Successful Societies

How Institutions and Culture Affect Health

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Responding to AIDS in Sub-Saharan Africa

Culture, Institutions, and Health

Ann Swidler

Peter Hall and Rosemary Taylor (Chapter 3, in this volume) suggest that we think of the health and happiness of individuals as depending on the resources they can mobilize to confront the challenges that face them. An analogous argument might apply to collectivities, from families and communities to national states. Examining the massive threats to human health created by the AIDS epidemic in sub-Saharan Africa, I ask what shapes the resources collectivities can bring to bear to meet the challenges of AIDS.

This chapter lays out broad questions about the role of institutions and culture in responding to AIDS. It draws on research during three visits to sub-Saharan Africa (Botswana in July 2003 and June 2006 and Malawi in June and July of 2004 and 2006), about seventy interviews with staff from nongovernmental organizations (NGOs) working on the ground on AIDS projects across sub-Saharan Africa, and an initial effort at mapping the universe of organizations responding to Africa's AIDS pandemic.

OUTLINING THE ISSUES

No one questions the enormity of the AIDS crisis on the African continent. The epidemiological models are inexact, but the best estimates are that of the approximately 33 million people currently infected with HIV, more than 22 million are in sub-Saharan Africa, with an estimated 1.7 million Africans newly infected in

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2007.[1] Perhaps 17 million Africans have already died of AIDS, and in some places deaths among groups such as teachers, nurses, and soldiers threaten the collapse of entire institutional spheres.[2] Households and communities are exhausted by care for the dying, children are orphaned, and whole communities are devastated by the loss of those whose labor would have supported the old and the young.

The AIDS epidemic dramatizes the ways the vitality of social institutions can matter for health. AIDS is both similar to and very different from other health challenges nations face. On the one hand, capacities to confront the epidemic depend in part on the same resources – health infrastructure, national wealth, administrative competence, and political will – required to meet other public health challenges. On the other hand, in Africa HIV is transmitted primarily through sexual contact, so dealing with HIV/AIDS has not been purely, or even primarily a medical matter.[3] The well-worn techniques of international public health–vaccinations, clinics, visiting nurses, even sanitation and such amenities as wells, latrines, and nutrition – are largely irrelevant. Since AIDS prevention cannot be administered by a determined government or international public health authorities, limiting the spread of HIV has depended on deeper, more complex, and less well-understood social capacities than has the response to many other health crises.[4]

[1] The figures here come from UNAIDS (2007).

[2] UNAIDS estimated 13 million cumulative AIDS deaths in Africa as of the end of 2003 (UNAIDS 2005: 28), an additional 2.3 million in 2004 (p. 3), 2.4 million in 2005 (p. 17), 2.1 million in 2006 (UNAIDS 2006: 2), and 1.6 million in 2007 (UNAIDS 2007). UNAIDS (2007) now acknowledges, however, that earlier methods of serosurveillance based on data from antenatal clinics overestimated HIV prevalence, so the earlier numbers should be adjusted downward. See Barnett and Whiteside (2002); de Waal (2003); Lewis (2003); Poku, Whiteside, and Sandkjaer (2007) on the devastating consequences of the epidemic.

[3] An article in *The New York Times Magazine* (July 6, 2006) by Tina Rosenberg makes this point repeatedly. She quotes Peter Piot, director of UNAIDS, as saying, "The technology is doing O.K., it's moving. But we have grossly, grossly neglected the social, cultural and personal stuff that makes it work." Rosenberg concludes: "Without attention to the social, psychological and cultural factors surrounding the disease, we are throwing away money and lives. This is the new frontier. Twenty-five years into the epidemic, we now know how to keep people from dying of AIDS. The challenge for the future is to keep them from dying of stigma, denial and silence."

[4] The development of efficient disease-prevention technologies does not guarantee that political and cultural barriers to their use will be overcome: Cases of polio erupted following suspicions in Northern Nigeria's Islamic provinces that the vaccine could cause sterility; a modest whooping-cough epidemic has emerged in the U.S. because some parents remain unconvinced of the vaccine's safety; and governments from the U.S. to China have resisted giving addicts clean needles because they do not wish to acknowledge or legitimate illegal drug use. Like family planning but more-so (Cleland and Watkins 2006), AIDS prevention seems to require changes in some of the deepest, most intimate, and least understood aspects of human behavior. Individuals and communities in Africa and elsewhere have found it enormously difficult to change embedded social and sexual practices (see, for example, Caldwell, Caldwell, and Quiggin 1989; Caldwell 1999; Hunter 2002; Campbell 2003; Kaler 2003; Watkins 2004; Chimbiri 2007; Swidler and Watkins 2007; Tavory and Swidler 2009).

The challenge of AIDS in Africa also raises wider questions about the way states and cultural communities operate in a contemporary globalizing world. African states are notoriously permeable to outside influences.[5] Even though they differ greatly in their administrative capacities, political stability, and transparency, they are also almost universally poor, so that their health spending relies heavily on outside donors who provide not only funds but also administrative support, monitoring, and often the basic direction of policy. Thus the AIDS crisis in Africa is not just a local crisis, but a focus of intense transnational energy and effort.

Hall and Taylor suggest that health and well-being depend on the relationship between the nature of the challenges individuals face and two factors: the individual and collective resources they draw upon to meet those challenges and their inner resources or "psychic resilience." In a similar way, we may think of collectivities as varying in their resources – most obviously in the economic resources they can use to promote the health and welfare of their populations, but also, very importantly, the capabilities they can draw on to address problems.[6] Here the crucial skills might be those required for effective governance, from the technical skills required for administration (in the AIDS arena, collecting and analyzing basic data about the epidemic; developing and managing budgets, and the bureaucratic skills required to make administrative systems function) to the political skills required to focus attention on a problem or to coordinate action among competing agencies and multiple jurisdictions.[7]

AIDS is worthy of special attention in part because it appeared during an era in which an emergent "transnational citizenship" has made the welfare of all people everywhere seem to demand global care and concern. Although it lies outside the scope of this chapter, we should note that just as citizenship constituted individuals as entitled to benefits from the states of which they are members, the emerging rules of the global order – from international tribunals to transnational political campaigns – have increasingly created a global cultural understanding in which all individuals have human rights that transcend their nation-bound citizenship rights and every collectivity has claims on the world's conscience.[8]

[5] Chabal and Daloz (1999); Callaghy et al. (2001).

[6] Peter Baldwin (2005) has shown that the industrialized democracies have also differed sharply in the conceptual, legal, and institutional resources they have drawn upon in the AIDS fight.

[7] As Hurricane Katrina illustrated, complex bureaucratic and administrative skills can be in short supply in the wealthy, industrialized nations of the Global North, with potentially catastrophic results. Similar gaps in administrative competence, but also in public attention, planning, and political coordination have led to dramatic variations in deaths during heat waves, from many thousands of elderly French men and women who died in the summer of 2004 to the hundreds of deaths in Chicago in the summer of 1999, whose political and social causes are analyzed in Klinenberg (2002).

[8] Jane Jenson (this volume) describes the history of changing citizenship regimes as they affect health policy. Amartya Sen (1999) has been the most influential proponent of a new, transnational regime in which all people have fundamental claims to capacities that produce freedom,

Indeed, AIDS has in some ways been the poster child for a global commitment to health.[9]

Finally, more than many other health challenges, responses to AIDS have depended on the collective equivalent of individual psychological resilience. The ability of institutions to mobilize and motivate their populations has been vital in effective responses to the epidemic.[10] Much less is understood, however, about the capabilities of collectivities to mobilize their energies than about the psychological resilience of individuals. Focusing on responses to the AIDS epidemic, this chapter argues that collective capacities shape health at two levels: on the one hand, responses to the epidemic depend on such political goods as leadership, organizational capacity, and collective commitment. Without these, no solutions to health challenges can be defined or implemented. But AIDS also reveals a deeper connection between collective mobilization and individual health. The persistent failure of even the best-designed public health campaigns directed at individuals to change AIDS-relevant behaviors – and the striking success of the few programs that have mobilized political and moral energies to fight the epidemic – suggest that health depends on collectively-valued identities and moral meanings as much as on individual prudential calculations.

while John Meyer and his collaborators have noted that promoting individual well-being is increasingly assumed to be the purpose of global and national political institutions (see, for example, Frank and Meyer 2002). Michel Foucault (1988: 152) notes the same collective attention to individual health and well-being, but reverses the relationship, emphasizing that the well-being of individuals matters insofar as it affects the "strength of the state." Examples of the burgeoning literature on transnational political campaigns include Keck and Sikkink (1998); Khagram, Riker, and Sikkink (2002); Tarrow (2005). On emerging understandings of individual rights that transcend nations, see Soysal (1994); Meyer (1999); Hagan and Levi (2004).

[9] AIDS was already a high-profile disease with a voluble and politically effective constituency in the United States, Brazil, Australia, and elsewhere when, after the mid 1980s, the enormity of the global pandemic produced a torrent of organizational activity and an ever-widening flow of resources, much of it channeled through (or originating in) the NGO sector. On the history of responses to the AIDS epidemic, see Altman (1994); S. Epstein (1996) on the United States; Berkman et al. (2005) on Brazil; Dowsett (1999) on Australia; and H. Epstein (2007) on the global response as well as Lancaster (2008) on AIDS and U.S. foreign aid. There is a large literature on the ambiguity of the NGO concept and the conflicting evaluations of the role and effectiveness of NGOs. For examples, see Fisher (1997); Keck and Sikkink (1998); Callaghy, Kassimir and Latham (2001); Khagram, Riker, and Sikkink (2002); Ferguson and Gupta (2002); and Sharma (2006). See the work of John Meyer and his collaborators (Boli and Thomas 1997; Meyer et al. 1997; Boli and Thomas 1999) for the argument that NGOs have been primary creators and promoters of the emerging world culture. According to the Resource Flows Project (2004), which tracks funding for population activities, from 1995 to 2002 AIDS funding increased from 9 percent to 43 percent of population funding with more than 400 percent increases in resources for sub-Saharan Africa, and with an estimated 57 percent of population assistance flowing through NGOs. Thus, by analogy to individuals who vary in their access to networks of social support, nations differ in their capacity both to attract and to work effectively with the innumerable organizations, individuals, and agencies that might provide help in combating the AIDS epidemic.

[10] Altman (1994).

The argument of this chapter is multilayered, so it is best to outline it briefly here. I analyze the contrast between Botswana – wealthy and well governed – where AIDS-prevention efforts have largely failed and treatment with antiretroviral drugs was slow to get off the ground, and Uganda – much poorer and less well administered – yet one of the rare cases of success in both prevention and treatment. The argument begins with two ways in which Botswana and Uganda are similar: both have political leadership committed to fighting the epidemic, and both have governments that, in quite different respects, fit their local political cultures, creating what, following Steven Cornell and Joseph Kalt, I call "cultural match."[11] Nonetheless, Uganda's AIDS efforts differed in a critical respect from those of Botswana because Uganda proceeded by mobilizing its population at the grass roots, through local communities and organizations, while Botswana pursued AIDS prevention through a top-down program of information and education. The specific information and even the programs were similar, but the ways in which they activated (or failed to activate) local communities were very different.

The third step in the argument probes why such grass-roots mobilization has been so important for AIDS prevention, and how the lessons learned might apply to health more generally. Community mobilization may be necessary to create the "normative ferment" that can lead to change in socially significant behaviors. Communities also provide one source of solidarity that can reduce the shame and helplessness that often accompany illness, affecting people's motivation to protect their health. Finally, the AIDS struggle raises wider questions about human motives: while rational, prudential interests may motivate some health behaviors, a great deal of evidence suggests that the sense of moral identity, shared fate, and commitment to others may be more important.

VARIATIONS IN POLITICAL RESPONSE: PROBLEMS AND PARADOXES

When it comes to HIV and AIDS, epidemiological and political questions cannot be separated. From the role of sexual coercion and rape in the spread of HIV to U.S. support for an international property-rights regime that limits poor countries' access to inexpensive generic antiretroviral drugs, politics shapes the AIDS pandemic.[12] In theory, the response to AIDS should be greater where prevalence is higher; however, variations in political response often seem independent of epidemiological urgency. Thus Senegal, where infection rates are low (about 1 percent of adults) and where the dominant strain of HIV (HIV-2) is less infectious than HIV-1, has mobilized one of the most effective prevention programs in Africa.

[11] Cornell and Kalt (2000).

[12] On sexual violence see Epstein (2001); World Bank (2002). On AIDS and international intellectual property-rights regimes see Kapp (2002); Loff (2002); Love (2002; 2006); Klug (2005).

One of the many ironies of the African situation is that infection rates are highest in the continent's more developed southern region (South Africa, Namibia, Botswana, Swaziland, and Zimbabwe, along with the much poorer Lesotho, Mozambique, Zambia, and Malawi) and among the wealthier and better-educated.[13] Furthermore, while collapsed or failed states certainly create barriers to dealing with the epidemic, state competence is no guarantee of effective action, as the South African case suggests.[14] Thus searching for the sources of variation in effective response to the epidemic is both an intellectual puzzle and a gripping practical challenge.

A Political Paradox: Botswana versus Uganda

One of the most fascinating puzzles of African AIDS is the contrast between Botswana's response to the pandemic and that of Uganda and, more recently, Kenya. Ugandans mobilized early to counter HIV/AIDS, lowering HIV prevalence from 29.1 percent of ante-natal clinic attendees in 1992 to 11.2 percent in 2001, with an estimated 7.1 percent of the adult population infected in 2005.[15] The government instigated a broad social mobilization that linked the campaign against AIDS to a nation-building rhetoric and a sense of collective empowerment that galvanized political party officials, churches, international NGOs, and community-based organizations in what was seen as a struggle for collective survival.[16] Botswana meanwhile saw HIV prevalence rise from 18.1 percent of ante-natal clinic attendees in 1992 to 36.3 percent in 2001 and 37.4 percent in 2003. Newer methods of estimating HIV prevalence from population surveys give lower figures than ante-natal clinic data, but the latest UNAIDS estimates still find Botswana's HIV prevalence among adults 15 to 49 years of age unchanged at 24 percent in 2003 and 2004.[17]

[13] The income inequality associated with greater wealth might account for the dramatically higher HIV prevalence in Southern Africa, if men with money can afford multiple partners and poor women and girls seek additional income through transactional sex. Recent evidence of the strong positive relationship between wealth and HIV prevalence within countries suggests that greater wealth may increase rates of HIV infection by allowing both women and men to have multiple partners (see Shelton et al. 2006; Mishra et al. 2007).

[14] On variations in political response to the epidemic, see Boone and Batsell (2001), Buvé, Bishikwabo-Nsarhazab, and Mutangadurac (2002), and UNAIDS (2005). Lieberman (2007) argues persuasively that ethnic fragmentation reduces the intensity of nations' responses to the epidemic. Zartman (1995), Herbst (2000), and Bates (2008), among others, attempt to explain state weakness or failure in Africa, but state strength and competence do not appear to explain success in actually reducing HIV prevalence.

[15] UNAIDS/WHO (2002; 2005); UNAIDS (2007): 11.

[16] Synergy Project (2002a); Green (2003); H. Epstein (2007: 158–67).

[17] The "2006 Global AIDS Report" (UNAIDS 2006: Chapter 2, pp. 9–11) and UNAIDS (2007) explain that newer data from population surveys (Botswana's most recent survey was in 2004) give lower estimates of HIV prevalence than the earlier reliance on ante-natal clinic data from pregnant women: because women have higher infection rates than men, because ante-natal clinics typically over represent urban and peri-urban areas, and because pregnant women represent only those women having unprotected sex.

Botswana is in many other respects a public health success. The WHO estimates that skilled health personnel attend 98.5 percent of births in Botswana, while in Uganda the comparable figure is 38.3 percent.[18] The most successful democracy in Africa, Botswana was aware of the epidemic early on and mounted a substantial public health response. Yet throughout the 1990s and up to at least 2003, despite the intervention of a variety of international organizations and foundations (most notably the Merck and Gates Foundations, Bristol Meyers Squibb, and the Harvard School of Public Health), Botswana's HIV prevalence continued to climb, vying with Swaziland's for the highest in the world.

Botswana's success in combining political stability with economic discipline to raise its standard of living some tenfold in the last twenty years suggests that the problem is not lack of governance capacity.[19] And the serious public health campaigns Botswana has mounted suggest that the problem is not lack of public health effort – or even of information. As we shall see later, the difference rests ultimately on the success of Uganda in mobilizing collective solidarities in the cause of AIDS prevention, while Botswana's failure says a great deal about the limitations of a model of health behaviors as arising from individual concerns about personal well-being. The contrast between Botswana and Uganda thus provides an excellent focus for examining critically the standard explanations for more and less effective efforts to combat HIV/AIDS.

Leadership

The leadership of Yoweri Museveni, Uganda's President, is universally credited with initiating Uganda's all-out battle against AIDS. Despite Museveni's growing reputation for corruption and repression,[20] the first ten years of his

[18] UNAIDS/WHO (2002); UNAIDS (2002).

[19] On Botswana's economic and political success, see Acemoglu, Johnson, and Robinson (2003); Leith (2005). The discovery of diamonds shortly after Botswana's independence in 1966 provided the resources to finance public health, education, and infrastructure improvements. Elsewhere, however, natural resources such as oil or mineral wealth have been a "resource curse" (see, for example, Sachs and Warner 2001), triggering political instability and civil war. Botswana's political institutions are credited with making its resources contribute to development.

[20] Museveni's decision in late 2005 – against the advice of President Bush, among others – to run for another five-year term and, in early 2006, Uganda's first multiparty elections, held with the head of the major opposition party under indictment on what seem to be politically motivated charges, have badly tarnished Museveni's reputation. Here is one of the harsher indictments: "He has attacked and looted Congo; he has allowed fantastic corruption within his inner circle; he has harassed journalists and cracked down on political dissent; he has amended Uganda's constitution to allow himself to serve indefinitely. In November [2005], he jailed his strongest opponent in this month's presidential election, charging him with rape and treason. Once touted as one of the 'new leaders of Africa,' an American political analyst wrote recently in a damning confidential report to the World Bank, '[Museveni] over the last eight years, has increasingly resembled the old.'" (Rice 2006: 12).

leadership – from 1986 to the mid 1990s – saw dramatic reductions in HIV prevalence due to a massive social mobilization against AIDS. Museveni recognized early in his presidency that AIDS was a fundamental threat to his society. The (perhaps apocryphal) story is that when Museveni's guerrilla movement came to power in 1986, after the savage dictatorships of Idi Amin and Milton Obote, Museveni sent his top military men to Cuba for training. The Cubans, who have practiced draconian AIDS-control policies, immediately tested the Ugandans for HIV; Castro then drew Museveni aside to tell him that he was facing a looming disaster.[21] Museveni used his very effective political party, the National Resistance Movement (NRM) as a vehicle for spreading AIDS awareness. (Here we might note that political parties that emerge from peasant-based guerrilla campaigns develop special political capacities – witness the Vietnamese, the Cubans, and the Chinese communists). Museveni committed himself to address the issue of AIDS in every speech he gave, and he decreed that every party official, all the way down the five-level party hierarchy, should do the same.[22]

When it comes to leadership, however, Botswana is also far ahead of most other African countries in the openness and commitment of its leaders on the AIDS issue. Even though Ketumile Masire, Botswana's president until 1998, was reputed to be somewhat more conservative or traditional culturally and thus more reluctant to speak publicly about AIDS, he did so, and Botswana had a vigorous condom promotion program as well as an "ABC" (Abstain; Be Faithful; or use a Condom) campaign modeled on that in Uganda. Festus Mogae, president from 1998 to 2008, has been outspoken on the issue, commanding national and international attention for his commitment to the fight against AIDS. A 2002 study of the seven hardest-hit southern African countries notes that "Though Botswana's HIV/AIDS epidemic is relatively young, the government has been open about the epidemic and has in some sense 'claimed' it as an appropriate issue for government intervention."[23]

But even this critic credits Museveni's activist and inclusive politics in his early years: "In Uganda, Museveni presided over the enactment of a new constitution, intended to protect human rights. He reversed racist economic policies, welcoming back investors from India, who had been kicked out by Amin. He promoted an open political culture, grudgingly tolerated a raucous free press, and was one of the first African leaders to talk honestly about AIDS, a disease destined to kill more Ugandans than all the country's wars and dictators combined. He maintained a frugal lifestyle and encouraged his underlings to do the same. Only one political party was allowed, the ruling Movement Party, but Museveni reasonably argued that such strictures were temporarily necessary: Uganda's old parties had fractured along tribal and religious lines. 'There were numerous signs to indicate that a process was moving forward that was positive in terms of setting the stage for a genuine democracy,' says Johnnie Carson, the American ambassador to Uganda from 1991 to 1994, who has since become critical of the regime" (Rice 2006: 13).

[21] Garrett (2000).

[22] See the detailed political analysis in Putzel (2004).

[23] Whiteside et al. (2002).

Education and Information

Botswana has not ignored the epidemic. A synthesis of public opinion data from seven Southern African nations notes that in Botswana as elsewhere in the region knowledge of the epidemic is extensive. Many people (and in some countries a majority) report knowing someone who has died of AIDS in the last year. Wealthier than most countries in the region, Botswana stands out because its citizens give relatively high priority to government action against AIDS.[24] Widespread AIDS awareness and a sense of the importance of the threat have nonetheless failed to change behavior. Neither knowledge about how HIV is transmitted nor a general sense that the government cares about the epidemic has been sufficient to change health behaviors or to begin to turn the infection rate around. As one study of 1,372 students at the University of Botswana notes, "students have factual knowledge and information about HIV/AIDS, but their actual sexual practices and behavior do not reflect this high level of knowledge. Students engage in risky sexual behavior including sexual experience in early youth, unprotected sex, and casual sex with multiple partners."[25]

Money, Government Competence, Public Health Infrastructure

Botswana has an excellent system of public health. Not only is Botswana's government recognized as one of the least corrupt in Africa or elsewhere in the developing world, but it has also spent a good deal of its diamond wealth in socially egalitarian ways: providing universal, free primary education; moving rapidly toward universal secondary education; and providing an extensive set of local health clinics staffed by Family Welfare Educators, said to be respected senior women from their communities. The government of Botswana's AIDS/STD Unit has an exemplary system of Home Based Care that includes teams of nurses and counselors who provide support and assistance to caregivers, try to assure that people take their medications consistently, give nutrition counseling, and provide special food supplements where necessary.

Money has not been the problem in Botswana, at least not a shortage of money. Botswana is, as I have said, relatively wealthy by African standards with GDP/capita of about US$14,300 in 2007 and an estimated economic growth rate of 4.7 percent.[26] Because the country has honest, capable government and good infrastructure, it has also attracted sizable outside funding to combat AIDS, most notably $17 million plus free antiretroviral drugs from Bristol-Myers Squibb, and US$100 million (plus Merck's free antiretrovirals) that the Bill and Melinda Gates and Merck Foundations committed to the African Comprehensive HIV/AIDS Partnership (ACHAP) – this in a country with 1.7 million population of whom perhaps 330,000 are HIV positive.[27]

[24] Whiteside et al. (2002: 21).
[25] Seloilwe et al. (2001: 204). See the similarly disheartening evaluation in Chilisa (2001).
[26] This is Purchasing Power Parity (PPP) GDP/capita (Central Intelligence Agency 2008).
[27] Brubaker (2000); Grunwald (2002); Meldrum (2002); Motseta (2003); Ramiah and Reich (2005).

Public Health Campaigns of Various Stripes: Condoms versus Abstinence

The contrast between Botswana and Uganda does not rest on the kind of public health policy each pursued, at least at the level of explicit policy. Indeed Botswana had an ABC campaign modeled on that in Uganda.[28] Apparently public health messages were everywhere – on billboards, on buses, on the radio – a saturation effort so extensive that some observers believe it became counter-productive, so that no one listened anymore.[29]

There was, however, a difference in the public health approaches Botswana and Uganda actually implemented. Both Uganda and Botswana used the ABC approach; however, their efforts differed dramatically. Uganda mobilized its entire society, ultimately emphasizing locally rooted campaigns to reduce multiple partnerships: urging people to "Love Faithfully" and to practice "Zero Grazing." Following the advice of the international public health community, Botswana actively encouraged condom use. One informant reports having a videotape from 1987, taken in a village some distance from the capital, of a group of public health nurses singing "the condom song" and waving condoms above their heads as they danced.[30] Another educated, urban informant reported that concerts held to promote condoms to the young with music and dancing would end with people getting drunk and then going out and having unsafe sex.[31]

NGOs and Outside Funding

Uganda mounted one of the most effective anti-AIDS campaigns in the world.[32] One of the reasons for this success is certainly that Uganda encouraged a variety of NGOs, including faith-based and community organizations, as well as many international organizations to become involved in combating AIDS. Thus the first, organizational-level look at the contrast between Botswana and Uganda would focus on the NGO response.

One striking aspect of Botswana's situation has been the absence of an energized, vigorous, autonomous NGO sector. One of my informants noted that as of 2003 there were only twenty or so AIDS-related NGOs in the country, loosely coordinated under an NGO AIDS commission.[33] But when the modest outside funding that some of those organizations had received at their inception dried up, the organizations became largely inactive. In 2004 many

[28] A note on terminology: the dominant group in Botswana is the Tswana. An individual member of the group is a Motswana, plural Batswana; the language is Setswana.
[29] See Allen and Heald (2004: 1144).
[30] Interview # 18, April 3, 2003.
[31] Interview # 17, March 27, 2003.
[32] Synergy Project (2002b); Green (2003); Allen and Heald (2004); Low-Beer and Stoneburner (2004); Stoneburner and Low-Beer (2004); H. Epstein (2007).
[33] After ACHAP, the Merck/Gates-funded initiative, began offering small grants in 2004 many more organizations appeared, but there is no evidence that funding has in fact produced a more vocal civil society nor more openness about the epidemic.

community organizations emerged when ACHAP announced a program offering funding, but when that funding flagged, most of these organizations turned out not to have an autonomous base. Not only did ACHAP fail to stimulate a broad NGO response in Botswana, but in some ways it also further weakened local organizational capacities. Indeed, a Motswana informant noted that ACHAP had even begun competing directly with NGOs, offering the example of how, after a local group held a conference on how practitioners of traditional medicine might work with modern AIDS therapies, ACHAP hired someone to work with traditional medical practitioners (to add insult to injury, they hired an international, with no ties to the local practitioners – and worse, a woman trained as a "sangoma," a traditional sorcerer, looked down on by practitioners of traditional medicine).[34] A high-ranking member of one of the UN agencies in Botswana put the matter more bluntly, saying, "ACHAP has become a monster!" Thus despite its generous funding and ambitious goals, this major effort to transform AIDS in Botswana had remarkably little success in AIDS prevention and a very uncertain start in providing antiretroviral drugs.

Culture, Legitimacy, and the Problem of "Cultural Match"

The question of why vigorous NGOs did not emerge in response to the AIDS threat in Botswana is not just a question of the influence of outside funding behemoths. It goes deeper, to the link between culture, institutions, and health in Botswana. Another Motswana informant noted that "we Batswana are too modest, too humble, too polite."[35] What she meant is that there is little sense of outrage, or even of urgency about the AIDS issue in Botswana, despite incessant funerals, growing numbers of orphans, illness and deaths in every family. In a sense, Botswana's political culture is one of pride in and reliance upon an effective, capable government.[36] If one looks at Botswana's history – both its centuries-long success in avoiding the worst impacts of colonial rule, and its

[34] Interview # 36, July 15, 2003.

[35] Interview #27, July 4, 2003.

[36] Allen and Heald (2004: 1147) note both the top-down style of the government of Botswana, and its link to traditional sources of legitimation: "One of the new strategies to complement the ARV programme was called 'total community mobilisation'. This, as with so much else in Botswana, was designed as a top down intervention. An army of field-officers were to undertake door-to-door visits, and to talk at various community gatherings and hold workshops. During colonial times, local level government in Botswana had remained largely in the control of the *dikgotla* (sing. *kgotla*), the 'traditional' structure of chiefs and their associated councils. Since Independence, in 1966, as state control has become increasingly centralised, their power has been considerably eroded. Nevertheless, the basic structure of the *dikgotla* remains, with councils at all levels, from the sub-ward up to the ward, village, tribe and thence to the house of chiefs. It runs both in parallel with government bureaucracy and is incorporated into it, or rather side lined by it. *Dikgosi* (chiefs) still sit everyday in their courts and are paid a Government stipend but their powers of independent action are curtailed."

rulers' success in creating a stable, honest, administratively efficient modern state[37] – the tendency of contemporary Batswana to rely on government to take care of problems is understandable. And against the background of violent conflict, corrupt misrule, and economic chaos elsewhere on the African continent, Botswana indeed seems like a peaceful, well-governed paradise.

Botswana's success in building capable government nevertheless undermined the effectiveness of its AIDS programs. As two long-term observers of AIDS programs in both Botswana and Uganda note, "in Botswana, years of efficient, centralised government [have led] to a systematic disempowering of local councils"; however, in Uganda the local councils set up under Museveni's National Resistance Movement were elected and operated with considerable autonomy.[38]

In one respect, Botswana and Uganda are similar, I believe, scoring high on that elusive feature of compatibility between deep-rooted cultural patterns and contemporary institutions of governance that Steven Cornell and Joseph Kalt have called "cultural match."[39] Mikael Karlström has described the close cultural connections between Uganda's contemporary governing structure – a one-party democracy – and traditional Buganda political forms. The president of Uganda, Yoweri Museveni, has argued that Uganda is not yet ready for competitive democracy, but his National Resistance Movement has introduced a complex system of local elections on a nonparty basis.[40] Local politicians seek election, but as individuals rather than representatives of political parties. Karlström argues that – at least in the Buganda region – local people see this political system as democratic in the sense of embodying Ganda conceptions of civility and civic virtue:

> the embodiment of these features [of Uganda's limited democracy] in the system of clans and king is viewed as the foundation of a "civil" and unified socio-political order. Such unity (*okwegatta*) is regularly advanced as a prime political value and as the underlying reason for clan activities and even the existence of clans. Less well educated Buganda were often surprised to discover that in my homeland there are no clans and would ask me, "How can you be united without them?"[41]

Unitary rule by Museveni's NRM allowed him to mobilize the Ugandan population in the AIDS fight, while local elections constrained officials to

[37] Both phases of Botswana's history are dramatic and reflect extraordinarily well on the royal family, the descendants of King Khama III, who went personally to ask Queen Victoria to make Bechuanaland a British Protectorate, to protect it from a threatened Boer invasion. Khama III's grandson, Sir Seretse Khama, became the first president of the newly independent nation, Botswana's George Washington, followed after his death by a democratic succession (Parsons 1998). See Acemoglu, Johnson, and Robinson (2003) and Leith (2005) on Botswana's economic success.

[38] Allen and Heald (2004: 1150).

[39] Cornell and Kalt (2000); see also Englebert (2000).

[40] Kassimir (1999).

[41] Karlström (1996: 492).

encourage, rather than exploit the collective goods created by NGO activity. As Karlström notes:

> Since previous Ugandan governments ran local affairs through centrally appointed civil service chiefs, it is also the RC [Resistance Council] system which has provided Ugandans with their first significant experience of democratic governance at the local level. As I have tried to show, this pyramidal system of indirect representation is eminently assimilable to the Ganda Model of legitimate authority as constructed from the bottom up and founded on nested solidarities. It is also the first electoral system to resonate with the preference for regulated, as opposed to total, competition.[42]

Uganda's democracy not only empowered local communities. It created just the right environment for NGOs to flourish, constraining forces that elsewhere compromise NGO effectiveness. One of my interviewees, a Ugandan who founded a micro-lending NGO in Eastern Uganda, illustrates the "multi-layeredness" of an NGO's cultural and political embedding. He noted that local officials did not demand bribes because they all wanted to take credit for the NGO's successes to improve their chances in local elections.[43] Thus partial, rather than full electoral competition – and, not unimportantly, a political culture that resonates with traditional Ganda understandings of clan and kingship – seems, at least through the early 1990s, to have generated a political dynamic that encouraged, rather than discouraged public goods.[44]

Like Uganda, which reinstated the local powers of the Buganda kings, Botswana has preserved the *kgotla* system of local courts and customary law and has incorporated the eight Tswana chiefdoms into its constitution as a modern House of Chiefs, advisory to the national legislature. Members of the traditional royal line, as well as the local chiefs of each village, also continue to play a vital role in national life.[45] Perhaps most importantly, Botswana has assimilated the traditional *kgotla* style of consensus-based consultation under a *kgosi* or chief into the political culture of its contemporary democracy.[46]

In Botswana's case, however, its tradition of orderly, consensus-based democracy, even though it seems to have produced leadership with real vision and courage (both the first president, Seretse Khama, and the most recent president, Festus Mogae, come in for high praise, Mogae being regarded as far ahead of most others in his government on AIDS issues), has stood in the way of bold action on AIDS. Botswana's leaders have spoken out about AIDS and encouraged a wide variety of international collaborations, but the very traits that made Botswana's government such an African success story have stymied its AIDS efforts.

[42] Karlström (1996: 498–9).
[43] Interview # 7, August 2, 2002.
[44] Though see Mamdani (1996); Karlström (1999.
[45] Sir Seretse Khama, grandson of Botswana's great nineteenth-century ruler, King Khama III, was Botswana's first elected president. His son, Ian Khama, was the country's vice president and head of the Botswana Defense Force. In 2008, following elected presidents Ketumile Masire and Festus Mogae, he succeeded to the presidency.
[46] See the papers collected in Holm and Molutsi (1989).

One example is Botswana's vaunted freedom from corruption. I was told by frustrated internationals that any government purchasing requires an elaborate system of open bidding, slowing down attempts to streamline AIDS activities. Others from outside organizations trying to work with the government of Botswana reported that it was impossible to get standard procedures waived even in the AIDS emergency. Botswana's pride in its administrative competence proves a similar liability. Delivery of antiretroviral drugs was slowed by a shortage of doctors and nurses, yet both groups resisted having their tasks done by less qualified professionals. In an epidemic where drawing blood has been essential for monitoring the spread of the disease (sentinel surveillance), HIV testing, and managing antiretroviral therapy, Botswana has no phlebotomists – specialists in drawing blood but without the broad training of doctors or nurses – and the existing professionals resist having such unqualified people do their jobs.

In contrast, Uganda's limited no-party democracy provided a stimulating environment for the operation of a wide variety of NGOs and for an array of international collaborations. As Tim Allen, a social anthropologist with twenty-five years of experience in Uganda notes, "one of the most remarkable aspects of the HIV/AIDS campaigns in Uganda is the way they have involved everyone including international agencies, NGOs, government ministers and journalists, to pop stars, Catholic priests, local councils and soldiers. There has indeed been a considerable degree of mass mobilization."[47] In part, one might say, the state-building strategy of Museveni's National Resistance Movement, after a devastating civil war, was to mobilize around the AIDS epidemic in order to draw international assistance and to bring more of society under its purview. One Ugandan observer, Kintu Nyago, notes that Uganda's success against the epidemic depended on the "democratic reforms that characterised the post 1986 period. This new political climate unleashed people's creative energies to respond to this pestilence. This occurred through free debate in the media and the broader public realm, which helped demystify the disease, in addition to the formation of people-centered NGOs such as TASO [The AIDS Support Organisation] and the Aids Information Centre." He also credits the "decentralisation and the introduction of the Local Council system," noting the kind of collaboration that was encouraged between community groups and local-level party officials:

> The women, youth and people with disabilities were particularly targeted for empowerment. This meant that scientifically proven information would smoothly flow from the top to the Local Council leadership, who would in turn disseminate it to a receptive population. It's this local coalition of the LCs, clan head, local imam and pastor, or bwana Mukulu [parish priest] together with Community Based Organisations that helped change the tide through community ownership of the anti-AIDS campaign.[48]

[47] Allen (2006: 20).
[48] Nyago (2003).

Tim Allen and Suzette Heald note the importance of Uganda's local councils in promoting behavior change:

> Although members of these locally elected bodies were originally not paid salaries or stipends, they were able to make informal charges for their services. Most importantly, they derived their authority directly from the President, and were supported by the army. They were also given a great deal of latitude in deciding how to operate. They were supposed to act as advocates for their people at each level of the administration, collaborate with aid agencies and monitor security. In Moyo District, and in many other parts of Uganda they become active in promoting awareness of HIV/AIDS, often putting up their own health promotion posters. In some cases they also became active in not just promoting behavioural change, but in enforcing it.[49]

They note the sharp contrast with the way local authorities function in Botswana:

> In addition to a hereditary chief or headman, each village [in Botswana] now has a range of elected village committees (including one for AIDS), who report to village chief and council but also, and more importantly, to the Village Development Committee and thence to government offices higher up the hierarchy. But the wheels of the bureaucracy grind exceedingly slowly. ... [C]hiefs can no longer act independently of this committee structure, nor committees independently of higher approval. In 2003, we heard of two cases where chiefs wanted to put up their own HIV/AIDS posters in their kgotla – but permission had to go up to NACA (the National AIDS Coordinating Agency) and then come down. In over two years in one case, and in over three in the other, no such authorization had come down. But these chiefs were exceptions. We did not see much sign of those few we visited in 2004 wanting to act.[50]

Uganda's democracy not only empowered local communities. It created the right environment for NGOs to flourish, constraining forces that elsewhere compromise NGO effectiveness. Botswana's political culture created effective government institutions but without the ability to mobilize local communities.

Solidarities and Silences

Bound up with issues of political culture and organizational style lies the problem of stigma. Over and over again, throughout Africa, the deep sense of shame about AIDS, the fear of isolation of people living with AIDS, and the reluctance of everyone from heads of state to local clergy to talk about the issue seems to stand in the way of effective prevention and treatment. Stephen Lewis, the UN special ambassador for AIDS, reported that when he urged Daniel arap Moi, Kenya's former president, to speak out about Kenya's AIDS crisis, Moi replied, "We don't talk about nasty things." In Uganda, Museveni's determination to speak openly about AIDS and about the changes in sexual practices necessary to prevent it is credited with breaking through the stigma

[49] Allen and Heald (2004: 1150).
[50] Ibid: 1147.

and silence surrounding the disease. And in Uganda as elsewhere in Africa, the few celebrities, such as musicians, who have been willing to come out as HIV positive are reported to have made an enormous difference.[51]

Stigma has indeed played a role in Africa's AIDS crisis, but the meaning of the term – both its nature and possible remedies – have been misunderstood in the West. In my view, this gets to the heart of the Botswana paradox, and the contrasting outcome of AIDS-prevention efforts in Uganda versus those in stable, peaceful Botswana. Stigma is a problem virtually everywhere.[52] My Ugandan informant reported that the taboo on discussing anything connected with sex among clan or family members creates special difficulties for the AIDS education his micro-lending NGO aspires to do. An informant who had done AIDS work in a South African mine reported that to be revealed as HIV positive would be "social death" within the macho community of miners, even though the mine authorities knew that 40 percent of the miners were infected.[53]

In Botswana, I heard again and again how stigma was slowing access to antiretroviral therapy, even though in theory the treatment was available free to anyone who needed it. Since people wouldn't acknowledge that they were HIV positive, they delayed therapy until they were desperately ill, thus overwhelming limited clinical facilities.[54] Nurses in the government's AIDS/STD Unit reported having to paint over the insignia on their vans in order to be able to enter the neighborhoods where they worked, having patients refuse home visits if the nursing staff wore uniforms, and having parents and other care givers refuse to acknowledge that their adult children were ill with AIDS even as those children died.[55] Funerals in Botswana routinely include a detailed recitation of the life and death of the deceased, including full detail about the final illness, but I was told over and over again that AIDS is never mentioned. Two of my interviewees, both nurses, reported having been assigned the funeral oration about the final illness of a family member because of their medical training, and then being told by the families that they could not mention AIDS.

Yet stigma, if it means discrimination or social rejection, is not quite the right concept to describe what is happening in Botswana. One informant, an influential director of AIDS services for a major mine, said that she became aware of the paradoxical nature of the situation when she realized that work units, which might be at full strength with ten workers, were requesting four additional workers. When she investigated, she found that the units actually

[51] See Eaton (2004).
[52] See Farmer (1992) on the association between AIDS witchcraft in Haiti; also Ashforth (2005). Campbell et al. (2005) like many others find that the association between AIDS and sexual immorality generates stigma.
[53] Interview 19, April 29, 2003.
[54] Interview #33, July 9, 2003. See also Grunwald (2002).
[55] Interview # 31, July 8, 2003.

had ten workers on the payroll, four of whom were too sick to work. So the mine foremen were carrying their sick workers, protecting them from losing their jobs, rather than firing them or discriminating against them in the usual sense.[56] In this sense the silence surrounding AIDS is partly denial, but it is partly a kind of protective refusal to push the infected person outside the relationships of solidarity upon which he or she depends. People recognize when they or their relatives are ill with the symptoms of AIDS, but they protect themselves and each other from the socially disruptive, public acknowledgment of the disease. There is thus a kind of protective tenderness behind the secrecy and suppression of AIDS stigma in Botswana.

If stigma does not result in discrimination or a loss of rights and benefits,[57] the meaning of variations in political and cultural response to the epidemic becomes clearer. What stigma and the resulting secrecy do is to prevent the direct mobilization of social solidarities to confront the realities of the epidemic, both for those who are infected and those who are at risk. Most analyses of the sources of effective response to health threats still assume, implicitly or explicitly, that information and education lead people (as autonomous, rational individuals) to make prudentially motivated health decisions. But as we have seen for Botswana, even universal or near-universal health information about HIV/AIDS risks does not lead, by itself, to behavior change. Botswana has done a good job of informing its people and alerting them to the danger they face. Their president has spoken out, according to a *Washington Post* report, "warning his people in fiery speeches that they are 'threatened with annihilation,' chairing his country's AIDS council, and badgering his health officials with questions about condom distribution in prisons and construction timetables for clinics."[58] Batswana are well informed; indeed they have been inundated with health messages about AIDS. They have had high-quality professional attention – respectful and caring – for people living with AIDS in the Home Based Care service of the AIDS/STD Unit of the ministry of Health. Then what is missing?

What is missing is precisely the activation of social solidarities, the sense of community and the mobilization of collective identities, that can create the elusive behavior changes (abstinence, partner reduction, and condom use) that can reduce the epidemic's devastation. As Tim Allen has noted, based on his twenty-five years of anthropological fieldwork in Uganda, "If declining HIV incidence is linked to behavioural changes in the most intimate aspects of social relations, then changes are required in understandings and expectations

[56] Interview # 26, July 4, 2003.

[57] Stigma as social isolation is also closer to Erving Goffman's (1963) original meaning. For him, a stigma was something that made a person a *defective interactor*, meaning that others could not smoothly enact the ritual proprieties of normal social interaction. It was this social defectiveness – and thus the isolation from the ritual encounters that affirm social solidarity – that made a particular trait a source of stigma.

[58] Grunwald (2002).

of accountability and duty – in other words, in what it means to act in a moral way."[59] Such mobilized solidarities may also be necessary to encourage people to seek out and persist with the antiretroviral therapies that can extend the lives of those living with HIV and AIDS.

The crucial difference is whether responses to AIDS activate the NGOs, community organizations, churches, and village authorities that have played such a crucial role in Uganda and in some of the other African societies that are starting to show declining rates of HIV infection. To give a sense of what this means, let me quote another informant, an AIDS activist from Zambia, describing how her organization, the Society for Women and AIDS in Zambia (SWAAZ) – an organization now numbering some ten thousand volunteers, organized into local chapters, with only a tiny paid staff – waged its campaigns:

> When we go into an area to work on HIV/AIDS we sensitize the women about AIDS, we mobilize. But we go to the Health Ministry for the statistics and the data to know how many people are dying, how many are infected. When you go to a rural area you go first to the Ministry of Health. Then you go to the village head man. Then go to the village chief.
>
> Last year [we] went to the Eastern region. First we had a workshop for all the chiefs. We had eighty-one chiefs there. And we told them that because they are guardians of traditions, they are influential. They were very excited, they all said, "Come to my village; come to my village."
>
> Then we meet with the village headmen. A small village will have between one hundred and two hundred people. If they are close together we can put five villages together, and they can form subcommittees. And then, after a year, they have to hold elections. They are volunteers. They have to take the responsibility for mobilizing themselves. There has to be a contact person that SWAAZ communicates with. Then there should be a chairperson that is in communication with Lusaka, and he communicates to the other village leaders. You have to find someone who can write and read. And usually you use the address of the village headman, the church, the police if there is a police station nearby.[60]

Such bottom-up mobilization dispenses nothing more than information and exhortation – the same information and exhortation that has been offered in Botswana. But in Uganda, Zambia, and even to some degree in parts of Kenya and Tanzania, such collective mobilization is also producing that other elusive property – social solidarity – making new health behaviors, and the willingness to take life-saving drugs, part not only of protecting one's individual health but of participating in the collective process of saving one's community. The Botswana case demonstrates – as clearly as anything could – that individual prudential interests are not enough. Human beings seek participation in social community. And where to participate in that community as a full member is to maintain the smooth, polite, considerate, civil style that characterizes Tswana

[59] Allen (2006): 8.

[60] Interview 15, March 25, 2003.

social life, people will – and do – repeatedly choose death over the potential social isolation that would arise from openly acknowledging a dreaded disease.[61] But civility and politeness are features of Ugandan political culture as well. In the Ugandan case, however, the ferment of collective mobilization – by churches, TASO, community organizations, government officials, and a multiplicity of NGOs – has at least in part broken through isolating stigma to produce profound changes in attitudes and behavior.

THE HEART OF THE MATTER

Uganda's success and Botswana's wrenching failure illustrate the intersection of the political and the cultural, the institutional and the moral. Botswana's success as a modern state has in part involved great receptivity to technocratic advice. Botswana has imported legions of experts on matters from economic policy, to investment strategy, to schooling and health care. Uganda has also welcomed a variety of international actors as well as encouraging local nongovernmental and community organizations of all sorts. But in Uganda, the president, Yoweri Museveni, made the fight against AIDS a national crusade. He included the AIDS issue in every speech he gave; he insisted that all the officials of the National Resistance Movement, down to the local level, discuss AIDS in every speech and every public meeting. Uganda's National Resistance Movement also authorized its Local Councils to enforce community moral norms.[62] So the many public health messages were reinforced by a huge variety of locally sponsored activities, like school groups putting on theater presentations about the danger of HIV and AIDS.[63]

The really crucial difference between Botswana and Uganda has not been the vigor of their responses to the pandemic, or even their educational efforts. Rather, Ugandans were led to see action against AIDS as part of a collective narrative,[64] one that made them central players not only in protecting themselves as individuals, but in participating in a community that was endangered and demanded heroic effort. Botswana may have done everything right, but it did not create the sense of shared fate, of collective meaning, and of necessary sacrifice that could bridge the gap between the isolation of individual fear and social stigma and the necessity for collectively shared action. This would suggest that a broad social movement – the pattern of Brazil and Uganda, but not of Botswana – makes the fight against AIDS not just a matter of individual prudence, but of a collective moral struggle, so that individual changes in health behaviors are part of a broader sense of community morality, and

[61] On the link between Tswana conceptions of civility and the reluctance to acknowledge AIDS as the cause of death at funerals, see Durham and Klaits (2002).

[62] Allen (2006): 23.

[63] See Obbo (1995); U.S. Agency for International Development (2002).

[64] I am indebted to Chaviva Hosek of the Canadian Institute for Advanced Research for this phrase.

perhaps of a kind of nationalist mobilization on behalf of group well-being. The very competent, but more technocratic response in Botswana – however well-conceived and carefully carried out, however much information about the virus and warnings about its dangers were disseminated – simply couldn't match the political commitment and the moral enthusiasm, at all levels of the society, that galvanized Uganda.

CONCLUSION

The comparison between Botswana and Uganda raises a broader set of issues about responses to the AIDS epidemic, about culture and health, and finally about human behavior more generally. Several analysts have pointed out the failure of most – indeed nearly all – of the Western-inspired efforts at AIDS prevention in Africa.[65] One explanation is that public health experts exported strategies that had worked in Europe and North America, rather than grounding their strategies in local African conditions: condoms appeared to have led to dramatic reductions in HIV incidence in the Global North, so international public health authorities saw condoms as the best, and sometimes the only, effective AIDS prevention.[66] Another, somewhat broader view of the problem is that along with a reliance on condoms, Western experts advocated the whole set of policies and political commitments that had been important for prevention campaigns in the West, especially in the gay community.[67] Confidentiality, voluntary and anonymous testing, human rights, and freedom from stigma and discrimination were seen as the fundamental weapons for fighting AIDS.[68] Yet this standard recipe of human rights combined with HIV/

[65] See H. Epstein (2007); Potts et al. (2008). Catherine Campbell (2003), in a courageous book on an AIDS prevention project among prostitutes and miners in South Africa, explores failure in what was supposed to be a "best practice" project that lived up to all the ideals of "stakeholder buy in" and "participation."

[66] The most visible proponent of this view has been Edward C. Green (2003) who claims (p. 58), "Condom use was widely believed to be the best solution to sexually transmitted AIDS in the United States; it was even believed to have been responsible for reducing HIV infection rates among gay men in some key cities where infection levels among gay men reached extremely high levels." Green and others who agreed with him have been embraced by the proabstinence religious community (and of course by the Bush administration's PEPFAR program). This political embrace has cast the conflict as one between condoms and the ABC approach, while obscuring the really important factors at work.

[67] Writing in *The Lancet*, De Cock et al. (2002) note: "The approach to HIV/AIDS has its roots in the early history of the epidemic in the USA, when its pathogenesis and natural history were little understood, treatment options were few, and society was at best unresponsive and at worst discriminatory towards a focal epidemic spread by male-to-male sex and injecting drug use. During that time, when no treatment was available, an unusual coalition was formed between the gay community, medical and public health practitioners, and civil liberty proponents to avoid prevention measures that might 'drive the epidemic underground'" (p. 68).

[68] Allen (2004) notes that "the human rights of those who are HIV positive are privileged over those who are not. It is very understandable why this is the case, but in public health terms

AIDS information and exhortations failed to galvanize an effective response to the epidemic in Botswana.

The lessons of the American, Australian, and Brazilian gay communities' fight against AIDS – and the ways these lessons do apply directly to Africa's AIDS epidemic – have been widely misunderstood. Neither condoms nor protection of human rights were in themselves keys to reducing HIV transmission. These commitments were part of a much broader mobilization of gay communities in political, cultural, and moral response to the epidemic.[69] The social, political, and moral mobilization of gay men led to dramatic behavior change that turned back the tide of new infections. Using a condom signified not protecting oneself from other men who were dangerous; rather, practicing safe sex signaled gay men's pride in their identity, their love of other men, and their commitment to their community.[70] Gay men used condoms (public health officials in San Francisco estimate that at the peak of the safe sex campaigns, condoms were used in something like 95 percent of all gay male sexual encounters) because practicing safe sex enhanced their own identity as moral persons. That powerful identity rested in turn on deep identification with their community, and on the simultaneous pride (and fear) of a group that mobilized politically to demand respect and protection and to shape the medical and public-health response to the disease.[71]

The contrasting experiences of Uganda and Botswana also point to larger questions about the fundamental motivations for human behavior. Michèle Lamont has described "the world in moral order."[72] When asked about their sense of self and about what they value, French and American working-class men describe their desire to see the world as governed by a moral order and to see themselves as filling a valuable place in that order. So even the powerful

it is potentially counterproductive. Moreover, if the rates of infection occurring in southern Africa were occurring in a rich country, such as the UK or Canada, it would be surprising if extreme measures were not introduced. The extraordinary responses to the SARS virus in 2002–03 make that very clear" (p. 1127). See also De Cock et al. (2002).

[69] Dennis Altman (1994) analyzes the remarkable array of community organizations that mobilized in response to the AIDS epidemic and discusses the political opportunities and constraints that made such organizing more successful in some contexts than in others. He quotes from a French AIDS organization's pamphlet to suggest the general role played by such organizations: "One alone cannot change his or her behavior: a social movement and opinion leaders are needed" (p. 43).

[70] Writing of the Australian gay community in the 1980s, Dowsett (1999: 227) claims that "gay communities were working hard to create a 'safe sex culture' in their educational activities, using the idea of 'a community acting together to protect itself'. This notion of a safe sex culture is not merely a documentation of aggregated behaviour change; rather, it is a framework of ideas, practices, images, language, preoccupations and activities that insinuate safe sex directly into the centre of daily life for gay men. It means that any involvement in gay life is also an immersion in HIV/AIDS and in its key concern of developing, sustaining and living with safe sexual practice."

[71] See Altman (1994) and Epstein (1996).

[72] Lamont (2000).

engine of individual interests operates within a larger understanding of a moral order and the individual's place within it. Myra Bluebond-Langner, an anthropologist who studies decision making for dying children, has noted that when parents make decisions about how far to prolong treatment for their dying children, they act "not in terms of the weighing of risks and benefits, but in the construction of identities that can survive what the body may not."[73] That same commitment to the preservation of a moral identity, one affirmed by one's community, is also central to AIDS decision making. In the West, acting rationally in one's interest is considered part of an adequate identity, both for individuals and in many respects for organizations and nations as well.[74] Yet even in Europe and North America, with our long history of individualism, rational, individual self interest has played a surprisingly small role in reducing HIV transmission.

In Africa, despite the consistent presumption by international donors that rational self-interest is the fulcrum on which behavior can change (witness the commitment to Voluntary Counseling and Testing as the necessary prerequisite to behavior change and the persistence of the conviction that Information, Education, and Communication [IEC] will change behavior), the evidence is entirely in the other direction.[75] Uganda and other places that have mobilized moral solidarities on the ground have been able to dramatically reduce unsafe behaviors, but even the clearest knowledge of the most direct threats have been unable to overcome people's commitment to valued moral identities.[76]

As Hall and Taylor note, contemporary health researchers have gathered powerful evidence that, at the individual level, social support and social networks play crucial roles in health – strengthening the immune system,

[73] Bluebond-Langner (2003).

[74] See Dobbin (1994a; 1994b; 2004).

[75] In a February 10, 2004, Op-Ed essay in the *New York Times*, Richard Holbrooke and Richard Furman wrote: "Of all the mind-numbing statistics about H.I.V. and AIDS, the most staggering – and important – is this: 95 percent of those infected worldwide do not know they are harboring the most deadly virus in history, and are therefore spreading it, however unintentionally." Despite the U.S. commitment to the notion that individuals can't protect themselves and others without knowing their status, there is little evidence that knowing one's HIV status is linked to behavior change and no evidence that individuals' knowledge of their HIV status is necessary for effective prevention.

[76] Some of the most striking evidence comes from the debate over condoms. The effectiveness of consistent condom use in preventing HIV transmission is estimated at about 90 percent. In Africa, governments and NGOs have been quite successful in increasing the aggregate numbers of condoms distributed, with proportions as high as 85 percent of men in some places reporting condom use with high-risk partners. But this increase in condom use has had no measurable impact on HIV prevalence. Why? It appears that the very association of condoms with promiscuity, prostitution, and nonregular partners has made using condoms unacceptable with spouses or even steady boyfriends and girlfriends. Thus the semiotic coding of the condom makes it incompatible with intimacy and affection, even for those who know they risk infection (Agha et al. 2002; , S. Allen et al. 2003; Hearst and Chen 2004; Kaler 2004; Chimbiri 2007; Tavory and Swidler 2009).

speeding recovery from heart attacks, and promoting health behaviors.[77] This chapter, and this volume as a whole, address parallel phenomena at the collective – community or national – level and offer a possible reinterpretation of the efficacy of individual-level social support. The comparison of Botswana and Uganda suggests that individuals' ability to act rationally to protect their health – their ability to face frightening realities, to change socially significant behaviors, and even to value their own well-being – may depend both directly and indirectly on collectively-generated meanings. It is hard to identify the precise mechanisms at work here. But evidence from Uganda and Botswana, as well as the experiences of successful AIDS prevention in Brazil and in Australian, American, and European gay communities, suggests that people can make even difficult changes in behavior when they feel they are making a socially validated effort for a moral end. Furthermore, social solidarity may alter the shameful aspects of disease (and remember that illness in general is often experienced as a personal moral failing)[78] to allow people to take care of their own health and to ask or expect others to help them. We typically think of social support as aid and assistance – sometimes psychological – that others give us. But the major benefit of social support may be instead that it makes us feel valuable enough that we are worth taking care of.

The kinds of collective mobilization that happened in Uganda (and in some other AIDS-affected communities around the world) are in some ways specific to a particular national experience and the collective mobilization that a new regime and an assortment of local organizations and international NGOs were able to achieve. But at another level, the contrast between Botswana and Uganda reminds us that human flourishing is fundamentally tied to collective processes and more specifically to the ways collective meanings shape the significance of individual lives.

[77] See Keating and Hertzman (1999) and Berkman and Kawachi (2000) for major overviews of evidence and arguments.

[78] See Sontag (1978).