropology Perspectives on Male Circumcision to Prevent HIV"*, **María Cristina Álvarez Degregori** reflects on the impact of male circumcision in sub-Saharan Africa as a strategy to prevent HIV transmission between women and men. In this chapter a series of co-factors are introduced which, because of the absence of ethnographic inquiry, are omitted in the majority of studies on which "pro-circumcision" policies are based. These co-factors are related to the processes, dynamics and cultural reinscriptions of meaning that may be generated by interventions into the social construction of masculinity, power imbalances in gender relations, sexual practices, and the vulnerability of women and girls to HIV infection.

To all these chapters, in simplified form, has been added a selection of the most relevant comments from the group discussions of the chapters during the final two days of the workshop. Naturally this does not reflect the richness of the exchange of ideas and experiences that took place; for that we would have to write another book. We feel, however, that it is important to include in the record, even if in highly summarized form, something of the interdisciplinary exercise that informed the final content of the chapters in this book.

This book is not intended to be a manual or research guide, but an introduction to a social science approach to the public health problem of improving access to sexual and reproductive health services – which is both one of the Millenium Goals and a fundamental human right – by those sectors of the population that are the most vulnerable: women in the context of the AIDS epidemic in sub-Saharan Africa. This is an approach that allows the reader to see common problems in everyday practice from a different vantage point; not a biomedical view, but one that contributes to clearer identification of factors often overlooked but of decisive importance in shaping the final results of health policies, programs, and projects.

This book embodies the inclination toward dialogue and exchange with which it came into being. For this reason, included at the end are the e-mail addresses of the authors and of Medicus Mundi Catalunya. All of us are open to contact with readers.

For all involved in the design of health policies, programs and projects aimed at facilitating women's access to sexual and reproductive health services, their implementation, or their evaluation, this book is a collective, unanimous and solidary message from the authors and from Medicus Mundi Catalunya, an encouragement to make use of insights from the social sciences in order to broaden the range of available knowledge and enhance the lens of observation in pursuit of better results.

THE MISSING LINK IN ADDRESSING THE CHALLENGES OF THE HIV/AIDS EPIDEMIC IN SUB-SAHARAN AFRICAN COUNTRIES

Dr. Elizabeth Madraa
National STD/AIDS Control Programme
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There is enough evidence to show that sexually transmitted infections, including HIV, remain unaddressed in reproductive health services; yet most HIV infections are both sexually transmitted and closely associated with pregnancy, childbirth and breastfeeding. In addition, the root causes of both reproductive health problems and HIV/AIDS are similar because they are related to social and cultural factors, poverty, gender, inequality and marginalization of the most vulnerable populations, particularly women. Therefore, forging closer linkages between sexual and reproductive health and HIV/AIDS would result in the significant benefit of achieving a reduction in HIV/AIDS infections through mother-to-child transmission. This, in turn, could result in achieving universal access to reproductive health services by 2015, reversing the AIDS epidemic, and mitigating its impact on these vulnerable groups.

It is now over two decades since the HIV/AIDS epidemic first devastated the world. While the situation in Europe and North America seems to be contained, Asia, Eastern Europe and Africa south of the Sahara continue to struggle with the severest impact of the epidemic. Africa south of the Sahara is now home to over 60 percent of the world's people who are HIV/AIDS infected. Earlier strategies developed for HIV prevention, care and treatment seemed not to have an impact on the reduction of new HIV infections in the region because HIV/AIDS strategies have always failed to include the missing link: cultural and social factors. We adopted and implemented strategies without consideration of the social and cultural environment within which people infected and affected by HIV/AIDS lived. Gender inequalities and the special vulnerabilities of women and girls were never taken into account in programs to prevent to HIV infection in this sector of the population. While it is known that HIV infection in Africa south of the Sahara is 80 percent heterosexually transmitted, this has not been linked to sexual and reproductive health among girls and women of reproductive age. Therefore more children continue to be born with HIV infection from infected mothers, and more girls and women continue to be infected with HIV.

Strategies to induce behavioral change have been designed and implemented without reference to insights from anthropology and other social sciences that would have increased the social acceptability of such critically important tools for HIV prevention as condoms. In addition, civil society and community-based organizations have been left out of the picture. The acceptability of services such as HIV testing and counselling, care and social support, and use of ARVs is negotiated in a broader social and cultural context that we cannot afford to ignore. If Africa is determined to bring the HIV/AIDS epidemic under control within the next 10 years, we must abandon these failed approaches and develop new strategies to address the drivers of the epidemic in Africa. We should focus on core groups such as sex workers, migrant laborers, internally displaced persons and refugees, and consider issues such as gender mainstreaming in HIV/AIDS, ensuring availability of barrier methods which women can own and control, human rights, poverty, war, insecurity, in- and out-migration, and other forces which have a significant impact on the success of any HIV prevention policy.

Finally, research on HIV/AIDS should not be the exclusive province of bioscience. Real progress will be made when behavioral and biological scientists design joint research projects which recognize that all illness, including epidemic disease, forms part of wider social and cultural processes and cannot be addressed independently of them. The introduction of new practices is likelier to meet with success if it is linked to existing cultural practices. It is time for Africa to design its own strategies to control the HIV/AIDS pandemic and lessen its impact on especially vulnerable groups. This book is a first step in that direction.

ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN MOZAMBIQUE: AN ANALYSIS OF ORGANIZATIONAL CULTURE AND INSTITUTIONAL OBSTACLES

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Faculty of Arts and Social Sciences
Departament of Archaeology and Anthropology
Eduardo Mondlane University, Maputo

"The question is certainly not to know whether the virus exists there before some curious gaze, but whether, from the moment it is transformed into a symbol of the illness with which it was constructed, it has explanatory power and is efficient in orientating effective intervention. It is a biological artefact, invented by scientists in the same way as all other human artefacts, from the wheel to the computer."

Sérgio Carrara, 1994

"Medical belief systems are specific to society which produces them"

K. White, 1991

SYSTEMS OF HEALTH AND BIOMEDICINE AS SOCIAL CONSTRUCTIONS

Ideas about health services, health systems and practices of the supply and demand of health services are not necessarily perceived and operationalized in similar ways in all contexts, especially when, in some cases, the central point of the question might have the same biological, physiological or organic basis, if we want to leave to one side other dimensions of illness, such as the spiritual dimension, for example.

This assumption prompts us to think about health systems and institutions from a relativistic, contextualized perspective, even while keeping in mind the globalizing dimension of the hegemonic discourse and representations of modern biomedicine which is, itself, socially constructed and as such, capable of being understood as such.

Proceeding in this way means keeping a constant opening for analysing the operational forms of health service delivery and understanding the mutations which constantly (re)configure their implications in the broadening of access, and the relevance and quality of services provided.

Maintaining a permanent (self) reflexive and analytical dialogue in relation to aspects of health and illness is not a new idea. Medical Anthropology of the 1960s, and even many years before this, pointed in this direction, underlining the importance of, amongst other things, studying the genesis and stucturing dynamics of health care institutions, even though the emphasis was placed, at this point, on institutions of mental health. (White 1990).

Other social scientists and anthropologists, especially those from the American tradition, invested in understanding the phenomenon of illness, distinguishing between its pathological manifestation or biological order, and individual and subjective perceptions of illness and the cultural order.

In parallel, the classical english ethnographies focussed on the need to understand the practices of cure, theories of illness, especially notions of dementia and body, witchcraft accusations, possession cults and cleansing rituals.

In all of this, meanwhile, as White (1990:2) rightly noted, various links were established between medical thinking and anthropology in the constitution of scientific and institutional practices, underlining two assumptions:

1) Biomedicine is not a natural science but rather actions which seek to transform a range of data and affirmative values into factual assumptions;

2) The professions and institutions are the result of political and social struggles, and not the outcome of natural objects capable of being scientifically apprehended.

Re-introducing these two assumptions and the fact that distinct representational constructions of illness and medical systems co-exist within a determined context, as Joan Muela's paper (included in this collection) demonstrates, aims at prompting the maintenance of heuristic vigilance over our own beliefs regarding health systems and their institutional apparatuses. We often take these as given, as natural, and if we proceed on this basis, we will obliterate the fact that they also can/must be objects of analysis to be taken into account in programmatic objectives. Finally, then, the success of a project, system or mechanisms for cure depends, in large measure, on the existence of networks of social relations which sustain it meanwhile as a discourse endowed with authority, form and working structures.

Looking into the institutional forms of health systems is not simply attempting to understand the internal dynamic of “rituals” of health service delivery (of modern and traditional medicine), but also broadening the framework of the wider context in which the experience of illness and cure is developed. As Foucault (1979:83) said, the process of creating norms for medical practice and knowledge takes place in a social and relational context.

This being the case, researching institutional practices of health service provision thus implies analysing interactive processes in their ideological, political and processual dimensions which confer particular characteristics upon the specific form of service provision and health systems, here understood as constituted by and constitutive of cultural reality.

Bringing the institutional domain into the territory of culture has the heuristic advantage of relativizing, and not endorsing a priori the modern representations which sustain our common sense ideas of medical practice. The idea of formal modern medicine should not be taken as imanent, autonomous and universally identical. Speaking of modern institutional medicine is to talk of different forms and mechanisms of institutionalization and tipification of practices associated with this notion, which vary as a function of context and a series of other conjunctural and contextual elements.

Looking into the institutional forms of health systems is not simply attempting to understand the internal dynamic of “rituals” of health service delivery (of modern and traditional medicine), but also broadening the framework of the wider context in which the experience of illness and cure is developed.

As tipifications, thereapeutic agencies or health systems are not only involved in the management of a corpus of valid knowledge, constituted in codes or language moves about the processes of definition, diagnosis and treatment of illness but also define and establish, consciously or unconsciously, the mechanisms of access and/or restriction to the services provided for them.

We need to understand institutions as the outcomes of interactive and communicative processes through which individuals construct a web of meanings for their experiences of affliction. In the constuction of meanings, inter-subjective and existential factors mingle with forms of interpretation which are culturally signified. From this perspective, cognitive structures should be analysed as the outcome of the social production of knowledge. Thus cognitive models should be analysed in their plasticity and their capacity to respond to situational challenges.

Institutions reflect society, it not being possible to conceive of exclusively biological, instrumental or aesthetic processes in human behaviour. The body is emblematic of social processes.

Any therapeutic agency, in defining its institutional areas of action, designs the situations which are found within these areas. Thus it is to be expected that within treatment agencies the conventional images held by the health workers of the patients reflect only that experience of illness which equates to the (stereotypical) cognitive stuctures relevant to these agencies. This is to say that every therapeutic agency reduces the diversity of social experiences to a given group or model of practices and routines. These in turn could mask the obstacles which limit the access and relevance of the services to be rendered to potential beneficiaries and clients, as we will see in the example taken from the Mozambican reality.

These questions are especially relevant in a context where a wide range of treatment services are available and used by individuals and collectivities, during the complex cycles of establishing meaning and demand for mechanisms of cure or relief in the face of illness.

HEALTH CARE INSTITUTIONS AS SUBJECTS AND OBJECTS OF CULTURE: THE CASE OF MOZAMBIQUE

In order to analyse the vast and complex institutional apparatus armed around the applied treatment clinics of the Mozambican health services, I will begin by shedding some light on the perceptions which the system itself and the health institutions have on their role and consequent shortcomings in performance.

In analyses generally made on questions related to the accessibility of sexual health and reproductive services, including those of prevention and care in relation to HIV/AIDS in Mozambique, emphasis has been placed on “socio-cultural factors” and the shortage of human and material resources.

The Strategic Plan for the Combatting STI/HIV-AIDS (MISAU 2004); The MISAU (2005) Strategic Human Resources Development Plan; The National Plan for the Combatting of HIV/AIDS (National Council for Combatting HIV/AIDS 2005) and the Plan for the Reduction of Absolute Poverty (Planning Ministry 2006) are the country's principal programmatic and strategic instruments which vehemently indicate the existence of functional lacunae in the national health system, resulting from the shortage of human and material resources.

Various other programmatic documents, such as the evaluation reports on initiatives of the programmes of sexual and reproductive health, such as the reports of the Geração Biz ('Generation Biz'/Youth-Friendly Health Clinics) Programme (2006) also point in this direction. Statistical indicators, such as those making up the Demographic and Health Survey (IDS 2003), where the principal data relating to behavioural aspects and the performance of the national health network indicate, in quantitative terms, slight annual increases in the numbers benefitting, in terms of access, to health services, including mother-child health and sexual and reproductive health for adolescents and youth.

The idea of formal modern medicine should not be taken as imanent, autonomous and universally identical. Speaking of modern institutional medicine is to talk of different forms and mechanisms of institutionalization and tipification of practices associated with this notion, which vary as a function of context and a series of other conjunctural and contextual elements.

What these documents emphasize is the existence of operational lacunae in the national health system, consequent upon stated structural limitations in the:

1) **Geographic distribution of the health network,**
2) **Level of precariousnes of the health infrastructure available in the country;**
3) **Unavailability of material resources and personnel in health units;**
4) **Shortage of medical stock and/or lack of pharmaceuticals ;**
5) **Shortage of qualified personnel in the health system;**
6) **A low ratio of doctors per inhabitant;**
7) **Drain of public health service personnel into non-governmental organisations with more attractive and competitive salaries.**

At the top of the long list of "things" and services that the national Mozambican health system "lacks" is the issue of the non-existence or degraded state of the infrastructure.

This being the case, the focus of planners aiming to improve the national health delivery system is, consequently, the broadening of access to health services, the latter being defined as a measure associated with the quality of services provided, being centred on improvement, construction, implantation of health system infrastructures, reduction of regional imbalances in terms of distribution of health units and placing of more qualified "cadres" in health units, moving on to the training and re-skilling of existing health professionals.

Apart from the self-diagnosis made by the national health system, other relatively similar readings and interpretations have come out of indirect analyses of specific programmes such as the sexual and reproductive health programme for adolescents and youth called Geração Biz ('Generation Biz'). This programme (PGB) has been implemented, since 1999, with the assistance of the United Nations Population Fund and Pathfinder International, in partnership with the Ministry of Health, Youth and Education.

The actions of this programme are directed towards, amongst others, responding to the needs of adolescents and youth in the area of sexual and reproductive health, having a strong clinical component associated with the national health network, which is the component known as 'SAAJ' (Serviços Amigos dos Adolescentes e Jovens/ Friends of Adolescents and Youth Service), apart from its school and community components. This component is realised through a shared Programme partnership with the Health Services, where space is available and a specific number of health professionals have been trained in practices "welcoming to adolescents and youth".

Generally the SAAJ component is implemented by female health providers, who are given about 80 hours of training, by PGB, and are incentivized to work in a unit annexed to or near the other health units. It is in these adjacent spaces that the SAAJ operates, as units directed to the provision of counselling services to adolescents and youth.

The quantitative indicators of the Geração Biz programme in relation to SAAJ point to the fact that despite the services provided in these clinics being aimed at both boys and girls, the majority of people attending are girls and they do so not exactly for counselling on other aspects of sexual health and reproduction, but in order to obtain pre-natal assistance, when they discover the onset of a pregnancy.

In this programme two principal elements stand out: the first is that in the places where an SAAJ unit operates there is an effort to improve material conditions and make available resources which make the environment "welcoming", with medecinal resources and an environment which favours the holding of seminars, with audio-visual resources and which also has space for counselling, with the necessary privacy for clients. This first element refers to the material aspects conceived of as the minimum requirements, with the right to certification, with its own stamp, developed for the purpose, as being the appropriate installations for the provision of a worthy and attractive service for youth.

To insist on analysing the health system and its results with an emphasis only on questions of material forms and not of its semantic content, as happens in Mozambique, means, perhaps that the system is rooted in a perspective which does not take into account the fact that formal medicine does not take place only in the pure codification of the organization.

A second part refers to the investment needed to train the health service providers who are to attend to the youth seeking out the SAAJ. The emphasis in the training modules aimed at these health professionals is on the aspects of cordiality, friendliness and respect for the positions or idiosyncracies of adolescents and youth so that they should feel welcomed by a professional who does not make value judgements in relation to the client's sexuality, but who attempts to provide appropriate assistance and the reception necessary for the specific case.

Despite all the praise which has accompanied the programme performance evaluations, important aspects of these evaluations touch on the question of the disparity of time during which the service providers are available to assist youth, which is considered very little; and the fact that these services are considered by too many health administrators as a separate project, with some financial resources, and which could be attractive to house a reduced number of "selected" providers, who are seen as beneficiaries of the eventual additional incentives coming out of the programme, (which could include training sessions or trips to exchange experiences).

Despite the efforts to integrate and absorb the programme's concept into the national health system, and despite its having been inscribed, in various strategic documents, as a model to follow, the SAAJ is relatively marginalized in the health service provision process and is still not incorporated as part of the routine tasks of the health system. A dramatic example of this process of partial appropriation of the programme was found in Zambézia Province, in the district of Nicoadala, where the SAAJ functioned in an installation annexed to the main health unit. But when the Programme for the Prevention of Vertical Transmission was instituted, with help from USAID, with more financial resources at that time, it was the first to be closed in order to make space for a new programme.

The health providers interviewed in relation to the interruption of the programme underlined the fact that since there was no longer any clarity over the continuity of the programme assisted by Geração Biz, and also since the only two people who had been directly exposed to the project were now no longer available, it was judged convenient to proceed with the changes made in the provision of space.

What was dramatic about this change was that the adolescents and youth who frequented the programme, as community activists who complemented and helped the specialised service providers were not ever informed about the changes underway. And the irony in all of this is in the notion of the 'Friends of Adolescents and

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1 The paper by Elsa Jacinto, also included in this collection, underlines another aspect which corrleates with this notion of the SAAJ, which is the idea of "Humanizing Childbirth" institutionally, which has implications for the way relations between pregnant women and health service providers are conceived.

Youth Service', which was sought to institute and generalize within the health network: the idea that it is possible to render assistance in a more attractive and welcoming form for the users of the health services[1].

This angle, associated with the quality of services rendered, the manner in which they are provided, the readiness of the institutional apparatus to respond to or dialogue with users of the health services does not usually appear in the annual global reports on the performance of the health sector.

What is generally highlighted in these evaluations is a long list of shortages of material goods, such as vehicles, laboratories, pharmaceuticals, equipament and other things. No mention is made of institutional culture, its forms of functioning, except through warnings in expressions which allude to corrupt functionaries demanding from clients illegal payments for services which should be rendered free of charge. Other cases mentioned are linked to violations of the code of professional ethics through lack of confidentiality of some personnel who reveal the sero-status of people taking the HIV test.

This type of approach is highly reductionist, unidirectional and conceived in a diadic perspective of opposition, to the extent that the dimension "socio-cultural factors" is associated only with the potential beneficiaries and users of the national health system, seen as actors in permanent confrontation with a series of so-called traditional values in permanent conflict with the values of modernity, associated with formal western medicine.

Here, the client or user of the health services is seen as an actor bearing sociocultural values which do not favour the spread of formal medicine. The user of services is seen as responsible for not using the health clinics, or for the failure of prescribed treatments, assuming that he/she, for various reasons, has not followed the advice of the health service professionals.

The other side of the diad comprises the formal system of health, conceived as a mechanical structure, readily transposed from one context to another, and able to continue functioning in the same way as long as the necessary material conditions and human resources are brought together. This perception loses sight of the dialogical and dynamic character of social and cultural values and is based on a system of accusation and negation, which looks at the tip of the iceberg (users of the health services and its material resources) as the main cause for its limited access and the low quality of services rendered in health units.

The constructivist perspective allows us to remember that social representations of health/illness include many dimensions, which constitute social and individual expressions, involving cultural and social relations, and as a manifestation of social contradictions and political struggle. The form of functioning of a particular health system is a process of inscription, codification and creation of hegemonic norms of discourse and representations which gain coercive force through their habitual use, in the way that we can interpret Bordieu's (1992) notion of habitus.

Apart from norms, apart from rules for functioning, and apart from scientific knowledge, or alongside them, there exist the subversion of values, improvisation, power games in the exercise of the medical profession, all of which manifest themselves in different forms and have effects on those aspects related to access to and quality of services rendered.

Invoking Foucault (1979), we understand that the institutional dimension of the health system is a permanently created, recreated and re-elaborated body of ideas, practices and representations. The dominant conceptions of the body, health and illness are constructed in the practice of the dominant official medicine, the dominated pole being represented by the somatic culture which retranslates, reorganizes within its logic, the effects of scientific medicine.

Seen from another angle, the formal health system represents an institutional apparatus comprised of a series of practices, routines, prescriptions, structures of discursive heirarchy, of authority, emblematic symbols which comprise a whole, a complex working corpus which, despite the appearance of having been formed, is highly dynamic, within a context which is conditioning and conditioned by the institutional culture of which it is constitutive.

The apparatus to which I refer here is generally understood or masked by health professionals under the prerogative of objectivity and universality granted to scientific modern medicine and by the social recognition which goes with it.

With these assumptions in mind, to insist on analysing the health system and its results with an emphasis only on questions of material forms and not of its semantic content, as happens in Mozambique, means, perhaps that the system is rooted in a perspective which does not take into account the fact that formal medicine does not take place only in the pure codification of the organization.

The challenge still to be overcome is to analyse the performance of the health system through demystifying the passive organicism with which the practice of formal medicine is attributed, and to bring it into the domain of culture, thus underlining through this, that despite their form, the institutional stuctures of health contain a set of ambiguities which reflect a tension between the positivism of the majority of practices and measures adopted and the ideological and political dimensions which compete amongst themselves.

The example of the uncritical substitution of the SAAJ by the VTP (HIV Transmission Prevention) indicates the existence of an internal institutional effort to better manage and use space within the formal health system. But it also reveals a process of evaluative ranking of services, often conditioned not by the systematic evaluation of the costs and the social, economic and symbolic efficacy of the services rendered, but through its weight, the international donor community trailing its assistance, and the immediate demands for results, with an exclusionary focus on the programmes supported by it.

Flowing from the assistance provided by the American Presidential Initiative on HIV/AIDS and sexual health (PEPFAR), for example, the various beneficiary organisations are invited bi-monthly to present the famous ‘success stories’, many of which are gross fabrications on the part of the implementing body, and difficult to justify, made under the threat of losing the assistance provided. Here, once again, the idea that another valid form of materializing the “art” of rendering medical care is being constituted does not appear in the picture.

The rapidity with which new approaches and forms of health service provision are introduced or substituted, with examples from a time period of little less than five years, could come to confuse potential beneficiaries or targets of the services which are introduced and/or withdrawn. In little less than five years, Mozambique has already introduced systems for the administration of Retroviral Therapy, the programme for the Prevention of Vertical Transmission, the Friends of Adolescents and Youth Services, referred to above, and the Offices for Voluntary Testing and Counselling, this last recently renamed Health Counselling and Testing.

All of these transformations are conceived of in positivistic and almost mechanistic terms, in which the dimension of social relations, systems of signification and re-signification of the assumptions and practices introduced are not taken into account. What happens in the complex chain of structural networks of people involved in the operationalization of the health system and their relation to potential beneficiaries also needs to be constantly taken into account, in order to be able to understand other bottlenecks in access and quality of services delivered, or to be delivered, very definitely apart from those purely material aspects, which are also, without doubt, important.

The introduction of new programmes or new health programme components and services, and proper health service functioning routines in different corners of the country, recognize specialisms which are, actually, spaces for the occupation and presence of the institional health apparatus, whose appropriation, interiorization and operationalization is made by the health service providers, but also by their potential clients, in a syncretic manner, and through the aggregation of multiple understandings and experiences. Apart from norms, apart from rules for functioning, and apart from scientific knowledge, or alongside them, there exist the subversion of values, improvisation, power games in the exercise of the medical profession, all of which manifest themselves in different forms and have effects on those aspects related to access to and quality of services rendered.

We must understand these institutions as the results of interactive and communicative processes through which individuals and collectivities consume a network of meanings for their experiences of illness. In the construction of consciousness, intersubjective and existential factors mix with forms of interpretation and action which are culturally founded.

The recognition of this sociocultural dimension which characterizes the practices of the provision of services and the serial enumeration of its constitutive elements, could, as well as re-evaluating the historicity which is also part of institutional conduct, represent a contribution to the broadening of the horizon of the conceptual framework of the different types of obstacles which limit the amplification of access and quality of health services rendered.

In seeking to analyse the problems and obstacles which condition the broadening of access to health services we should try to consider holistic evaluations and approaches, which do not exclude the system of practices, routines, relationships of interpersonal and politico-ideological forces which constitute and form the institutional framework of health service operations. Apart from the material obstacles, obstacles associated with institutional "cultures" in the provision of services, at all levels, need to be brought forward in strategic and programmatic reflections.

DISCUSSION AND COMMENTS,C. MATSINHE

- It is possible to have an impact on biomedical institutions and on traditional medical systems in order to bring about changes that can improve access to services, given that the institutions themselves and their institutional culture – historically and socially constructed – are dynamic, and thus not immune to change.

- Coexisting medical systems and multiple therapeutic pathways are not an exclusive feature of African medical systems. They are universal.

- Against the assumption that theory and its application – practice – are two separate worlds, we should reinforce the idea that a good intervention necessarily requires a good theory.

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INEQUALITIES AND VALUES IN REPRODUCTIVE HEALTH: WOMEN'S VULNERABILITY AND THE FEMINIZATION OF AIDS

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1. INTRODUCTION

In many societies, the experience of living with HIV/AIDS marked by gender inequalities, discrimination and stigmatization leads to avoidance of reproductive health care and treatment. The fear of ostracism accentuates the reluctance of men and women to confide in others and reveal their health status. In this situation, those most in need of information, education and counselling do not take advantage of health services even when they are available.

Health programmes start from the assumption that the information provided will lead to an automatic transformation in people's behaviour in response to illnesses, without taking into account the different and ever-changing socio-cultural factors that affect the adoption of certain practices.

Behaviour change is not necessarily the result of individual will; it is the outcome of a combination of factors that include coercion, resistance, and access to resources. Changing illness behaviour requires, first of all, the simultaneous availability of information and the resolution of problems within health services. Second, the agents of change should also alter their own behaviour so that their actions and attitudes constitute examples to be followed.

Interventions to bring about behaviour change are necessary in order to improve access to sexual health and reproductive services. Sexual and reproductive health is defined as a general state of physical, mental and social well-being in relation to sexuality and reproduction that includes respect for patients' rights.

This chapter, based on research in rural areas of central and southern Mozambique, argues that in order to reach this ideal and bring about the desired changes, it will be necessary to identify a number of social and economic processes requiring long-term cultural consensus. It is equally imperative that democratic principles be observed and materialized (i) in legislation adopted, (ii) in political commitments, and (iii) in the conception and implementation of programmes and in the operation of services that reflect social values of equity, respect for human rights, the recognition of difference and citizen participation.

Crucial for achieving the required changes is the promotion and adoption of practices and values regarding sexual and reproductive health that are more consonant with social reality in all its diversity and dynamism, and with a more equitable definition of gender roles. This will require an intensification of information and education campaigns.

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However, understanding these values and practices requires a greater investment in and promotion of social science research in the various regions of different countries, in order to evaluate programs and services, influence the policy debate, and document little-known realities, particularly representations, practices and discourses around sexuality and reproduction. At the outset it needs to be established how, in reality, this or that society experiences, thinks about and symbolizes health and illness, processes which ethnographic enquiry can elucidate, since they are linked to historically and culturally based structures of signification.

2. METHODOLOGY

In the collection of empirical data among women and girls living with HIV/AIDS who were the subjects of the study on which the analysis presented in this chapter is based, we emphasised questions relating to pregnancy, maternity and family planning in the context of sexual and reproductive rights. Most women acquire their own medical histories through these experiences, which also bring them into contact on a more or less regular basis with health services and medical care.

However, we did not overlook contacts with key informants of both sexes among both health professionals in clinics and practitioners of traditional medicine, as well as with local political and administrative structures. This strategy was intended to produce data that would allow a complete picture of the coverage and efficacy of community-based health and gender interventions to emerge.

3. THEORETICAL FRAMEWORK

The theoretical framework underlying this chapter is a view of gender as part of social reality, relational and transversal, in interaction with cultural capital and generationally variable, not as a condition that, in and of itself, determines differences in vulnerability (cf. Oakley 1972; Scott 1986). Seen thus, gender is a space for cultural signification, an interpretive process within a complex and dynamic framework of socially rooted values.

This theoretical model pointed us towards a perspective that seeks to take account of the social construction of inequality. Thus special attention was given to socially constructed differences constructed between men and women in access to and control of health resources, but also with regard to inequalities among women themselves. It is not realistic to refer to women in a generic way, since age, social position and status within the family unit have an effect on their ability to make decisions about their own bodies.

Cultural factors are of tremendous importance in structuring family behaviour. Men and women act within a cultural framework that establishes gender relations, roles and behaviours marked by inequality.

Women's social position is determined by the structure of the family unit to a significantly greater extent than is the case for men, a difference that emerges through the various stages of their life cycle. This means that a careful appreciation of differences within the family situation is crucial. Women are not only women: they are daughters, daughters-in-law, wives, widows, mothers, wives of migrants, mothers-in-law, etc. Their authority, autonomy, responsibility, obligations and workload varies by status. Therefore, in order to calculate the likelihood of access to treatment by women and girls living with HIV/AIDS, it is necessary to see how their position in the family could affect their access to these services.

Addressing gender equality in health requires exploring how gender roles and the division of labour (constructed within the family and in society) can influence the ability of men and women to participate in activities that promote health, and identifying constraints of a cultural or material nature that constitute barriers to health service access.

Our conceptual apparatus also includes power as action, one group's domination over another (Foucault 1978), in order to draw attention, first and foremost, to how hierarchies are constructed between family members with regard to control of and access to goods and resources; but also to power relations between health service providers (doctors and nurses, who control medical knowledge) and patients; and specifically to gendered power relations when the health professional is a man and the patient is a woman.

Also pertinent is the concept of social exclusion, understood as a process through which people are denied access to rights and benefits provided by the state through its public institutions, and thus a process through which people are deprived of the rights of citizenship.

Deploying the concepts of gender and power together with the concept of human rights allows us to show that vulnerability (which limits women's access to services) has three dimensions: a *behavioural dimension* formed by representations and hegemonic discourses which shape perceptions of maternity in a context of HIV/AIDS risk; a *cognitive dimension* consisting of denial of the right to information, specifically to education in matters of sexuality; and a programmatic dimension centring on services which should provide an improved quality of health care in an equitable manner (UNFPA 2003).

4. THE BEHAVIOURAL DIMENSION OF VULNERABILITY

Cultural factors are of tremendous importance in structuring family behaviour. Men and women act within a cultural framework that establishes gender relations, roles and behaviours marked by inequality.

These norms confront young women as challenges that take the form of pressure to marry early and have many children. Because women's bodies have the power to create life, they have special value in agricultural societies where labour power is all-important. Large families guarantee the continuity of units of production from one agricultural cycle to the next.

When she marries, a woman must become a mother; this is the pathway to social acceptance, recognition, and approval (PNUD 2001). The biological ability to have a child is interpreted culturally as a "natural" woman's function that defines femininity (Rosaldo and Lamphere 1985). This explanation, which emphasizes women's reproductive capacity and sees motherhood as the principal goal in life, defines childlessness or sterility as a deviant form of behaviour. In this way, a woman's decision to limit her fertility stands in opposition to the cultural centrality of motherhood and the desire to perpetuate the family by bringing a child into the world, independently of possible risk to her life. The total fertility rate in Mozambique was still high a generation ago, around 6.7 percent in 1980, but by 1997 it had dropped to 5.6 percent and by 2003 it was 5.5 percent. The rate of contraceptive use increased from 6 percent in 1997 to 17 percent in 2003 (INE 2003). Some of the women interviewed were attempting to limit the number of children and space their births (44 percent considered a spacing of at least two years). They were taking advantage of the declining importance of kinship in certain areas, of new socio-economic dynamics, and of new cultural configurations, and were driven by the desire to control their own bodies and contest structures of domination.

The research showed that there was little discussion and communication between spouses in relation to reproductive questions and their implications for family health, especially with respect to family planning. Norms and rules rooted in tradition treat sexuality as taboo, and constitute obstacles to an effective exchange of information and knowledge between husbands and wives.

Thus, any attempt to give voice to HIV-infected women or to attend to their reproductive concerns must consider how women view and position themselves with regard to reproduction in general, and to the exercise of their reproductive rights in particular. For example, is resistance to the use of contraceptives linked to a desire to have children that is shaped by previously internalized cultural, economic or emotional imperatives? What impels a seropositive mother to take her pregnancy to full term, even when she knows that her child could also become infected? In many regions there are prohibitions on the termination of pregnancy because children are considered a gift from the ancestors.

In this study, 53.3 percent of the men interviewed and 46.7 percent of the women said that it was the man's right to determine the number of children in a family unit. Thus, culturally defined values community values in terms of sex limit reproductive choice. Men are primarily responsible for decisions about family relations, especially contraceptive use and family size. Decisions about fertility are, then, conditioned by the person who controls and allocates the family's economic resources.

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Improved communication between marriage partners and the exposure of men to information on family planning has the potential to contribute to improved sexual health and respect for reproductive rights at the family level.

Ideas about health and illness are traceable to people's experience in their families of origin. As they grow up, they learn ways of combating ill health through a system of beliefs and practices grounded in local culture. Women are seen as a "repository" of infections and illness, responsible for bringing illness into the house. This leads them to conceal symptoms, and reinforces the culture of silence. Several of the diseases they carry are considered "spiritual", a result of the ancestors' displeasure when social rules are broken.

Although people recognize the importance of health clinics and the services they provide, recourse to the *nyanga*[1] to cure some illnesses is a consequence of the belief that the hospital treats only the symptoms of illness, not its

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[1] **Nyanga** is the designation given to a traditional healer in the Tsonga language. There are two subcategories, nhyangarume and nyamussoro. The first works with medicinal plants and does not have the power to deal with possessing spirits. The second is a specialist in spirit possession.

causes. In those cases in which illness results from punishment by the ancestral spirits, modern medicine has no power whatsoever. Serious illnesses, including AIDS and other STDs are considered a sign of the ancestors' displeasure, and it is advisable to seek the ultimate causes of the situation by consulting a diviner.

The diviner mediates between two worlds, making clear and comprehensible that which is obscure and unintelligible to ordinary beings. The diviner creates a configuration of symbols whose meaning must be revealed. In contending with events beyond human perception and understanding, divination provides legitimation and creates consensus, not only in critical moments of moral and social crisis, but in many other situations as well.

The existence of illness, whether arising from natural or supernatural causes, determines the logic of diagnosis and treatment, and of curative ritual practices. Rituals and the administration of principally plant-based medications constitute the primary treatment mechanisms. However, the efficacy of phytotherapy is not limited only to its pharmacological benefits. All our interlocutors agreed that the curative power of plants was also derived from the words spoken by the diviner to the ancestors, who transmitted this knowledge to him.

5. THE COGNITIVE DIMENSION OF VULNERABILITY

Access to education and information is a key factor in preventing STDs, since education creates an affinity with medical discourse and makes people more open to its messages. The dissemination of information and promotion of access to comprehensive and quality reproductive services are protective factors with transformative power for individuals, who remake their roles in a changing cultural context. The better informed they are, the stronger and more confident women feel about making decisions and choices in relation to their own health and self-care. But more than 70 percent of girls leave school after the age of 13 for reasons that include early marriage, poverty and the low value placed on their education by parents and teachers.

In addition, level of education provides some explanation of inequalities in morbidity and mortality since, the higher it is, the lower the incidence of chronic illness, and health is self-monitored (Cabral et al. 2002). Schooling for women is crucial in a country where the material conditions of life are not the best for them, given their reproductive role at the domestic level. The higher the level of education, the greater a woman's knowledge of how to protect her own health and that of her children, thus reducing the risk of contracting certain illnesses.

However, young women do not have the right to information on sexuality, contraceptives and other services because they are still not seen as sexual beings. It is thought that efforts to make this information accessible to them could lead to promiscuity and increased vulnerability.

Opinion makers and parents do not feel free to discuss questions of sexuality. Parents, whose opinions count the most, do not feel comfortable talking about matters of sexuality. Parents are not the people with whom adolescents normally discuss questions related to sexual behaviour, although these evidently form part of family concerns, and they feel more at ease finding confidants outside of the family (Agadjanian 2001:299).

Recent research on the dynamics of socialization processes and behavioural norms among young people shows that they obtain information on sexuality mainly from friends and people a little older than themselves, since talking about sex with adults is considered disrespectful.

How these communication systems are regulated primarily reflects the level of tolerance within the family system for the individuality and autonomy of each family member. When the boundaries are narrow, the strategies observed in the system limit the expression of autonomy.

But strategies can be adjusted and autonomy won in accordance with the changing needs and abilities of each family member. For example, in the defence of common interests linked to maternity and reproduction, women sharing common spaces (standpipe, market, health clinic) exchange confidences and advice on home remedies for illnesses, more effective contraception methods and ways of getting access to them. For those migrating from countryside to town, where knowledge of contraceptive methods was scarce, informal networks determine access to information. (Cf Loforte, 2000).

However, the rupture in sexual education has not affected the construction of a sexual identity amongst youth. Young women are still represented as objects of desire and socially legitimated as dependent on a man, which makes it difficult for them to negotiate abstinence from sexual relations (Osório and Arthur 2002).

Health providers, who are similarly the bearers of a certain cultural and symbolic baggage, also need to be better informed and to develop their communication and counselling skills in order to deal with their patients. We found that weaknesses in services can also be traced to providers' failure to understand the social environment that affects contraceptive use, and women's attitudes and behaviour regarding contraceptive methods and basic information on perinatal HIV transmission. There is little information on the real causes of irregular condom use and women's cultural perceptions of its effects, and the factors that lead to demand for services prenatally (85 percent of women) but not at the time of birth, when the absentee level is around 37 percent[2]. We feel that the work of providers should go far beyond providing information on AIDS and prescribing condom use, since the effects of cultural representations and practices are present in the daily life of both women and health care providers, and demand profound changes in their attitudes. This requires a better grasp of the concepts and perceptions that constitute the users' world view.

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In this context, anthropological research can provide health professionals with important tools for deepening their thinking on these problems, improving educational activities both during consultations and in talks given to pregnant women and new mothers. Gender differences and inequalities could be clearly and directly addressed, as well as their influence on the construction of women's identity and sexuality, power relations between sexual partners, and issues in the prevention and treatment of illness. There could be an attempt, finally, to break the information barrier, removing blinders that prevent women from seeing that the risk of contracting the virus is often to be found in the construction of the feminine condition itself.

6. PROGRAMMATIC VULNERABILITY

The Continental Framework for Reproductive Health Policies[3] advocates a reinforcement of the health sector component through allocation of resources, in order to improve universal access to services, including reproductive health and the integration of gender into development programmes.

Thus, the programmatic dimension leads us to an analysis of the contributions of programmes at the institutional level to the reduction of the vulnerability of men and women to problems of reproductive health. We need to analyse questions of geographic accessibility (the physical location of services); the transportation available; the distances over which women and girls have to travel in order to reach health clinics; the extent to which services are equipped with infrastructures and medications that facilitate accessibility; and finally to identify the factors, such as signage, that persuade a potential patient to seek services. In the communities studied, we found that the location of health centres forced users to travel long distances: 44 percent of the women interviewed stated that they had to travel between an hour and a half and two hours to reach the closest clinic. These clinics worked under deficient conditions including shortages of essential medications, beds, and personnel, above all female triage staff[4]; they were also marked by unequal power relations between health professionals and patients manifested in impatience and delayed provision of care, and the favouring of family and friends in providing care. All of these factors destroyed respondents' motivation to seek out health services.

In relation to young people and adolescents, we found that because of the shortage of personnel,

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[2] There are various reasons behind this absenteeism: the desire to give birth in a more familiar and welcoming environment; the need for the mother-in-law to be present at birth to detect whether any complications could be related to acts of infidelity; and distance from the health clinic when the woman is already in labour and lacks transportation.

[3] See Document of the African Union Commission, Maputo, 2006.

[4] According to the women interviewed, female nurses make a difference in attendance, since the women feel more at ease speaking with them about their illnesses and concerns; examination of their most intimate parts can take place without the constraints and shame normally felt.

or their lack of knowledge of this group's specific reproductive health needs, there was:

- Little information and few services accessible to them,
- Little or no involvement in planning, implementation and monitoring of reproductive health programmes,
- Unattractive services given the negative attitudes of the providers and lack of policies to guarantee access.

Access to reproductive health services is complex and demands investment in education and information as well as profound transformations in organizational culture. This complexity is magnified if we view its functioning through "gendered lenses" (Gupta 2000). In this way a conceptual framework which outlines the different types of response necessary for greater efficacy of services could facilitate the interventions required. Reproductive health programs that recognize gender differences, which promote services that are sensitive to the different needs of men and women and remove barriers to access, are important. However, in order to change the dynamics of gender relations in fundamental ways, greater emphasis should be placed on the institutional changes, from a technical and structural point of view, that are necessary to eradicate inequalities; on the urgent need to enable women and men to have greater access to and participation in health programmes; and on helping women to overcome obstacles they face in obtaining services or contraceptives. "Structural aspects" refers to institutional systems, processes and structures which routinely, continually and comprehensively identify and respond in an appropriate manner to the different ways in which gender affects health programs.

Dealing with the needs of clients requires learning and observing what they want, their priorities and preferences. The diagnosis and knowledge of seropositive status could unlock appropriate responses from the health services which would lessen self-blame on the part of women.

7. RECOMMENDATIONS

Access to reproductive health services is complex and demands investment in education and information as well as profound transformations in organizational culture. This complexity is magnified if we view its functioning through "gendered lenses" (Gupta 2000). In this way a conceptual framework which outlines the different types of response necessary for greater efficacy of services could facilitate the interventions required. Reproductive health programs that recognize gender differences, which promote services that are sensitive to the different needs of men and women and remove barriers to access, are important. However, in order to change the dynamics of gender relations in fundamental ways, greater emphasis should be placed on the institutional changes, from a technical and structural point of view, that are necessary to eradicate inequalities; on the urgent need to enable women and men to have greater access to and participation in health programmes; and on helping women to overcome obstacles they face in obtaining services or contraceptives. "Structural aspects" refers to institutional systems, processes and structures which routinely, continually and comprehensively identify and respond in an appropriate manner to the different ways in which gender affects health programs.

Dealing with the needs of clients requires learning and observing what they want, their priorities and preferences. The diagnosis and knowledge of seropositive status could unlock appropriate responses from the health services which would lessen self-blame on the part of women.

A variety of approaches could be used in the context of educational programmes:

The observation of client-provider interactions, identifying points of contact and disagreement

- The measurement of patient flow to determine the length of waiting time to see a health care provider
- Client surveys and interviews following use of the health services
- The involvement of women and girls in the creation of programmes appropriate to their needs
- Open discussion within the community on the possibility of creating health promotion groups
- The production of educational materials in simple language for uneducated women

Greater participation of women in programmes should not imply the exclusion of men, since both share responsibility for reproductive health.

Programs will be more effective if planned by both men and women.

It is important to involve young people, since they are in the process of developing their identities and constructing attitudes, beliefs and options regarding sexuality. It is imperative, then, to promote activities which contribute to gender equality and avoid behaviours which put them at risk as well as their partners and any children they will have in the future.

Gender role perceptions start forming very early, but dominant ideas of masculinity only change with the passage of time. Risk-taking behaviour can be averted if men and women are offered alternative models of masculinity which are not based on unequal relations of power.

The State creates conditions in which particular groups can be free of certain illnesses. By the same token, it should offer others the means to attain the same positive health outcomes (Cabral et al. 2002); that is to say, it should make medical care and medications available to various segments of the population in order to reduce social or geographic asymmetries in access to health.

DISCUSSION AND COMMENTS, A. M. LOFORTE

- There is agreement on the need to deconstruct and dismantle, through anthropological analysis, generic images of “the African woman” (both as “woman” and as “African”) and of the “African man”, both of which are sources of endless stereotypes.

- Women are not passive victims, but social actors interacting with other social actors, although from a position of “structural vulnerability”.

- Generational inequalities affect women’s access to health services, and in particular to information about sexuality, especially for adolescents and the elderly, who are considered to be asexual.

- There was considerable emphasis on the sexual violence to which adolescent girls are subject and their vulnerability to

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NOTIONS OF SEXUALITY:
RESPONDING TO THE DREAMS AND DESIRES OF YOUNG PEOPLE PERINATALLY INFECTED WITH HIV IN UGANDA

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CONCEPTUAL FRAMEWORK

In HIV/AIDS programming, concern for the vulnerability of African populations to HIV infection overwhelms the more positive realities of sexuality, which is an equally important part of the African experience (Undie and Benya 2006; Spronk 2006). Emerging research has challenged that lack of balance, and there have been increasing efforts by researchers, policy makers and program managers to develop a broad framework on sexuality and sexual health to guide the design of programs to meet sexual realities and needs on the ground (APHRC 2005). In response to this, the framework developed by WHO/Global (2002) is a useful tool for engaging broadly with both the negative and the positive realities of sexuality. The framework encompasses sex, gender, identities and roles, sexual orientation, pleasure, intimacy and reproduction. Sexuality is described as something that is experienced and expressed in thoughts, fantasies, desires, beliefs, values, behavior, practices, roles and relationships. In relation to sexuality, WHO has also emphasized that sexual health is not merely the absence of disease, dysfunction or infirmity, but rather a state of physical, emotional, mental and social well- being. Therefore, addressing sexual health requires a positive and respectful approach to sexuality and sexual relationships. Until recently, however, sexuality in the context of HIV/AIDS programs has been conceptualized as a disease problem and therefore tended to embrace a limited number of themes, including disease (risk) and reproduction. Consequently, HIV/AIDS programs have been predominantly designed to respond to negative constitutions of sexuality.

EXISTING GAPS IN HIV/AIDS PROGRAMMING

The almost exclusive focus on the negative implications of sexuality has limited a broader understanding of sexuality and its application in HIV/AIDS programming, a problem compounded by funding restrictions as well as a reluctance to acknowledge that it is quite natural for People Living with HIV/AIDS (PLHA) to have sexual needs and desires and to act upon them (Berger 2005). Worse still, studies on the sexuality of PLHA have been narrowly defined and tend not to ask questions about desire or how sexuality may be a source of happiness, personal fulfillment and well-being. More often than not, these studies have been conceptualized within the disease framework, mainly responding to questions related to risky sexual behavior to the neglect of other vital elements of sexuality (Spronk 2006).

For instance, recent studies on PLHA receiving antiretroviral therapy (ART) have been premised on the assumption that the success of ART may be closely associated with a reduction in protective and preventive behaviors. Consequently, these studies have tended to explore high-risk sexual behavior of patients receiving ART. The questions normally asked relate to sexual intercourse in the last six months, number and type of sexual partners, knowledge of sexual partner's HIV status, disclosure of HIV status to partner, condom use during last sexual intercourse and experience of sexually transmitted disease.

In addition, if sexuality is discussed during client counseling it tends to be about risk assessment, behavior, practices and condom use. The tendency has been to desexualize PLHA, a situation exacerbated by the fact that service providers seem neither interested nor motivated nor prepared to find out about client sexuality desires. Even though HIV/AIDS programs promote the concept of positive living, the content has focused on proper nutrition, exercise and controlling stress. Issues related to sexual desires are not given due attention, thus threatening the very right of PLHA to exist, let alone to love and to be loved. Talking about positive living without embracing issues of sexuality has often left most clients unprepared for satisfying sexual lives; and worse, it encourages non-disclosure of their HIV status to potential and existing partners.

Increased access to ART has enabled people living with HIV to live positively and resulted in improved quality of life. Most young people living with HIV describe quality of life as "wanting to be like any other young boy or girl", an aspiration connoting sexuality. Therefore, it can only be anticipated that young people infected with HIV increasingly desire to act upon their sexuality and would appreciate the opportunity to talk and ask questions about their sexuality. Certainly they have a right to enjoy their sexuality and indeed emerging studies make a case for the re-sexualizing of HIV/AIDS programming (Berger 2005). Also, a recent study in Canada highlights the importance of healthy sexual development for young people with perinatally acquired HIV now maturing into adolescence and adulthood (Fielden et al. 2006). While some existing HIV/AIDS treatment centers in Uganda are beginning to make an effort to re-sexualize HIV/AIDS programming, these efforts have mainly targeted adults living with HIV and have tended to emphasize reproduction and integration of family planning into HIV/AIDS programming. The sexuality of young people perinatally infected with HIV has hardly been given due attention.

YOUNG PEOPLE LIVING WITH HIV: SEXUALITY EXPERIENCES, DREAMS, AND DESIRES

The number of African children living with HIV continues to escalate despite the advances made in prevention of mother-to-child transmission. Ninety percent of the estimated 3 million children living with HIV are found in sub-Saharan Africa (ANECCA 2003). Whereas previously it was never anticipated that infants born with HIV would have the opportunity to live on to adulthood and sexual development, the roll-out of treatment programmes has made this possible, albeit for a small but growing proportion. True numbers of living children and young people aged between 10-19 years born HIV-positive are almost impossible to find, but some indications are available. For instance, TASO Uganda's oldest surviving HIV perinatally infected client turned 23 years old this year. TASO has also registered 4,696 young people living with HIV since infancy. The Pediatric Infectious Disease Clinic (PIDC) in Mulago Hospital in Uganda has over 500 young people living with HIV between the ages of 10 -19 years.

These young people are now beginning to explore their sexuality; they are dating and some of them are beginning to share intimacy. During this year alone, TASO reported 184 pregnancies and PIDC reported 7 pregnancies among young people receiving HIV/AIIDS treatment, care and support through these organizations, and staff at these centers suspect that more are likely to become pregnant. It is unclear whether these pregnancies were intended or unintended. We know, however, that HIV infection has not significantly changed attitudes towards childbearing in Uganda (Kirumira 1996). The desire to have children early in adult life is very high, including for PLHA, and a romantic relationship is commonly not considered legitimate unless it produces a baby. Generally, Ugandans have their first sexual experience very early in life. According to the 2004-2005 HIV/AIDS sero-behavioral survey, 14 percent of young women and men have sex before age 15, and 63 percent of women and 47 percent of young men have sex before age 18 (Ministry of Health and ORC Macro 2006). Thus in this context, young people living with HIV may desire and/or succumb to familial and social pressure to have children early so that they do not die without offspring, but existing HIV care and support programs do not seem to address the fertility aspirations or desires of this small but rapidly growing population of young people.

The difficulties of working with young people in general on issues of sexuality are made even more complex in the case of young people living with HIV. At present, key interventions to alter disease transmission and prevent pregnancy among young people have tended to emphasize delaying sexual debut, reducing the number of sexual partners, and increasing correct and consistent condom use. A major limitation, however, is that these interventions have tended to target the general population, who are assumed to be either HIV-negative or unaware of their HIV status. The absence of targeted research on the sexuality of young people perinatally infected with HIV has rendered this impossible. At the very best, treatment, care and support programs have attempted to encourage young people living with HIV to postpone sexual initiation. This, however, is not always possible since some young people are always going to have sex, whether or not they are discouraged from doing so. Studies conducted elsewhere show that at least 27 percent of young people with perinatally acquired HIV were sexually active (Fielden et al 2006). Anecdotal evidence from TASO Uganda and South Africa (http://www.irinnews.org) also suggests that most HIV-positive individuals are likely to seek relationships amongst themselves. This emerging evidence reinforces the need to understand relationships among young people living with HIV and their implications for HIV/AIDS programming.

SEXUAL RIGHTS OF YOUNG PEOPLE LIVING WITH HIV

WHO (2005) emphasizes that for sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. Nonetheless, the right to sexuality information and services for young people living with HIV continues to be neglected. The UN (General Assembly Comment NO 3 January 2003) Convention on the Rights of the Child highlights the need to give careful attention to the sexuality of children. The convention underscores the fact that children require relevant, appropriate and timely information tailored to age levels and capacity that enables them to deal positively and responsibly with their sexuality. The convention also emphasizes that effective HIV/AIDS prevention must avoid censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information. Consistent with their obligations to ensure children's survival and development, signatories of the convention must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality. Recent WHO/UNFPA guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings have also underscored the need to address the particular sexual and reproductive health needs of adolescent girls with HIV, ensuring the availability of age-appropriate information and counseling on sexuality and safer sexual practices, and offering adolescent-friendly family planning counseling and services (World Health Organization 2006).

POSSIBLE SOLUTIONS: RESEARCHING THE SEXUALITY OF YOUNG PEOPLE LIVING WITH HIV

Generally, the sexuality dreams and desires of young people living with HIV in Uganda and elsewhere in Africa are not known. Researchers need to generate a body of evidence that will create awareness among program managers and policy makers. Thus, exploratory and descriptive studies are needed within the broad framework of sexuality to guide the design and development of interventions that respond to the actual sexual realities of young people living with HIV. These studies should address the following issues:

- Family background, reflections on childhood, puberty and adulthood, lifestyle, and friendships

- Emotional acceptance of HIV and life in general: perspectives on growing up, feelings and thoughts about personal life, life goals and what they wish to be

- Perspectives on motherhood and fatherhood: attitudes, experiences and perceptions about early parenthood (whether boys have ever made their partners pregnant), responses to unintended pregnancies; readiness to be a parent

- Self-esteem: anxieties, dreams and hopes about self, relationships

- Love and loving: dating, justifications regarding love, sex and dating, reasons for relationships

- Sexual histories: sexual desires and intentions/experiences/exploration/expression; worries, emotions and excitement about sex; general views about sex

- Sexual experiences: identifying the right moment for girls and boys to start having sex, expression of feelings, whether they have ever had sex, both desired and undesired (sexual abuse and coercion)

- Puberty and development: perceptions about masculinity and femininity, negotiating puberty, self-care, decision-making and partner communication, most difficult and confusing part of development

- Having and not having children: attitudes, desires, pressures, expectations, knowledge of ways to prevent pregnancy

- Services and information: sources, need and demand, utilization of sexual and reproductive health services; opinions and preferences regarding existing services and what type of services they would like to have

Methodologically, these studies should be both quantitative and qualitative in nature. Ethnographies on young people living with HIV are needed to gain an insight into their inner lives and how they navigate their passage to sexual maturity. Distinctions will need to be made between young people living with HIV by their social characteristics: those in and out of school, married, pregnant, parents, singles, those in relationships, those involved in support groups, etc. In-depth data on the personal lives, feelings, desires, social and interpersonal dynamics that influence their sexuality should be gathered through recording life-history narratives and case stories. Emphasis here should be on an "emic" approach; that is, on trying to understand how young people living with HIV construct their sexuality while living with HIV and discovering how they view their own situation, and how they go about life in general. Case stories illustrating events around sexuality should be elicited, and young people living with HIV should be encouraged as much as possible to relate particular events of relevance in their lives.

Group discussions could also generate useful data on group opinions, perceptions, and attitudes around sexuality as well as sexual and reproductive health education and services needs. Group discussions could be organized around: 1) young women living with HIV who are single; 2) young men living with HIV who are single; 3) young women living with HIV who are pregnant; 4) young men living with HIV who are fathers; 5) young men and women living with HIV who are in school; and 6) young married women living with HIV.

Surveys on young people perinatally infected with HIV are also necessary to provide quantitative data that could be used as evidence to urge policymakers and program managers to consider the inclusion of different sexuality perspectives into HIV/AIDS programming.

In addition, existing HIV/AIDS treatment and support programs will need to be reviewed within the WHO framework in order to identify existing intervention gaps in sexuality-related services and information for young people living with HIV. The review should involve both a desk and stakeholder appraisal. A desk review of current treatment, care and support HIV/AIDS programs documents is necessary to determine the content and the extent to which they facilitate or influence the provision of sexuality-related supportive information and services to young people living with HIV. The stakeholder analysis should include key informants from governmental institutions, private organizations, non-governmental organizations, faith-based organizations, health development partners, and technical assistance agencies. Possible areas of focus for discussions with key stakeholders include the following:

- Factors that influence the provision of sexuality counseling to HIV-positive young people; probe for funding ideology, technical gaps, etc.

- Service providers' understandings and/or interpretations of sexuality counseling for HIV-positive young people and level of support for it

- The extent to which sexuality and reproductive health counseling and related services have been integrated

- Content of counseling training and services: issues recognized/receiving attention and which aspects are not receiving attention and why

- How is sexual and reproductive health counseling introduced and what is its content? To whom it is offered and why?

- How are broad sexual and reproductive health concerns of HIV-positive young people handled within existing services?

- Capacity for existing HIV/AIDS treatment, care and support programs to handle the sexuality concerns of HIV-positive young people: skilled personnel (composition and training of service providers), existence of necessary infrastructure, protocols and guidelines, review of training needs and other resources

LINKING RESEARCH TO INTERVENTIONS

It is critical that research on young people living with HIV is linked to interventions. Researchers should facilitate this link through the data interpretation process and by identifying possible interventions together with policymakers, program managers, donors, and beneficiaries. Generally, actual interventions that embrace a broad perspective on sexuality only become apparent after detailed information on notion of sexuality among young people living with HIV has been gathered. However, possible strategies or interventions may include the following:

- Integrating of sexuality concerns into treatment, care and support programs for young people living with HIV

- Developing sexuality counseling guidelines and a sexuality desire assessment tool for young people living with HIV. The sexuality desire tool could be used to screen clients systematically for their sexuality desires and needs so that services providers can offer the appropriate information or services, or refer clients appropriately

- Developing a counseling curriculum for young people living with HIV for counselors

- Developing a life skills curriculum for young people living with HIV

ACurrently, HIV/AIDS care in Uganda other African countries is organized around pediatric and adult care. Most young people living with HIV receive their treatment, care and support through pediatric care clinics and a few receive services through adult care clinics. Either way, the tendency has been to handle young people living with HIV as if they were young children. While some service outlets have incorporated child counseling into their treatment, care and support package, this falls short of mentioning sexuality issues let alone empowering young people living with HIV with necessary information to enable them balance rights and responsibilities, make informed decisions about their lives and contribute to their quality of life in general.

Existing counseling and support packages will need to be updated, reorganized and/or redesigned to 1) address the gap between pediatric and adult care; and 2) embrace vital elements of sexuality for young people living with HIV. In order to be effective, interventions will need to address the sexuality desires and dreams of young people living with HIV and engage different agencies and groups working with young people living with HIV. To facilitate this link, researchers will need to create strong liaisons with existing stakeholder communities as well as existing support groups for young people living with HIV to solidify consensus on possible interventions and their design as well as to stimulate exchange between research teams and actors involved in programming.

Emphasis should be on ensuring that adolescents living with HIV, programs and organizations are all involved in designing the interventions. A key analytical issue to be addressed is the negotiation of the gap between treatment, care and support programs and the actual sexuality needs of young people living with HIV. Researchers should use data from the exploratory studies to make program managers aware of the sexuality desires and dreams of young people living with HIV that need to be addressed. Up to now, treatment, care and support programs have focused on changing people's behavior. I anticipate that data from these studies will serve instead as a concrete basis for generating discussions on how existing HIV/AIDS programs will have to change. The possibility of programs offering value-free information on sexuality to young people living with HIV also has to be debated.

RECOMMENDATIONS

Sexuality dreams and desires of young people living with HIV remain neglected in HIV/AIDS programming. There is a need to rethink sexuality in HIV/AIDS programming, and the WHO framework offers the starting point and opportunity for doing this. Social science research should appropriately engage with the WHO discourse and create a body of knowledge that balances concern for disease with issues of positive sexuality such as loving, dating, desires, happiness and growing up among young people living with HIV in order to guide HIV/AIDS programming appropriately. Following this model of sexuality, HIV/AIDS treatment, care and support programs will need to provide young people living with HIV with information and practical support to understand their sexuality as they grow up in order for them to negotiate vital aspects of their sexuality, enjoy positive lifestyles, and avoid undesired consequences such as unwanted pregnancies, infection of others and self re-infection. Effective sexuality counseling should also be provided so that young people living with HIV can make informed choices and be able to balance responsibility with sexual and reproductive rights.

DISCUSSION AND COMMENTS, H. BIRUNGI

- Sexuality, a central theme in AIDS prevention efforts, should be approached in a positive manner, emphasizing sensuality, fantasies and pleasure.

- In terms of application, this proposal requires a radical shift in the nature of the health messages that figure in HIV/AIDS prevention campaigns, which should not be based on “fear” and “risk”, but on the satisfaction of desires in a healthy and responsible way.

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THE MULTIPLE DIMENSIONS OF VULNERABILITY TO HIV/AIDS IN AFRICA: A SOCIAL SCIENCE PERSPECTIVE

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INTRODUCTION

As Schneider and Moodie (2002) point out, the impacts of HIV/AIDS on the critical infrastructures that sustain the security, stability, and viability of modern nation-states are manifold. Although HIV/AIDS is overwhelmingly concentrated in sub-Saharan Africa with epicenters in eastern and southern Africa, the future epicenter of the pandemic appears to be the Asian continent, particularly India, China and Russia. Should the epidemic spread to India and China as it has done in eastern and southern Africa, the ramifications could be tragic for the region and the whole world. Consequently, examining the multiple dimensions of HIV/AIDS vulnerability in sub-Saharan Africa may provide insights for targeting intervention.

This paper has three main objectives. The first objective is to develop a theoretical framework that is rooted in the contributions of social science to medicine and public health in order to understand the multiple dimensions of vulnerability to HIV/AIDS in Africa. A conceptual framework is developed to identify the major drivers of vulnerability to HIV/AIDS in Africa. The second objective is to offer an analytical case study, using the results of a study conducted in low socioeconomic income areas of the city of Lilongwe in Malawi, which highlights in concrete terms some of the multiple dimensions of vulnerability among men and women with specific reference to HIV/AIDS. Finally, a few recommendations on how some of the factors that put people at risk of HIV infection may be reduced or even eliminated are offered.

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THE CONCEPTUAL FRAMEWORK OF VULNERABILITY

In this paper we define vulnerability broadly. As the World Council of Churches (1999) notes:

> Vulnerability means that something or someone can be hurt or wounded; it means to be exposed to danger or attack, to be unprotected... to be vulnerable in the context of HIV/AIDS means to have limited or no control over one=s risk of acquiring HIV infection or, for those already infected with or affected by HIV, to have little or no access to appropriate care and support. Vulnerability is the net result of the interplay among many factors, both personal (including biological) and societal factors, it can be increased by a range of cultural, educational, demographic, legal, economic and political factors (World Council of Churches 1999:11).

During the past 20 years many studies have been conducted and data collected in an attempt to understand this complex epidemic. While there is no paucity of studies on AIDS in Africa, biomedical and epidemiological models of inquiry continue to dominate the research agenda. Biomedical studies have increased our understanding of the physiological mechanisms of HIV by examining the association of infection with viral load (Quinn et al. 2000), chemotherapeutic preventions of vertical transmission (Wiktor et al. 1999, Connor et al. 1994), and the interaction of HIV infection with frequently occurring sexually transmitted diseases and urinary tract infections (Wasserheit 1992, Grosskurth et al. 1995, Diallo et al. 1997). The results of these studies have been valuable in providing insights on who might be at increased risk due to the presence of exacerbating infections, at what point those who are already HIV infected might be more at risk of infecting others, and how transmission of HIV from mother to child might potentially be mitigated.

On the other hand epidemiological studies, for their part, have focused attention upon sexual behavior patterns of individuals within designated risk categories, namely commercial sex workers, military personnel, and truck drivers (Kreiss et al. 1986, Bwayo 1994, Ndinya-Achola et al. 1997, Pickering et al. 1997). Most of these investigations set out to answer the question of what kinds of sexual exchanges take place between and among these populations to explain high rates of HIV transmission. How many partners, for example, commercial sex workers have, or when, where, and how often drivers along particular truck routes engage in commercial sexual exchange are characteristic focal points. Most importantly, however, epidemiological studies emphasize the degree to which commercial sex workers and others utilize condoms in their sexual exchanges. Behaviorally based studies have generated useful insights about patterns of sexual practice within particular groups in specific regions of Africa, and they have illuminated sometimes tragically high rates of HIV within specific regions and occupations. They have also informed prevention programs that rely upon educational outreach and condom availability.

Biomedical and epidemiological studies prove inadequate, however, on several levels. First, a primary focus on so-called risk groups erroneously focuses attention on occupational category rather than on social practice. It subsequently presumes that all individuals within each category are at risk of HIV or are already infected, and conversely creates the impression that no one outside of these categories is vulnerable. These studies fail to ask the question of why individuals engage in the behaviors they do, and consequently they fail to focus on those social, political, cultural, and economic factors that generate conditions of vulnerability to HIV. As the anthropologist Waterston (1997:1383) suggests, the dominant solutions to AIDS, in focusing on the individual as the locus of disease and prevention, are those least threatening to the status quo. Not only do educational outreach and access to condoms leave root causes of HIV untouched, they rest on the presumption that individuals can automatically change their behaviors with the benefit of awareness and condom possession.

A growing number of social scientists in critical geography, anthropology, and other fields diverge from the dominant paradigm of behavioral-based research by interrogating the institutional, ideological, and historical structures of inequality fostering the spread of HIV.

It is in this light that we offer a different perspective in this paper to the study of HIV/AIDS in sub-Saharan Africa, i.e. a conceptual framework of the major drivers of HIV in sub-Saharan Africa, particularly the multiple dimensions of vulnerability. The overarching multiple dimensions or factors include: colonial labor migration patterns, gender empowerment variables, variables that measure poverty, development and disease burden, and variables that measure government attitudes and commitment in the fight against HIV/AIDS. The conceptual model also includes a discussion of other drivers such as global forces and the role of culture in the proliferation or abatement of the epidemic.

A growing number of social scientists in critical geography, anthropology, and other fields diverge from the dominant paradigm of behavioral-based research by interrogating the institutional, ideological, and historical structures of inequality fostering the spread of HIV. An increasing number are asking the questions of what and how factors converge to create risky conditions for particular individuals and groups within sub-Saharan Africa. Rather than focusing on patterns of sexual exchange per se, critical social science research investigates the multiple and interrelated reasons why women or men get placed in situations that increase their likelihood of engaging in risky behaviors, thereby increasing their vulnerability to HIV. One of the primary factors increasing HIV transmission in southern Africa, for example, is a pattern of male out-migration driven by depressed national economies and labor-intensive mining industries in South Africa (Adepoju 2003, Girdler-Brown 1998, Decosas et al. 1995, Brockerhoff and Biddlecom 1999, Haour Knipe and Rector 1996, Upton 2003). The result is male workers away from their families for long periods of time and women increasingly unable to fend for themselves while their husbands are gone (Chirwa1998, Campbell 1997, Zuma et al. 2003). In other areas, prolonged war has disrupted local economies, displaced populations, and rendered longstanding social practices untenable (Bond and Vincent 1997, Kalipeni and Oppong 1998, Lyons 2004). In most areas of sub-Saharan Africa, economies are struggling and poverty is rampant, making it difficult for families to stay together in one place or for individuals to maintain viable incomes without resorting to potentially risky sexual economies (Akeroyd 1997, Addai 1999, Becker et al. 1999, Decosas1996, Fourn and Ducic 1996, Rugalema 2004, Lurie et al. 2004).

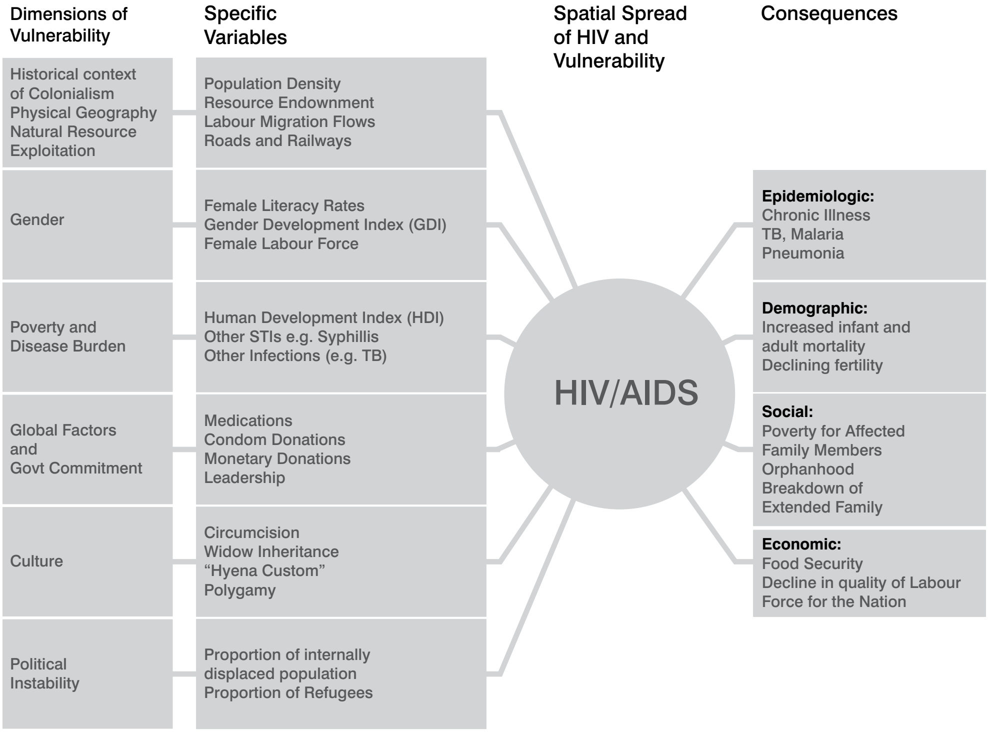
In this vein, Eileen Stillwaggon's work on the determinants of the spread of HIV maintains that the over-sexualized African is a myth, suggesting instead that the variation in space of other social, economic, and health determinants can explain the distribution of HIV prevalence across sub Saharan Africa (see Stillwaggon 2000, 2001, 2002, 2003). In light of the above brief literature review, there are several areas of inquiry that need to be addressed in a comprehensive manner in order to understand the complex macro- and micro-level drivers of HIV. In developing a conceptual framework for this study we have identified six such areas which we believe constitute the major multiple and overarching dimensions of vulnerability. These are the historical context of colonialism and labor migration, gender, poverty and disease burden, global forces, culture, and government attitudes (see Figure 1). As noted earlier, the central aim of this paper is to highlight these drivers and offer some specific case studies that highlight the scenarios of vulnerability as highlighted in the model.

The Historical Context of the Colonial Economy

The high prevalence of HIV/AIDS in the AIDS belt (southern and eastern Africa B see Figure 2 about the progression of HIV in space and over time) is strongly related to the interconnectedness of the physical environment, history, international migration, and Eurocentric views of the region (Yeboah 2004). Because of the excellent climate in eastern and southern Africa conducive to European settlement, rich soils, presence of numerous minerals (gold and diamonds among them) and other resources, Europeans came to settle to this part of Africa in contrast to tropical West Africa. In doing so, they established islands of economic development, setting in motion massive movements of labor from rural areas to resource rich areas in eastern and southern Africa. The intermixing of peoples on a grand scale meant also the spread of various diseases from one part to another, particularly sexually transmitted diseases.

An excellent example here is South Africa. The high prevalence and incidence rates of HIV/AIDS in South Africa are illustrative of the lingering impact of colonial rule and its economy. South Africa has a long history of political unrest as well as racial and social tensions. The legacy of colonization and apartheid includes a large population of economically disenfranchised people. During apartheid the black population, which comprised 80 percent of the total population, was forced to live on only 13 percent of the total land area of South Africa. Much of this land was environmentally marginal, of poor quality for agricultural purposes, and lacked any meaningful resources to form

* **Figure 1:** Conceptual Framework of Vulnerability to HIV/AIDS in Africa



viable livelihoods for the black population of South Africa (Desmond 2001, van Niekerk 2001). This lack of economic prospect has forced many black people to migrate on a seasonal basis to towns, cities and mining areas. With the end of apartheid over a decade ago, South Africa has emerged as a leading economic power, but continues to struggle with the economic marginalization of selected population groups. This struggle has indirectly contributed not only to South Africa's rapid increase in HIV/AIDS cases but also to the challenges facing the country in combating the epidemic.

The major economic factor contributing to the rapid spread of HIV/AIDS in South Africa is migrant labor. In South Africa, migrant workers include rural to urban migrants, foreign workers, truck drivers, young women, and mine workers. Because of the dearth of job opportunities and very low incomes in rural areas, many heads of households, mainly young men, are forced to migrate to urban areas in order to find employment. It is generally assumed that when young men leave rural homes in search of work in urban areas, they may engage in sex with other women at areas of destination, putting the women or themselves at risk of infection. Prolonged separation from their wives encourages miners to have sexual relationships with other women and, for that matter, other men. When they return to their rural homes, those infected with HIV infect their rural partners as well. This circular migration is typical of the patterns of movement of young men and women throughout southern Africa (Horwitz 2001, Campbell 1997). A substantial amount of research has also focused on the role of truck drivers in southern and eastern Africa as a major player in the rapid spread of HIV/AIDS (Gilgen et al. 2001, Gould 1993, Bwayo 1994, Mbugua et al. 1995, Lankoande et al. 1998, Laukamm Josten et al. 2000, Marcus 2001). In short, the colonial economy that was introduced in southern and eastern Africa during colonial rule has fostered a fertile environment in which men and women find themselves vulnerable to the rapid spread of HIV.

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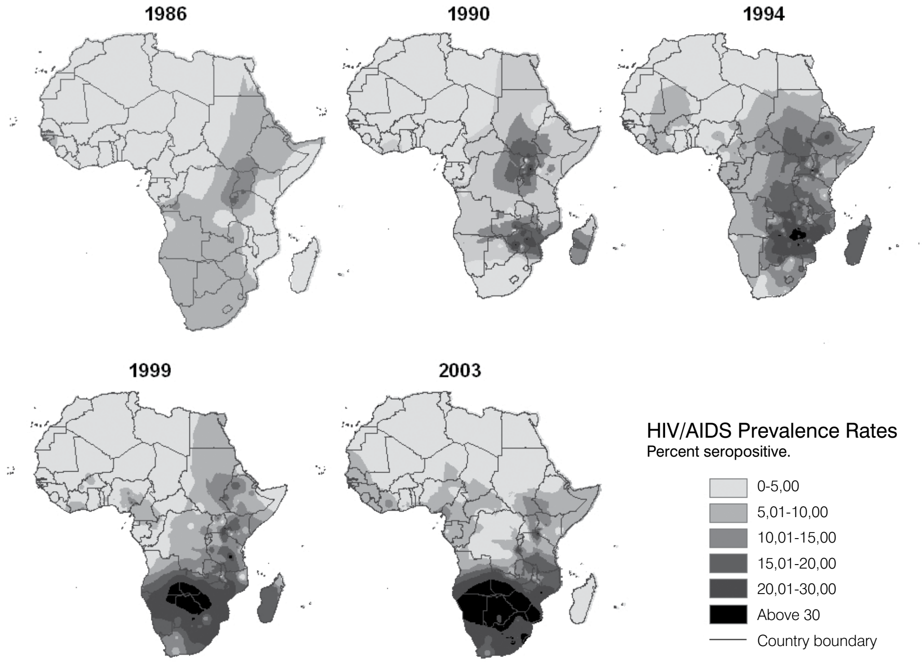
Gender and Vulnerability to HIV/AIDS
In a recent study, Duffy (2005) finds that in Zimbabwe women's existence is difficult and oppressive, and their socialization to become workers and mothers occurs within a context of limited voice, subservience, violence, and economic powerlessness, all barriers to HIV prevention. Through analysis of sociocultural and economic factors, it is suggested that cultural beliefs and practices, along with national and international forces, support and sustain gender inequality (Duffy 2005). She argues that for a change in the AIDS crisis, prevention strategies need to be multifaceted, consider people's culture and context, and include gender analysis. Indeed, when we examine the statistics on prevalence and incidence of HIV/AIDS in sub-Saharan Africa it is clear that the pandemic has increasingly affected women. As Delay (2004) notes, women's biologic, cultural, economic, and social status can increase their likelihood of becoming infected with HIV. It is therefore important to examine variables that measure gender empowerment carefully in order to understand the variation of this pandemic in both time and space.

Indeed, what needs to be emphasized here is the hypothesis that gender equality is crucial if this disease is to be arrested. Female autonomy is important in the sense that a single mother with children and duly employed in gainful employment is unlikely to resort to commercial sex work, for example (Kalipeni 2000). Study after study has found out that women's vulnerability to HIV is closely related to gender relations, economic dependency and cultural factors. Women and girls are particularly vulnerable because of their lower social status, which in turn influences their economic status. Social factors including unequal access to education, training, and assigned roles in society contribute towards vulnerability (Travers and Bennett 1996, Akeroyd 1997, Lamptey et al. 2002, Kalipeni et al. 2004, Campbell and Mzaidume 2001).

Poverty and Disease Burden
As Stillwaggon (2001) points out, even a brief survey of economic conditions in sub-Saharan Africa in the years in which the AIDS epidemic began reveals an extremely compromised health environment. She notes that from 1970 to 1997, sub-Saharan Africa was the only world region to experience a decrease in food production, calorie

HIV/AIDS Prevalence Rates for Selected Years



* HIV/AIDS Prevalence Rates for Selected Years

supply and protein supply per capita. In another lengthy paper, Stillwaggon (2002) discusses the major factors, all related to poverty, that have made Africa a fertile terrain for the spread of the epidemic. These include economic background of African health, parasitic diseases such as malaria, trypanosomiasis, onchocerciasis and numerous other diseases including sexually transmitted diseases and tuberculosis as co-factors for HIV/transmission, and poor nutrition which compromises the immune system. In a similar vein, Lau and Muula (2004) list a number of factors as drivers to HIV including worsening economic conditions, food shortages, and urbanization. Indeed, many studies have argued that poverty reduction is key to containing HIV/AIDS.

The high prevalence and incidence rates of HIV/AIDS in South Africa are illustrative of the lingering impact of colonial rule and its economy.

Global Forces and Government Commitment

Under this dimension of vulnerability, if data were available, one could examine the assistance from the developed countries in terms of medications, vaccines, condom donations, and monetary donations. In a recently published article, Kalipeni and Mbugua (2005) critically review the international response to the HIV/AIDS epidemic in Africa and lament the missed opportunities over the past 20 years. However, these two authors also comment on the many efforts that have been exerted from the developed world to ease the suffering brought about by this epidemic in the developing world, particularly Africa. Lurie et al. (2004) show how policies of structural adjustment and economic restructuring introduced by the World Bank and the International Monetary Fund may have contributed to the spread of HIV in developing countries.

For the few cases of success in combating this disease, government commitment, not in terms of money but rather idiosyncratic leadership qualities, has proven to be extremely useful in either stopping the epidemic in its tracks (e.g. Senegal) or reducing the high HIV/AIDS rates (e.g. Uganda). For an in-depth examination of these two case studies see the following studies Hogle et al. 2002, UNICEF 1999, Uganda AIDS Commission 2002, Oppong and Agyei Mensah 2004, Meda et al. 1999). Based on the above two examples, we note that whereas it is true that sub Saharan Africa remains by far the worst affected region in the world, there are hopeful signs that it may be possible to stem the tide of the epidemic if the international community, governments and the concerned communities work together. A closer examination of the Uganda and Senegal cases show that the introduction of the ABC prevention model was not emphasized over the cultural practices. Indeed, polygamous relations in Senegal (a largely Islamic society) were not done away with, but on the contrary were respected as a "traditional and effective means" of prohibiting promiscuity and therefore preventing STIs [in the Islamic religion, promiscuity is punishable by death; however, polygamy is an accepted norm and in a polygamous union the husband is expected to be faithful to his wives and the wives to their husband which explains polygamy as being an effective means of prohibiting promiscuity and prevention of the rapid spread of STIs].

The Cultural Dimension

Perhaps the most complex driver of the variation of HIV/AIDS in sub-Saharan Africa is culture. Yeboah (2004) writes that one of the most difficult issues to write about in terms of HIV/AIDS in Africa is African culture(s) because one may fall victim to the fallacy of portraying African culture as inferior, unfortunately a trap which many authors on this subject have fallen into. It has, for example, been noted that Africans are sex positive (e.g. they highly sexual), promiscuous, immoral, that they practice evil customs such as polygamy, widow inheritance, and the immoral deflowering of young girls (the hyena custom), and so on (see for example, Rushing 1995, Shannon et al. 1991, Oppong and Kalipeni 1999). Indeed, the cultural paradigm in the spread of HIV/AIDS posits that traditional practices, often conducted in secrecy, may carry increased risk of sexually transmitted infections and that multiple partnerships are more socially acceptable than in other cultures. Further it is noted in this paradigm that women have little control over their sex lives, and thus vulnerable to HIV (MacDonald 1996). Yet in terms of polygamy other studies have found a perfect mismatch between HIV/AIDS rates and rates of polygamy. Polygamy is most intense in northern Africa where it is a well entrenched institution in Islamic societies and yet this same region is experiencing the lowest HIV/AIDS rates on the continent (Tastemain and Coles 1993, Oppong 1998). In contrast to such stereotypical views and research, other scholars have found that some practices on the continent may actually aid in stopping the rapid spread of the epidemic. For example, a map resembling the HIV/AIDS rates in 1989 is presented in a paper by Caldwell and Caldwell 1994. This is a map of the societies that have traditionally not circumcised males. The hypothesis is that there is a strong positive relationship between not being circumcised and HIV/AIDS rates..

> In short, the colonial economy that was introduced in southern and eastern Africa during colonial rule has fostered a fertile environment in which men and women find themselves vulnerable to the rapid spread of HIV.

Political Instability

The final dimension identified in the conceptual framework in Figure 1 that puts many people at risk of infection is political instability. As highlighted in Kalipeni and Oppong (1998) Africa has had its fair share of political strife which has generated millions of refugees and internally displaced peoples. The consequences and potential for the spread of disease has been tragic. AIDS is particularly worrisome among refugee populations, particularly powerless children, young girls and women (Kalipeni and Oppong 1998). Sexual violence and exploitation are a shockingly frequent experience for refugee women before or during flight and even in refugee camps. A recent scandal in the Democratic Republic of the Congo has revealed that young girls, as young as 10 years of age, are not immune to rape by even United Nations soldiers supposedly posted at the camps to protect them from marauding rebels (Holt 2004). Where political instability is rife, sexual violence is routinely an element of the persecution of women. Unfortunately, a high risk of infection with sexually transmitted diseases including HIV/AIDS accompanies all sexual violence against women and girls (UNICEF 2001). Yet refugee women commonly lack even the most basic elements of reproductive health care while facing unwanted pregnancies, unsafe abortions and other risks such as sexually transmitted diseases.

VULNERABILITY TO HIV: THE CASE OF A LOW INCOME AREA OF LILONGWE IN MALAWII

Utilizing the specific framework discussed above it is possible to envisage specific scenarios of vulnerability before and after infection. The framework makes it possible to examine the social, political, economic and cultural factors which increase the vulnerability of people to

HIV/AIDS. These factors result in situations of powerlessness of individuals and communities at large. Below we offer specific cases in which people become vulnerable.

Study Design and Limitations

In 2003 Kalipeni and Ghosh carried out fieldwork on the perception of risk to HIV among men and women in Chinsapo, a peri urban area at the southwestern tip of the city of Lilongwe. Chinsapo is a low socioeconomic residential area on the outskirts of the city of Lilongwe. It exhibits both rural and urban characteristics, and its residents predominantly commute into the city center of Lilongwe to work in the informal sector selling crafts and household items by the side of roads. Many of the residents in this area are new migrants from rural Malawi. We were interested in finding out how women in this area are responding to the HIV/AIDS epidemic. Chinsapo, as a residential area, is characterized by high population density and lack of building standards. The poor and new immigrants prefer to live here because they spend less money on rent. As an immigrant society, many of the people that leave here are in the 15 44 year age group.

Study after study has found out that women's vulnerability to HIV is closely related to gender relations, economic dependency and cultural factors.

In this study, we employed a typical social science design in collecting the data using two well-known and tested methodologies, i.e. a structured questionnaire which was administered individually to 60 randomly selected women and two focus group interviews with 20 women, 10 women per focus group. In early 2003 we developed a proposal for this study entitled AHIV/AIDS in Malawi: A Gendered and Vulnerability Perspective". The proposal was submitted to the University of Illinois Institutional Review Board and the Institutional Review Board for the Protection of Human Subjects at Dominican University of California for ethical clearance for the research in Malawi, since we were going to involve human subjects. The submission of the proposal included consent protocols for both one on one interviews and the focus group interviews, which were both in Chichewa, the local language, and English. All the participants knew how to read and write, at least in Chichewa. Permission to hold the structured and focus group interviews was also obtained from the councilor or the headman of the ward in which the participants were selected.

The focus group interviews were segregated by gender, which was necessitated by the fact that Malawian society is dominated by men. Women do not ordinarily speak if men are present; however, in groups of women only, they often speak their minds openly. For the one-on-one structured interviews with women, we chose female interviewers based on the premise that the questions in the questionnaire were sensitive and private issues, and that women would be more open to discuss these issues with female rather than male interviewers. In these interviews, questions were asked about religion, family background, economic conditions of the individuals, marriage history, family planning and social networks, fertility, sexual partnerships and HIV/AIDS. The two female interviewers were familiar with the area as they also lived here and spoke the local language, Chichewa, understood by all the residents. For the focus group interviews, discussions were informal in nature. We asked about people's perceptions and understanding of HIV, what people thought about prevention of infections, and changing social and cultural practices. Surprisingly, the focus group discussions were a great success as women were more open to discuss issues than in the structured one on-one interviews.

Indeed, the results of the one-on-one interviews confirmed our fears. For example, a number of the female respondents were not comfortable giving the requested information on their knowledge and practices regarding AIDS, and whether they had talked with friends about family planning and AIDS. Other women were afraid or shy about giving information on extramarital affairs because they feared that we might report the information to their husbands, in spite of the fact that the consent form emphasized confidentiality. Some women refused to be interviewed because they said the questionnaire had too many questions and that they were afraid that their husbands might find them being interviewed because of the length of the interviews (about an hour and a half). A few women refused to hear mention of certain words such as condoms because of their religious beliefs which forbade them to say such words. Women who objected to being interviewed or to continuing the interview after it had started were dropped from the sample.

Example 1: Gender and Poverty

In this study, a young woman, age 17, who had migrated from a rural area of Mchinji District, 54 miles west of Lilongwe City, told us the following story (see Ghosh and Kalipeni 2005):

> *I was in standard (grade) 6 at Guillimme Catholic Primary School when my father died in 2002. He used to grow tobacco to pay my school fees. Without him around, and coming from a family of 6 children, four boys and two girls, I was forced to drop out of school. My mother could now only afford to send the two boys to school. My mother asked me to see if I could come here in Lilongwe to look for a job. I came to stay with my aunt who lives in Area 10. But after 6 months I could not find a job and I was forced to move out of my aunt's house as they have their own children to look after. A friend of mine took me in here at Chinsapo. She also does not have any employment. During the day we go to Lilongwe Market to sell second hand goods, but there is a lot of competition there. At night we try to do all we can do to get a little income. Sometimes we stand by the roadside to see if we can be picked, at other times we go to Lilongwe Hotel, Lingadzi Inn and other such places when there is a conference. If we are lucky in a night we might come back home with a bout K200 (US$1.50). Some men they just use us without paying us and we are afraid of being beaten to ask for the pay. Life is tough here in the city, but it is even tougher in the village where I came from. From time to time I am able to send a little money to my mother but I don't reveal how and where I get it.*

For the few cases of success in combating this disease, government commitment, not in terms of money but rather idiosyncratic leadership qualities, has proven to be extremely useful in either stopping the epidemic in its tracks (e.g. Senegal) or reducing the high HIV/AIDS rates (e.g. Uganda).

It is easy to see that poverty and the low status of women have resulted in this girl's precarious situation. In further interviews with her she revealed that she was scared that she might get infected with HIV. She indicated that some men like to use condoms and others don't like condoms and she has to oblige in both instances and she needs the money badly. The HIV infection rate among commercial sex workers in Malawi is very high (estimated at 70% infection rate B see Cole and De Blij 2007), as many of the clients are HIV infected and pass the virus on to the girls as they in turn pass it on to other clients. But as noted by this girl, they are forced into these acts by the untenable circumstances they find themselves in.

Example 2: Gender and the Status of Married Women

In the same study by Ghosh and Kalipeni in 2003, a married woman clearly articulated her position in the marriage, particularly the factors that make it difficult for women to protect themselves (see Ghosh and Kalipeni 2005). This woman noted the following:

> ***My husband died 6 months ago. He got so thin, began coughing, developed a rash, much like the rash that affects people with this disease they call AIDS. I know he died of AIDS because I too I am losing weight and beginning to cough. I know I have it and I am soon going to die. I have three kids and I am worried as to who will take care of them once I am gone! It is very worrisome. I knew that my husband was moving around with these girls of low morals but I was afraid to ask him to take precautions. I wish I had left him immediately. I knew he was a cheater, but I am powerless, as I come from a poor family. The cattle he paid for the bride-price have all been slaughtered or sold by my parents.***

This woman comes from the northern part of Malawi where patrilineal groups such as the Tumbuka ethnic group are predominant. They follow the patrilineal system in which bride-price (lobola) is paid for women before marriage. Once a woman is married divorce is almost impossible as she would have to repay the bride-price back to the man's relatives. This puts women in bondage to men. Thus, married women, even if they are faithful to their husbands, are at risk of being infected by unfaithful husbands.

Example 3: Labor Migration and Vulnerability to HIV

Kalipeni and Ghosh (In press) also conducted interviews with men in the Chinsapo area. One of the men we interviewed is typical of young Malawian men that migrate to South Africa to work in the mines. He had completed standard 8 which is the highest level in primary or elementary school. Upon completion of standard 8, he did not proceed to secondary or high school but rather chose to migrate to South Africa to work in the mines. This gentleman, now in his late 30s in terms of age, noted the following.

> *I completed my elementary schooling going up to Standard 8 [elementary school Grade 8] long time ago in the early 1980s at Ntakataka in Dedza District. Immediately I completed my standard*

> *8 studies, I left for South Africa on WENELA in those days, they call it THEBA now. I was working in a gold mine in Joburg. You know, with WENELA, we used to stay there for three years nonstop without coming home. But I had to go to earn money because I wanted to marry this girl. I came back after three years, married my wife and went back again. You know WENELA would not allow us to bring our wives with us. In South Africa I had this kazintombi [girl] that I used to visit from time to time. I think I made her pregnant but I can't be sure because she had other men but she pointed me out. I came back for good to Malawi in 1995. Since then I have been very sick, my wife just died last year and I am now taking care of my kids all by myself. One is in secondary school and the other two are here with me. I think it is this kachilombo disease. [Kachilombo is one of the many names for HIV/AIDS in the local language Chichewa – for the many local names used to refer to HIV/AIDS see Muula 2005].*

More discussion with this gentleman revealed that it was not just in South Africa that he was moving with other women, but also in Chinsapo. It is likely he might have gotten the disease from South Africa, brought it back to Malawi, and infected his wife and others in Chinsapo. Indeed, the major driver of the HIV/AIDS epidemic in southern Africa is thought to be the colonial labor migration system, as amply discussed in our framework.

Where political instability is rife, sexual violence is routinely an element of the persecution of women. Unfortunately, a high risk of infection with sexually transmitted diseases including HIV/AIDS accompanies all sexual violence against women and girls

TACKLING AND DIMINISHING VULNERABILITY TO HIV/AIDS

As Stock (2004) points out, Africa is one of the most important producers of minerals that symbolize opulence and solid, inflation-proof wealth. About 25% of gold and over 50% of diamonds in the world come from Africa. Yet, as Stock (2004) laments, the continent is known for its poverty rather than its prosperity. Indeed, as one examines the dimensions of vulnerability in the conceptual model, many of them are deeply rooted and they are here to stay. The historical context of colonialism and its long-lasting effects cannot be done away with overnight. However, for some of the factors, there are certain actions which could be implemented at the local level with genuine government commitment and well-meaning international support. Below we offer four important general recommendations to remove some of the obstacles that put women and children in vulnerable positions in sub-Saharan Africa.

1. Fixing gender inequality

An aspect that lends itself well to the fight against the proliferation of diseases including HIV is female autonomy, agency and empowerment. This is also the easiest to tackle and yet many African countries lag behind. It has been shown throughout the world that educating women has great benefits for the rest of society in many ways than one. We recommend that researchers, policy makers, international donors, and African governments should take on greater responsibility for the total cost of education, particularly for girls who have lost their parents and are therefore unable to afford an education on their own. Equal access to education for both boys and girls should be considered as a long-range strategy to combat this disease.

The thinking here is that the limited education of girls increases their vulnerability because it limits their options for knowledge to protect themselves from sexually transmitted diseases and limits their options for employment thus resulting in their having to resort to informal employment, which at best may be domestic work and at worst, may be selling sex. Any form of employment, whether it overtly involves selling sex or not, places women at risk of sexual abuse because of the limited physical and social power that women have in the employment arena and the lack of monitoring or regulations in such employment. Ensuring that women have access to education and have the opportunity to complete their education is, therefore, one way of reducing their vulnerability. Education for women often means economic independence and the ability to choose freely from the various employment opportunities available, many of which do not expose them to HIV infection. In short, specific emphasis should be placed on protecting and educating vulnerable groups, particularly infants, children, women and the very poor. All efforts should be made to ensure the care of orphans, particularly females who are vulnerable to sexual abuse, in order to reduce their risk of HIV infection.

Another recommendation in this direction is increasing the availability of microcredit loans to women. Many women remain in relationships in which they are at high risk for HIV because they are economically dependent on their promiscuous partners. Having an alternative source of income that allows women to be economically independent gives them the freedom to disengage themselves from an unhealthy relationship if they are concerned that the relationship places them at risk for HIV infection.

Where violence against women is well entrenched, governments should enact appropriate laws and enforce them to make it illegal. Heavy penalties in such offences should be levied. One way the media in Malawi is assisting in this respect is to print horrific stories of such acts in their newspapers with the hope that this would shame the perpetrators and would-be perpetrators. Horrific stories of men defiling their female babies and adolescent daughters, men mutilating or cutting off the limbs of their wives, men dousing their wives with petrol and setting them on fire, aggravated assaults and rape and so on are today openly reported in the newspapers. The printing of these stories and the identification of the perpetrators in the news has had the effect of “naming and shaming” the perpetrators, but certainly more needs to be done.

It is easy to see that poverty and the low status of women have resulted in this girl’s precarious situation.

2. Poverty, disease burden and global assistance

As noted above, Africa is a rich continent but sadly it continues to be a basket case. Years of exploitation and neglect during the colonial era and the post-independence era have seen untold suffering on the continent. We recommend continued support from the international community in one form or another. Examples might include appropriate forms of aid and technology, provision of affordable medications to treat all forms of maladies, not just HIV, provision of assistance to educate the population on how to avoid being infected with HIV and so on. As we argue elsewhere, the only way African countries are going to move through the various stages of the epidemiologic transition is through the eradication of communicable diseases on a sustainable basis. Indeed, advances in the development of vaccines and chemotherapeutic agents have brought many communicable diseases under control (see Kalipeni 2000). But these need to be made available widely to those who need them, particularly those afflicted with HIV/AIDS. With reference to poverty, lender and donor nations should continue their programs leading to debt forgiveness so that African countries can begin to focus on investing in education, health and real development to end poverty and hunger.

3. Culture

We recommend extensive but culturally appropriate research on this topic. We often hear about the detrimental effects African archaic customs and traditions have on the spread of the HIV/AIDS epidemic. However, nobody seems to have any data on the prevalence of these customs. How widely spread and practiced are customs such as widow inheritance, deflowering of girls (hyena custom) and polygamy? What other cultural customs are out there that might help spread this disease? How might these customs be abolished in a culturally acceptable manner? There is currently great need to conduct micro-level research in this area via the social science paradigm.

4. Political instability

Political instability is an intractable problem in many African countries that are experiencing or have experienced civil strife. Nevertheless stronger political and economic commitment and action by local, regional and international actors can certainly help to achieve long lasting solutions. In this regard, we recommend continued political reform and peace accords, engagement and empowerment of pan African organizations, foreign policy changes by Western governments and greater vigilance of non governmental organizations (NGOs) such as Medicus Mundi Catalunya in the surveillance of disease outbreaks and allocation and distribution of relief aid in refugee camps. Pan African organizations such as the African Union at the continental level and ECOWAS, the Southern African Development Coordination Conference (SADCC), the Arab League, etc. at the regional level should be empowered not only to keep the peace at the continental level and in their respective regions but also to prevent escalation of political violence and conflict. We also strongly recommend that there be accountability of peace keepers guarding refuge campus to make sure that abuse of vulnerable groups such women and children (as recently happened in the DRC) does not occur.

5. Labor Migration

The historical context of labor migration is here to stay and will continue into the unforeseeable future. However, the consequences of migration on family and the proliferation of HIV and other diseases can be mitigated through corporate social responsibility. For example, in the case of the mining industry in South Africa companies could inform truck drivers and migrant laborers about risk factors and thereby increase awareness. This will help to reduce the cases of HIV/AIDS, medical cost, and improve productivity. In addition, living quarters for migrant laborers could be dramatically improved. Improvements might include, for example, building of apartment blocks to allow families to come with the men to places of work from their home countries.

Once a woman is married divorce is almost impossible as she would have to repay the bride-price back to the man's relatives. This puts women in bondage to men. Thus, married women, even if they are faithful to their husbands, are at risk of being infected by unfaithful husbands.

CONCLUSION

In this paper we have highlighted a number of dimensions of vulnerability to HIV by developing a conceptual model of how the macro- and micro-conditions might lead people to engage in behaviors that put them at risk. These dimensions are rooted in the history of the continent, especially its colonial interlude. The historical context of colonialism and its economy based on labor migration, contemporary gender issues, poverty and disease burden, global forces and government commitment, and the cultural context have all intertwined in complex ways to put peoples of sub-Saharan Africa at risk of contracting HIV. This framework for understanding vulnerability argues that while behavior and actions are inherently important in vulnerability to HIV, the context is even more critical. Such individual behaviors and actions occur in a social and spatial context, and usually in response to larger-scale social and cultural phenomena, and other dictates or pressures. Thus, any assessment of or research on HIV vulnerability has to include global, national, regional and community factors that influence or exacerbate personal vulnerability. In short, vulnerability is multi-dimensional and results from multiple combinations of factors.

DISCUSSION AND COMMENTS, E. KALIPENI

- The role of education in the struggle against HIV/AIDS is key, because it can contribute to improving women's capabilities and thus to reducing their vulnerability.

- Based on the problematic described by Kalipeni – men with wives in both their country of origin and in the neighboring country where they work – it is clear that both the structure and the concept of family appear to be undergoing a change that, in turn, may affect the epidemiology of AIDS.

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COMMUNITY PARTICIPATION IN IMPROVING ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES: THE MOZAMBIQUE EXPERIENCE

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1. INTRODUCTION

Reducing the rate of new HIV/AIDS infections, as well as of maternal and perinatal mortality, of necessity depends upon universal access to integrated and quality sexual and reproductive health services, particularly in Africa, where both human and material resources are scarce.

Preventing HIV/AIDS transmission, achieving a 75% reduction in its spread by the year 2015, and improving maternal health present an enormous challenge, given the poverty and associated high levels of maternal mortality in the countries of sub-Saharan Africa. Maternal mortality varies from 124 to 1300/100,000 live births in southern African countries with HIV prevalence rates varying from 2% in Madagascar to 38% in Swaziland *(African Union Commission 2006)*.

Reducing the rate of new HIV/AIDS infections, as well as of maternal and perinatal mortality, of necessity depends upon universal access to integrated and quality sexual and reproductive health services, particularly in Africa, where both human and material resources are scarce.

The entire community, both collectively and individually, is urged to reinforce partnerships, and through these develop more effective, low-cost strategies in order to save the lives of the millions of women who die annually.

Only 11% of persons with AIDS in Africa have access to antiretroviral therapies, as against 14% in Asia and 62% in Latin America. The number of young women infected with HIV is almost double the number of infected men in sub-Saharan Africa. It is estimated that in 2001 between 6% and 11% of young women were living with HIV/AIDS, compared with 3% to 6% of young men.

The death of a woman has negative repercussions on the economy of the country as well as on the family. Breastfeeding reduces the family's expenses, especially among the poorest. In addition, most women do not work outside the home, and it is they who care for, educate, and feed the family's children.

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2. CONCEPTUAL FRAMEWORK

Globally, at the end of 2005, the total number of people living with HIV/AIDS (PLWHA) was estimated at 38.6 million, of whom 5.4 million were in sub-Saharan Africa.

The WHO 2005 analysis of causes of maternal death in Africa showed that of the 9 principal causes, HIV/AIDS infection occupied 4th place (6.2%) *(WHO 2005)*.

In most countries where prenatal care, pregnancy and post-natal clinics are an essential part of primary health care, these offer a key opportunity for women's access to services related to the prevention, care and treatment of HIV/AIDS.

Recent studies have shown that in services where health activities are integrated into primary health care, all patients can receive optimum coverage *(Unger et al. 2006)*.

Access to health services is an important factor in health systems and has a direct impact on the control of the population's health. Measurement of access favors the development of evidence-based health policies. Universal access to institutionalized health care requires a well-structured health system in which the community has a central role.

In order to facilitate comprehension, some concepts used throughout this chapter are defined below:

Community: a group of people sharing the same language, rituals and ceremonies, values and norms, having a common history and joined by relationships of mutual support *(Israel 1994).*

Community Empowerment: a state in which the members of a community establish a participatory dialogue through which they identify the things they have in common, resolve conflicts within the community, make decisions and construct new strategies for change. This implies that individuals use their skills, capacities and resources in a collective effort, and influence decisions and changes that take place in the wider social system *(Ibidem).*

Home Care: The Ministry of Health distinguishes between care and home visits.

Care: This is the service provided at home to PLWHA (Persons Living With HIV/AIDS) and their families, which includes: health education, prevention and HIV/AIDS counseling, treatment of symptoms, drug treatment adherence and the referral system between the National Health System (SNS) and the community, with a view to the reduction of HIV transmission and holistic care of PLWHA.

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Home Visits are contacts made with persons or families with the aim of offering social, emotional and spiritual support.

The National Health System does not offer home care (HC), but exercises regulatory functions that include coordination, setting of guidelines, monitoring and evaluation, technical supervision by outpatient services (OC) and health units (HU) by trained professionals.

The major determinants of high maternal morbidity and mortality are delays in the receipt of both general health care, and of appropriate and timely obstetrical care. These determinants are organized into three types, known as the "three delays" *(Maine 1997)*:

First Delay – delay in the decision to seek health care

Contributing factors: illiteracy, low educational levels, poverty, lack of adequate information, women's low status and cultural factors.

Second Delay – delay in reaching a health clinic with appropriate medical and obstetric care.

Contributing factors: the network and distribution of health clinics, distance between home and health clinic, and the availability of transportation.

3rd Delay – delay in receiving necessary and adequate care in the health clinic.

Contributing factors: the referral system, shortage of essential drug supplies, shortage of materials, lack of staff trained to handle obstetric emergencies.

3. THE EXPERIENCE OF MOZAMBIQUE

Mozambique is considered one of the poorest countries in the world. Its current population is estimated, on the basis of the 1997 census, to be about 19,980,935, of which 23% are women of reproductive age and 30.7% are children aged from 0 to 9 years.

On the African continent the average life expectancy at birth is currently 47 years, compared with an estimated 62 years if there were no AIDS. In Mozambique the life expectancy from birth before AIDS was estimated at 42.5 years as against the 27.1 years projected for 2010 . The national prevalence of HIV is 16.2% *(MISAU 2005).*

The Demographic and Health Survey (IDS) carried out in 1997 showed a fertility rate of 5.7% per woman and prenatal coverage of 71.4%, but only 30% of births occurring in health institutions. Forty percent of adolescent girls had already given birth, and the average age at first sexual experience for girls was 16. Knowledge of the existence of AIDS was 80.20% among women, against 93.75% for men. Over two thirds of women (66.26%) knew of no way to avoid HIV infection, as against 47.45% of men. Condom use among women was 1.5% and 3.2% for men.

These results – uneven coverage, high levels of prenatal care, and low institutional birth rates, as well as low condom use combined with high levels of knowledge about AIDS – led us to understand the need for operational research informed by the social sciences.

In addition, because it considered maternal mortality a problem of great importance in

Mozambique, the Ministry of Health simultaneously conducted a review of 90 maternal deaths in 7 of the 11 provinces between 1998 and 1999 in order to identify the principal determinants of maternal morbidity and mortality, as well as an evaluation of the requirements for safe childbirth. The methodology used for the study was based on " Module VI – Review of Maternal Deaths", which is part of the Needs Evaluation for Safe Childbirth (OMS *Safe Motherhood Needs Assesment*).

The study of maternal deaths included various factors influencing these deaths, from the structure of the health services to the community, and had as its objective the design of strategies at various levels to improve maternal and child health. Among the principal causes of maternal death identified were those related to pregnancy, birth and postpartum: puerperal septicemia, hemorrhage and rupture of the uterus. Malaria, anaemia and AIDS were identified as indirect causes of maternal death..

Of the 90 families interviewed, 74% experienced a delay in the decision to seek medical care. Of these, 66% took more than one day to decide to take the patient to the the health clinic.

With respect to utilization of health services, 46% of the women did not go to even one prenatal care visit; 34% had between 1 and 3 visits; and 19% had 4 or more visits.

Community empowerment is interconnected with individual and organizational empowerment.

Of the total number of persons living with HIV in Mozambique, 80,000 are children, 570,000 are men, and 800,000 are women. There is a growing HIV prevalence tendency in the population aged 14 to 24 years.

Factors related to the community, such as deciding to seek medical care without delay and the accessiblility of the health clinic, are of great significance for maternal mortality.

The majority of deaths occurred within the first 24 hours, even in health clinics with adequate human resources, medications and materials. This fact points to late arrival at the clinic (personal experience).

Following a review of the conclusions of the study, recommendations were made for specific actions which would support the development of the National Strategy for the Reduction of Maternal and Perinatal Mortality, based on the model of the 3 delays, and its five-year Operational Plan (implemented in 2001), which envisaged, among other objectives, increased access to sexual and reproductive health services *(Ministerio da Saúde 2000)*.

The Demographic and Health Survey (IDS) carried out in 2003 showed an improvement in maternal and child health indicators by comparison with the 1997 IDS. Hospital births increased from 30% to 47.7%; the maternal mortality rate dropped from 692 to 408 deaths per 100.000 live births, and the level of infant mortality from 219 to 178 per 1000 births. Knowledge of AIDS among women increased from 82.20% to 95.66%, and from 93.75% to 97.88% for men. The percentage of women who knew of no methods for avoiding AIDS dropped from 66.26% to 36.24%, although for men the reduction was smaller, from 47.45% to 39.06%. There was a significant improvement in condom use for both sexes: 1.5% to 20.4% among women and 3.2% to 33.8% among women.

The advances achieved in 2003 resulted from the implementation of activities related to the three delays, in spite of degraded infrastructure, shortages of equipment, medications, water, and energy as well as the scarcity and unequal distribution of human resources, with a greater concentration of qualified personnel in provincial and district capitals to the detriment of health clinics located in remote areas.

Activities related to the first delay: Promotion of increased knowledge, and community involvement and empowerment in matters related to reproductive health through:

- Training of community-based leaders and organizations in matters of health: warning and danger signs during pregnancy, birth, postpartum and during the first days and weeks of life; nutritional education with a focus on the pregnant woman and child; and promotion of good breastfeeding practices.

- Training of community activists for: provision of home care to persons living with HIV/ AIDS; community distribution and resupply of contraceptives; mobilization of pregnant women with regard to prenatal assistance, institutional birth, post-natal visits, family planning and MCI (management of childhood illness).

- Training of community youth activists to foster communication with young people through *Geração Biz* ("Generation BIZ"), a joint program of the Ministry of Health, the Ministry of Education and Culture, and the Ministry of Youth and Sport, intended for young people both in and out of school.
- Creation of community transportation systems, with assistance from various sources: bicycle, scooter and animal traction ambulances.
- Capacity building, sensitization and mobilization of traditional birth attendants in order to encourage women to use maternal and child health services and halfway houses for expectant mothers who live far from health clinics.
- Involvement of men in matters related to maternal and child health.
- Joint construction by communities and NGOs of halfway houses for pregnant women who live far from maternity clinics.

Factors related to the community, such as deciding to seek medical care without delay and the accessiblility of the health clinic, are of great significance for maternal mortality.

Community involvement contributes in a significant manner to the increase in access to sexual and reproductive health services.

Activities related to the second and third delays: Improvements in transport availability, the patient referral system, refitting and equipping of health clinics, training of obstetric and emergency care providers, and an increase in the number of health clinics offering basic and comprehensive obstetric care.

Because of the increase in HIV/AIDS prevalence among young people, the Friends of Adolescents and Youth Services (SAAJ) was created as part of the multisectoral Adolescents and Youth Reproductive Health Services (SRAAJ/HIV/AIDS) program for basic care, with community-based satellites that enjoy a high degree of acceptance by adolescents and youth.

To prevent mother-to-child HIV transmission, prenatal-to-postnatal strategies were adopted and integrated into primary health care services. These strategies included providing information about transmission of STIs and HIV; promoting safe sex by ensuring the availability of condoms; promoting counselling and voluntary testing with the "opt-out" option (patients are tested for HIV unless they refuse testing); the diagnosis and treatment of STDs and other infections; promotion of healthy eating habits, discouraging the consumption of alcohol,

tobacco and drugs; and referral of HIV-positive cases for antiretroviral treatment, *(Ministerio da Saúde 2004).*

The experience of sites where the opt-out option is being implemented is that the refusal rate is less than 5%.

Community members are trained through health promotion activities carried out by health professionals in partnership with the United Nations and with NGOs, following a carefully structured programme using audiovisual aids.

Community health workers are selected and trained through initiatives arising from the community itself or from joint initiatives involving the community and the health clinic . These activities are unpaid and participants receive T-shirts and other promotional goods by way of incentive.

4. LITERATURE REVIEW

A review of the literature reveals the existence of certain factors that do not facilitate community use of sexual and reproductive health services *(Edmuns 1987):*

- Long hours spent waiting for treatment or counseling
- Unhelpful attitudes on the part of health professionals
- Distance and travel time to health clinics
- Location of services
- Hours of operation
- Charges for services
- Lack of information about and clear explanation of procedures

In a study carried out on pregnant women in Peru (Proyecto 2000) measuring use of sexual and reproductive health services, the study group was given guidance during prenatal consultations and home visits on a range of topics including self-care, recognition of warning signs, nutrition, psychological counselling, and newborn care. The control group received no guidance. The results of the study showed greater use of services by the study group than by the control group.

Bloom et al., in a study carried out in India, concluded that sociocultural barriers must be addressed, especially during birth, in order to encourage women's acceptance and use of health services.

5. RECOMMENDATIONS

1. Ensure high-quality integrated health services with a view to optimum use of human resources, using the potential of existing resources, and diminishing the stigmatization of the chronically ill, particularly those living with HIV/AIDS.

2. Carry out ongoing in-service training in order to bring health professionals' emergency care skills up to date. This should include treatment of complications resulting from antiretroviral treatment.

3. Reinforce links with the local community by bringing together community leaders and health professionals to deal with problems affecting the community through joint analysis and planning.

4. Analyze the role of traditional birth attendants and clearly define their role in the reduction of maternal mortality, based on evidence not only from Africa, but also from other parts of the world.

5. Promote operational research on the cultural and socioeconomic determinants of decision-making regarding the utilization of health services.

6. Reinforce the social network of community support through small projects which respond to community needs and improve quality of life.

6. PERSPECTIVES

The development of operational research projects should be prioritized. The results of such research constitute the scientific base of evidence on issues specific to the development of appropriate health messages that will not conflict with aspects of culture. This will produce harmonious strategies that are comprehensible to the communities they are meant to serve and can therefore be implemented.

- What are the cultural barriers within communities that impede access to health services?

DISCUSSION AND COMMENTS, E. JACINTO

- It is necessary to take into account social networks as a key resource in access to health services (they provide information and support; they pressure women to avail themselves of health services or to avoid them, etc.)

- In the domain of public health, the social sciences should focus on problems identified either by health professionals, or – preferably – through the work of interdisciplinary teams.

- Traditional birth attendants: if the function assigned to them is referral of women to the hospital in order to give birth, we should be aware that (1) they will continue to attend births since, for a variety of reasons (birthing rituals, trust, etc.), they are highly valued in the community; and (2) the medical system needs them because otherwise it lacks the resources to attend all births.

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OVERCOMING OBSTACLES TO THE PROVISION OF HIV/AIDS CARE, SUPPORT AND TREATMENT THROUGH A PUBLIC, PRIVATE AND CIVIL SOCIETY PARTNERSHIP: THE TASO UGANDA EXPERIENCE

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INTRODUCTION

The world now recognizes that care, support and treatment are key to preventing further spread of HIV. Giving hope to people living with and affected by HIV/AIDS reduces stigma, encouraging those who are HIV-positive to come out openly and give a human face to the pandemic, and ultimately enables more effective prevention. A community without hope cannot take the steps necessary to prevent the spread of HIV.

The world is also recognizing that as care, support and treatment begin to roll out, women and girls who are the most vulnerable and most impacted by the AIDS pandemic are falling between the cracks. Stigma and fear of stigma are now recognized as key reasons why many women are unable to access treatment and other HIV-related services. A clear example is that of efforts to roll out prevention of mother-to-child transmission of HIV services. Many women in African countries are not seeking out these services for fear of stigma. A new mother will fear being seen not breastfeeding her baby as this will immediately lead others to the conclusion that she is HIV-positive. If she has not shared this information with the significant others in her family and community because she fears that she will be stigmatized, she might choose to breastfeed even though she knows that this increases her baby's exposure to HIV.

Care and counselling services which extend to the family, and community education and sensitization with meaningful involvement of HIV-positive people in community programs contribute greatly towards addressing stigma and improving access to services by the most marginalised.

This chapter will highlight the unique features of the foundation of TASO (The AIDS Support Organization), its package of care and support services, and the pivotal role it has played in Uganda's relative success in responding to the challenges posed by the HIV/AIDS pandemic. The TASO example will be used to illustrate the fact that public and civil society partnership can be used to address issues of access to HIV services for the most marginalized, including women and girls.

TASO´S MISSION

Uganda was deeply fortunate in that as early as 1987 it saw the establishment of TASO, an organization which provided care and created a supportive environment for people living with HIV and AIDS (PLWHA), enabling them to come forward and be open about their status even long before the introduction of antiretroviral treatment. TASO understood in those early days that since its focus was on poor people, the majority of who were women, its natural partner was the Ministry of Health and its public health units. Over the years a remarkable partnership between TASO and the Ministry of Health has created excellent services for PLWHA in those hospitals where TASO is situated. In addition, through its training programmes TASO was able to reach out and train hundreds of health workers around Uganda in care and support skills. TASO and the MOH have an existing memorandum of understanding that recognizes the work that TASO does both within government health facilities and in the communities they serve.

The AIDS support organization TASO in Uganda is one of the earliest grassroots community responses to the HIV/AIDS pandemic in Africa. TASO was founded in 1987 as a support group for and by people living with or affected by HIV/AIDS. One of the founding members, my husband Christopher Kaleeba, was diagnosed with AIDS in June 1986 and died within a year of his diagnosis in January 1987. By the time of his death, however, the momentum of "living positively" had caught on, and I helped to lead the transformation of the support group into a fully fledged AIDS service organisation which is now recognised as one of the key pillars on which the success of the national response to HIV/AIDS in Uganda rests.

Twelve of the original founder members of TASO were themselves HIV-positive, while the others were close family members and one was a physician. TASO founders adopted "living positively" as their slogan in order to counter predominantly negative messages giving the impression that a positive diagnosis was synonymous with a death sentence. At the time, the public, health practitioners and national leaders were engaged in a debate over the merits of spending meagre resources available within the health care system to care for people who were dying. TASO founders persuaded the authorities, through practical demonstration of what could be done, that people with AIDS, if cared for, can achieve a good quality of life and can greatly contribute to prevention. TASO founders were realistic and recognised that they were dealing with a fatal illness, but they were very concerned that people who were dying of AIDS were being neglected by family and friends and were not being given a chance to die with dignity. Those families which stuck it out and cared for their loved ones who had AIDS were isolated, stigmatized and had no support from their communities, not even from their faith communities. The TASO founders also believed that HIV prevention would not be possible without restoring hope within communities, and that as long as stigma and prejudice against people with HIV continued, the pandemic would continue to spread. They were convinced that a community without hope cannot protect itself from an infection like HIV.

TASO expanded its “living positively” slogan, adding “dying with dignity”, and as the support group began to evolve into an organisation, the founders developed a clearly articulated philosophy: TASO’s mission was to contribute to a process of restoring hope and improving the quality of life of people and communities affected by HIV infection and disease. TASO developed a package of services deriving directly from this mission, which have evolved in content and scope:

Provision of HIV/AIDS counselling services
Counselling services are provided for people who are infected with HIV and their families at TASO centres, in hospital wards and in homes by trained personnel. Though the emphasis is on HIV/AIDS counselling, TASO also offers information, guidance and referrals on sexually transmitted diseases and family planning, particularly to women.

The TASO counselling package includes pre-test, post-test, and prevention counselling as well as ongoing support. Since the majority of the clients who seek TASO services are women, careful steps are taken to bring the spouse and significant others into the counselling circle, as failure to do so may lead to blame and rejection of the woman, particularly by her spouse. She then becomes the entry point into the family and community, beginning with the persons to whom she chooses to disclose this information. With her consent, and using the process she is most comfortable with, family members are given counselling and guidance as to how to support and enable her to live positively. Family counselling is aimed at dispelling fears of contracting infection through ordinary day-to-day contact with the infected person, and education in simple nursing and care techniques and early detection of common opportunistic infections such as tuberculosis. Opportunity is also provided for HIV testing as well as reinforcing prevention messages. Emphasis is placed on self-care, lifestyle change, good nutrition, treatment adherence, a positive sex life, and succession planning. Counselling also incorporates elements of palliative care, spiritual reflection, and bereavement counselling for family.

Provision of medical services
Since its inception, TASO has provided complementary medical and palliative clinical care and support to PLWHA at the counselling centres two to three times a week. One TASO centre in Entebbe offers clinical outpatient medical care five days a week in response to heavy demand and ongoing operational research at the centre. Services were developed primarily to address medical conditions associated with HIV infection, management of sexually transmitted diseases, and family planning. TASO services were planned to complement those offered at the overburdened national health care facilities. Supplementary community outreach clinics were also developed to operate once a month as a way of providing services to clients who cannot utilise the centre-based services because of the high cost of transportation and their fragile state of health. These outreach clinics are linked with community volunteers who mobilize local clients to use the service, and place them in touch with voluntary counselling and testing services.

This comprehensive medical care package formed the foundation upon which

TASO has built a growing program of antiretroviral treatment. With 7000 clients on ART by end of 2006, TASO is currently one of the key providers of ART in Uganda.

Training and capacity building
TASO undertakes training of HIV/AIDS counsellors and clinical managers, community trainers its for own work, for the Ministry of Health, and for other partners in and outside Uganda. Training and capacity building in organizational development is also offered to community-based organizations through which TASO-like services reach people

in those geographical areas where TASO does not operate directly (see Figure 2 for a map of TASO centers). This enables the package of care to reach more people and makes the work more sustainable. Being the first institution to train HIV/AIDS counsellors not only in Uganda but in all of Africa, TASO has faced a growing demand for training from other organisations with similar activities. It has in turn grown and expanded its capacity, thanks in part to sustained interest and commitment by its funding partners, which include the government of Uganda. The largest portion of TASO financial support comes from international funding, which makes TASO vulnerable. Training curricula have also been developed for the various cadres of community AIDS workers including peer educators and other community resource persons, community trainers, counsellors and counsellor trainers.

Internationally, TASO has shared its experience with and provided training to participants in many AIDS care and prevention initiatives from various African countries. TASO has continued to strengthen its capacity to provide training in order to cope with the increasing demands.

TASO counsellors mobilise, support and train communities to carry out effective AIDS care and prevention activities. In Ugandan districts without TASO centres, TASO offers support to district-level and community-based organisations (CBOs) to integrate HIV/AIDS care and prevention services into their operations. The training provided to CBOs includes counselling skills, basic accounting, bookkeeping, resource mobilisation and project management.

TASO operates a library located within the training centre to complement the training offered. A collection of reading materials and videotapes on national and international responses to the AIDS pandemic are available to users.

Peer counselling and support at the day centre
TASO has day care centres in all its counselling centres where HIV-positive people come periodically for peer support and counselling to help them cope with the day-to-day demands of "living positively". Clients registered with TASO are empowered to maximize their independence and quality of life through participation in various activities such as tailoring and weaving. This helps the clients to develop and practice skills they may later use for individual self-help projects. This shared space in the day care centre also helps to break the isolation felt by HIV-positive people, particularly in the first days, weeks and months following their diagnosis.

HIV-positive people join drama groups at the centres The members of these groups have played a significant role in sensitisation and dissemination of AIDS awareness to communities through a program of public talks, theatre and personal testimonies about their experiences with HIV/AIDS. These drama groups have a powerful impact on their audience, giving AIDS a human face and increasing the potential for behaviour and attitude change among the public.

AIDS challenge youth clubs (ACYC)
These clubs are formed under the auspices of all TASO centres primarily by young people who are children of TASO clients as a means of using their collective experience of living with parents with HIV to deal with this reality and prevent themselves from contracting HIV. The groups disseminate HIV/AIDS information and life skills by reaching out to young people, both in and out of school. Their voices and concerns are a source of insight for TASO with regard to appropriate interventions for young people. TASO provides the training and logistics that enable the clubs to operate.

Material assistance
TASO solicits material assistance in terms of foodstuffs and patient care kits for its clients. This means that these materials are provided as and when they become available. In recent years TASO has had a renewable agreement with the World Food Program (WFP), as well as intermittent supplies from other organizations (International Care Relief, CAFOD). The food is then made available by TASO to community leaders who assess needs and distribute it to the most needy clients in their communities.

Support for AIDS-affected children
Children are the priority concern of most of TASO's clients. TASO therefore offers regular counselling and guidance to all TASO clients' children to ensure a psychosocial environment that enables them to cope with the stress of living with AIDS in their family and prepares them for a possible future without one or both parents. Parents are counselled and guided to disclose their status to their children using interactive methods such as the memory book/box, and to prepare a will. This helps to avoid disputes related to property inheritance, and protects the children from being destitute when their parents die. In addition, TASO provides financial and material support to a limited number of

orphans and vulnerable children selected from the neediest client families. Financial assistance often takes the form of payment of school fees and purchase of scholastic materials and school uniforms. Even from among the needy families, only two children, a girl and a boy, can be supported financially. Children are followed after the death of parents through guardian families who receive help through counselling to provide a supportive environment for the children's social and psychological development.

Advocacy and involvement of HIV-positive people.

TASO has exemplified the involvement of people living with or affected by HIV/AIDS right from its inception. HIV- positive people are encouraged to meet and share their experience of living with AIDS, to provide and receive peer support, and to develop their leadership potential. Those who choose to be open about their status and to be involved in advocacy work are trained and supported, and become the foundation of TASO'S advocacy work within the communities. They often use music, dance and drama to transmit credible messages of positive living, and in so doing give the pandemic a human face and voice in the community.

In addition, TASO has developed a governance structure that has involvement and active participation of HIV-positive people at all levels, from the grassroots to the board of trustees. Through advocacy at international, national and local levels, TASO increases sensitivity and influences those who occupy responsible positions in society to contribute something positive towards the well-being of the infected and affected, and to eradicate the negative effects of the epidemic, especially stigma.

Community mobilization and AIDS education

TASO mobilizes communities to take charge of issues that influence their ability to prevent HIV, to care for affected community members, and to mitigate the impact of the disease in their community. It uses existing community structures of governance, faith-based and cultural groups to identify volunteers who then receive training that allows them to mobilize community resources and facilitate care. People living with AIDS or those affected by HIV play a critical role by sharing their experiences. This involvement of HIV-positive people introduces and maintains openness about AIDS in the communities and thus creates an environment that enables HIV-positive people to live with dignity. As a result, HIV-positive people, particularly women, have taken up leadership positions on issues that go beyond HIV/AIDS.

The power of openness in addressing AIDS

From its inception, TASO recognised the power of openness. TASO founders came to the conclusion that while AIDS stigma thrived and people with AIDS were ostracised and died without dignity, the disease would remain underground and continue to spread. Early TASO volunteers who came out openly about their status were the pioneers of Uganda's response. They constituted an essential element of openness at the personal and family level that facilitated a process of "self-risk assessment", a critical step in taking those actions which help individuals to protect themselves and those close to them.

The openness that made a difference in Uganda had to happen at different but interconnected levels of society. The flow diagram (see Figure 1) can be very helpful in illustrating how the levels connect and have led to visible changes in the pandemic in Uganda, both in lowering the rate of infection and in changing attitudes towards both people with HIV/AIDS, and towards the disease itself.

Taso's key success factors (from the Taso draft strategic plan 2008-2012)

TASO's current executive director, Dr. Alex Coutinho, summarizes the six Ps of TASO's success as follows:

P for "Purpose"

TASO articulated its "purpose" very early in its efforts and takes every opportunity to make all stakeholders aware of and contribute to the purpose of the organization. This purpose is captured in the mission statement: "TASO exists to contribute to a process of preventing HIV infection, restoring hope and improving the quality of life of persons, families and communities affected by HIV infection and disease".

This purpose has provided a road map for all TASO planners and implementers to align programming to the mission, which in turn has enhanced focus, resulting in more effective performance..

P for "Principles" (TASO values)

TASO values have created a distinctive culture for clients, staff, volunteers, and all stakeholders who interact with TASO to unite for the common cause of responding to the HIV epidemic. The TASO family brings together a rich mix of diverse persons, careers, backgrounds, experiences and capacities. Promotion of family spirit makes possible a social blending and bonding that is necessary for the kinds of challenges encountered in direct service delivery to HIV-infected people in a low-resource setting. TASO is guided by the following principles, usually referred to as TASO values:

1. Equal rights, equal opportunities, shared responsibility

2. Obligation to people affected by HIV infection

3. Human dignity

4. Family spirit

5. Integrity

P for "Product"

For more than 18 years TASO has cared for over 150,000 people infected with HIV, pulling many of them back from the brink of despair and hopelessness. TASO has consequently become a household name synonymous with a broad range of compassionate care options usually presented as the philosophy of "Positive Living with HIV". With time, Positive Living has been enriched by the advent of ART, the basic care package, and prophylactic techniques.

TASO's social support services (child education support, food aid and sustainable livelihoods) for the neediest clients have had an additional impact in improving clients' quality of life. TASO services form a holistic care package.

P for "Partnerships"

Partnership has been a core determinant of the organizational and programmatic growth and sustainability of TASO. TASO's partners and beneficiaries include people living with HIV; communities affected by HIV; the government of Uganda and particularly the Ministry of Health and Uganda AIDS Commission; donor agencies and technical support partners; various civil society entities; and TASO staff and volunteers.

P for "Proof"

TASO realized quite early the need to develop and sustain the capacity to provide accountability to all stakeholders. TASO consistently provides accountability (proof) at the following levels:

1. Programmatic accountability (we do what we pledged and agreed with stakeholders to do both quantitatively and qualitatively)

2. Financial accountability (we spend on what we pledged and agreed with stakeholders to do, and endeavour to spend and report in a way that is as true and fair as possible)

3. Cost-effectiveness accountability (we endeavour to our best capacity to generate the maximum benefit of the pledged and agreed-upon services from the available resource envelope)

4. Governance accountability (we regularly and consistently demonstrate all the above forms of accountability to all agreed stakeholder structures)

P for " Posterity"

TASO consciously undertakes activities aimed at ensuring sustainability of the spirit, character and resolve of TASO programming by:

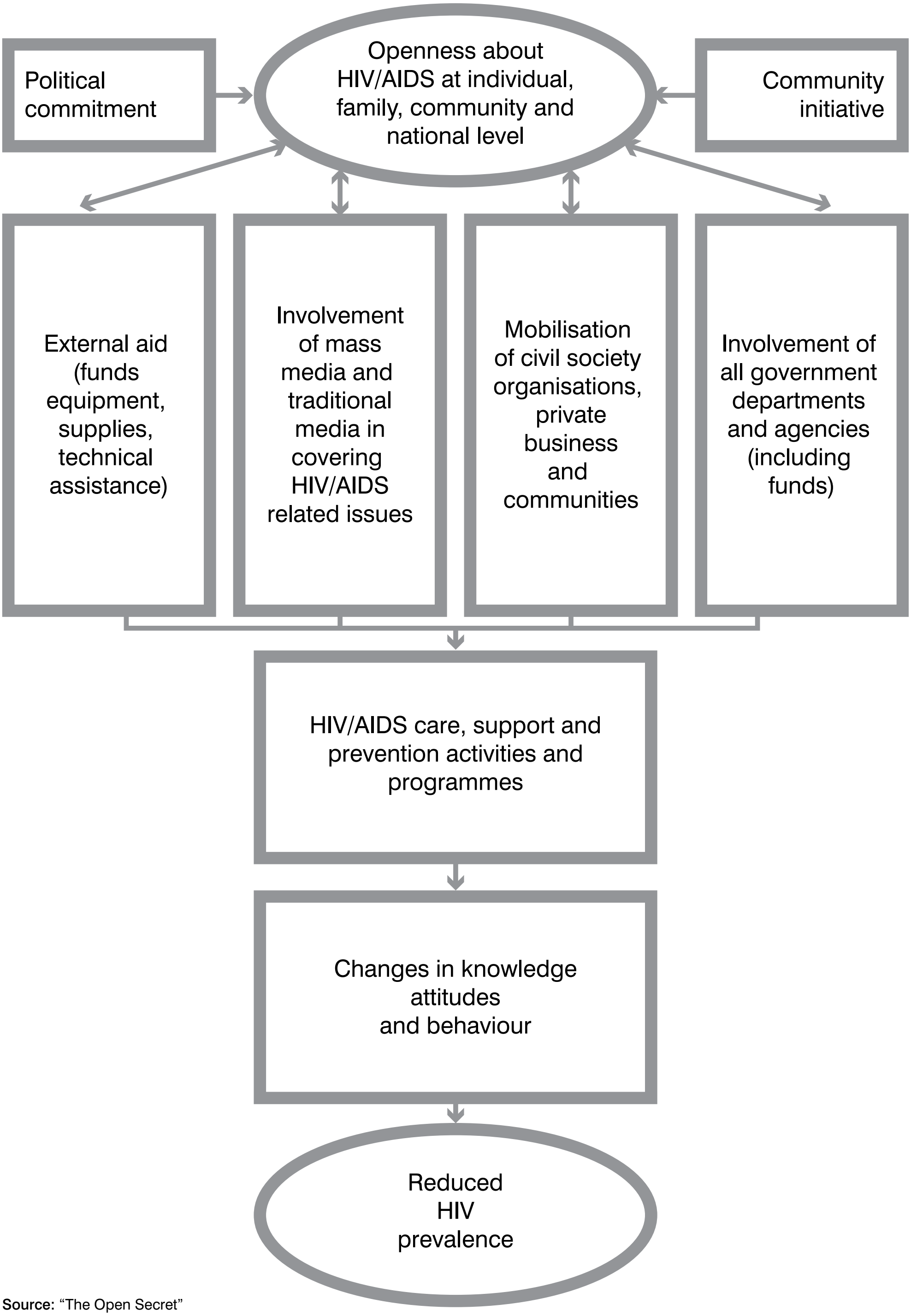
1. Branding

2. Franchising the TASO concept

3. Capacity-building at community and national levels

4. Alignment to national policies and strategies

THE POWER OF OPENNESS TO THE CHALLENGE OF HIV/AIDS



Source: “The Open Secret”
people facing up to the AIDS pandemic in Uganda.

DISCUSSION AND COMMENTS, N. KALEEBA

- There are several kinds of stigma: (1) stigmatization of persons with HIV; (2) self-stigmatization; (3) stigmatization of health professionals working in the AIDS field; and (4) stigmatization of countries where people living with HIV/AIDS are stigmatized (that is, these countries are held responsible for the situation in which patients find themselves).

- On the view of the Catholic Church regarding the use of condoms, different positions have emerged within the African Church hierarchy: comdemnation, tolerance (these two represent the majority), and support.

- A key idea: “openness”. Participatory strategies (for example, the projection of films) are important in facilitating this openness. Nevertheless, openness is not an option for everyone, nor is it appropriate in every circumstance.

APPENDIX
Timeline of HIV/AIDS Epidemic in Uganda

Timeline of HIV/AIDS Epidemic in Uganda (Major Highlights)	
1982	First AIDS case in Uganda diagnosed; response largely based at community level
1986	President Museveni embarks on national anti-AIDS campaign Uganda's health minister announces to WHO assembly the presence of AIDS in Uganda
1987	Sixteen volunteers affected by HIV/AIDS form TASO
1988	First national survey conducted; average prevalence found to be 9%
1990	AIDS Information Centre formed to provide voluntary counselling and testing
1991	Prevalence among pregnant women aged 15-24 peaks at 21% UNAIDS estimates the national prevalence to have peaked at 15%
1992	Government adopts a multisectoral approach to addressing the epidemic HIV prevalence in young pregnant women begins to decrease between 1991 and 93
1994	Various government departments establish individual AIDS control units Government borrows $50 million from World Bank to address the epidemic Other donors increase this amount to $75 million to set up the STI Project under the Ministry of Health
1995	Uganda announces what appear to be declining trends in HIV prevalence
1997	Ugandans participate in a study using antiretroviral drugs for PMTCT
1998	Prevalence among pregnant women aged 15-24 falls to 9.7% The Drug Access Initiative established to lobby for low prices for ARV medication; establishment of infrastructure necessary for ART access
1999	Uganda MOH starts to pilot voluntary HIV testing using rapid tests
2000	Government begins to mainstream HIV/AIDS issues in the PEAP
2001	World Bank agrees to spend $47.5 million over the next 5 years on Uganda's HIV prevention and treatment programmes UNAIDS estimates national prevalence to have fallen to around 5% in 2001
2003	Uganda included among the PEPFAR beneficiary countries Uganda begins to benefit from the Global Fund
2004	PLWHA start accessing ARV medication funded by Global Fund and PEPFAR HIV testing scaled up in Uganda
2005	Global Fund suspends all funding to Uganda HIV prevalence reported to be rising again (UHSBS finds 6% adult HIV prevalence)

Source: TASO draft Strategic Plan 2008-2012

Pillars of Uganda's National HIV Response
Multisectoral approach to HIV prevention and control including care and support services; adopted as early as 1990.
Involvement of political leadership.
Openness about the epidemic, which is vital to fighting stigma and discrimination.
Support and involvement of development partners at all levels of government and civil society.

Source: TASO draft Strategic Plan 2008-2012.

MEDIA AS MEDICAL INTERVENTION: HIV/AIDS AND THE STRUGGLE FOR WOMEN'S REPRODUCTIVE HEALTH CARE IN SOUTH AFRICA

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> *It is 50 years since the women's march [to protest the pass system], but the women of South African battle with HIV, poverty and patriarchy. Yet we live in a country with a Constitution which guarantees equality of all citizens.*
>
> **Sipho Mthathi**, 2006

> *The political economy of underdevelopment, more than sexual intercourse, is killing Africans. Poor harvests, rural poverty, migratory labor systems, urban crowding, ecological degradation, and the sadistic violence of civil wars are the primary threats to African lives. When essential services for water, power, and transport break down, public sanitation deteriorates and the risks of cholera and dysentery increase. African poverty, not some extraordinary sexual behavior, is the best predictor of AIDS-defining diseases.*
>
> ***Charles L. Geshekter,*** 1995

The Confidential Enquiry into Maternal Deaths shows that non-obstetric related infection (HIV/AIDS) is the biggest killer of pregnant women in South Africa. Prevalence among pregnant women attending public clinics has increased from 0.7 % in 1990 to 30.2% in 2005. There are some communities where HIV prevalence among women is up to 60% (Mthathi 2006:1). In 2005 the Actuarial Society of South Africa estimated that there are +/- 5.2 million people infected with HIV, with women being 5% more likely to be infected than men (Mthathi 2006: 3).

INTRODUCTION

On the walls of the new constitutional court in South Africa, and in museum exhibitions across the country, women are celebrated for the role they played in the struggle against apartheid. However, the HIV/AIDS pandemic signals the continuation of race, class and gender oppression in the post-apartheid era with infectious illness, sexual violence, and the gendering of blame preventing women from seeking adequate sexual and reproductive health care. The Confidential Enquiry into Maternal Deaths shows that non-obstetric related infection (HIV/AIDS) is the biggest killer of pregnant women in South Africa. Prevalence among pregnant women attending public clinics has increased from 0.7 % in 1990 to 30.2% in 2005. There are some communities where HIV prevalence among women is up to 60% (Mthathi 2006:1). In 2005 the Actuarial Society of South Africa estimated that there are +/- 5.2 million people infected with HIV, with women being 5% more likely to be infected than men (Mthathi 2006: 3). Sipho Mthathi, General Secretary of the Treatment Action Campaign (TAC), writes, "We have won the war against apartheid, but we do not have equality for all. While we have a Bill of Rights proclaiming to protect the rights of women, we clearly have not won the war against patriarchy" (2006:3).

Drawing on ethnographic research conducted while traveling with a mobile cinema unit in the Western Cape, this chapter offers an effective intervention for breaking the silences that prevent women from accessing sexual and reproductive health care. Due to multiple social factors including poor governance, insufficient availability of HIV treatment, stigma, the gendering of blame, and economic dependence, women are often unable to speak openly about testing, disclosure, mother-to-child transmission, sexuality, and treatment. Using qualitative field methods as a diagnostic tool for identifying the obstacles that prevent women from seeking reproductive and sexual health care, we have found that entertaining, non-didactic documentary films about HIV/AIDS promote open discussion among women and mobilize community based support structures for people living with HIV.

Steps for the Future, or *Steps* – Social Transformation and Empowerment Projects, is an HIV/AIDS advocacy campaign that fuels open discussion about HIV/AIDS through facilitated screenings of locally produced documentary films about living positively with the virus. *Steps* was conceived by Ikka Vehkalahti, documentary commissioning editor at YLE Finnish Broadcasting Company, and Don Edkins, a South African documentary film producer. The collaborative initiative is the largest documentary film project to be undertaken in Africa, with thirty-seven films, ranging in length from four to seventy-four minutes. The films were produced for national and international television and for non-broadcast distribution. While this chapter focuses only the non-broadcast distribution of the films in the Western Cape Province of South Africa, the reach of the films in Southern Africa is tremendous. The films have been dubbed into fifteen languages, and are shown throughout Southern Africa by way of mobile cinema units. The project points to the efficacy of mobile, multi-sited facilitated film screenings, which has diagnostic as well as well as significant intervention outcomes.

ANALYTIC APPROACH: TOWARDS AN APPLIED VISUAL ANTHROPOLOGY

Interpretive frameworks in visual media studies suggest that audiences are active agents in the construction of meaning (Abu Lughod 1999, Askew 2002, Collier 1986). Asa discipline that emphasizes the value of an interpretive approach, visual anthropology has much to offer by way of informing media advocacy programs geared towards HIV/AIDS education. We have found that the presentation of factual information about HIV/AIDS is not effective as an intervention, and that knowledge about HIV/AIDS does not necessarily lead to practice in contexts where social and economic barriers prevent incorporation of information. Communication strategies that engage audiences in debates about these obstacles are thus more likely to lead to the transmission of ideas, and suggestions for solving problems.

Audiences interpret documentary films, and their agency in this regard poses a challenge to health care workers whose medical imperative is to send clear messages about HIV/AIDS transmission and prevention. My observations of audiences in Southern Africa suggest, however, that while interpretive approaches might appear to be at odds with the demands of HIV/AIDS educators, the use of non-didactic, or non-prescriptive, documentary films enables viewers to grapple with complexity and engage with processes of finding a range of resolutions to living with HIV/AIDS. Documentary films that offer respect to their audiences' interpretive abilities can break the silence, and move people beyond current denialist tendencies. The didactic approach in media campaigns promoting safer sex practices as the solution to HIV fails to address the economic, political, and social obstacles that impede the easy incorporation of media messages. It is within the context of these constraints that films in the *Steps for the Future* collection form part of a media-advocacy campaign that aims to redress the dominant media's shortcomings, while acknowledging the limitations of such an intervention.

Photograph courtesy of © Day Zero Productions

Photo 1. *Steps* community screening of *A Red Ribbon Around My House.* Directed by Portia Rankoane, 2001.

The films in the *Steps* collection draw on the wisdom of the African dilemma tale by respecting audiences' interpretive abilities. Dilemma tales are a form of African folktale, and "like many other folktales, their content is often didactic, but their special quality is that they train those who engage in these discussions in the skills of argumentation and debate…" (Bascom 1975:1). The narrators of dilemma tales engage audiences in a dialogical mode of communication, and are thus more effective in breaking silences than didactic communication strategies. In the preface to William Bascom's book on African dilemma tales, Sol Tax (1975) writes,

> *They are not only intellectual puzzles that sharpen the wits and promote discussion; they also point out that in human affairs there are no answers, but only difficult choices – which call into play conflicting moral values. That this was known to folk peoples from time immemorial – and forgotten by each new generation in cultures which lack such story-telling devices – is a lesson for modern educators.*

Using qualitative field methods as a diagnostic tool for identifying the obstacles that prevent women from seeking reproductive and sexual health care, we have found that entertaining, non-didactic documentary films about HIV/AIDS promote open discussion among women and mobilize community based support structures for people living with HIV.

Bascom writes that dilemma tales leave audiences with difficult choices that "usually involve discrimination on ethical, moral, or legal grounds" (1975:1). He writes, "Sometimes the dilemma is resolved by the narrator after his listeners have argued their conflicting points of view, but often it is not" (1975:1). The case study presented here reflects the efficacy of this approach for addressing the difficult choices that women make in relation to sexual and reproductive health. Film facilitators, like story narrators, guide viewers to reach new understandings through dialogue.

CASE STUDY: BREAKING THE SILENCE AMONG WOMEN IN THE WESTERN CAPE

Manto Tshabalala-Msimang's failure to manage the treatment of HIV/AIDS in South Africa is well known, yet the everyday initiatives among ordinary citizens who resist the Health Minister's pseudoscientific response to the HIV/AIDS pandemic, and who beg for funds to maintain primary health care are less known. HIV/AIDS clinics, state hospitals, legal firms, schools, churches, activist groups and the media, are just a few examples that draw attention to the ways in which sexual violence, economic dependence, stigma, and poor governance prevents women's access to sexual and reproductive health. The *Steps* intervention intends to contribute to this effort.

The case study presented here considers the reaction of women from Masipumelela Township to the film *Mother to Child*. The film is about two women who attend the Baragwanath prenatal clinic in Soweto. They are part of a clinical trial in which HIV positive women are given access to Nevirapine. In our impact study of the *Steps* project, Alosha Ray Ray Ntsane, the facilitator of the session wrote;

> *The screening ends and initially the women remain silent. The silence is followed by a sudden upsurge of questions on testing, confidentiality, treatment and disclosure. The discussion that ensues is one in which there is the sharing of personal experiences. Stories of family and friends being ill, difficulties encountered in condom negotiation and the lack of confidentiality at the local clinic, dominate the discussion.*
>
> *The room is filled with a buzz as the women develop the preliminary action plans for addressing the problems in their community. A woman in her late twenties is the driving force. They unanimously agree to write an article to the local paper exposing the lack of professionalism on the part of health counselors in their area.*
>
> *The women request to leave the craft centre early on this particular day. They are off to the clinic to get tested. I am amazed at the impact the screening has had, but perhaps a little apprehensive at the prospect of some of the women testing HIV positive. The main question being, are they ready and would they have the necessary support in the event of testing positive?"*

Ntsane's concern stems from the discussion that *Mother to Child* raised during the facilitated session. The women explained that local HIV/AIDS counselors do not keep visits confidential, with the result that women who test often return home to find that they are no longer welcome. They feared being beaten by their partners for being tested, abandoned by their partners and families, or blamed for bringing HIV home. If transportation were made available to visit clinics outside their immediate community, women said they would be more inclined to test.

Photo 2. Pinky with her baby and partner in *Mother to Child* directed by Jane Lipman, 2001.
Photograph courtesy of © Day Zero Productions

Asanda Mofu, a high school student from Queenstown, reinforces the concerns among women about testing and disclosure. She said, "As a student living with HIV, I struggle… We do not receive (enough) information about HIV/AIDS… and nurses discriminate against us when we go to the clinic after school. They shout at us for wanting condoms and contraceptives…" (Mthathi 2006:1). Stigma among health care workers emerged as a major obstacle to women's sexual health care. A possible solution to the problem would be the promotion of the documentary films in the series that tackle stigma in clinics, where staff and patients could share in the viewing context. Screening the films in clinics would also have the advantage of providing a form of entertainment for patients forced to wait for medical attention. The films create an atmosphere of playfulness that is often missing in media messages about HIV/AIDS, and it is the element of play and the non-prescriptive nature of the *Steps* films that makes them effective communication strategies.

Precisely because the films in the series catalyze open discussion and questions about HIV/AIDS, this media intervention can be used to communicate detailed information about women's sexual and reproductive health. Common questions after film screenings included whether using two condoms is safer than one, whether one must use a condom if both partners are already HIV-positive, if anal sex is safer sex, if birth control prevents HIV transmission, and whether men can cure HIV by having sex with virgins. These questions highlight the lack of proper information about transmission, and can provide useful insights to health professionals when discussing the modes of transmission with patients.

Mother to Child is an emotive film that provides the kind of detailed information that pregnant women need, and also a powerful story of disclosure that supports testing. All pregnant women in prenatal care receive AZT at 32 weeks, and 3TC and nevirapine during labour. Once the child is born, mothers are counseled about breast feeding. They are advised to formula feed rather than breast feed due to increased risk of transmission. The Department of Health policy guidelines for HIV-positive mothers emphasize that there is a risk of transmission through breastfeeding.

Marc Colvin writes that "Among HIV-positive mothers in South Africa the risk of transmitting HIV to the baby through breastfeeding ranges between 7% and 20%, with about 25,000 babies being infected each year from breast milk. In Africa it is believed that about 4% of cases of mother-to-child transmission of HIV are due to breast feeding" (2006:14). Colvin recommends that if women have access to clean water then they should use formula, "but many, mostly black, women must breast feed their babies and run the risk of infecting their child with HIV. This is an unjust situation. Instead of accepting this apartheid style status quo, organizations like the TAC should be fighting for conditions under which

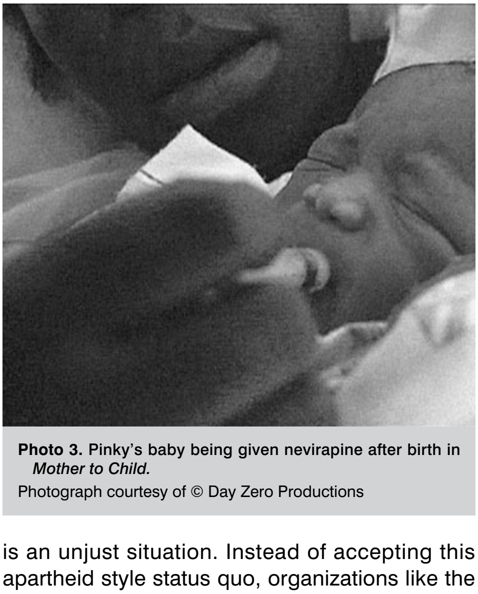

Photo 3. Pinky's baby being given nevirapine after birth in *Mother to Child.*
Photograph courtesy of © Day Zero Productions

all HIV-positive women can safely formula feed their babies" (2006:14).

After seeing *Mother to Child*, a number of women expressed their reluctance to formula feed in the presence of relatives and friends. They said that formula feeding is the same as disclosing an HIV-positive status, and that they formula feed only when alone. If local water sources are unclean, or if women do not have access to water, then they must rely exclusively on breast milk. If women cannot afford formula they must also rely exclusively on breast feeding. However, alternating between breast feeding and formula feeding poses the highest risk to babies (McKerrow 2001). According to Coutsoudis et al. (1999), who studied women who never breast fed, exclusively breast fed, and mixed feeding, the group who never breast fed and exclusively breast fed had the same transmission rate of HIV at three months. In breast feeding mothers, the virus could be neutralized by specific immune factors in breast milk, while formula prevents the transmission of HIV altogether, except in cases of unsanitary conditions. The women in Masipumelela were also unaware of the increased risk of transmission due to direct contact with blood caused by cracked nipples and mastitis.

The *Steps* team left the screening with the sense that community leaders had been identified to carry forward the process of information sharing. The women suggested that patients have the opportunity to see the films while waiting at clinics. As already indicated, the benefit of clinic based screenings would be the opportunity for medical staff to discuss with patients the obstacles that women face when seeking sexual and reproductive health care, and encourage people at clinics who may be there for unrelated reasons to consider testing for HIV.

Another film in the *Steps* collection that inspired women at screenings in Southern Africa was A Red Ribbon Around My House. The film explores the conflict between Pinky, a woman who publicly discloses her status, and her daughter Nthombi who feels shamed by her mother's status. Nthombi said that if she was HIV-positive she would "keep it to herself until the grave." Pinky resists Nthombi's particular concern that she not disclose in church.

Marc Colvin writes that "Among HIV-positive mothers in South Africa the risk of transmitting HIV to the baby through breastfeeding ranges between 7% and 20%, with about 25,000 babies being infected each year from breast milk.

She believes that the church should not promote condoms because people might interpret the gesture as condoning sex before marriage. Religious leaders are divided, however, about the way to address the pandemic. Reverend Teboho Klaas of the South African Council of Churches is outspoken about the limits of the ABC approach. He writes,

> *Abstinence is available as a choice to only a few and should be encouraged to those who make that particular choice. However, many women do not have a choice when it comes to protecting themselves…The SACC has called on churches to define abstinence and put it into context. We would like to see this being openly discussed, rather than simply prescribing dos and don'ts (2006:12).*

Photograph courtesy of © Day Zero Productions

Photo 4. Pinky and Nthombi in *A Red Ribbon Around My House.*

The Human Rights Watch in Uganda argues that "abstinence-only programmes do not delay the age at which young people start having sex. …There is no evidence showing that abstinence only education is effective for preventing HIV, sexually transmitted infections and pregnancy" (2006:4). In spite of ethnographic evidence that supports this analysis, virginity testing, plus an emergent right-wing political party, promotes abstinence over safer sex practices. Women are worried not only about the risk of HIV infection, but also exposure to genital herpes, vaginal thrush, and the HPV (human papilloma virus) that causes abnormal cells of the cervix, and if untreated causes cervical cancer.

Women in South Africa are guaranteed only three free pap smears in a lifetime at the ages of 35, 45, and 55. Medical doctors are concerned that three pap smears are not adequate to promote gynecological health. Condom use is essential not only as a barrier to the HIV virus, but also other sexually transmitted infections. After all the screenings in Southern Africa – South Africa, Mozambique, Lesotho, Namibia, and Zambia – women complained that men are resistant to using condoms, and that they would like more access to female condoms. Health care professionals would also prefer that femidoms be made more freely and widely available in public rest rooms and clinics, though their sheer size and visibility may not solve the problem of men's resistance.

Critical medical anthropology points to the structural inequalities that underpin the epidemiology of infectious illness (Farmer 1992, Geshekter 1995, Nattrass 2001). In *The Moral Economy of AIDS,* Nicoli Nattrass writes,

> *South Africa is increasingly divided along class lines with the gap between the employed and the unemployed… The horrifying element that AIDS brought to the picture is that the divide has meant the difference between life and death for many people. Those without access to jobs (especially good jobs) have borne the brunt of the AIDS pandemic and will continue to do so until a national treatment plan has been fully rolled out (2004:170).*

Photograph courtesy of © Day Zero Productions

Photo 5. Zachie Achmat of the Treatment Action Campaign calling for effective anti-retroviral treatment in South Africa in *It's My Life*, directed by Brian Tilly, 2001.

Women at screenings throughout Southern Africa explained their predicament with regard to condom negotiation in ways that link it with the feminization of poverty. Women agreed that their financial dependence on men, plus the threat of physical violence, were major obstacles when it came to condom use. Women said that using condoms is not simply a matter of choice, but a risky process that could lead to deeper economic crisis and social expulsion. Safer sex messages in the media that promote condom use are not sensitive to relations of power and domination that undermine women's ability to choose safer sex practices. In voicing these concerns, women in Masipumelela Township created a network of support and sharing that had not previously existed at their institution, and they also made important links with the HIV/AIDS counselors from the *Steps* team. The next step, as I suggest below, would be building relations between mobile cinemas, HIV/AIDS counselors and health care clinics.

CONCLUSION: MEDIA AS MEDICAL INTERVENTION

Documentary films, when they are non-prescriptive and when they touch on local concerns in local languages, can make significant contributions to identifying the obstacles that undermine the ability of women to utilize health services in sub-Saharan Africa. They also have the advantage of entertaining audiences and moving audiences to find solutions within networks of care. I have argued that non-didactic documentary films enable viewers to grapple with complexity and engage with processes of finding a range of resolutions to the HIV/AIDS pandemic. Documentary films that draw on the wisdom of the African dilemma tale offer respect to their audiences' interpretive abilities and can rupture the silences that compound the isolation of physical suffering and fear of HIV/AIDS. Using visual media as a diagnostic tool, I was able to identify poverty, stigma, sexual violence, and the gendering of blame as the key obstacles that prevent women's access to sexual and reproductive health care in South Africa. The mobility of cinema means that this method can be used in urban and rural settings where medical institutions operate, and where specific ethnographic information might very well assist in the delivery of services and patient care.

To end on a positive note, South Africa's Deputy Health Minister Nozizwe Madlala-Routledge has begun speaking bluntly about the shortcomings of the government's Aids programme. She is taking action to redress state failings, and concurs with the women in this study that stigma must be tackled. In an interview with Kerry Culligan in the Sunday Times, Madlala-Routledge argued that "When people come forward under the present conditions of stigma, it is most disturbing when they must then wait in a long queue. So that is the very immediate challenge" (Culligan 2006). I suggest that building relationships between mobile cinemas and mobile or stationary clinics would assist in the delivery of sexual and reproductive health care to women in Southern Africa. Films could be screened while patients are waiting to be seen, and 'audience' members could be tested and counseled at the same time.

DISCUSSION AND COMMENTS, S. LEVINE

- Innovative methodologies that include audiovisual media have a great capacity for stimulating both individual and collective reflection on changing attitudes toward illness and the stigma of AIDS.
- These films should be seen not only in communities, but also in the halls of power: Parliament and other places where decisions are made about health policy.

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SEXUALITY AND GENDER RELATIONS IN HIV TRANSMISSION: PROPOSALS FOR RESEARCH ON PREVENTION

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THE PROBLEM OF HIV PREVENTION IN WOMEN

In most of the world, more than half of the new cases of HIV infection are diagnosed in women (UNAIDS 2006). The great discrepancies in the rates of HIV infection reflect women's greater vulnerability, both biologically and—more profoundly— in terms of powerlessness (Farmer et al. 1996), which makes it difficult for them to negotiate with whom, when, and how they have sexual relations. In the majority of cases, women are infected by stable sexual partners on whom they depend for their own survival and that of their children. In countries at war, many women are infected through acts of sexual violence (Cohen et al. 2005). Even when women know of methods for preventing infection, unequal relations between men and women make it difficult for them to negotiate condom use successfully. All these situations arise with greater frequency in countries in which large proportions of the population live in extreme poverty and are subject to structural violence, as in many African countries or in Haiti (Castro and Farmer 2003; Farmer and Castro 2004).

The limited successes of efforts to prevent HIV transmission over the past two decades show that in public health interventions, knowledge concerning the complexity of sexuality, gender relations and the rights of women in different social contexts is often limited. These are areas of human experience about which social anthropology has been generating knowledge since the pioneering ethnographic work of Bronislaw Malinowski and Margaret Mead in the 1920s (Malinowski 1987 [1929]; Malinowski 2001 [1927]; Mead 1928).

The limited successes of efforts to prevent HIV transmission over the past two decades show that in public health interventions, knowledge concerning the complexity of sexuality, gender relations and the rights of women in different social contexts is often limited. These are areas of human experience about which social anthropology has been generating knowledge since the pioneering ethnographic work of Bronislaw Malinowski and Margaret Mead in the 1920s

Since the etiology of AIDS was first known, strategies for the prevention of HIV infection have centered on the dissemination of information on transmission of the virus (sexual, intravenous, or mother-to-child), based on the assumption that access to information is the first step toward changing individual behavior. In the case of prevention of sexual transmission of HIV, these individual behavioral changes may include sexual abstinence, later initiation of sexual activity, reduction of the number of sexual partners, or the use of barrier methods (male and female condoms), and, in the future, of microbicides.

Although access to information about these strategies may be a first step in preventing HIV infection, putting them into practice requires further changes which go beyond what is possible through individual agency and will, first of all for the obvious reason that sexual relations involve more than one person. Second, acting on information about HIV prevention may require access to money, material resources (such as housing), or opportunities for personal development (education, employment). For example, a person whose only access to a place to live or other material resources is through a relationship that includes sex may well be in a more vulnerable position than someone who is economically independent when it comes to making decisions about when and how to have sexual relations. Third, informational campaigns are often based on the assumption that a change in behavior that is beneficial for health is sufficient incentive for people to adopt it unhesitatingly. Nevertheless, other priorities may take precedence over health because they are perceived as more immediate or compelling. For example, a woman who knows how to prevent HIV infection may risk acquiring it through selling sex without a condom if she must feed her children or pay the cost of their schooling. For reasons such as these, for people living in conditions of heightened vulnerability to act on health messages about HIV prevention, they also need opportunities to develop themselves and their capabilities through access to health care, food, education and paid employment.

It is in this context of fatigue and pressure that advances in the development of microbicides take on fundamental importance in the response to the AIDS pandemic. Microbicides are creams or gels that act as a chemical barrier. The woman applies them intravaginally (they may also be applied rectally) and for several hours or even days they block HIV infection by deactivating the virus, preventing its entry, or interrupting replication (Coplan et al. 2004). Microbicides have the advantage that they can be applied easily, discreetly, and outside the context of sexual relations. Since they are not contraceptives, they can be used by women trying to become pregnant, although some microbicides may also contain spermicides (Doncel 2006). More than 15 types of microbicides, some of which include antiretrovirals, are currently being studied in clinical trials (Dhawan and Mayer 2006).

THEORETICAL FRAMEWORK FOR THE STUDY OF HIV PREVENTION IN SEXUAL RELATIONS

Anticipating obstacles to the distribution and use of barrier methods such as microbicides for the prevention of HIV infection requires the study of the economy of sex—the complex personal and social space in which sexual relations take place and, in some cases, decisions are made about preventing pregnancy or sexually transmitted diseases. The study of the social function of sex is crucial for preventing HIV transmission, and involves three main areas: sexuality, gender relations, and women's rights.

First of all, sexual relations are a response to complex social and political concerns often related to fertility and reproduction. Both sexual relations and their meaning are dynamic and vary according to social position defined in terms of gender, age, education, social status, religion, skin color and ethnicity. How is knowledge about sexuality transmitted? Is the risk of HIV transmission a priority for women and men from different social contexts? Does prevention of HIV infection compete with other needs and concerns (food, housing, health care, work, family)? What is the impact of social pressure on sexual relations? What is the lived experience of sexuality for women and for men? What can we learn about the prevention of HIV transmission from attempts to distribute and promote the use of contraceptives in different social contexts?

Second, sexual relations reflect power relations between genders, within a single gender, and other markers of social position. How is the distribution of consensual sex, survival sex, commercial sex, or coerced sex reflected in gender relations? How are women and men involved in decision-making processes related to sexual relations? What is the impact of social pressure on gender relations?

Third, the legal status of women in all societies has a fundamental role in the ability of women to negotiate their sexuality. What is the legal status and personal autonomy of women in each social context? Do women have the same access as men to housing, land, health care, employment or inheritance? Are there laws condemning certain sexual practices (rape, same-sex sexual relations, polygamy, child sexual abuse, domestic violence, extramarital relations, sex change) and some of their consequences (contraception, abortion)? Are these laws being applied, and does this have an impact on sexual practices?

The final aim is to understand why people have sex (beyond desire and pleasure), and what their implications are at different social and economic levels and along different gradients of social inequality.

CASE STUDY: SEXUALITY AND HIV TRANSMISSION AMONG CUBAN WOMEN

The HIV epidemic in Cuba reflects the fact that social transformations that favor access to opportunity and contribute to a decrease in social inequality and extreme poverty can constitute basic instruments in the prevention of HIV transmission. This suggests that in order to prevent HIV transmission in Africa and other regions of the world, it is vital to develop health social policies that go beyond behavioral change in sexual practices. A comparative and cross-cultural perspective is essential to social anthropology, and it is one of the most important contributions the social sciences can make to public health.

Since HIV was first detected in Cuba at the end of 1985 (Pérez Ávila 2006b), the infection has had a greater impact on the male population. The first people diagnosed were men who had worked in Africa in international missions. Upon their return to Cuba, some of these men infected their partners, most of whom were women. Within a short time, HIV began to predominate in men who had sex with men, whether exclusively or in parallel or alternating sexual relationships with women. Of the 972 persons who received a diagnosis of HIV in 2005, 71.3 percent were men who acknowledged having sex with other men, 16.5 percent were women, and 12.2 percent were men who identified themselves as heterosexual (Ministerio de Salud Pública 2006c).

While it is true that HIV infection in Cuba is increasingly contained within the population of men who have sex with men, understanding the distribution of the virus requires deeper analysis of the complexity and dynamism of human sexuality, of the social reactions generated by certain sexual relations and manifestations of sexuality, and of the evolution of social structure and the position of women in this structure (Castro, in press). It is important to begin by asking these questions about the Cuban population in order to achieve a greater understanding of the social factors that influence HIV transmission and clarify why it is that in Cuba women enjoy a certain degree of protection from HIV infection by comparison with women elsewhere in the world.

One of the most striking characteristics of the distribution of HIV infection in Cuba is that, although the number of women who receive a diagnosis of HIV increases nearly every year, the proportion of women diagnosed with HIV relative to the proportion of men diagnosed with HIV is decreasing: in 2005, only 16.5 percent of all new cases of HIV occurred in women, considerably lower than the highest percentage, 37.6 percent, in 1988 (Ministerio de Salud Pública 2006c). Of the total of 7,639 persons diagnosed with HIV in Cuba by the end of August 2006 (Ministerio de Salud Pública 2006a), 1,488 (19.5 percent) were women. The estimated prevalence of HIV in Cuba is 0.1 (UNAIDS 2006), the lowest in the Americas and one of the lowest in the world, while the prevalence of HIV in pregnant women is 0.01 (Ministerio de Salud Pública 2006b). It is estimated that in Cuba 99.4 percent of HIV infections are acquired through sexual contact (Ministerio para la Inversión Extranjera y la Colaboración Económica 2002) and that 75 percent of women are infected through sexual relations with men who also have sex with men (Pérez Ávila 2006a).

A comparative and cross-cultural perspective is essential to social anthropology, and it is one of the most important contributions the social sciences can make to public health.

Like other aspects of public health in Cuba (Cooper, et al. 2006; Farmer and Castro 2004), the situation of HIV is a counter-example to what is happening in the rest of the world. In Cuba, the distribution of HIV reflects the absence of extreme poverty and the relative absence of marginality. As in other countries, however, it is in situations of extreme family dysfunction that HIV tends to appear. This is shown in the case of Marimar,[1] a 29-year-old woman interviewed in 2005 during a study aimed at understanding the recent increase in pregnancies carried to term by Cuban women living with HIV (Castro et al.,n.d.). Unlike her sister, Marimar managed to avoid the repeated rape attempts from her stepfather. Her resistance upset her mother, who kicked her out of the house. Marimar, a young child, wandered around for some time. When she was diagnosed with HIV at age 13, she was transferred to a sanatorium outside of Havana. It was 1991, and was no longer able to complete her 8th grade. Quarantine was then, and until 1993, mandatory in Cuba for all people living with HIV. Marimar made occasional visits to her grandparents, despite the fact that they made her sleep on the floor, threw household items at her, and called her la muerte ("death"). While living at the sanatorium, Marimar had three abortions. At the time, she says, there was neither prevention nor treatment for children born to HIV-positive parents. When her grandparents died Marimar inherited their house and moved in with her husband, whom she had met in 2001 in the sanatorium. Four years later, she had her only son, who was born HIV-negative thanks to prophylactic measures to interrupt mother-to-child transmission of the virus. Completely reintegrated into Cuban society as a result of public policies in response to HIV, Marimar now wants to pursue her education and become a lawyer.

Preliminary analysis of the results of a representative study of the Cuban population receiving antiretroviral therapy indicates that regardless of their age, the majority of women living with AIDS received no information about sexuality during childhood or adolescence from family members (Castro and Aragonés 2006), most often because it was considered an inappropriate subject for family conversation. It may be the case that the larger public and domestic conversational space occupied by sexuality in recent years, and subsequently

[1] Her name has been changed to preserve confidentiality.

greater condom use, are related to the decrease in HIV transmission rates in Cuba.

In addition to the absence of extreme poverty and greater openness on the subject of sexuality, the distribution of HIV infection in Cuba reflects that women are in a good position to negotiate their sexual relations. Two hypotheses suggest this. First, Cuban women enjoy equality of access to opportunities for education and employment thanks to the efforts of the Cuban government to promote social equality, including gender equality. In 2003, for example, women represented more than 60 percent of the professional and technical work force (Alfonso Fraga 2006). Second, basic needs such as food, housing, education and health care are guaranteed by the government without cost or at a subsidized cost, even though social inequality has increased since the mid-1990s (Domínguez et al. 2004; Espina Prieto and Rodríguez Ruíz 2006). The combination of these two factors allows women to be less dependent economically on men, which strengthens their ability to negotiate sexual relations.

It is possible that the higher status of women in Cuba is related to a decrease in homophobia or heteronormativity (Sierra Madero 2006). Contempt for men who have sex with other men generally indicates dominance of the image of the virile man and devaluation of the role of women in society. Greater public openness about questions of sexuality may be the result of efforts both to normalize different expressions of sexuality and to improve the position of women in Cuban society. It would be interesting to know whether, as a result of these changes, there are fewer men in Cuba who are forced to have sexual relations with women in order to hide their desire for men and avoid social rejection; whether men who have sexual relations with both men and women do so more out of desire than in response to social pressure; and whether they do so with the knowledge of their female partners. If this were the case, it would be important to analyze whether a greater symmetry between sexual desire and sexual practice is related to a decrease in cases of HIV transmission from men to women.

RECOMMENDATIONS

Access to such basic needs as medical care, food, education and employment gives women the necessary tools to achieve greater agency and put into practice the information they receive to negotiate sexual relations, as the Cuban case shows. The large-scale structural changes that must take place in order to halt the transmission of HIV, however, require a level of political support that, in many other countries, could take longer to achieve than creating the AIDS vaccine. Until this is available, the introduction of microbicides may represent a fundamental contribution to the reduction of HIV transmission to women. In addition to advances in the chemical composition of microbicides and the results of the clinical trials now in progress, successful mass use of microbicides requires, first of all, an understanding of the complexity of sexuality, gender relations and women’s rights; and, second, transfer of this knowledge to the development of concrete, on-the-ground strategies to promote microbicide use.

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DISCUSSION AND COMMENTS, A. CASTRO

- The introduction of microbicides in areas where "dry sex" is practiced can be difficult since, among other reasons, vaginal fluids are considered impure and a moist vagina raises suspicions of infidelity.

- In programs designed to introduce microbicides, it is necessary to explain carefully what they are for and how to use them, since mistakes in use were discovered in the course of trials carried out in Africa.

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RAPPROCHEMENT OR RESISTANCE? UTILISING TRADITIONAL HEALING PRINCIPLES AND PRACTICE TO ENHANCE HIV/AIDS TREATMENT IN SOUTH AFRICA

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INTRODUCTION: UNDERSTANDING THE OBSTACLES TO HIV/AIDS TREATMENT

Statistics on HIV infection in South Africa record up to 5.2 million people living with the virus. Highest infection rates are reported from the townships and 'informal settlements' where the majority of black people live[1].These figures underline the grim reality that, despite improvements to the country's public health services, access to treatment continues to be highly problematic.

What are the obstacles to treatment in South Africa, and how are they explained? Barriers may be categorised as structurally imposed, and socially or self-imposed. In the former category the primary hurdle has consisted in the government's ambiguous stance on the disease, and on ARV therapy. President Mbeki's denialist pronouncements are well documented; the health minister has added to the confusion with her support for references to ARVs as 'poisonous' (a particularly loaded term in African healing understandings, where it is generally applied to describe witchcraft). This obfuscation accounts, at least in part, for the administration's delayed response to the epidemic - a persistently slow and inconsistent rollout programme which has been the subject of intense public debate and academic criticism (for example Ashforth 2005: 107-8; Benatar 2001: 364; Nattrass 2004a: chap 2). This is not the whole story however, for the rollout is further constrained by being implemented within an already overstretched and under-resourced Public Health Service that is now barely coping with the burden (Letsoalo 2006). Infrastructural weakness compounds the difficulty. In the rural areas public health facilities are often prohibitively remote from any form of public transport, but even in the sprawling townships patients must resign themselves to spending a whole day in travelling to, and then waiting for, treatment.

This picture is necessarily backgrounded by chronic unemployment, and although joblessness obviously results in a state of general impoverishment, the persistence of gender inequality in South Africa ensures that the burden of dealing with the consequences falls disproportionately upon women. Indeed poverty and unemployment exacarbate the corrosive effects not only of enduring gender inequity (sometimes justified by dubious assertions of 'cultural' traditions (Mthathi 2006)), but also of gender-based violence. Younger women, girls, and boys are especially vulnerable to sexual exploitation (Mthathi 2006; Susser and Stein 2000), often accompanied by the sort of violent coercion that, as Dunkle at al demonstrate, represents an increased risk of HIV infection (2004). Unemployment and the despair associated with privation encourage the insidious commoditisation of sex. In the absence of basic welfare support, for example, women and girls can be more easily persuaded to exchange (frequently unsafe) sex for material favours (Dunkle et al 2004: 1417; Preston-Whyte 1994: 248-250), or to become pregnant to access the Child Support Grant. Meanwhile the link between an AIDS diagnosis, ARVs, and health-determined access to a Disability Grant has been shown to be potentially prejudicial to treatment regimes (Nattrass 2004b). For women poverty has other, more prosaic, consequences. To visit a 'local' clinic for instance, mothers are obliged to arrange childcare, albeit carrying their youngest with them, intensifying their anxiety. Since women rarely possess money of their own, sourcing the funds to finance the journey represents another barrier to their accessing treatment. When the trip is focused on treatment or testing, the issue becomes even more fraught, as even sympathetic partners will question the purpose of the visit.

This brings this examination of obstacles to treatment for HIV/AIDS to the socially or self-imposed, and thus to a consideration of the potent combination of stigma, fear, and denial which continues to envelop the disease in South Africa. Denial, whether of the disease itself, or of one's own status, whilst it is abetted by government pronouncements, is also stoked by a customary unwillingness to discuss sexuality. Add stigmatisation, and it is not difficult to understand why campaigns promoting HIV/AIDS testing and behavioural change are proving ineffective[2]. Males are especially reluctant to test (Beck

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[1] The Western Cape Province in which this research is situated boasts the lowest HIV prevalence in the country, a tribute to its early commitment to antiretroviral treatment. See Naimak 2006.

[2] To date, the government's primary policy intervention has focused on the familiar but ineffectual 'ABC – Abstain, Be faithful, Condomise' message.

2004) and generally contest the use of condoms, notably within marriage relationships, aggravating infection risks for all women and for the children who result from unprotected liaisons. Women, on the other hand, are unjustly vulnerable to the gendering of blame (Leclerc-Madlala 2001), and wives and mothers advocating condom use are themselves accused of 'being dirty' (another euphemism for witchcraft), or 'having something to hide.' Regrettably, the gender inequities underpinning these attitudes are proving persistent across generations. Studies in KwaZulu-Natal for example, demonstrate a disturbing level of almost unconscious sexually coercive behaviour by young men (Leclerc-Madlala 2001; Tillotson & Maharaj 2001). Under these circumstances it is hardly surprising that infections continue to rise, especially amongst younger women (WHO 2006a).

COPING WITH HIV/AIDS - HEALTH POLICY AND TRADITIONAL HEALERS IN SOUTH AFRICA

How has the administration dealt with the issue of medical pluralism in the context of the availability of treatment? The existence of competing ideologies of healing in South Africa's public health environment has not improved access to treatment, a somewhat paradoxical situation which is, at least in part, again linked to government equivocalness. Take for instance the Comprehensive HIV and AIDS Strategy (Department of Health 2006). In this document the administration expresses token respect for traditional healers, describing them as 'pillars' of the strategy. The text however completely fails to develop this apparently pivotal role, an omission which doubtless helps to explain (and provides a convenient excuse for) the continued exclusion of traditional healers from HIV/AIDS interventions. Meanwhile, reinforced by the administration's ambiguity about ARVs, the health minister's advocacy of 'choice' in HIV/AIDS treatment has erroneously convinced some patients that 'natural' remedies will cure the disease. Her promotion of (often incorrectly labelled) 'traditional' therapies adds fuel to the fire by encouraging opportunistic claims for 'cures'[3] (Beresford 2006; Geffen 2005; Herman 2006). Such evidence of charlatanism (whether or not it originates from traditional practitioners) validates medical professionals in their familiar characterisation of all traditional healers as incompetent or dangerous[4] rogues or 'witchdoctors'[5]. Frustrated with the inadequate rollout of ARVs, doctors conclude that government is forcing patients into 'non-scientific' treatment choices (Lederer 2006; Nattrass 2005). Overall then, the administration's assertion of a 'holistic' HIV/AIDS policy, whilst arguably intended to encourage treatment choice and rapprochement between medical paradigms, has perpetuated alienation. Thus a potential advantage of medical pluralism is lost; instead of being reciprocally engaged in interventions against the epidemic, the two ideologies continue to operate separately, often acrimoniously.

COLLABORATION OR INCORPORATION?

The theoretical notion of collaboration between the paradigms in HIV/AIDS interventions is hardly new (World Health Organisation 1978). Premised on the advantage to overburdened health services in harnessing an influential and culturally appropriate healing ally, many traditional practitioners support the idea, and notwithstanding historical differences, several efforts have been made to establish interaction in South Africa[6]. But 'cooperative' projects have tended to be uni-directional and educative, and participating healers frequently express disappointment at the persistent indifference of biomedical practitioners to the potential of learning from traditional African healing (Leclerc-Madlala 2002a: 9)[7].

Before leaving this brief consideration of cooperation, it is important to draw attention to some doubts about the consequences of collaboration that act to deter some traditional practitioners from cooperation with biomedicine. First, there is the risk to individual healers that their collaboration with the local public health services face criticism, from clients and other healers, of betraying traditional aetiology and practice. Those who oppose cooperation across medical

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[3] The activities of the Rath Foundation are notorious in this respect, not least in the township of Khayelitsha in the Western Cape (Geffen 2005: 187-194). Some traditional healers, accepting the 'traditional' label attached to Rath's vitamin regimes, have supported their distribution.

[4] Some anthropologists have also implicated traditional healers in the creation of 'dangerous' beliefs or practices. But the spread of the notorious 'virgin cleansing myth' for instance (Leclerc-Madlala 2002b: 92; Schoepf 2004: 23) whilst attributed to traditional healers is scantily evidenced (Matthews 2005: 149). Similarly alleged connections between re-use of razor blades and the spread of the disease are unproven. In this context, the iatrogenic spread of the disease through medical injections is not contested (Moore et al 2001; WHO 2006b).

[5] The existence of charlatans is uncontested. Government legislation, in part aimed at curbing their activities, has recently been enacted but remains to be tested (THPB 2004).

[6] See Wreford 2005b for a comprehensive review of collaborative schemes in Southern Africa.

[7] It is not without irony that anthropologists engaged in ethnographies of traditional medical systems often discover their research marginalized or ignored by biomedical professionals and designers of public health programmes.

sectors for example, allege that collaboration actually represents (or inevitably results in) incorporation, and the consequent subjugation of traditional understandings of health and illness by the hegemony of biomedical discourse. Others are concerned about biomedicine's symbiotic relationship with the commercially driven interests of pharmaceutical companies. They fear the exploitative potential in collaborative medical relationships, not least in relation to the commercial benefits accruing to the development of 'indigenous knowledge'[8]. Nonetheless, the longevity of traditional healing in Africa, and the active support of many healers, suggests that the discipline is sufficiently flexible to flourish within a framework of mutually receptive cooperation.

Using a case study from the Western Cape Province, the remainder of this chapter examines the limitations of the educative approach to collaborative endeavours, and, whilst acknowledging the difficulties, makes some suggestions for the design of collaborative HIV/AIDS interventions organised within a methodological framework at once more extensive and mutually respectful.

THE CASE OF HOPE IN THE WESTERN CAPE

The HOPE[9] Cape Town project which informs this study commenced in October 2005 with three specific aims[10]: To encourage collaborative referrals between biomedical personnel and amagqirha/izangoma; to avoid possible disruptions to ARV regimens through contraindications with traditional remedies, and to persuade more men to test[11]. Nine Xhosa-speaking female amagqirha, and five HOPE Community Health Workers (CHWs), participated, all living and working in five townships around Cape Town. The project commenced with a six-week course, held at Tygerberg Academic Hospital in Cape Town, which covered familiar educative territory: Biomedical understandings of HIV/AIDS, STIs, opportunistic infections, and the action, prescription and administration of antiretrovirals, PMTCT, safer sex strategies, and so on. Treatment adherence, and the risks of contraindications to ARV efficacy were emphasised. The course was innovative in its incorporation of a four week- long VCT counselling module[12]. The effect of this initial stage can be summed up in the words of one igqirha: 'everything was clearer in my eyes. This is what I've been looking for. You must know what you want to do for the people.'

The research evidence supporting the chapter is based on direct participation and observation of the HOPE course, and follows the experience of its first year of implementation. Data sources include fieldnotes, supported by recorded in-depth interviews with participating amagqirha, and group interviews with the CHWs involved. Where appropriate, fieldwork evidence gathered over several years of involvement with traditional healers in the Southern Cape is also employed[13].

TRADITIONAL HEALERS AND THE TREATMENT OF WOMEN AND CHILDREN

Some advantages to engaging traditional healers in HIV/AIDS interventions are obvious: They are accessible, usually affordable[14], and available 'out-of-hours'; their appointments are open-ended, and they are culturally attuned to their clients[15]. As healers, the amagqirha/izangoma can rely on traditional respect and customary connections: They are popularly understood to be wise in local knowledge[16]. Sharing the township lives of their clients, the HOPE practitioners are all too aware of the risks (and temptations) for women and children living with impoverishment[17]. At least two have personal experience of living with HIV/AIDS, and most have shared stories of

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[8] The Medical Research Council in South Africa is one of several institutions carrying out in vitro research into the efficacy of some traditional remedies in treating the immune system. The MRC acknowledge however that their work is severely under-funded, and the question of the ownership of 'indigenous knowledge' in the context of intellectual property rights remains highly problematic (Dr. Matsabila, MRC: Personal communication Nov 2005).

[9] HOPE (HIV Outreach Program and Education) operates training, education and outreach projects in clinics and day hospitals throughout the Western Province.

[10] The project is the first of its kind in the Western Cape. For a complete description of the course design and objectives see Hippler et al 2005. Wreford 2006 presents an analysis of the effectiveness of the initial stages of the project's implementation.

[11] A fourth objective to enable traditional healers to carry out sputum tests awaits a protocol from the Provincial Health Authority.

[12] The counseling module was designed and co-ordinated by ATTIC (AIDS Training Information and Counselling Centre) Western Cape.

[13] The author is a practicing isangoma and a social anthropologist.

[14] The question of charges for amagqirha/izangoma services is complex. For some considerations of the issue discovered in relation to the HOPE project see Wreford 2006: 26-28.

[15] This is by no means universal of course. One HOPE igqirha, acknowledging the importance of belief, humbly remarked: 'It depends on the individual person's belief and faith, whether they believe in traditional healing or in western medicine.'

[16] The healers' relationship with women in particular often starts during pregnancy: For example, expectant mothers approach the amagqirha for medicine to ease delivery (isicakathi), and after childbirth protective beads (amatatyisi) may be tied at the child's waist and neck to help to promote growth.

[17] In this cash-strapped economy several of the HOPE practitioners maintain second jobs to support their practice.

unfaithful partners. Building on these relationships, and equipped with counselling skills, the HOPE healers are ideally positioned to open up dialogue about HIV/AIDS.

In the context of the HOPE scheme additional general benefits can be identified. First, the healers' acceptance of the biomedical interpretations of HIV as (for the present) without cure, and their advocacy of ARV treatment, should ensure that these amagqirha will not offer bogus or harmful treatments[18]. Secondly, because HOPE amagqirha are able to recognise the biomedical difference between symptoms of STIs and HIV/AIDS, they are unlikely to offer remedies which might treat the former but leave the virus untouched[19]; nor will they employ remedies which might undermine an immune-compromised system. Thirdly, they act as conduits of all these new understandings to the community, and can encourage other healers in their neighbourhoods to take up collaborative opportunities. Fourthly, their understanding of means of transmission makes them useful promoters of behavioural change, including the use and distribution of condoms[20]. Finally, since men tend to consult amagqirha/izangoma before biomedical doctors (particularly regarding STI symptoms), the benefits already described should support women in their struggle for access to testing and treatment. This potential returns the discussion to the question of secrecy, stigmatisation and denial of HIV/AIDS introduced earlier in the chapter.

The combined fears of discovery, and of stigmatisation after disclosure, continue to enforce the necessity for trust, secrecy and confidentiality in treatment programmes (Almeleh 2006). In the public health sector this is a particularly contested arena. Many patients refuse to visit their neighbourhood clinics 'because people will be curious' - simply being seen there is perceived as enough to generate unkind gossip. Moreover, clinic staff are notorious for their indiscretion, being seen, as one HOPE CHW bluntly put it, 'too easy about disclosing status.' But popular censure and attitudes also operate as powerful deterrents to clinic attendance. In particular, adolescents seeking condoms are vulnerable to very public admonitions, especially from older clinic workers, for their 'dirty' behaviour.

In contrast to the clinics' porous reputation amagqirha/izangoma are obliged to keep their diagnosis, and all client information, confidential. One igqirha underlined the importance of secrecy: 'If you diagnose someone then whatever they should discover from that person you have to keep it to yourself because it's a secret. That person can then say OK, I am able to come back to this person because this person can really keep confidential information.' The igqirha/isangoma surgery then, is trusted as a safe environment for the sharing of personal secrets. The HOPE amagqirha are extending this acknowledged responsibility, providing active support and relief until clients living with the virus are prepared to disclose. One healer has adopted a positive woman into her household, encouraging her to talk until 'She becomes stronger and can live with the problem.' Other healers voluntarily accept visits from clients seeking 'talking' (as counseling is popularly described) and food.

As an incentive for collaboration, the healers' new treatment advocacy role presents other important potential advantages for the development of their own practice. For instance, it offers an opportunity to re-open a dialogue with disenchanted young people, whose outwardly disrespectful attitude often masks a very real apprehension about African healing traditions (not least in its ambiguous relationship to the discourse of witchcraft). Making use of their access to condoms, for example, the amagqirha/izangoma may engage the youth in conversations that will not only reinforce safer sexual practice in the time of HIV/AIDS, but may conceivably dilute fears about traditional practice, and lead to renewed interest and respect for the paradigm.

Pursuing this alterative theme, there exists another potentially dynamic transformative role for the healers, this time in the field of gender relations. Thus the amagqirha – already recognised as community counsellors and confidantes - may conceivably develop this advisory responsibility to include a subtle mode of gender activism to challenge the customarily dominant (and often violent) behaviour of men, especially in intimate

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[18] Bogus 'cures' for the disease are distributed by charlatans posing as traditional healers. They demand considerable sums of money. Two HOPE CHWs reported cases of 'traditional healers' in their areas asking up to R3000 for 'the medication for HIV.' Tangwa remarks that the very act of requesting such exhorbitant sums is the mark of the fraud (2005): Genuine healers, as the author's teacher stressed, must never over charge, and risk losing their healing gift if they do so.

[19] The question of 'cure' in traditional African healing equates with absence of symptoms, with obvious and serious implications for the asymptomatic stages of HIV. See Wreford 2005a: 64-66.

[20] HOPE amagqirha report that young people, in particular, visit them to obtain condoms.

relationships (Dunkle et al 2004; Moffett 2006). In their interactions, these older, wiser, and mostly independent women could be influential in drawing their male, and female, young and older clients, to a consideration of new values for intimate sexual relationships and the distribution of power within them.

BUILDING RECIPROCITY, ENLARGING THE FOCUS OF COLLABORATION

The HOPE project has to date followed a familiar educative pattern. Although the treatment benefits in this approach are evidenced in increased numbers of clients referred by the healers for testing, as a genuinely collaborative tool the method is limited by its bias towards the biomedical model. The remainder of this chapter develops two versions of the HOPE pilot project, envisaged now as a more expansive and reciprocal act of collaboration. The first suggests incorporating elements of the traditional pharmacopoeia into the scheme, while the second visualises the project incorporating a direct engagement with the aetiology and ritual practice of amagqirha/izangoma.

Increasing therapeutic efficacy 1: The traditional pharmacopoeia and the treatment gap

The HOPE course focused on ensuring that the amagqirha work in concert with biomedical understandings of HIV/AIDS and its treatment. To this end, the risks of possible contraindications between ARVs and traditional treatments were highlighted. However, in the context of the competition between therapeutic ideologies traced earlier in the chapter, and this chapter's emphasis on reciprocal medical collaborations, the absence of any discussion of the healers' remedies (for the immune system and STIs for instance) was significant, not least because the clients who visit an igqirha are seeking a remedy in terms of the amagqirha/izangoma paradigm. Even after testing positive, some will refuse the biomedical route. Recognising this reality, the scenario outlined below attempts to demonstrate how collaborations like the HOPE project could be developed to provide environments for the active investigation of the efficacy of amagqirha/izangoma remedies in the treatment of HIV/AIDS.

In South Africa public health patients who manage to access ARVs do so only with CD4 counts of 200 or below. The time between a positive HIV diagnosis and this point may be several years long: a period I will call the 'treatment gap'. During this stage biomedicine offers palliative care, antibiotic treatment for STIs and opportunistic infections (with potential further damage to the immune system), and nutritional and lifestyle guidance. Amagqirha/izangoma meanwhile, insist that there exist traditional remedies that can be safely and effectively used to strengthen the immune system and treat STIs, notably during this period. Since there is no evidence of contraindication between traditional remedies and antibiotic therapy, could amagqirha such as the HOPE participants not be encouraged to employ immune-boosting herbs and STI therapies during the treatment gap? This approach (if only for patients preferring the traditional route) would have the additional advantage of offering a manageable locus for scientific research into the efficacy of the healers' remedies.

In the HOPE situation, unfortunately, the persistence of biomedical prejudice already threatens to sabotage this possibility. One igqirha reports that clinic staff are actively deterring clients from re-visiting the healers, telling them 'to stick with the clinic'. For patients prescribed ARVs this position might seem explicable, but for those who do not qualify for ARVs, it is unjustified, and undermines the confidence of the amagqirha in the reality of collaboration[21].

Increasing therapeutic efficacy 2: Using traditional aetiology to enhance treatment

HIV/AIDS epitomises the 'magical, impenetrable, inscrutable, uncontrollable [and] darkly dangerous' symbolic qualities which define the global consequences of modernity as envisaged by the Comaroffs (1993: xxx). Accepting their hypothesis, HIV/AIDS is also, I suggest, especially susceptible to the alterative power of ritual. Developing the theme of medical reciprocity elaborated above, the subsequent section focuses on the aetiology and ritual practice of amagqirha/izangoma and proposes that the appropriate incorporation of both could have significantly impact on popular perceptions of HIV/AIDS and

[21] As pointed out in Fn18 the definition of 'cure' in HIV/AIDS is contested, and the attitudes of the clinic staff may be further influenced by allegations of charlatanism. Nonetheless, much in the same way as ARVs (albeit at the most advanced stage of the disease), act to slow down or inhibit progression of the virus, traditional therapies can boost the immune system. Both paradigms successfully strengthen immunity - at different stages of the disease. Both can restore a patient to better health, but neither can cure. I have suggested elsewhere that the substitution of 'cure' with the phrase 'restore to health' would avoid confrontation in this arena and thus assist medical cooperation (Wreford 2005a: 66).

thence on the success of biomedical treatment interventions.

Despite the fact that illness interpretations have enormous agency in healing strategies the HOPE project has notably omitted consideration of amagqirha/izangoma aetiology. For example, amagqirha/izangoma and their clients customarily draw on the authority of ancestral spirits for answers to the 'why me? Why now?' questions that usually accompany the appearance of illness in Africa. This position is no less operative in the context of HIV/AIDS[22]. Amagqirha /izangoma are however, equivocal about the ancestors' role in identifying HIV/AIDS. One HOPE practitioner confirmed 'yes, the ancestors do recognise AIDS', but immediately qualified this by noting that the 'old people didn't have this AIDS.' Another exclaimed: '[the ancestors] they died earlier before! It's a new illness! They knew only about other illnesses.'

This aetiological ambivalence is particularly significant when discovering the appearance of STIs and HIV/AIDS, for the ambiguity creates the sort of interpretative lacunae popularly filled by notions of pollution, contamination, and witchcraft discourse[23]. Sexual infidelity, for example, may provoke guilty feelings, but should symptoms[24] then appear, fears of pollution and the threat of witchcraft are also evoked. Having made the connection between sexual (mis)behaviour, pollution, and possible witchery, clients, male and female, consult with the healer of contamination and witchcraft - the igqirha/isangoma. Whist it is undeniable that some clients employ witchcraft simply as a mask behind which to hide their HIV status (Ashforth 2005), in the context of accessing treatment that informs this volume, my researches suggest another, more potent, rationale for assertions of witchcraft causation in HIV/AIDS (Wreford 2005a: 72-77). What is at stake is the issue of personal agency in the face of a death-bringing illness. ARVs may be available in South Africa, but an HIV diagnosis is nonetheless often received as a death-sentence: In the absence of a cure, the patient feels impotent. The imputation of witchcraft, on the other hand, has agency, for it offers the possibility of an intervention aimed at healing, the chance of an empowering action.

For instance, regardless of the source of the pollution, the first, essential, step to recovery involves the ritualised application of a remedy to cleanse and purify the body (and spirit) of the corrupting influence[25]. In the case of alleged witchcraft, harsh purges are customary, which of course, presents a challenge for HOPE amagqirha. They recognise that enemas and emetics are to be avoided in an immune-compromised patient[26]. The client, on the other hand, offered a less aperient medicine (amayeza), may feel cheated of the expected treatment for the problem, and thus be left in doubt as to its efficacy. I now suggest a means of transforming this apparent stalemate. Building on the authority of the amagqirha/izangoma as healers of pollution and witchcraft, I propose that the aetiological construct of witchcraft as an agent of HIV/AIDS causation, and cleansing rituals as an agent of its transformation, could be powerfully employed in the context of amagqirha/izangoma practice. I am persuaded of three potential outcomes of the voluntary participation of those living with the HI virus in appropriately designed cleansing ceremonies: First, individuals and families living with the HI virus could thus be provoked, not to bogus physical recovery, but towards a powerful healing of the emotional distress of the disease. Secondly, such rituals, carefully executed, would do much to undermine the personal and collective negativity of the stigma that attaches to HIV/AIDS. Finally, taken together, these outcomes would enhance the possibilities of a more proactive engagement with the disease, and its treatment in South Africa.

CONCLUSIONS AND RECOMMENDATIONS

In this chapter I started by suggesting, somewhat controversially, that it is a little unreasonable for biomedical doctors to continue to blame amagqirha/izangoma for their medical ignorance,

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[22] Wreford 2005c: Chap 2 offers a comprehensive exploration of 'the question of ancestors' in amagqirha/izangoma practice.

[23] While ideas such as the agency of ancestors, or the power of witchcraft may seem anachronistic to western medical practitioners steeped in scientific certitude (and indeed in other African countries such as Uganda: Noerine Kaleeba, Personal Communication Nov 2006), the aetiology of the beneficence and malevolence of living or other-worldly beings continues to have enormous authority in the lives of many South Africans. For discussion of the umbilical relationship between amagqirha/izangoma and witchcraft see Wreford 2005c: Chaps 3 and 8. For the implications for HIV/AIDS see Wreford 2005a: 68-77.

[24] The symptoms of witchcraft, and its aetiology, are remarkably congruent with those of HIV/AIDS. For additional coverage of the connections see Wreford 2005a: 68-74.

[25] The harsh action of some purging substances is a source of contention between amagqirha/izangoma and western trained doctors, especially when applied to clients with HIV/AIDS. Severe applications are generally administered by enema or emetic, but gentler methods such as steaming, smoking, ointments, and bathing in herbal mixtures are also available.

[26] Looking at this issue from the traditional perspective, some healers use the same logic to question the efficacy of ARVs for immuno-compromised clients.

or accuse them of sabotaging western care, unless the doctors themselves are willing to engage the healers in reciprocal collaborative arrangements. Biomedical professionals will doubtless have appreciated the 'educative' content of the HOPE course described here, while the explanations of the healing agency attributed to ancestors, or notions of pollution and witchcraft discourse may have been more problematic. Nonetheless it is my hope that overall, the chapter has underlined the urgency of establishing reciprocal contact between traditional healers and biomedicine in HIV/AIDS interventions.

I have promoted a more respectful engagement with the principles of amagqirha/izangoma in the belief that this might contribute to a better outcome for the future rollout of ARVs in South Africa. Obviously, biomedical doctors could benefit from the human resource represented in traditional healers. But I argue that simply seconding them into existing programmes prolongs the one-way communication familiar to 'educative' cooperative experiments, and potentially alienates a powerful healing ally. I propose that drawing amagqirha/izangoma into the design and implementation of treatment interventions would be more productive and mutually beneficial. To achieve this however, doctors need to develop professional relationships with traditional healers, and better understand the complexity of therapeutic choices faced by patients. Through these reciprocal discoveries doctors might begin to appreciate that, for many of their patients, traditional methods and practice actually work, and may be effectively incorporated into western medical interventions.

To facilitate such dialogue I recommend that policy designers and project planners give consideration to the following:

1. That guidelines for interventions like the HOPE project be established to facilitate their establishment in conjunction with public health facilities in urban, and rural areas of South Africa.

2. That staff in the public health sector be encouraged to develop professional relationships with amagqirha/izangoma focused on reciprocal familiarisation with understandings of health and illness[27].

3. That medical education promote these initiatives by incorporating modules that actively engage with amagqirha/izangoma and their aetiologies[28]: (To facilitate this, where necessary, students should become familiar with at least one black South African language).

4. That, in cooperation with traditional healers, additional resources be invested in scientific research into the efficacy of remedies used by amagqirha/izangoma, with particular emphasis on the 'treatment gap'.

5. That, drawing on the healing dynamics of notions of contamination and the power of ritual cleansing in amagqirha/izangoma practice, traditional healers, working in partnership with public health facilities, be encouraged to evolve rituals to counter the emotional distress, and stigma attached, to HIV/AIDS.

I am aware that considerable resources would be required to successfully implement these proposals. However, in the light of government's commitment to traditional healing as expressed in the Comprehensive HIV and AIDS Strategy, and its advocacy of 'choice' in South African HIV/AIDS treatment regimes, I suggest that political and financial assistance for the recommendations offers the administration an opportunity to demonstrate genuine support for, and encouragement of, these aims.

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[27] Anderson and Kaleeba 2002 describe successful examples of such partnerships from Uganda and Kenya.

[28] The author is currently engaged in such an initiative with the Primary Health Care Unit, Groote Schuur Hospital Medical School, University of Cape Town.

DISCUSSION AND COMMENTS, J. WREFORD

- Traditional African medicine is capable of integrating aspects of biomedicine without being absorbed or appropriated by it.

- Discussion focused on whether medical institutions should be the main proponents of "integration" or "collaborative relations" between different medical systems, or whether this should be left to persons who already, in their normal practice, integrate different medical systems.

- If traditional medicine can be analyzed as a "medical system", it is also the case that they contain an important mystical and religious component that is inseparable from their "medical" aspect.

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MEDICAL PLURALISM IN AFRICA

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INTRODUCTION

When we consider the problem of access to health care – in this case, access by women with HIV/AIDS (or at risk for HIV infection) to prenatal care and other medical services – a question immediately arises: to what extent do representations of illness ("beliefs") and traditional healing inhibit or otherwise limit access to biomedical institutions?

There is a tendency to think that if people do not use medical services, it is because they have had recourse instead to traditional medicine, but in fact this explains nothing. The real issue is understanding when, why and for what kinds of problems women choose either traditional medicine or biomedical services; when, why and for which problems they do not use them; and when, why and for what kinds of problems they have recourse to both. Instead of attempting to answer these questions through a detailed analysis of the weaknesses of traditional medicine, which would not get us very far, it would be more useful to compare the characteristics of the two types of medical specialists and forms of medical practice. This is the perspective of medical pluralism.

In its broadest sense, "medical pluralism" means that different representations of health and illness, but also of understanding and practicing the therapeutic arts, coexist within the same geographic space. In Africa, as elsewhere, medical pluralism is the rule rather than the exception, and people tend to use the various medical traditions to which they have access in ways that may be exclusive, sequential, or complementary. For this reason, any study focusing on medical traditions in themselves, as if their histories, development and qualities were independent of interactions with other therapeutic resources, is necessarily incomplete. Medical pluralism is broad and varied, and includes a wide range of themes which include formal and informal relations between biomedical institutions and traditional medicine; illness representations understood as combinations of elements from a variety of origins; and the issues that come into play when people choose one medical system over another.

The aim of this chapter is to develop a conceptual framework for research on medical pluralism applied to public health programs. The examples used are drawn from the literature on access to prenatal services in Africa, and from my own research.

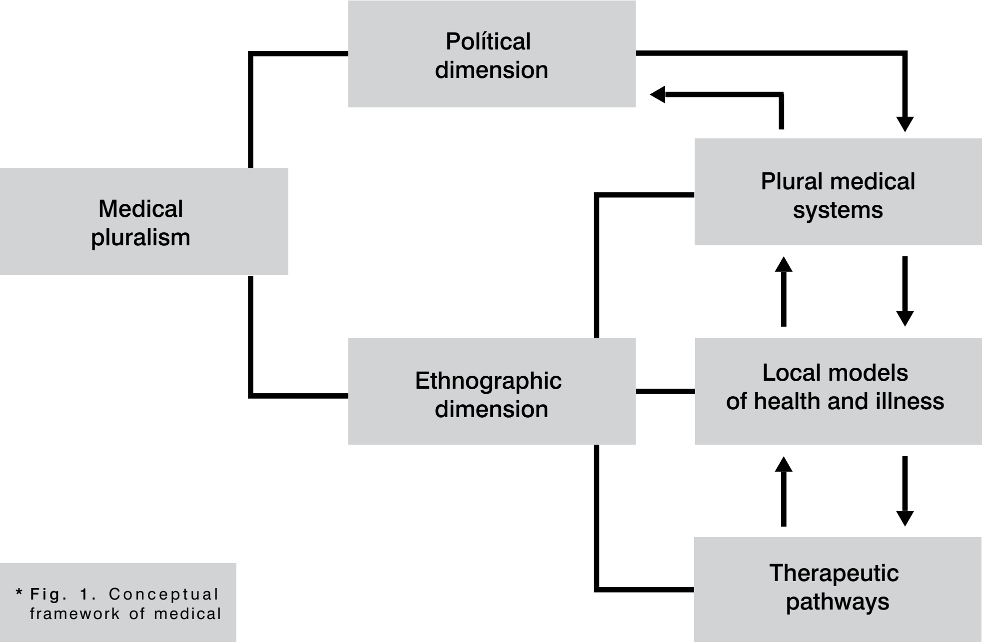
THE CONCEPTUAL FRAMEWORK OF MEDICAL PLURALISM

Medical pluralism is a very broad field of research involving a number of relevant aspects, but before dealing with the conceptual framework on which this chapter is based, I want to point out that medical pluralism should not be confused with cultural pluralism, although they may have certain features in common. The form of biomedicine practiced in any African country cannot be considered "foreign"; it possesses as many local elements as it does universal elements. In the same way, throughout its history traditional medicine has become transformed by the incorporation of new elements from various sources through the agency of traveling healers, for example, or the influence of Islamic medicine or biomedicine, but also of traditional Chinese medicine or ayurveda in East Africa.

Arguing against the assumption that people prefer "their own" local medical traditions, several authors, such as Rekdal (1999) and Katz (1982), have demonstrated just the reverse; that is, the widespread conviction that the medical traditions of Others (or those of certain groups whose healers enjoy a prestigious reputation) are more efficacious than one's own. In any case, determining whether different medical traditions correspond to different cultural universes, and whether this constitutes a reason for choosing one over another, is a matter for further research and should not be an a priori assumption.

As a conceptual framework, medical pluralism has two well-defined dimensions, although to a certain extent, for analytic purposes, these should be studied separately (Fig. 1):

1. The first dimension is political, involving opinions framed in ideological and/or pragmatic terms concerning how different medical traditions should coexist. A political discourse on medical pluralism concerns which medical traditions should be present in a given community or country, what their legal status should be



* Fig. 1. Conceptual framework of medical

(that is, whether any should be excluded or prohibited), and how they should interact . In international health, the most influential and best developed approach to the coexistence and integration of medical traditions is the Program for Traditional Medicine (PTM) of the World Health Organization (WHO 1978; 2002)[1].

2. The second dimension is ethnographic. From this perspective, different models of health and illness, medicine, and medical practice are seen to coexist within a given geographic area. This includes a plural medical system, representations of illness and models of treatment, and people’s use of different medicines. These three fields of ethnographic study (plural medical systems, local models of health and illness and processes of treatment) are necessarily interdependent.

If the problem is the use of medicines and access to biomedical resources, two classic themes of the study of treatment processes, this is the point of departure. From this perspective, I now proceed to the analysis of plural medical systems, the characteristics of the medical traditions shaping them, and representations of illness.

PLURAL MEDICAL SYSTEMS

Years ago, Dunn (1976:134) defined a “medical system”[2] c as the organized totality of social institutions and cultural traditions that have been constituted as a result of preventive or therapeutic behavior deliberately directed toward achieving or maintaining health. Nonmedical institutions, such as churches, also form part of such medical systems if, for example, they perform exorcisms to expel demons that cause illness or madness; on the other hand, dietary prohibitions or prescriptions, or habits of behavior, even if they induce health, are not included if their purpose is only religious or aesthetic

The totality of medical systems (or medical traditions) coexisting in a given society form the medical system of that society (Field 1976). It includes ideas, practices, institutions, and medical specialists from the various medical traditions,

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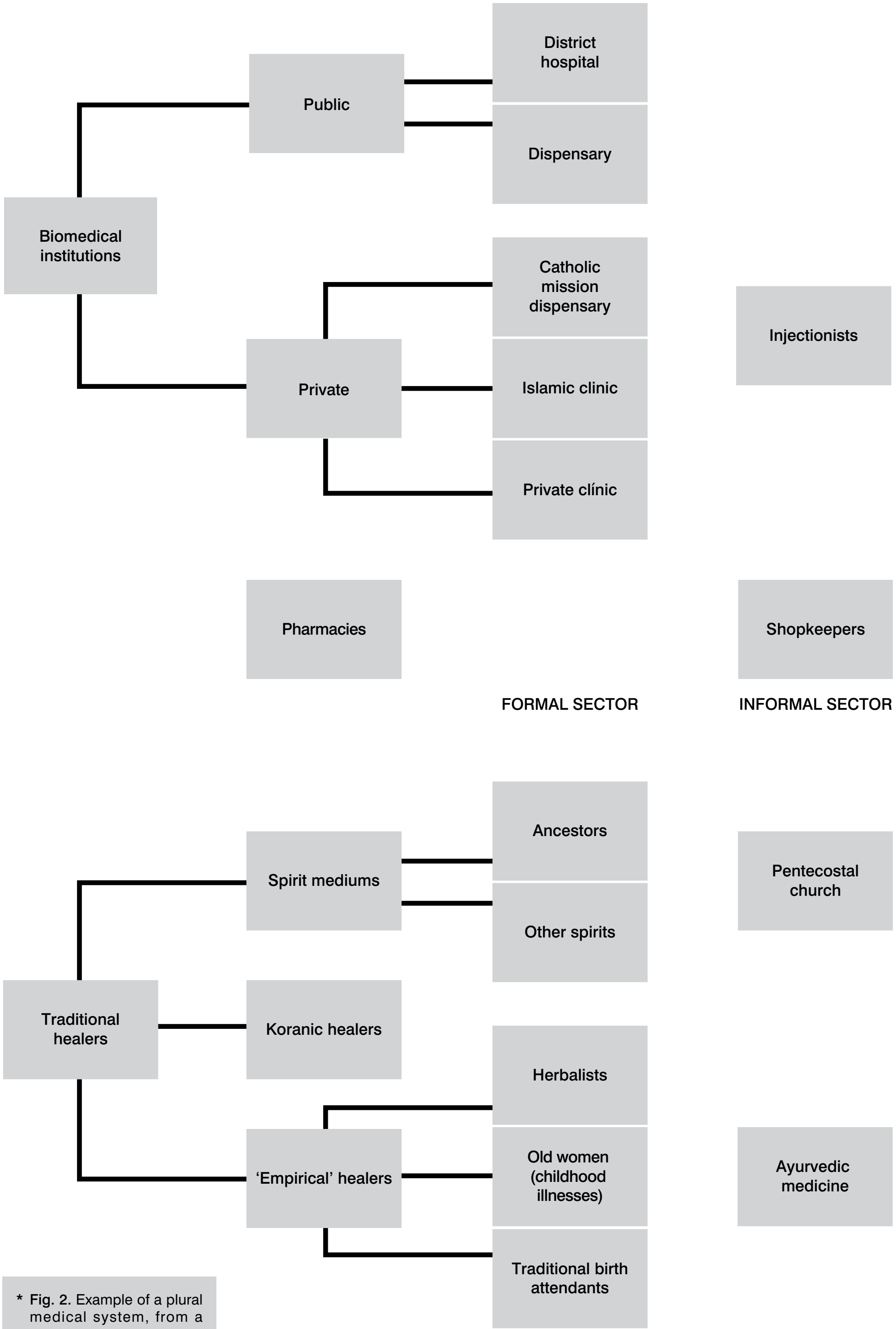
[1] The strategies promoted by WHO are of three types: 1) a type of integration we might call “sycretic” involving the formation of a new health system that is a síntesis between biomedicina and tradicional medicines, organized by scientific criteria (this is the sense of “integration” found in the 1978 document); 2) collaboration or cooperation, in which coexisting medical traditions remain autonomous but refer patients to each other if they believe they could be treated more effectively within another medical tradition; and 3) the participation of tradicional healers in the public health system as community health workers.

[2] The concept of ‘system’ is interesting because it makes reference to the interactions between medical traditions, and places them in ecological, social and political context. They should not be understood as closed, self-regulaticg, static systems with well-defined limits, but as open and subject to constant redefinition as a result of historical processes.



* **Fig. 2.** Example of a plural medical system, from a semi-urban community in East Africa

but it also includes the priest who performs exorcisms, the shopkeeper who dispenses medications along with cosmetics and other consumer ítems, or the traveling diviner who, among other omens, interprets those predicting his clients' state of health. To this pluralistic totality of medical traditions, linked to a society or a territory, Leslie (1976) gave the name of "plural medical system"; Kleinman (1980) called it a "health care system"; and Press (1980) called it a 'multisystemic medical configuration" or "plural medical configuration".

Nevertheless, although the use of medicinal plants during pregnancy is frequent (Varga et al. 1997), and traditional birth attendants (TBAs) play an important role through the process of pregnancy as well as during childbirth and the postpartum period (Helman 2001), this is not only a consequence of the relative unavailability of biomedical resources (Varga et al.1997), not does it inhibit the use of prenatal services. The tendency is to combine biomedicine and traditional medicine; and even where women prefer traditional childbirth, they do not for this reason avoid using prenatal care services if these are available.

The internal structure of plural medical systems varies from society to society, not only according to the medical traditions involved but also according to the differences between, for example, how biomedicine is organized in different countries in terms of coverage, costs (whether copayments are required), protocols, etc. The constitution (or structuring) of plural medical systems is a historical and sociopolitical process determined by alliances and conflicts between different medical traditions, health policies, and strategies for attracting clients, both in biomedicine and in traditional medicine. In this process, the social position of medical traditions (especially in terms of prestige), their distinctive characteristics, their legal status, and the therapeutic spaces they occupy (that is, for which illnesses they are considered effective) are shaped. When we analyze the plural medical system of a given community, we consider the following:

1. The medical traditions of which it is made up, and their geographical distribution
2. The historical relations between medical traditions
3. Which medicines are thought to be useful or effective for the treatment of which illnesses, or aspects of illness
4. The acceptability and legitimacy (both social and official) of medical traditions, including the legal status of traditional medicine and the role of associations of tradicional medicine, if any[3]
5. The structure and institucional culture of medical traditions, including biomedical institutions[4], as well as the characteristics of the medical traditions constituting the plural medical system

CHARACTERISTICS OF MEDICAL TRADITIONS

The totality of the plural medical system constitutes, to frame it in market terms, the "medical product" available in the community being studied. The study of processes of treatment focuses on the "demand" for these services. A widespread error in health promotion consists in the belief that the biomedical services on offer are, by definition, superior to those of traditional medicine, without taking into account either local criteria for acceptability and efficacy or the real conditions in which biomedicine is practiced, including the structural, political and economic framework within which it operates.

The characteristics of medical traditions play a role of primary importance in understanding both their acceptability in the community and their real use by that community. We should consider, for example, the comparative costs of treatment, including direct costs (medical and nonmedical) and indirect costs; form of payment (whether in cash, in kind, or in labor); waiting time; distance and other factors associated with physical acceptability; specialist charisma; and trust or perceived efficacy of and satisfaction with the various medical traditions

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[3] The difference between social and official legitimacy is important because some traditional healers may seek collaborative relationships with biomedical institutions in order to acquire a social prestige that they lack without such a relationship (Fassin and Fassin 1998).

[4] See Cristiano Matsinhe's chapter in this volume on the institutional culture of biomedicine in Mozambique and the obstacles it generates to health care access.

in the community, to name only a few relevant characteristics.

A frequently espoused idea is that traditional medical systems, unlike biomedical institutions, have characteristics that make them especially attractive to the population. The image, or stereotype, is that of a traditional medical system that shares social values, "beliefs" and a world view with its patients, that sees human beings in a holistic way, that is concerned with and treats illness or the emotional component of the disease, and understands the patient's social context; an image that stands in contrast to biomedical professionals, who are seen as socially and culturally distant from their patients, and focused on organic pathology (disease)[5]. There is tremedous variety and we should be cautious about generalizing, but in the case of prenatal care and especially childbirth, this stereotype comes closest to reality.

Nevertheless, although the use of medicinal plants during pregnancy is frequent (Varga et al. 1997), and traditional birth attendants (TBAs) play an important role through the process of pregnancy as well as during childbirth and the postpartum period (Helman 2001), this is not only a consequence of the relative unavailability of biomedical resources (Varga et al.1997), not does it inhibit the use of prenatal services. The tendency is to combine biomedicine and traditional medicine; and even where women prefer traditional childbirth, they do not for this reason avoid using prenatal care services if these are available.

What, then, are the obstacles? In the literature on access to prenatal services in Africa we find mention of distance, lack of transportation, lack of privacy and costs (even when medical care is free, there is still the cost of transportation)[6]. The very structure of prenatal services may constitue a barrier to their use. For example, in a study caried out in Burkina Faso (Peeters et al. 2006, internal research report), it was found that, because prenatal care clinics were public spaces (meeting places where rumors circulated easily), women with unwanted or socially unacceptable pregnancies – and these included women infected with HIV – did not keep prenatal care appointments. Another key factor is the behavior of health professionals. The most frequent complaints about this include negligence, verbal and occasionally physical abuse, and humiliating the patient (Pires et al. 2002). The stigma of AIDS may increase women's fear of being humiliated and abused (a very real risk) and, as a result, give them further motive to avoid using prenatal services. For these reasons it is very important to understand women's perception of the services offered in prenatal clinics, in particular those having to do with the control of infectious diseases (HIV/AIDS and sexually transmitted diseases), because their design and operation may either inhibit or facilitate access to prenatal care.

REPRESENTATIONS OF ILLNESS AND MEDICAL PLURALISM

Together with the characteristics of medical traditions, illness representations in a pluralistic medical context are a key element for understanding the use of the various therapeutic resources available to the population. Illness representations include models of causality, transmission or contagion; of risk, or susceptibility to illness (which persons are likeliest to become ill, and when); and models of protection, seriousness of the illness, symptoms[7], etc. These models are related to representations of the body, models of therapy, and, finally, to ideas about what is normal and what is abnormal, moral values, and world view.

A question often posed is how health messages become integrated into local models, and how this affects practices. There are several logical possibilities: biomedical concepts may simply be known, but not believed[8], or they may be misinterpreted or reinterpreted; they may displace local terms and concepts, coexist with them as a parallel system[9], or be combined syncretically with previously existing knowledge. In any community we find different forms in which the "pluralism of ideas" can be observed.

A very important aspect that often goes unremarked is that health professionals also

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[5] Various authors such as Velimirovic (1990) and Waxler-Morrison (1988) have criticized this stereotype using good counter-examples.

[6] Ndyomugyenyi et al. (1998); Schultz et al. (1994); Magadi et al. (2000); Materia et al. (1993); Okonofua et al. (1992); Telfer et al. (2002); WHO (1998). See also the chapter by Elsa Jacinto in this volume, in particular the section devoted to the "three delays" and the role of tradictonal birth attendants in reproductive health care.

[7] See also Kleinman's (1980) concept of "explanatory models".

[8] It is well documented that in responses to qustionnaires, people typically repeat health messages, giving the answers they believe the interviewer expects or wishes to hear. For this reason questionnnaires do not necessarily reflect either the knowledge or the beliefs of the population (Yoder 1997).

[9] Different explanations of illness, even if they seem contradictory, may be used to give meaning to illness in different contexts (Staiton Rogers 1991).

reinterpret biomedical information (obviously in a deeper way than nonspecialists do) on the basis of cultural models and systems of social values. For example, the biomedical theory of infection is full of ideas relating to "pollution or ritual contamination", which is heavily stigmatized and has a negative impact on both practitioner-patient relationships (in particular with patients infected with HIV[10]) and on the reception of health messages[11]. A sample of health professionals should always be included in any study of local representations of illness.

Possibly the most interesting form of the "pluralism of ideas" is syncretism. 'Syncretism' is a technical term extensively used in the study of religion to define changes in popular models as a result of the combination of elements originating in different religious traditions, but it is extremely useful for analyzing the effects of health messages on local models of illness and treatment (Hausmann-Muela et al. 1998; 2002). The basic idea is that people absorb and dynamically reinterpret biomedical information (received via the mass media, in schools, in doctors' offices, etc.), working from their own cultural models of illness representation and practice. The result of this process is a new synthesis[12] that allows them to interpret illness and give it greater meaning than a stricly biomedical model would permit.

In working with models of therapeutic pathways, it is very important to remember that access cannot be explained by a single factor in and of itself. The relative weight and impact of factors should be understood relationally and in context. For example, even if an illness is considered serious, the action taken in response will be quite different depending on whether it is known that there are, or are not, therapeutic resources to be found in the health center.

Obviously, syncretic processes affect a broad variety of domains in different ways. Perceived susceptibility to infection, for example, is often explained by behavior (failure to use condoms, or "being promiscuous"), but also in terms of the "strength" or "weakness" of "blood", including all those factors that contribute to strengthening or weakening it (food, emotional states, etc.) (Hausmann-Muela et al. 2002). The forms of syncretism which are the most relevant, because they lead to dual therapeutic pathways, are those that join biomedical concepts to withcraft or the actions of spirits. Here the "bridge" that permits syncretism is the logic of double causality.

In one of the classic works of anthropology, Evans-Pritchard (1976 [1937]) wrote that the Azande know perfectly well that, for example, the action of termites can weaken the wooden supports of a granary to the extent that it collapses. But if anyone is crushed to death by a granary while resting in its shade, they will attribute his death to witchcraft. The action of termites explains only the how, but witchcraft explains the why of his death. A similar example, but one that integrates concepts originating in biomedicine into the logic of witchcraft, is found in Gluckman (1976). He recounts the death from typhus of the son of an African schoolteacher, an educated man. The teacher insisted that it was a case of witchcraft. When a sociologist tried to argue that it was a case of death from natural causes, the teacher replied, "I know that my son caught typhus from a louse that came from a person sick with typhus, who died of that illness. But why did that louse choose my son, and not any of the other boys he played with?". In accordance with the principle of double causality, termites and typhus are the natural and secondary causes, while witchcraft is the primary and socially relevant cause.

In local representations of illness, the modes of interaction between concepts (etiologies and mechanisms of contagion) originating in biomedicine and in witchcraft are various. From the literature and from my own fieldwork, I have gathered the following examples: (1) witches may send the vectors that transmit disease (lice, mosquitoes, etc.), contaminate water or food, etc.; (2) witches may induce their victims to adopt risky behaviors (they may "forget" to use a condom, sleep under a mosquito net, etc.); (3) witches may obscure or camouflage the illness (the results of medical tests are normal although the person is sick), or prevent the treatment from

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[10] This is evident, for example, in aversión to shaking hands with an HIV-positive person as a result of ideas about pollution, or discriminating against persons with HIV/AIDS because of the moral charge of the illness.

[11] In particular, misinformation on forms of contagion and use of preventive measures.

[12] Syncretic models are open and constantly changing. In fact, all culture is syncretic – or "mixed", as Amsèlle (1990) suggests – mixtures of prior mixtures whose origins are lost in history.

working; (4) witches may cause "false" illnesses that imitate precisely the symtomatology of malaria, cancer, AIDS, etc., but cannot be treated with drugs.

These are not simple ethnographic curiosities. They have important implications for epidemiology and public health:

1. Knowledge of the illness is not incompatible or inconsistent with a world view that includes witchcraft and the spirit world.
2. The logic of imitation and of double causality goes far to explain the sequential or complementary use of biomedicine and traditional medicine.

> **Medical pluralism is a conceptual framework that can make it possible to move beyond "beliefs" and decontextualized sustems of traditional medicine. It invites us to think in relational terms, and includes as objects of study all of the medical resources present in a given community, representations of illness, and the use of medical resources by the population. As a conceptual framewirk, it allows us to systematize a broad range of factors, which in turn makes possible the analysis20 of problems and complex realities in a relatively short time frame, adapted to the duration of the project**

THERAPEUTIC PATHWAYS

The study of therapeutic pathways includes illness behavior, whether intended to prevent or to treat illness either in the domestic or in the professional sphere. It also includes factors influencing illness behaviors, such as the processes and contexts (ecological, sociocultural and political) in which they are found.

The logic of double causality allows us to explain to a considerable extent the existence of mutiple therapeutic itineraries, and in particular why patients resort to traditional medicine after being diagnosed and/or treated in a medical context, a not infrequent practice engaged in by patients diagnosed with HIV/AIDS. In any case, this logic does not exclude other strategies including the desperate search for a solution[13] and pragmatism[14], or explanations such as the lack of resources in biomedical health centres. In relation to this, I would like to emphasize that recourse to traditional medicine is not only stimulated by "beliefs" or the benefits of traditional therapies, but also forced by the failings of biomedicine and the lack of political will to achieve substantial improvements in access to drug treatment.

Illness representations allow us to understand for which illnesses people choose one type of medicine or the other, or why many people use both. Certain characteristics particular to one medical tradition or the other can explain why people – in this case, pregnant women infected with HIV, or who suspect that they may be infected – hesitate to use medical services (for example, the way they are treated by medical professionals, or fear of rumor), while other characteristics may limit access to services even when people wish to use them (for example, distance or cost). The characteristics of medical traditions and the interpretation of illness form part of the study of treatment processes[15], but there are other factors in play as well.

Models of therapeutic pathways can be found in social psychology, geography, sociology and medical anthropology. Normally we work with adapted models that combine features from different sources. It is important to keep in mind that since these are models centering on action and the factors that condition it, some authors emphasize agency (the ability of persons to act on their own behalf), while others emphasize the structural limits of action ("structure" should be understood as ideological-cultural[16] and sociopolitical as well as material). It would be just as wrongheaded to see structural limits as absolutely deterministic as it is to believe that strength of will combined with knowledge make it possible to overcome any obstacle. What is necessary is to understand (1) both the

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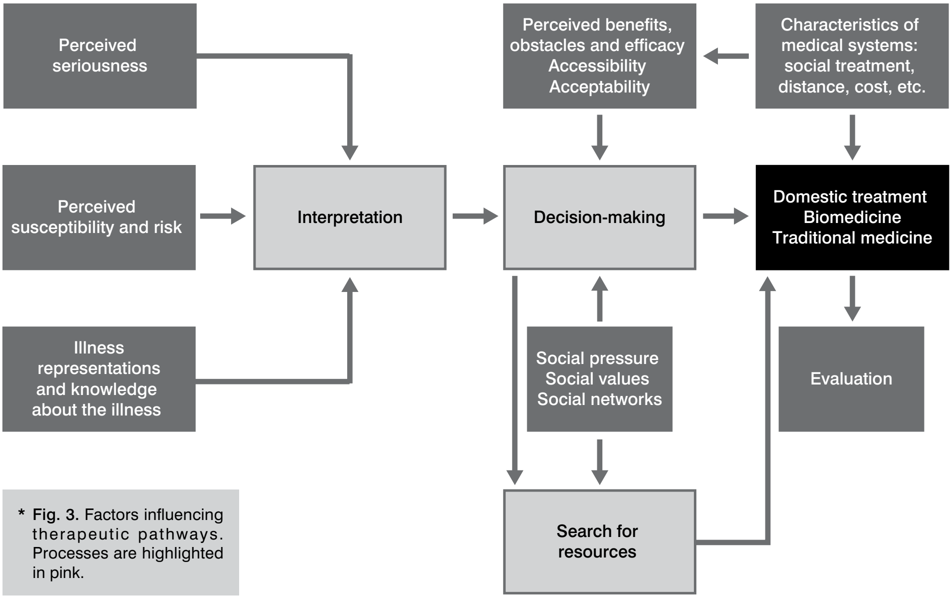
[13] In confronting intractable problems, chronic pain, and doubt, medical pluralism always offers another source of hope after one approach fails (Benoist 1996).

[14] Pragmatism may be of two types: (1) use of biomedicine and traditional medicines to treat different aspects of the illness "because they work"; (2) changing from one medical tradition to another for "practical reasons" either of a material nature (cost, for example) or an emotional nature (the way one is treated, for example).

[15] See Conner and Norman (1995) and Hausmann-Muela, Muela and Nyamongo (2003).

[16] For example, the ability to act (agency) depends on, among other things, women's perception of themselves (see Ana Loforte's chapter, this volume).

[17] The chapter by Kalipeni, Ghosh and Valhmu in this volume presents a complex but clear conceptual framework that makes it possible to organize the factors contributing to



* **Fig. 3.** Factors influencing therapeutic pathways. Processes are highlighted in pink.

structural obstacles to action[17] and the strategies used, successfully or not, to overcome them; and (2) which groups are especially vulnerable. One of these groups is made up of pregnant adolescents. A series of studies carried out in Nigeria (Okonofua et al.1992), Kenya (Magadi et al. 2000), and Uganda (Mbonye et al. 2005) show that pregnant adolescents and unmarried women are the groups with the least access to prenatal services.

The model shown below includes factors from the health belief model, Good's processual model, Andersen's sociobehavioral model, and Azjen's theory of planned behavior:

In working with models of therapeutic pathways, it is very important to remember that access cannot be explained by a single factor in and of itself. The relative weight and impact of factors should be understood relationally and in context. For example, even if an illness is considered serious, the action taken in response will be quite different depending on whether it is known that there are, or are not, therapeutic resources to be found in the health center; whether distance is a greater obstacle when the demands of work are at a maximum; when the perceived benefits can only be understood in relation to the perceived obstacles (the cost of treatment or the stigma of an HIV diagnosis), etc. We should also keep in mind that perceived efficacy of drug treatment, for example, does not exclude the conviction that other therapeutic actions – whether traditional, neotraditional, or novel – are equally efficacious, as is shown dramatically by the practice of having sexual relations with a virgin.

An examination of all the factors involved is not possible here, but some space should be devoted to social networks, social values, and social pressure. The stigma suffered by people with HIV and the gender ideologies that permeate decision-making as well as unequal access to economic and therapeutic resources form part of social values. The support of one's social network is fundamental for access to prenatal services. To give a few examples: (1) the persons who give advice, participate in any rituals performed, and accompany women to prenatal care services (generally, these are women); (2) the persons who pay the direct and indirect costs of biomedical services; and (3) peer pressure, for example in the case of adolescents who urge other adolescents to go to sexually transmitted disease clinics.

Since pregnancy is a family matter, therapeutic pathways should be seen in the context of the social organization of procreation and ideologies of gender and kinship[18]. It is important to know who decides where to go when a woman is pregnant and it is possible that she may have been infected with HIV, how decisions are made,

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[18] See Ana Loforte's chapter, this volume.

[19] Telfer et al. (2002).

what mechanisms are used to force people to abide by them, and whether women make use of strategies to resist or counteract social pressure. It is also important to know the reasons for lack of social support, as well as for the existence of small and impoverished domestic units, the absence of relevant persons, lack of interest on the part of hysbands, stigma, etc.[19].

RECOMMENDATIONS

Medical pluralism is a conceptual framework that can make it possible to move beyond "beliefs" and decontextualized sustems of traditional medicine. It invites us to think in relational terms, and includes as objects of study all of the medical resources present in a given community, representations of illness, and the use of medical resources by the population. As a conceptual framewirk, it allows us to systematize a broad range of factors, which in turn makes possible the analysis[20] of problems and complex realities in a relatively short time frame, adapted to the duration of the project.

Although in this chapter I have focused on traditional medicine, programs that include the perspective of medical pluralism should contemplate not only the possibility of collaborative relationships between biomedicine and traditional[21], but also community participation in the management of health care[22].

DISCUSSION AND COMMENTS, J. MUELA

- It is necessary to exercise some quality control over traditional medicine and the role that healers' associations can play in the regulation of traditional medicine, based on criteria that do not emanate solely from bioscience.

- A question: should traditional healers be able to administer pharmacological treatment in emergency situations when it is impossible to refer their patients to a hospital or health center?

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[20] Clear objectives, a solid conceptual framework, and a methodological design appropriate for the problem studied are key elements for a good research project. See Iqbal Shah's chapter (this volume) on research methodology.

[21] See Joanne Wreford's chapter (this volume) on cooperation between traditional medicine and biomedical institutions.

[22] The case of TASO (The AIDS Support Organization) in Uganda is a good example of the type of active community participation I have in mind (see Noerine Kaleeba's chapter, this volume).

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ADDRESSING SEXUAL AND REPRODUCTIVE HEALTH NEEDS: APPROPRIATE AND TIMELY USE OF QUALITATIVE RESEARCH METHODS

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Note: The views expressed in this chapter are those of the author and may not necessarily reflect those of the World Health Organization (WHO).

INTRODUCTION

Since the early 1980s, the HIV pandemic has continued to take a heavy toll in human life and suffering. Sub-Saharan Africa has continued to bear the brunt of the global epidemic. In 2006, 63 percent (24.7 million) of the 39.5 million people infected globally with HIV were living in sub-Saharan Africa (UNAIDS and WHO, 2006). Among the 4.3 million people newly infected with HIV in 2006, 2.8 million were living in sub-Saharan Africa: more than the combined total of all other regions of the world. In 2006, 72 percent (2.1 million) of all global AIDS deaths (2.9 million) occurred in sub-Saharan Africa. Women in this region carry the major burden of HIV/AIDS; they are more likely than men to be infected by HIV and they are also more likely to be the caregivers to those living with HIV. Across all ages, 59 percent (17.7 million) of people living with HIV in sub-Saharan Africa in 2006 are women, an increase of over one million since 2004. For every 10 adult men living with HIV in this region, there are about 14 adult HIV-positive women.

Despite concerted efforts to stem the tide, the number of HIV-infected people, the number of the newly infected and the annual number of AIDS deaths have continued to grow. The global response to the pandemic in terms of financial and professional support has been impressive. Cumulatively, significant resources have been devoted to programmes and interventions to prevent and manage HIV infection and to care for those living with HIV/AIDS. Of late, national governments and the world community have focussed on the provision of antiretroviral therapy, and by June 2006 one million people in sub-Saharan Africa were estimated to be receiving antiretroviral treatment.

The HIV pandemic has also brought together scientists from such diverse disciplines as the social sciences (anthropology, demography, economics, psychology, sociology), epidemiology, public health and the biomedical sciences to find solutions to several intractable issues including behaviour change, compliance and others that have been traditionally within the domain of the social sciences. The advent of the HIV pandemic also brought into public discourse the hitherto taboo and sensitive subject of sexuality and sexual behaviour. With several programmes and interventions experiencing less than the projected success and with access to HIV services still largely constrained, despite being relatively well-funded and better-staffed, attention has turned to finding answers to the questions of why the lack of success and how best to overcome barriers in expanding access to such services. Why do some programmes succeed and others fail? Why do people continue to practice risky sexual behaviour even though they know how to protect themselves? Public health specialists are increasingly turning to social scientists or attempting themselves to use qualitative research methods to fill knowledge gaps in order to improve provision of services to those who need them most. On the establishment of the WHO Commission on Social Determinants of Health, the late former Director General of WHO, Dr. J.W. Lee stated: "Public health is a social issue. ...interventions aimed at reducing disease and saving lives succeed only when they take social determinants of health adequately into account" (Lee 2005).

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This chapter focuses on the role of social science qualitative research methods in providing practical information critically needed by public health specialists and programme managers to improve the quality and accessibility of sexual and reproductive health services. Qualitative research is justified on its own for generating and advancing knowledge, building theories or exploring the beliefs or practices of people in different cultural contexts. The focus of this chapter is, however, on its public health relevance. I first define qualitative methods, highlight their contribution to public health, and explore reasons for their relative neglect by public health specialists or programme managers. I then describe how the potential of qualitative methods can be used, illustrating with an example. The chapter concludes with a recommended strategy of triangulation of research methods as the optimal approach to measuring and explaining access to services – information that is critical for implementing culturally appropriate, locally acceptable, and successful interventions.

Objective

The main objective of this chapter is to review the potential of qualitative research methods in addressing people's sexual and reproductive health needs through in-depth study of the underlying contextual and individual factors..

Statement of the problem

Qualitative research methods provide unique and much valued scientific strength in understanding and explaining the underlying contextual and behavioural factors which facilitate or impede access to sexual and reproductive health services. Yet, their implementation has been patchy and the record of success uneven. This chapter explores the reasons for this and suggests a strategy for blending qualitative and quantitative methods.

QUALITATIVE RESEARCH METHODS: DEFINITION AND PURPOSE

Qualitative research is defined more by its purpose than by the methods used. When the primary purpose is to explore and explain behaviour rather than measure and describe it, or when the issues are unfamiliar or the vocabulary locally used is not known, qualitative research methods provide the research options necessary to fill knowledge gaps. The characteristics of qualitative research noted by Ulin et al. (2002) are:

- Asks why, how, and under what circumstances things occur
- Seeks depth of understanding
- Views social phenomena holistically
- Explores and discovers
- Provides insight into the meanings of decisions and actions
- Uses interpretive and other open-ended methods
- Is iterative rather than fixed
- Is emergent rather than pre-structured
- Involves respondents as active participants, rather than subjects
- Defines the investigator as an instrument in the research process

There are three underlying assumptions of qualitative research. First, data on cultural meanings, values and culturally prescribed behavioural patterns require in-depth cultural explanations that cannot be numerically ascertained. Second, cultural patterns of behaviour need to be studied holistically. Third, a given social group or community manifests a degree of uniformity or homogeneity of cultural patterns, and therefore information given by a few respondents may be generalized to the entire group or community.

Qualitative research methods provide unique and much valued scientific strength in understanding and explaining the underlying contextual and behavioural factors which facilitate or impede access to sexual and reproductive health services. Yet, their implementation has been patchy and the record of success uneven. This chapter explores the reasons for this and suggests a strategy for blending qualitative and quantitative methods.

An array of qualitative techniques has been applied in sexual and reproductive health research. A method-by-method discussion of their breadth, strengths and limitations is beyond the scope of this chapter. The main approaches can be grouped into three: (1) individual in-depth interviews (the "conversational partnership"), which include key-informant interviews and case studies; (2) group-interview approaches that include focus group discussions (FGDs), informal group interviews and participatory action research (PAR) techniques; and (3) observational techniques consisting of participant observation, observation of specific events, observation of interactions and informal, unstructured observations. Table 1 further elaborates the most commonly used techniques by research objective or question and approach.

Various approaches in applied research combine qualitative and quantitative data collection techniques. Some of these focus on communities, while others focus on services and service delivery. Rapid appraisal procedures started with rapid rural appraisal (RRA), used by multidisciplinary teams to collect data from people in the community. The expansion of this method by involving community members as partners in information collection, analysis

Table 1: Main Qualitative Research Techniques, By Research Question and Approach

RESEARCH QUESTION	APPROACH	RESEARCH TECHNIQUE
How people behave in public?	Observe them	Participant observation
How people behave in private?	Ask them to keep diaries	Personal documents
What people think or how they behave in private?	Ask them	In-depth interviews
Where people go?	Chart their movements	Behavioural mapping
What are the normative (accepted or expected) behaviours?	Organise group discussions	Focus group discussions
What is the local vocabulary (for illness or behaviours or other issues)?	Ask them	Free-listing
How to organize and search for behaviour patterns?	Systematically group items from free-listing	Pile-sorting

and decision-making processes resulted in the approach known as participatory rural appraisal (PRA). PRA is a set of methods for conducting participatory and qualitative research with the aim of permitting people to describe and analyze their own situation, and evaluate constraints and opportunities. PRA is more an approach and a tool for community development than a research strategy. The priority is to generate information for action rather than for advancing knowledge with wider application.

Qualitative research is defined more by its purpose than by the methods used. When the primary purpose is to explore and explain behaviour rather than measure and describe it, or when the issues are unfamiliar or the vocabulary locally used is not known, qualitative research methods provide the research options necessary to fill knowledge gaps.

Rapid assessment procedures (RAP) adapt ethnographic methods to collect qualitative information on people's views and beliefs about health and the treatment and prevention of disease. They also provide insights into social and cultural factors influencing behaviour. Focused ethnographic studies (FES) are yet another type of rapid assessment procedure which applies ethnographic research techniques to address issues of relevance for planning of interventions. This approach has been used for studying sexual behaviour and STI/HIV, and generally involves interviewing key informants, site visits to the community and clinics, and social mapping. This provides insights into contextual factors which may constrain access to services by those who need them.

THE CONTRIBUTION OF QUALITATIVE RESEARCH IN PUBLIC HEALTH

Qualitative research has contributed to public health in many different ways. In some cases it has led to discoveries, and in others it has identified the patterns that reinforce or offset the susceptibility of individuals and communities to poor health outcome. One example of the former type is the discovery made by Dr. John Snow (1813-1858) that cholera was transmitted not by breathing polluted air – the prevailing theory at the time – but by water contaminated by the waste of other cholera sufferers. By talking to local residents, he identified the cause of the cholera outbreak in Soho, England in 1854. In a letter to the Editor of the Medical Times and Gazette, Dr Snow wrote:

> *"On proceeding to the spot, I found that nearly all the deaths had taken place within a short distance of the [Broad Street] pump. There were only ten deaths in houses situated decidedly nearer to another street-pump. In five of these cases the families of the deceased persons informed me that they always went to the pump in Broad Street, as they preferred the water to that of the pumps which were nearer. In three other cases, the deceased were children who went to school near the pump in Broad Street…".*

A recent example is the development of a low-cost, sustainable participatory intervention with women's groups in rural Nepal that reduced neonatal mortality by 30 percent and had many other positive public health outcomes (Manandhar et al. 2004). While quantitative research methods such as knowledge, attitude, and practice (KAP) surveys or the randomised clinical trials (RCTs) describe cause-and-effect relationships, qualitative methods provide explanations of such relationships and assist with the development of interventions for prevention and care.

BARRIERS TO THE SUCCESSFUL USE OF QUALITATIVE RESEARCH METHODS

The scope and purpose of qualitative research methods should make them most appealing for development planners, public health professionals and researchers alike, yet the record of their acceptance and utilization remains mixed at best. The reasons for this range from lack of recognition and misunderstanding of the purpose of qualitative methods to their misapplication or misinterpretation of results.

Lack of recognition and understanding

Most development planners and public health professionals continue to rely primarily on numerically expressed quantitative information in making decisions about programme design and implementation. Chambers (1997) and Bleek (1987), among others, refer to the predominant quantitative paradigm that dismisses entirely or belittles qualitative research methods and findings. Chambers (1997: 39) points out that "within and between professions, status and respectability are sought and can be gained through quantification, mathematical techniques, and precision." Some anthropologists and sociologists have turned to quantitative surveys to gain scientific respectability. Bleek (1987: 317) explains this predicament:

> *"I was often chided by colleagues about the statistical weakness of my research. Because my sample consisted of only 42 adults, its representativeness was challenged". Indeed, in many public health circles the scientific rigour, generalizability and reliability of qualitative data continue to be questioned. Short of time and lacking familiarity with qualitative methods, programme managers and public health professionals have continued to rely mostly on quantitative information, which is seen as precise. It is not uncommon to find medical professionals, who often lack understanding of qualitative methods, dismissing such methods as "unscientific" and their findings as "anecdotal".*

Moreover, some hold the mistaken view that qualitative methods are not compatible with "evidence-based" decision making, for they do not provide information from large surveys or randomised controlled clinical trials with intervention and control groups followed over time in search of specific cause-and-effect relationships.

Misunderstanding the purpose of qualitative methods

Lack of understanding of qualitative methods, especially among those with little or no social science research background, and familiarity with numerical presentations, have led some to use qualitative approaches to measure and describe numerically behaviour such as the incidence of abortion, percent of people using condoms, etc. Some public health professionals and programme managers have confined their interest in qualitative methods to knowing the socioeconomic and demographic characteristics of those accessing services. Qualitative methods are thus seen, erroneously, as an inexpensive substitute for large quantitative KAP surveys. This limited expectation from qualitative methods to describe behaviour has been misleading and futile.

Misapplication

Both published and unpublished material contains examples of misapplication such as using focus-group discussions (FGD) to elicit personal information or applying statistical techniques to FGD data. Also, KAP surveys have been used to generate information on attitudes, beliefs, perceptions and causes, which are much better addressed through qualitative research methods. This mismatch between study objectives and methods has weakened the utilization of social science research findings in public health.

Misapplying the biomedical model: the case of ethical reviews

The ethical principles of informed consent for participation in a study, privacy, and confidentiality of information are universally applicable. However, unlike biomedical interventions, qualitative research methods of talking with or observing people do not pose any health risks. Most ethical review committees, however, apply the biomedical model to social science research in reviewing ethical procedures. Indeed, most of these committees are composed of people familiar only with biomedical research methods and interventions and lacking a basic understanding of qualitative research methods and procedures. Some of these committees argue that personal interviews or observations are as hazardous and pose as much risk to the individual as clinical trials of drugs or treatment procedures. It is not uncommon for such committees to request that informed consent be obtained from each person present, for example, at a healing ceremony or ritual celebration prior to anthropological participant observation. Review of social science research proposals through a biomedical lens has not infrequently resulted in distortion of the intent, design and implementation of such research.

Poor timing

More often than not attention is turned to qualitative methods when things do not work out as planned. Many intervention programmes with substantial financial and human resources are set up with little or no information on the perspective of the people who need them most. When such interventions do not produce the desired outcome, health policy planners turn to qualitative research to find out the reasons why they were unsuccessful. Of course, insights can be gained from this use of qualitative methods, but many such programmes could be saved by conducting the qualitative research before implementation of the intervention instead of afterwards.

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Ulin et al. (2002) report on such a case, in which a programme providing female condoms and related information was suspended due to its apparent lack of success. The follow-up qualitative in-depth study of the reasons for failure revealed many insights that would have helped to design the intervention more effectively from the outset. For example, the study showed that clinicians were reluctant to distribute female condoms because they feared being accused of lacing the condoms with HIV virus, a rumour that was circulating in the community. Interviews with women revealed that many knew of the method but did not ask for it because they thought that providers either did not have it or thought it was ineffective, or even dangerous. Focus group discussions provided additional insights into power relations and gender issues within the community with important bearing on the acceptability of the female condom. All this information was helpful in addressing social and cultural issues, but came too late for the programme, which had already been withdrawn on the basis of quantitative research demonstrating “lack of success”.

Learning from qualitative research can be critical in designing appropriate interventions that meet people’s needs and preferences.

THE WAY FORWARD: TRIANGULATION

Much intellectual energy has been expended in debating the superiority of one type of research method over the other. Blending and integrating methods and data on the same issue, however, provides a more complete and holistic picture that is useful for designing appropriate programmes. A good social science research project both describes and explains. Evidence is accumulating that one without the other is not only incomplete and less useful, but at times potentially misleading. Together, both approaches provide insights that describe, explore and explain behaviour, taking full account of contextual factors and how they shape individual behaviour and responses.

More and more studies aim to include both qualitative and quantitative components. One such study was sponsored by the World Health Organization in Kenya, South Africa, Tanzania, Uganda, Zambia and Zimbabwe. The objectives were: (a) to ascertain the perspectives of sexually active individuals on the risks of HIV/AIDS and unintended pregnancy; (b) to investigate the strategies considered by sexually active individuals as appropriate, practical and effective ways to cope with these risks; and (c) to explore the opportunities for and constraints on changing behaviour, with particular emphasis on partner communication. The research design included focus-groups discussions (FGDs) followed by a survey and ended with in-depth interviews with women and men exhibiting high-risk sexual and reproductive behaviours. The eligible respondents were sexually active women aged 18 to 39 years and their married or cohabiting partners. The study sites included an urban and a rural area in each country.

FGDs, in general, yielded information showing major barriers to condom use with marriage. They also revealed normative answers and gender differentials. For example,

> *"It [condoms] is good but it is not applicable in our culture".*
> [Urban man, Uganda]
>
> *"Men will not use them in marriage because their wives are not prostitutes".*
> [Rural woman, Kenya]
>
> *"Condom use within marriage, that is impossible".*
> [Urban woman, Uganda]
>
> *"If you are seen with a condom, you are stigmatized…so carrying is a problem"*
> [Rural man, Kenya]

Based on FGD findings alone, one would conclude that there is little or no condom use within marriage in these societies. However, the quantitative survey of 6,140 men and women across the study sites showed that a non-negligible percentage of married or cohabiting women reported condom use (Table 2).

Participants in the detailed in-depth interviews were identified through responses to the survey questionnaire. These in-depth interviews revealed the personal coping mechanisms and strategies used to address the dual risks of HIV infection and unintended pregnancy. Women perceiving themselves at risk of HIV were found to be able to negotiate condom use. Taken together, the methods used in this study yielded several new insights including the promising potential of condom use within marriage, the contraceptive and condom decision-making power of women, and key implications for programmes and policies. The triangulation of research methods succeeded in dispelling the myths that condoms could not be used within marriage in Africa and that women lack any decision-making power. The study results presented opportunities for health professionals to promote condom use within marriage and to strengthen women's role and empowerment in promoting condom use. It also showed how each method can complement the others in providing insights into sensitive personal behaviour and the role of contextual factors. Qualitative methods can prove especially insightful in exploring the process by which condoms can be incorporated into married life, and integrated analysis of data generated by different methods can lead to informed and effective condom promotion programmes better suited to the needs of married or cohabiting couples in sub-Saharan Africa.

CONCLUSIONS

To expand services to those who need them most, much can be gained by applying qualitative methods appropriately and in conjunction with quantitative methods. Public health professionals need to avoid the risk of relying entirely on quantitative information for understanding human behaviour and for decision-making. It is best to measure behaviour quantitatively and to explain it qualitatively.

Qualitative research methods follow scientific principles and procedures to provide objective information on factors which impede or facilitate the use of services. Appropriate and successful use of such approaches requires expertise, knowledge and experience to avoid pitfalls and redundant research (for example, KAP surveys are often undertaken by health professionals who are unaware of existing survey information). Timely use of qualitative methods can inform policies and programmes and ensure their usefulness and cost-effectiveness. Whether the aim is to set up a programme or to design a quantitative survey to measure the incidence of a health outcome, qualitative methods are critical. Use of these methods should precede (and not follow) programme implementation. Their use should also precede any survey design or questionnaire in order to incorporate local concerns and terminologies. Applied in a timely and appropriate way, qualitative studies can generate insights that have a major impact on averting morbidity and mortality as well as avoiding unnecessary financial costs, as is evident from experiences in Mozambique, Nepal and in other countries (Grypdonck 2006).

Dialogue between qualitative researchers and public health professionals improves when the former address issues of interest to the latter or when qualitative research identifies clear policy implications, especially for short-term actions. Policymakers have relatively short time horizons and are interested in results that can be achieved quickly. Timely analysis, dissemination and provision of information can also facilitate a greater understanding and appreciation of qualitative research findings. Finally, multidisciplinary teams involving qualitative researchers as well as public health professionals are optimal for policy-relevant research to address people's needs more effectively by developing interventions that are both acceptable and affordable.

Table 2: Percentage of Married or Cohabiting Women Reporting Condom Use Within Marriage

CONDOM USE	URBAN	RURAL
SOUTH AFRICA	%	%
Current use for family planning	8,7	5,2
Consistent/occasional use with partner	31,3	11,1
KENYA		
Current use for family planning	2,2	1,7
Consistent/occasional use with partner	14,5	11,6
Uganda		
Current use for family planning	5,6	3,1
Consistent/occasional use with partner	21,8	11,0

DISCUSSION AND COMMENTS, I. SHAH

- It is necessary to carry out high-quality social research that addresses problems relevant to public health.

- It is necessary to work towards greater receptivity and openness on the part of health planners and medical professionals toward the contributions of the social sciences.

- The general feeling was that there is a growing interest in triangulating quantitative and qualitative research methods, even though in public health greater value continues to be placed on the former.

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CRITICAL MEDICAL ANTHROPOLOGY PERSPECTIVES ON MALE CIRCUMCISION TO PREVENT HIV

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Note: The views expressed in this chapter are solely the author's and do not necessarily reflect those of the institutions with which she is connected.

INTRODUCTION

About 25 million HIV-positive people live in the countries of sub-Saharan Africa, approximately two thirds of the affected persons in the world (ONUSIDA 2006), and the evolution of the pandemic in this region shows it to be shaped by a variety of cultural, social, economic, political and behavioral factors that permit, and even facilitate, the spread of HIV infection among the population, with devastating effects. In this context, the contribution of anthropology is especially valuable for understanding the matrix in which the disease is socially constructed, some of its epidemiological characteristics are defined, and behaviors that contribute to either the success or the failure of public health programs take shape.

In fact, since the appearance of AIDS, the social sciences in general and anthropology in particular have contributed significantly to the study of the multifactorial nature of the epidemic. In some institutional contexts spaces have been developed in which the social sciences have been linked with epidemiology or biostatistics, which are considered the "hard core" of public health. WHO, in its constitution as well as in a variety of public statements (Lee 2001), recognizes the importance of communities, cultures, values and social factors for health. Since 1998 UNESCO has worked together with UNAIDS on a project aimed at **a cultural approach to the prevention and treatment of HIV/AIDS.** In the context of this juncture between public health and the social sciences, AIDS also served as a catalyst that made especially evident the connection between health and human rights, thus broadening the human rights agenda.

As a consequence of these developments, it would appear to be the case that anthropology, like other disciplines, is now authorized to speak to the design and evaluation of HIV/AIDS policies and programs. En consecuencia, daría la impresión de que hubiese una constelación apropiada para que la antropología, tuviese palabra "autorizada", al igual que otras disciplinas, a la hora de diseñar o evaluar políticas y programas destinados al VHI/sida.

Nevertheless, a careful look at many of the programs aimed at HIV/AIDS in sub-Saharan Africa suggests otherwise. It appears that the diversity of factors contributing to the epidemic, which constitute the object of study for anthropology and the other social sciences, are reduced in the context of public health to a few "confounding factors", treated as if they could be controlled for by the research design, or statistically in the process of validating the biomedical studies which furnish the scientific evidence that forms the basis for the design of health policies that may be crucial in controlling the epidemic.

This chapter addresses some of these gaps through an analysis of the case of male circumcision, a procedure that has generated great expectations regarding the prevention of heterosexual transmission of HIV in sub-Saharan Africa.

From a critical medical anthropology perpective, I will analyze a series of factors that may significantly influence the impact of a policy intended to encourage male circumcision on a large scale. The "confounding factors" that have been underestimated, and those factors that have not even been taken into consideration – mostly of a sociocultural nature, which we might call "co-founding factors", since they are woven into the social fabric – interact in both space and time, and may have decisive effects in the middle and long term, particularly with respect to the situation of women, an issue of considerable importance given the progressive feminization of the AIDS epidemic.

THE CASE OF MALE CIRCUMCISION

Male circumcision (MC) is the removal of the prepuce, whether by surgical means in a hospital context or, as it is practiced among many peoples around the world, by traditional practitioners usually in a ritual context whose meaning is religious, social, or ethnic. In Africa, male ritual circumcision is widely practiced in the Muslim countries of North Africa, in Islamicized regions of southern Africa, and in other societies that traditionally practice circumcision as part of their rites of passage.

The association between male circumcision and HIV in sub-Saharan Africa, and epidemiological interest in it, dates from the late 1980s, when it was observed that geographic areas with a higher HIV prevalence coincide with areas in which male circumcision is a less frequently prescribed cultural practice (Bongaarts et al.1989, Moses et al. 1990, Caldwell and Caldwell 1996). Weiss (2000), in a systematic review and meta-analysis of medical sources, later found that circumcised African men were less likely to contract HIV through woman-to-man transmission of the virus. Both findings gave rise to a broad scientific debate to which other authors such as De Vicenzi and Mertens (1994), Ntozi (1995), Van Howe (1999), Siegfried et al. (2003), and Way et al. (2005) contributed discordant findings or argued against their colleagues' position citing confounding factors and other methodological limitations.

The three arguments adduced together in support of the biological plausibility of the preventive effects of male circumcision on the heterosexual transmission of HIV are the following:

- A higher density of immune system cells in the submucosal tissue of the prepuce, including Langerhans cells, which present themselves as targets for HIV-1 and as transmitters of the virus to the T-cells.

- The fragility of the mucosa of the prepuce and its vulnerability to abrasion during sexual intercourse;

- The preventive effect against other sexually transmitted diseases (STDs) characterized by genital ulcers, which would facilitate entry of the virus.

Analysis of this triad, endlessly invoked in a great deal of the literature consulted on this subject, leads to the observation that the strongest argument for biological plausibility is based on the pathologization of the normal anatomy, histology and physiology of the prepuce – surprising, to say the least, since this part of male anatomy is still insufficiently studied.

In fact the Langerhans cells, which are a first line of control and an "immunological early-warning system", are where they should be, that is to say, where the greatest risk of the entry of pathogens lies. And they do what they have to do, which is to say to intercept the invader and activate defence mechanisms through the T-cells.

Cold and Taylor (1999) had already pronounced on the relationship between Langerhans cells, circumcision and HIV. These authors, in an exhaustive survey of the embryology, anatomy, histology and function of the prepuce, indicated that, even after circumcision, residual mucosa remain in the glans and that there are Langerhans cells in the entire epidermis of the body of the penis. For this reason the surgical removal of the Langerhans cells is not only impossible, but also irrational. They concluded that at issue were normal immunological mucous cells, and not pathological entities needing excision.

Six years later a group of Dutch scientists (de Witte et al 2007) reinforced Cold and Taylor's empirical foundation when they discovered that the langerine (type-C lecithin) contained in the Langerhans cells, which was believed to transmit the HIV to the T-cells, acted instead to intercept them and facilitate their breakdown. The results of the study indicated that methods to combat the disease should promote and preserve, or at least not interfere with, the functioning of this protein.

Atashili (2006) takes another, also critical, view of this triad based on a thorough review of the existing literature. He argues that there is insufficient scientific support for the first two propositions, and contradictory evidence concerning the third regarding circumcision's protective effects against ulcerous genital diseases.

During the XVI International AIDS Conference (2006), other authors presented findings in disagreement with the logic of the protective effect of male circumcision. In contrast to the argument for an ecological relationship between HIV and male circumcision, Way et al. (2006) confirm this relationship in only one of the eight African countries they studied (Burkina Faso, Cameroon, Ghana, Kenya, Lesotho, Malawi, Uganda and Tanzania). In a case control study carried out by the US Navy among American sailors, Thomas et al. (2006) did not find that non-circumcised men were at greater risk for contracting HIV than circumcised men. Castilho et al. (2006) did not detect a greater risk among non-circumcised men for transmission of the virus from man to woman; to date, this study is the only source of information on this route of transmission.

Between 2005 and the end of 2006, the results of three controlled clinical trials were presented, one in South Africa (Orange Farm) (Auvert et al. 2005), one in Kenya (Kisumu) and one in Uganda (Rakai) (WHO 2006). These studies showed a 50 percent reduction of the risk of acquiring HIV in circumcised men.

As a result of these three studies, the WHO and the UNAIDS Secretariat commissioned an international specialist consultation which recommended that MC should be recognized as an important intervention in reducing the risk of heterosexual acquisition of the HIV infection by men.

However, in the same document (WHO and UNAIDS 2007) this recommendation is accompanied by a warning. Cathrine Hankins, Associate Director of the UNAIDS Department of Control, Evidence and Partnership stresses that:

> *"Nevertheless, we must be clear: male circumcision does not provide complete protection against HIV. Men and women who are considering male circumcision as a preventative measure must continue to use other forms of protection such as female and male condoms, delay the inception of the first sexual relationship and reduce the number of sexual partners".*

Meanwhile, leading on from the results of the three studies, the WHO (2006) already foresees an important increase - dramatic, according to some authors involved in the process (Groeneveld et al 2006) - in the spontaneous demand for surgical male circumcision in the African countries most affected by the AIDS pandemic, particularly Botswana, Lesotho, Swaziland, Tanzania and Zambia. The International AIDS Society (IAS) has called for a "careful but quick" implementation of male circumcisions.

In fact this has been a process with few surprises. The United States Agency for International Development (USAID) held a conference in September 2002 (USAID 2002) within the AIDSMark project framework to deal with the programmatic implications of MC for the prevention of AIDS. Many of the specialists participating in the event had also been at another meeting on the preceeding days, also sponsored by USAID, on the ABC programme[1]. So that it could already then be clearly understood that Male Circumcisions had an even closer relationship than the contiguity of the events, beginning with a C, the first letter of both Circumcision and Condom and as such interchangeable or substitutable. In the conference report one can see a medium term projection of the MC project and a carefulness preparation of all the variables for a rapid implementation, in anticipation of favourable results of the three clinical trials in Uganda, Kenya and South Africa.

The document's list of recommendations contained one which turned out to be appealing in the context of a scientific project

> *"Work with the media, i.e., be more proactive in providing balanced and accurate information to the press and possibly in responding to internet websites that may spread misinformation (such as materials posted by the more extremist anti-MC groups)"*(ver pg 136-137)

In fact it could be said that there was effectively diffusion for the clinical trials which created strong local expectations and which could in part be responsible for the increased demand for MC foreseen even before the results of the other studies became available. The international press has consistently reported on these studies in a way that has helped to transform male circumcision into something more than a scientific project. It has become a media phenomenon, a rather unusual development even when AIDS and Africa are involved.

Dangerous and worthless, they are attributes that form the basis of a rational ideology, ranging from demons to Langerhans cells, aimed at turning the foreskin into an error of nature – an ontogenic survivor – which is susceptible to be rectified by surgery in order to get things straight

In these shared arenas between science and the mass media the concept of a "surgical vaccine" (Groenveld et al. 2006), alluding to the protective effects of male circumcision against HIV, was created by one side and divulgated by the other.

> *MC provides a degree of protection against acquiring HIV infection equivalent to what a vaccine of high efficacy would have achieved (Auvert et al., 2005:1120).*

This semantic sleight of hand, which is based on concepts firmly established in the popular imaginary but outside their original context,

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[1] **ABC** (Abstinence, Be faithful, Condomise) of The President's Bush Emergency Plan for AIDS Relief (PEPFAR)

does not seem to help identify circumcision as a resource whose preventive effect of 50% risk reduction is balanced by the other 50% simply at risk. So little appears to contribute to the consistent use of female and male condoms by those women and men, as Dr. Hankins notes, that “have considered” male circumcision as a preventative measure.

This behaviour appears unlikely from the start, because, as indicated further on, women have very little access to decisions at this level.

On the other hand, it is public knowledge that the condom has been systematically subjected, during this time, to a campaign of penalization and discredit, in favour of abstinence, both by the Catholic Church as well as conservative religious groupings which have supported PEPFAR (and the ABC programme) (Girard 2004, GAO 2006, The Lancet 2006). These are two key sectors for the control of the worldwide pandemic, but more especially in Subsaharan Africa, it brings about the with the greatest economic resources for the fight against HIV/AIDS, the other because it controls a wide range of health care resources, in many cases the only ones available in the most undeveloped areas. For these reasons, both have an important capacity to bring pressure on local health policies, which receive or use their resources.

In this context, the challenge for health policy makers should not be establishing technical guidelines for surgical circumcision procedures, or creating brigades of trained circumcisers, or setting up special weekend circumcision services, but finding solutions to a wide range of chronic structural deficiencies in local health care systems, which may be more significant for the evolution of the pandemic in sub-Saharan Africa than Langerhans cells.

Therefore systematic and correct condom use, an innocuous, economical and reversible method which can achieve a level of effectiveness close to 100% (Chaya and Amen 2002) could merely turn out to be an evidentiary recommendation recommendation, when it is proposed to give coverage to MC, with only a 50% protection, irreversible, with greater risks and difficulties to operationalize, but which has the blessing of the most conservative sectors, perhaps because it has some consonance with abstinence and does not interfere with conception.

On the other hand, Halperin (2000) may not have been far off the mark when he observed in an interview:

> *… for men in Africa who are in risk of dying of AIDS, keeping the foreskin is the last thing in the world that they are worried about*

Although it is necessary to point out that we are not dealing with Africa only, nor with AIDS. The formal deconstruction of the prepuce is a process that goes back to the end of the 19th century. Proof of this is the reference – in relation to an alleged circumciser- which Dr. Ramondino, a well known doctor of the period, made about the demonic powers of this part of the male genital anatomy with such a great erogenous specificity. (cited by Gollaher 2000)

A century later, Halperin, another noteworthy figure in the circumcision paradigm in the time of AIDS, explained from within an evolutionary perspective, when and how the environmental conditions of our ancestors gave rise to the desire to circumcise (Halperin 2001).

Dangerous and worthless, they are attributes that form the basis of a rational ideology, ranging from demons to Langerhans cells, aimed at turning the foreskin into an error of nature – an ontogenic survivor – which is susceptible to be rectified by surgery in order to get things straight

And within the constellation of paradoxes which seem difficult to fit into any cultural logic, now, faced with the expansion of male circumcisions which are being medicalized and promoted in regions of Subsaharan Africa, it needs to be asked which recommendations will be proposed in relation to all the circumcisions carried out in unsanitary conditions, or rather, the majority of ritual or religious circumcisions carried out in Africa, Asia, the Middle East, Oceania, America and Europe. What recommendations for the named “routine infant circumcision” performed in some countries, with or without anaesthetic, without possibilities for their own consent and without any therapeutic indication? Such circumcisions, taken together, in terms of current statisitics, account for about 30% of the male population in the whole world. Which of these are to be legitimated and which not? How are such legitimations and delegitimations to be operationalized within the dominant and subordinate ideologies? Without doubt this plastered-over construction, which combines culture, science and nature, is far from being exhausted.

One of the highly probable risk as a consequence of increase in demands for surgical circumcisions in those African countries with the greatest HIV prevalence is that, if health service capacity is shown to be insufficient or inadequate, those requiring them will turn to the private sector, or to the traditional practicioners of other regional ethnic groups, thus opening up for them an unexpected market opportunity. This option, whilst not readily controllable, would, in a natural way, close the circle which begins with culture and returns to its origins (culture-medecine-culture) and could represent a health problem, including that of the control of HIV transmission.

From the point of view of health care resources, a significant increase in the demand for male circumcision would involve overburdening local health care institutions financially, operationally, and in terms of human resources. These health care systems tend to be structurally fragile for a variety of reasons depending on the particular nature of each case: the consequences of armed conflict; structural adjustment programs and the harmful effects of vertical programs; or simply because of poverty. Under these conditions, a policy of expanding surgical circumcisions in local public health services would reinforce dependence on external resources and probably lead to a reorientation of the distribution of these resources by donors, in which case we should ask at what cost, or in exchange for what. Perhaps, taking a holistic approach to the epidemic, this would be the opportunity to propose strategies to reinforce health systems by including sexual and reproductive health services, which provide care for women and are closely linked to HIV/AIDS control programs.

With the prospect of an scale-up of male circumcisions in sub-Saharan Africa, it is clear from an anthropological point of view that any intervention performed on the penis in a manner that is legitimated, promoted, positively valued and institutionalized, will have consequences that go beyond public health.

According to WHO, the world's highest levels of maternal mortality, which is an especially sensitive indicator for measuring access to and availability of health services, are found in sub-Saharan Africa, where the estimated figures for 2000 were 830/100,000 live births, and a 1/16 risk of maternal death over the course of a woman's reproductive life, compared with 1/2800 in wealthy countries. At the same time, and despite an important increase, antiretroviral therapy coverage has not managed to go beyond 23 percent of real needs (WHO 2006c). It has been calculated that in sub-Saharan Africa only 9 percent of HIV-positive pregnant women are able to make use of programs to prevent mother-to-child transmission of HIV.

In this context, the challenge for health policy makers should not be establishing technical guidelines for surgical circumcision procedures, or creating brigades of trained circumcisers, or setting up special weekend circumcision services, but finding solutions to a wide range of chronic structural deficiencies in local health care systems, which may be more significant for the evolution of the pandemic in sub-Saharan Africa than Langerhans cells.

With the prospect of an scale-up of male circumcisions in sub-Saharan Africa, it is clear from an anthropological point of view that any intervention performed on the penis in a manner that is legitimated, promoted, positively valued and institutionalized, will have consequences that go beyond public health. The social construction of masculinity and with it the process of gender socialization come into play here. Gender is not a watertight compartment for containing masculinity or femininity; by its very nature it is relative and comparative. And it is precisely in the context of gender relations that our protagonist, the one this book concerns especially, enters the picture: women in the context of Africa, in the context of AIDS, in the context of sexual and reproductive health, all of which are influenced by the way in which society contextualizes and constructs the relation between men and women.

Barker and Ricardo (2005) note that in any analysis of gender concerning men, it should be kept in mind that the various versions of masculinity found in Africa are:

- Socially constructed;
- Fluid through time and in space;

- Plural; there is no one masculine prototype or a single African version of “being a man”

This returns me to the studies that have demonstrated a protective effect for male circumcision in acquisition of HIV, and have served as a platform for calculating, using mathematical models and simulations, the large-scale impact of the intervention and the cost-efficacy relation in the long term, and for predicting behavior. This suggests an a priori construction of the generic African man, a figure situated in similarly generic, stable and homogeneous environments, engaging in predictable forms of sexual behavior and interacting with irrelevant male or female figures. From such a perspective, it is immaterial whether these interactions take place in Botswana or in Mozambique, or whether the actors are Zulu or Masai.

Some of the factors, described in detail by Barker and Ricardo, that affect the socialization of men in sub-Saharan Africa are economic independence, family formation, the role played by the elders of the group, rites of passage, legitimate sexual experience, and the violence associated with sexuality, which is relatively common among young men in a context of social change, urbanization, political instability, and armed conflict. Taking all these factors into consideration, it is possible to infer that male circumcision as health policy may generate a process of transformation of symbolic meanings that will surely involve more social actors than those who undergo the procedure. The dynamics and effects of this process cannot be predicted in the long term.

In this situation, the effect that male circumcision may have on women’s already limited ability to negotiate is a matter of concern, since circumcision only provides limited protection, and complementary methods of prevention such as condom use, or even abstinence and fidelity, are also under the control of men.

To reinforce this idea, I refer the reader to an observation by Richard Parker (2001) in a debate on power in sexual relations, in which he notes that the individual should never be seen as an isolated unit of study and analysis, but as an integral part of a couple or a community. To summarize, the prepuce is not a matter solely of concern to men, nor is the process of “becoming a man” in any society in the world. Women interact with men from various positions, as mothers, girlfriends, wives, mothers-in-law, sexual partners, friends, sisters, daughters… and they are not irrelevant, even in the most patriarchal societies.

In the literature reviewed, there are few studies on the acceptability of male circumcision for women as a means of HIV prevention (Mattson et al.2005; Scott et al. 2005). Acceptability is an attribute conditioned by the information received about the subject in question, and is thus highly variable and unstable. The reliability of the results, then, depends, to cite some conditioning factors, on the quality of the information used by the informant, the form in which it is presented, the number of respondents, the methodology used for investigation and the form or the context in which the study is carried out.

In sub-Saharan Africa, where HIV is transmitted primarily through heterosexual coitus, women constitute 59 percent of infected adults (UNAIDS 2006c). In this region of the world live nearly three quarters of all seropositive young people, approximately 6.2 million persons whose age ranges from 15 to 24 years, of whom 75 percent are women. The growing feminization of the HIV epidemic is reflected not only in the growing numbers of infected women, but in the interrelation between AIDS and women’s status in the family and in society.

There is a general consensus that certain fundamental gender inequalities facilitate the expansion of the epidemic or aggravate it, making women more vulnerable; see Loforte’s chapter in this book. Here I will attempt only to touch on the impact that a policy of encouraging male circumcision to prevent HIV transmission may have on gender inequalities.

The difficulty women experience in negotiating safe sexual relations is a result of power inequalities in relations between men and women. In this situation, the effect that male circumcision may have on women’s already limited ability to negotiate is a matter of concern, since circumcision only provides limited protection, and complementary methods of prevention such as condom use, or even abstinence and fidelity, are also under the control of men.

Some studies have evaluated the disinhibiting effect of male circumcision with respect to risky sexual behavior. Agot et al. (2006) concluded that during the first year following the surgery, circumcised men did not engage in more risky behaviors than uncircumcised men. Considering that the protective effect of circumcision is partial, the female part of the equation – the women with whom the circumcision "failures" had sexual relations after acquiring HIV – and the influence circumcision may have had in negotiations (if any) regarding safe sex, would be of special interest.

To return to a subject discussed above, but relevant in this connection, this is where the vaccine metaphor for circumcision breaks down. While the circumcised penis may function as a bodily and personal certificate of belonging to a group with lower risk of acquiring HIV, approximately 50 percent of the "vaccinated" group is at risk not only for acquiring HIV, but for transmitting it.

The social appropriation of the "vaccine effect" may have consequences for the feminization of AIDS, increasing the vulnerability of women and the stigma of those infected. In many African societies various illnesses are attributed to women, their families of origin, or their ancestors. In this context, stigma and blame are closely related and usually affect the weakest elements of society, generally young women who have not yet consolidated their social status in the group (75 percent of the HIV-positive population in sub-Saharan Africa). The "gendering of blame", a phenomenon which has been part of the debate on HIV and gender for several years (LeClerk-Madlala 2001), may worsen.

In addition to the notable absence of attention to gender, the dominant biomedical discourse omits other realities such as the social construction of masculinity, which is key in the construction of social relations between men and women or in the manner of relating sexually, and therefore on the behaviours which encourage or inhibit the expansion of the illness.

The International Community of Women Living With HIV/AIDS (ICW) communicated from Swaziland their dismay at an official AIDS prevention campaign: "The campaign is enforcing that women are responsible for the high incidence of HIV in the country as they are the ones spreading it" (ICW 2006).

In regard to this, ICW points out that women, who are subject to blame, are usually the first to know their HIV status, generally through prenatal care visits, and criticizes the campaign as sexist and likely to promote the feminization of the pandemic. In the same document, ICW identifies several failings of the strategic HIV/AIDS plan approved by the government of Swaziland in 2006 having to do with persons living with HIV/AIDS: the lack of universal and equitable access to care and treatment; the lack of commitment to their participation in the design, planning and implementation of actions directed to HIV/AIDS prevention on the national level; the absence of legislative measures to protect women and children from vulnerability to infection; and the absence of legislation recognizing and protecting the rights of those affected by the pandemic.

Swaziland is one of the countries with the highest rates of HIV prevalence in the world, 33.4% in adults and 39 percent in young women between the ages of 15 and 24 years seen in prenatal clinics (ONUSIDA 2006). It is the first country to include male circumcision in its new HIV/AIDS National Strategic Plan, which supports a nationwide escalation of circumcision services, which in turn is expected to result in a significant increase in demand for this intervention (Simelane and Halperin 2006; Tsela and Halperin 2006).

Namibia, like Swaziland, is another country with one of the highest rates of HIV prevalence, 19.6 percent in adults and as high as 43 percent in pregnant women in some regions of the country (ONUSIDA 2006). In Namibia there is an initiative called Parliamentarians for Women's Health aimed at improving women's and girls' access to health services, especially to treatment for HIV/AIDS, prevention, care and counseling. There is also a regional delegation of ICW.

Jennifer Gatsi, a member of both entities, has expressed her concern (personal communication, January 10, 2007) regarding male circumcision as a preventive measure against HIV. She explains that if this policy is not carried out carefully, using correct information, in such a way that the benefits are acceptable to both men and women, it could wipe out a great many of the gains achieved in areas affecting women and girls. At the same time, some old and dangerous customs may be revived and reintroduced, the apportionment of blame may intensify, gender relations may deteriorate, and the ability of women to make decisions regarding safe sex may be seriously affected.

These are, probably, paradigmatic examples for questioning the consequences, both direct and indirect, for women, of a programme to expand circumcision, and more especially propose a broad and critical policy of the messages used to promote it.

One of the factors that blocks entry of HIV, in addition to and as a consequence of the removal of the prepuce, is secondary keratinization of the glans resulting from exposure and friction. This histologic modification, which thickens the epithelium, thus distancing nerve endings from the surface and causing loss of sensation, together with removal of the specialized and richly innervated erogenous tissue of the prepuce, diminish penile sensitivity and may alter the physiology of orgasm by delaying ejaculation. In this sense, analyzing the acceptability of male circumcision in rural and urban areas of Zambia, Hodgins (2002:9) assumes this secondary effect as a marginal benefit that prolongs the woman's sexual pleasure, "as circumcised men are thought to be able to perform longer", although this evaluation appears to be influenced more by half a century of Western feminism than by African realities. In fact, expectations concerning male sexual performance are, in any part of the world, a social construction and as such one shared by men and women, subject to a wide variety of conditioning factors and closely linked to the assertion of masculinity and gender relations. Authors who have worked in sub-Saharan Africa, such as Barker and Ricardo (2006), confirm that among young men sexual relations are influenced by strong social pressures and constitute an important means of gaining respect and social status. In this context, the test of sexual competence and masculinity may be a greater number of sexual partners and multiple orgasms, as described by these authors and as indicated by the preliminary results of an ethnographic study in Mozambique (Aboobakar, personal communication). No doubt this would require a kind of sexual performance not envisaged by Hodgins' theory.

In this situation, the effect that male circumcision may have on women's already limited ability to negotiate is a matter of concern, since circumcision only provides limited protection, and complementary methods of prevention such as condom use, or even abstinence and fidelity, are also under the control of men.

The United States is the only country in the world that has routinely performed circumcision in hospitals on newborn male infants for decades, which explains the fact that approximately 80 percent of American adult men are circumcised. In this context, which would be especially suitable for analyzing the influence of circumcision on male sexuality, there are few publications on this subject. Nevertheless, while taking advantage of those cases where circumcision in adulthood allowed comparison of perceived alterations in sexuality, Fink et al (2002) studied 123 men, and identified weaker erectile function and a diminution in penile sensitivity following the procedure. Laumann et al. (1997) analysed data from the National Health and Social Life Survey and found a greater tendency among circumcised men for more varied sexual practices such as anal sex, oral sex and masturbation.This observation suggests that we are dealing with sexual resources to compensate, by an increase in friction, for the loss of penile sensitivity.

In some African countries such as South Africa, Senegal, Zaire, Cameroon, Malawi, Zambia, Kenya, Mozambique, Zimbabwe, and Nigeria (Orubuloyea 1995, Kun 1998, Baleta 1998) a sexual practice called "dry sex" has been reported. This consists in drying or narrowing the vagina, and/or increasing its temperature, prior to sexual relations through the application of douches or astringent preparations, wiping the vagina with cloth, or the use of other physical agents. Some ethnographies report that vaginal fluids are considered impure ("dirty") and evidence of promiscuity, and it is believed that their removal enhances fertility, or that some of these agents are used to prevent infections. Bagnol and Mariano (in press), in a study carried out in central Mozambique, describe women's perspectives on their own bodies, on what it means to be a woman and what are understood as satisfactory sexual relations for both women and men.

Generally speaking, dry sex practices – which increase penile friction during coitus and facilitate male orgasmic capacity – even when decided upon, accepted by, and even managed by women, whether in a domestic context or in commercial sex, may be conditioned by their social and economic vulnerability in relation to men, are usually painful, produce vaginal lesions, may injure the penis, and constitute a risk factor in

HIV transmission and for sexual and reproductive health.

The literature reviewed does not comment on a possible correlation between dry sex and circumcision, but we know that in the regions where dry sex is practiced, male circumsicion is also practiced. In addition to the African countries listed above, this practice also extends to Saudi Arabia, Indonesia, Malaysia, the Philippines, and Costa Rica. A comparison of dry sex practices to the prevalence of male circumcision by geographic distribution (see Drain et al. 2006) shows that 60 percent of the countries for which dry sex practices have been described also belong to the group of countries with high circumcision rates (above 80 percent), 20 percent to the group of countries with medium circumcision rates al (between 20 and 80 percent), and the rest to the group with low circumcision rates (below 20 percent). Hull and Budiharsana (2001) describe in detail the practice of dry sex in southeast Asia, where the male circumcision rate is also above 80 percent.

The only way to account for an otherwise inexplicable amnesia lasting 3900 years, from Moses to Pasteur, is by a steady process of scientific rationalization that transforms the concept of ritual purity into "hygiene" or "cleanliness."

It is noteworthy that one of the studies on this vaginal practice was carried out in Orange Farm (Beksinska et al.1999), where the first controlled trial on male circumcision was carried out five years later. The results of this earlier study, which did not include circumcision as a variable, show that 60 percent of the men and 46 percent of the women interviewed mentioned dry sex among their sexual practices, a figure that increased to 87 percent among young people between the ages of 15 and 24 years.

In another study carried out in Meru, Kenya, Schwandt et al. (2006) found that dry sex and anal sex practices were common among sex workers, that condoms were rarely used as a means of protection, that both practices were associated with sexually transmitted diseases, and that forced sexual relations were more frequently associated with anal sex.

The above information, taken together, suggests that the relationship between male circumcision and the practice of dry sex, which are in close geographic proximity should be studied and analyzed in order to locate male circumcision in the context of women's health and vulnerability in sexual relations to HIV infection.

The Meru area of Kenya is inhabited by an ethnic group of the same name, which traditionally practices ritual circumcision on boys at approximately 15 years of age, and on girls starting at age 14. In Chogoria Hospital, located in this region, the Meru rite of passage has been medicalized (Brown et al. 2001). Surgical circumcision performed in the hospital environment is completed with a period of seclusion, also institutional, whose "teachings" are adapted from the ABC program[2] for the prevention of HIV/AIDS.

The medicalization of culture – that is, the extension of the medical order to collective or individual domains of human experience – is a phenomenon that arose from the advent of the bacterial theory of disease, and was consolidated during more than a century of medical rationalism. The inexorable logic of this process leads to the culturalization of medicine, of which Chogoria Hospital's approach to circumcision is an example. From an anthropological perspective, this would be seen as symptomatic of modern medicine as a cultural system, in the same way that we would identify as cultural systems other medical traditions sharing the African space of medical pluralism.

In fact, male circumcision has a long history in the medicalization of culture, starting with the medical conception and legitimation of the concept of "surgical hygiene". The only way to account for an otherwise inexplicable amnesia lasting 3900 years, from Moses to Pasteur, is by a steady process of scientific rationalization that transforms the concept of ritual purity into "hygiene" or "cleanliness."

Apart from epistemological questions, however, for more than a century the concept of "surgical hygiene" has been searching for a legitimate place in the scientific community to facilitate the transformation of male circumcision from ritual prescription to medical prescription. As a result, circumcision has become both the most frequently performed and the most controversial contentious surgical procedure in the United States. This history , which dates from the end

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[2] ABC (Abstain, Be faithful, Condomise). President's Bush Emergency Plan For AIDS Relief (PEPFAR).

of the 19th century, has been thoroughly studied by Gollaher (2000) in his book *Circumcision: A History of the World's Most Controversial Surgery,* whose title clearly indicates that this is hardly a new issue.

To return to the Meru, as noted above, adolescent girls in this society are also circumcised for the same ritual and socialization purposes as adolescent boys. If it is the case that not all societies that practice male circumcision also alter female genitalia, what we can say with certainty is that all societies that practice female circumcision in any form, such as the Meru, also practice male circumcision (Alvarez Degregori 2001). Given this, however, in discussions of male ritual circumcision, there is a strikingly significant constant: the omission of its female counterpart. This contextual omission is not an isolated fact.

Therefore there is legitimate concern among policy makers that the promotion and medicalization of male circumcision may create obstacles to the eradication of female genital mutilation in those areas where both practices are in use. The concern is valid because, from an emic perspective, it would certainly be much more complex to dissociate two such similar practices than in "a gathering of specialists".

In the domain of policies designed to eradicate female genital mutilation (FGM), the systematic absence of any mention of male circumcision is striking, as is the absence of ethnographic reports attesting to the male/female duality of this practice. This omission is doubtless explained by an evident interest in dissociating one practice from the other. During a seminar in Burkina Faso (United Nations 1991) entitled "Traditional Practices Affecting Women and Girls", the following recommendation was adopted:

> *...ensuring that, in mind of people, male circumcision and female circumcision be dissociated, the former as procedure for* ***hygienic purposes****, the latter, excision, as a serious form of assault on the women's physical integrity.*

When there is a clear intention to omit the ethnographic perspective, as in this almost prescriptive statement, any questioning of its logic or attempt to link male and female circumcision practices is bound to be at least discomforting.

Stallings and Karugendo (2006), meanwhile, entered the theme tangentially in detecting a decreased risk of HIV infection among circumcised women in a study involving a total of 5,297 Tanzanian women participants. This result, which the authors describe as "connundrum", perhaps for the caution required in this case, is not especially surprising since in many areas with a lower HIV prevalence related to male circumcision, female circumcision is also practiced. Certainly no one would venture to claim that female genital mutilation could prevent man-to-woman transmission of HIV, or that this practice could reinforce abstinence, on which great importance is placed in some prevention programs. For this reason, we should respond to contradictions with critical reflection and comparative, systematic and scientifically valid research to overcome both the lack of knowledge in this area, and the absence of context from which the design of many health programs suffers, a problem which all too frequently goes unquestioned.

Therefore there is legitimate concern among policy makers that the promotion and medicalization of male circumcision may create obstacles to the eradication of female genital mutilation in those areas where both practices are in use. The concern is valid because, from an emic perspective, it would certainly be much more complex to dissociate two such similar practices than in "a gathering of specialists".

Paradoxically, human rights campaigns aimed at the eradication of female genital mutilation and at sensitizing public opinion around the world to this problem, have created difficulties for nontherapeutic male circumcisions performed on children in the wealthiest countries, whether of a religious, ritual, or cultural nature; and for routine circumcisions practiced on newborns in the United States and in other countries. A significant number of activist groups (International Coalition for Genital Integrity), in which the participants are, among others, physicians, nurses, jurists, affected persons, religious groups critical of the practice and a variety of other social actors, men and women from civil society in equal numbers, began to mobilize in the United States and other wealthy countries to include in the same human rights agenda as female genital mutilation male circumcisions performed on minors without therapeutic indication. The aim was to demand for male children in all parts of the world the same physical and psychological protections as those guaranteed for female children. A number of proposals in this regard were presented in various legislatures and regulatory bodies (MGMbill.org). At the end of 2001, in response to the death of a boy from complications resulting from a religious circumcision, Sweden was the first country to pass legislation against nontherapeutic male circumcision, and at the end of 2003 The Danish National Council for Children has called on lawmakers to make male circumcision illegal.

In this context it is possible to say that the indication of male circumcision for HIV prevention in subSaharan Africa appears tangentially opportune in counterbalancing the effects on public opinon, in the richer countries, of an especially delicate debate. This circumstance should not be left out of a thorough analysis of male circumcision in sub-Saharan Africa, because it necessarily widens our angle of vision to the political and ideological terrain and North/South relations.

CONCLUSIONS AND RECOMMENDATIONS

The implementation of male circumcision as a strategy to prevent HIV in the part of the world most ravaged by the pandemic presents a possible alternative, and for this reason, an enormous ethical challenge for those responsible for programmes aimed at controlling the pandemic.

The consistent absence of a contextual perspective and interdisciplinary participation in the design of health policies intended to increase male circumcision has led to substantial omissions that may have negative consequences especially for women and girls, as well as a boomerang effect on the expected results. These consequences are related to access to health services, gender relations, the ability and need of women to decide in matters of safe sexual relations, the feminization of blame, and stigma.

In addition to the notable absence of attention to gender, the dominant biomedical discourse omits other realities such as the social construction of masculinity, which is key in the construction of social relations between men and women or in the manner of relating sexually, and therefore on the behaviours which encourage or inhibit the expansion of the illness. With the intention of changing the direction of our gaze, and given the context in which this book is being presented, I consider it especially advisable and urgent to initiate studies of male circumcision from a social science interdisciplinary perspective, involving women activists from the countries most affected by the AIDS pandemic. These studies should analyze the forgotten, omitted or displaced factors in the biomedical approach which were highlighted in this chapter, and most especially, the impact that a policy directed towards the expansion of male circumcisions could have on the social condition of women and girls and on their vulnerability to infection by the virus.

DISCUSSION AND COMMENTS, C. ÁLVAREZ

- The object of study are the policies and strategies for AIDS prevention, an approach that is relatively rare in medical anthropology.

- Discussion focused on the role of “fashion” and the “politicization” of the prepuce in the increased demand for male circumcision in areas where it is not a traditional practice.

- Discussion focused on the relationship between science and ideology in health programs.

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GENERAL CONCLUSIONS

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This book was constructed through an extraordinarily intense and productive week-long process of dialogue, for which I was privileged to be the moderator and recorder, in late November 2006. During the first two days of that week, the authors presented their draft chapters to each other and discussed them with each other, asking questions and offering suggestions and comments. On the Wednesday of that week, the authors worked alone on their chapters, modifying them in light of their colleagues' questions and comments. The last two days of that week were devoted to a second round of chapter presentations in which the authors spoke about the changes they had introduced into their chapters as a result of the discussion of the first two days, and their colleagues responded to those changes. On the Friday afternoon, once each revised chapter had been presented and discussed, the group devoted the final hour to drawing some general conclusions out of the week's work. The conclusions that appear below are my synthesis of the ideas that emerged.

1. Interdisciplinary dialogue is both possible and productive of new insights. The task force is a diverse group of social scientists, some more academic and others more applied; physicians with significant experience in social medicine, public health, and international cooperation; and activists. In the making of this book, dialogue took place both across and within disciplinary boundaries: between medicine, the social sciences, and activism; between various disciplines in the social sciences (anthropology, sociology, and geography); and between different sub-disciplines within a single social science discipline. As Elsa Jacinto, one of the physician participants in the task force expressed it, physicians need no longer feel alone in their struggle against HIV/AIDS; they have an allies in the social sciences and among activists that share their goal of making treatment and prevention accessible to all. An alliance of this kind makes it likelier that research projects will ask the right kinds of questions, as Arachu Castro's chapter shows.

2. The study of political and institutional factors is of primary importance in improving access to sexual and reproductive health services. As Cristiano Matsinhe's contribution to this book demonstrates, the value of social science lies not only in studying the beliefs and perceptions of those who are cultural Others from the point of view of Western biomedicine and public health. The institutions of medicine and government within which health policies and interventions are designed, and the bureaucratic structures through which those policies and interventions are implemented, may profitably be subjected to anthropological analysis. The results of such studies have the potential for clarifying the processes through which institutions generate obstacles to access. As Cristina Alvarez' chapter on male circumcision to prevent HIV infection shows, public health and social science professionals alike must learn to interrogate the prevention policies of international aid agencies, which may have unintended negative health consequences for women.

3. It is not always easy for anthropologists and other social scientists to get a hearing from health policy makers and implementers, but this is not necessarily a result of deliberate exclusion. Those who make health policy are subject to many and varied claims on their attention, especially when, as in the case of HIV/AIDS, the stakes are so high. Disciplinary boundaries are reinforced by the bureaucratic structure of universities and the publishing strategies necessary in order to develop professional careers within them, and this means that professionals in all disciplines are less likely to read journals outside their own disciplines. If this happens with closely allied social sciences (anthropology and sociology, for example), barriers to the regular circulation of knowledge between the social sciences and the life sciences can be all but insurmountable. As Iqbal Shah urges, social scientists should rethink their publishing strategies, and begin trying to place some of their work in journals read by the medical and public health audiences they wish to reach. In the words of Harriet Birungi, social scientists need to become "positively aggressive" – that is, aggressive but in a positive rather than a negative way – in order to get a hearing from policymakers.

4. There are more points of convergence between public health and the social sciences than may be readily apparent. One of these points concerns institutional constraints on socially oriented health research. The model for human subjects review of research projects is drawn directly from the experimental sciences, and it is completely inappropriate both for the social sciences and for public health. This creates obstacles to developing knowledge about social realities that are centrally important in developing strategies to contain the HIV/AIDS pandemic. As Ezekiel Kalipeni recounted to the other task force participants, the human subjects review process at his university forced a change in his research design. The project was to have included adolescents, but the investigators were informed that the university would not release the research funds unless the cutoff age for respondents was raised to 18. Unless we can also understand the experience of children and adolescents as social agents, we will be deprived of knowledge that is necessary for the creation of more effective interventions. The development of a set of human subjects review criteria appropriate for social research is one potential platform for cooperation between public health and the social sciences.

5. Open and holistic forms of activism can effect real change. TASO in Uganda is a prime example of how the resources of civil society can be mobilized imaginatively and effectively into partnerships with both the private sector and government. As Noerine Kaleeba's contribution shows, the values on which TASO is founded – human dignity; transparency and accountability to all stakeholders; eliminating personalism in leadership roles; society's obligation to care for those with HIV/AIDS; an emphasis on restoring hope and improving the quality of life not only for individual persons but for families and whole communities – have a practical outcome in increasing the accessibility of HIV/AIDS treatment and prevention through sexual and reproductive health services, especially for the most vulnerable sectors of society. The holism of TASO's approach should be a stimulus to rethink approaches to sexual and reproductive health services. As Harriet Birungi's chapter demonstrates, the reductive approach to sexuality as a disease problem or a reproductive issue unrealistically leaves sexual need and desire out of the picture. The challenge of the future will be to help adolescents living with HIV to balance responsibility with their desire to form intimate relationships and create families.

6. As the contributions to this volume by Joanne Wreford and Susan Levine show, activism and research are compatible activities, and medical interventions are not limited to those available through the institutions of Western biomedicine. Medical pluralism, as Joan Muela's chapter argues, is the rule rather than the exception, and exploring the intersections and interactions between different healing traditions and representations of illness invites us to think differently: to examine the cultural logic that links elements in a complex process of health-seeking, rather than to dismiss traditional healing simplistically as an obstacle to effective medical care, or to focus narrowly on a set of causal "factors" that combine to produce a specific outcome.

7. Power and gender are closely linked in the transmission of HIV infection, as Arachu Castro's chapter shows. To recognize the special vulnerabilities of African women should not, however, lead us to construe them as passive victims, to deny them agency and voice, to represent them as generic African female Others. They are social actors interacting with other social actors, as Ana Loforte argues. This recognition helps to open spaces of dialogue that break silences, dismantle the stigma associated with HIV/AIDS, and facilitate access to prevention and treatment.

8. Biomedicine (including public health and health education interventions) tends to approach disease as an individual problem to be treated on an individual basis. What the chapters in this book show is that such an approach will never serve to help contain the HIV/AIDS pandemic in sub-Saharan Africa. Only a multifaceted approach that takes into account the social and cultural context of both the disease and the interventions brought to bear on it can do this. The context is broad and, as Ezekiel Kalipeni's chapter demonstrates, includes not only local cultural practices but macro-level processes such as the history of colonial exploitation in Africa and its long-term consequences: poverty, political instability, labor migration, and the displacement of populations.

9. A combined public health-social science perspective should become the rule rather than the exception. This task force intends to be a model of and for this kind of ongoing development and exploration of a shared space of research and intervention. Most of the participants in the task force had met previously, at the April 2006 VITA conference in Barcelona on HIV-AIDS in sub-Saharan Africa. There was spontaneous agreement at the end of it that they should retain contact with each other and look for future opportunities to continue working together. Several months later, the participants in the task force completed a week of work together on this book equally convinced that continuity was necessary, and with an incipient agenda for future collective projects.

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