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Changes and Choices:
An Analysis of Uganda's AIDS Response

A Thesis submitted in partial satisfaction of the requirements
for the degree Master of Arts

in

Anthropology

by

Hannah Geoffrion Read

Committee in charge:

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Professor Saiba Varma

2020

The Thesis of Hannah Geoffrion Read is approved, and it is acceptable in quality and form for publication on microfilm and electronically:

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Chair

University of California San Diego

2020

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ABSTRACT OF THE THESIS

Changes and Choices:
An Analysis of Uganda's AIDS Response

by

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Master of Arts in Anthropology

University of California San Diego, 2020

Professor Thomas J. Csordas, Chair

Uganda's AIDS epidemic was amplified by political breakdown and economic collapse during the 1970s and 1980s. Since then, however, Uganda has attracted international attention for producing the most dramatic decline in HIV rates in East Africa. Largely due to the

government's openness in addressing AIDS, Uganda's response to the epidemic has been characterized by diverse treatment and prevention efforts that reflect the country's historical, political, economic, and sociocultural circumstances. The scaling-up of antiretroviral therapy, for example, relies on social cohesion within a community to improve and protect the well-being of its members, while Christian prevention initiatives that focus on abstinence and fidelity tend to emphasize individual responsibility and autonomy. Because these two responses to AIDS draw on conceptualizations of the self and person that differ markedly, they are able to impact a greater number of people in Uganda's rapidly changing society.

Introduction

In 2011, 30 years since AIDS was first clinically recognized in the United States, the Joint United Nations Programme on HIV/AIDS (UNAIDS) released a report for World AIDS Day, announcing that new HIV infections and AIDS-related deaths had reached an all-time low since their peak in the mid-2000s (UNAIDS 2011: 6). UNAIDS Executive Director Michel Sidibé expressed optimism about the global AIDS response, writing that "Just a few years ago, talking about ending the AIDS epidemic in the near term seemed impossible, but science, political support and community responses are starting to deliver clear and tangible results" (UNAIDS 2011: 5). Yet his vision of "a world with zero new HIV infections, zero discrimination, and zero AIDS-related deaths" is still a long way off (UNAIDS 2011: 5). In 2010, 1.8 million people died of AIDS-related causes worldwide, and 2.7 million new HIV infections were reported (UNAIDS 2011: 6-7).

It is clear that sub-Saharan Africa continues to bear the brunt of the global HIV/AIDS epidemic. Since 1998, AIDS has claimed at least one million lives annually in the region. In 2010, 68% of the estimated 34 million people living with HIV worldwide resided in sub-Saharan Africa, though it comprises only 12% of the global population. Sub-Saharan Africa also accounted for 70% of new HIV infections that year (UNAIDS 2011: 6-7). In its 2011 report, UNAIDS revealed that efforts were underway to address the disproportionate AIDS burden shouldered by the region. In recent years, antiretroviral therapy has become more widely accessible in sub-Saharan Africa, and research to determine the effectiveness of new vaccines against HIV subtypes found in the region is currently being conducted (UNAIDS 2011: 7, 44). These efforts are partially responsible for a 26% decrease in HIV incidence in the region since

the epidemic's height in 1997 (UNAIDS 2011: 7). But this decline is not evident everywhere one looks.

Uganda, once hailed as "a Cinderella success story" of AIDS response, is one of only two African countries in which AIDS rates are on the rise (Kron 2012). The 2011 Uganda AIDS Indicator Survey (UAIS), carried out by the country's Ministry of Health, showed an increase in HIV prevalence from 6.4% to 8.3% in the previous six years (Ministry of Health 2011: 105). The report raised questions about AIDS-prevention strategies in Uganda, especially those funded by international donors. According to the New York Times, "Health experts blamed Uganda's government for becoming complacent since winning international acclaim, and reams of financial aid, for its AIDS efforts" (Kron 2012). Others such as Dr. Musa Bungudu, the United Nations' AIDS chief in Uganda, asserted that the nature of Uganda's HIV/AIDS epidemic has long been misunderstood: "There are a lot of sociocultural issues that need to be addressed. These are harsh realities." (Kron 2012).

Anthropologists have been addressing the sociocultural dimensions of HIV/AIDS in sub-Saharan Africa, including in Uganda, since the mid-1980s. As Douglas A. Feldman (2008) demonstrates in his review of the anthropological literature on HIV/AIDS in Africa, this has resulted in a considerable body of work that "has informed other major fields, including epidemiology, public health, health education, biomedicine, health policy analysis, and other social and behavioral sciences, for more than two decades" (Feldman 2008: 1). While earlier contributions focused on the social epidemiology of HIV, more recent anthropological research considers "the sociocultural and economic consequences of the disease; exploration of the social, cultural, historic context of AIDS; a critique of the political economy and gender inequality in

Africa; and an examination of HIV prevention, educational, and intervention programs" (Feldman 2008: 1). But these are challenging undertakings, to say the least.

As renowned medical anthropologist Paul Farmer (2006) articulates in *AIDS and Accusation,* "the anthropological study of AIDS should be more than a search for 'cultural meaning,' that perennial object of cognitive and symbolic inquiry" (Farmer 2006: 253). Rather, *"*a thorough understanding of the AIDS pandemic demands a commitment to the concerns of history and the political economy" as well as interpretive ethnography (Farmer 2006: 9)—what he elsewhere refers to as "an interpretive anthropology of affliction" (Farmer 1988: 80). Such a combination, he laments, remains to be demonstrated in the existing literature. According to Farmer, attention to the forces of history and political-economy is necessary in order to understand illness representations and social responses:

> 'history and its calculus of economic and symbolic power' help to explain *why* members of a particular community came to understand illnesses such as…AIDS in the manner in which they did. The category of 'sickness' is socially constructed, certainly, but on what foundation? Of what materials? According to whose plan, and at what pace? (Farmer 2006: 256-7).

Most importantly, argues Farmer, anthropologists must attend closely to the lived experience of persons with AIDS (Farmer 2006: 10). As Kleinman and Kleinman (1995) illustrate, anthropological analyses of suffering, when they are experience-distant, risk "delegitimating their subject matter's human conditions" (Kleinman and Kleinman 1995: 96).

Farmer's approach is particularly necessary when studying AIDS in Africa, in order to avoid the overgeneralization, ethnocentrism, and misrepresentation that plague many accounts—anthropological and otherwise. For one, Africa is often portrayed as a homogenous continent, despite its rich cultural, geographical, economic, and historical differences. This certainly applies to AIDS research in Africa, where studies of specific national groups or populations tend to refer

to results as characterizing a monocultural "Africa" or, perhaps, "sub-Saharan Africa"—what Oppong and Kalipeni (2004) refer to as, "The Overgeneralization Syndrome" (Oppong and Kalipeni 2004: 48).

What's more, certain accounts represent the epidemic in moralizing ways that highlight denial, shame, and stigma and advance unfortunate stereotypes. A 2001 Time Magazine cover story about AIDS in Africa described AIDS as a spark in the "dry timber" of African society, where "ignorance, promiscuity, and denial help generate HIV transmission" (McGeary 2001: 36). Craddock (2004) contends that such representations "tend toward unreflexive depictions of cultural practices as causal factors…[that] help reproduce vestigial colonial images of Africans as ignorant, hypersexual, and culturally backward" (Craddock 2004: 3-4). Like Farmer, she asserts that a more accurate understanding of the AIDS epidemic recognizes that it is deeply rooted in "historical antecedents, geopolitical relations, global financial configurations, government policies, local institutions, and cultural politics" (Craddock 2004: 5).

The approach articulated by Farmer and Craddock informs the perspective I aim to adopt in this paper. My analysis is focused on AIDS in Uganda, taking into account Uganda's historical, political, and economic circumstances. I examine responses to the epidemic in order to show how treatment and prevention initiatives are grounded in and encourage varying conceptualizations of the self and person. Ultimately, I argue that, because these conceptualizations differ, response efforts are able to reach a greater number of people in Uganda's rapidly changing society. I do this by looking at existing literature, both ethnographic and non-ethnographic. My sources range from epidemiological accounts of the early trajectory of HIV/AIDS in Uganda to recent case studies of specific interventions and prevention strategies. I

also draw from nonacademic sources such as popular media, in order to illustrate prevalent representations of the disease in Western culture.

First, I offer a brief history of HIV/AIDS in Uganda. Next, I focus on two examples of responses: the scaling-up of antiretroviral therapy (ART) programs that encourage "positive living" and Christian prevention initiatives that focus on abstinence and fidelity. The first, I argue, fosters collaboration and interdependence, while the latter encourages individual responsibility and autonomy. I then examine both cases through the lens of anthropological conceptualizations of the self and person. Finally, I reflect on the ways in which Uganda's varying responses to HIV/AIDS reflect and are particular to the dynamic nature of the country's political, economic, and social life.

1. A Brief History of AIDS in Uganda

Acquired immunodeficiency syndrome (AIDS) is the most advanced stage of human immunodeficiency virus (HIV) infection, at which point the body's immune system is badly damaged and one becomes vulnerable to opportunistic infections. Without treatment, people with AIDS typically survive about 3 years. An opportunistic illness decreases life-expectancy to about 1 year. While there remains no cure or vaccine for AIDS, treatment can slow the course of the disease.

AIDS was first documented in the Rakai district of south-western Uganda in 1982, making it the first African country to recognize the disease (Barnett and Whiteside 2006: 127). By 1987, Uganda had the highest rate of HIV in the world (Whyte 2014: 4). By the early 1990s, 13% of the country's adult population was infected with HIV. But by the end of 2003, this number had dropped to 4.1%— the sharpest decline in East Africa (Barnett and Whiteside

2006: 127). Uganda's success at combating the epidemic attracted international attention and was frequently referred to as a "miracle" (Boyd 2015b: 1, Nolen 2005, The Economist 2002,). The Economist suggested that, "Uganda shows that there is hope even for countries that are poor and barely literate" (Economist 1998). As a result of the renown, however, some sources likely exaggerated Uganda's success. As Kinsman (2008) writes, "the country's falling HIV prevalence rate became almost iconic, with the most widely circulated figures stating that the HIV prevalence had fallen from 30% early in the epidemic to 10%" (Kinsman 2008: 102). (See Figure 1.)

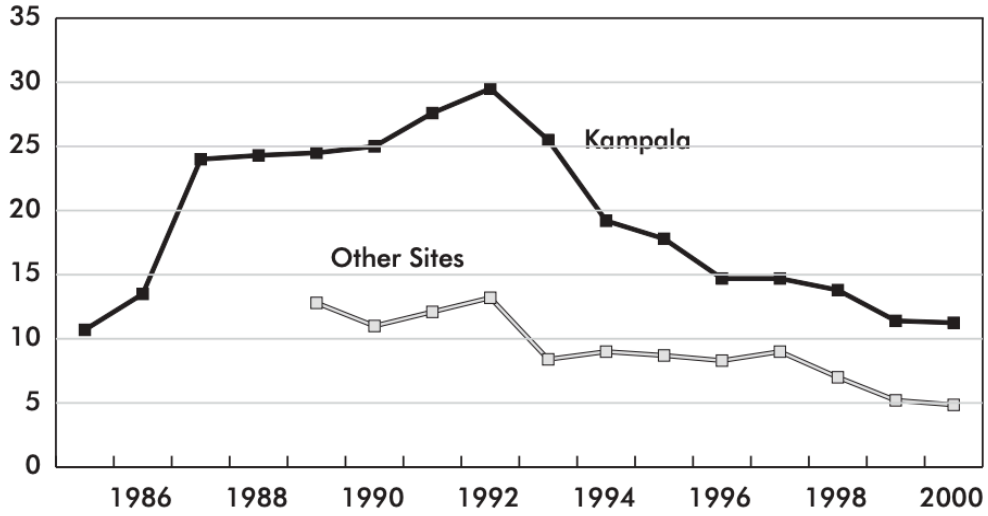

Figure 1: Median HIV Prevalence among Pregnant Women in Uganda (Green et al. 2002: 1

In 2002, global health scholar Justin Parkhurst published a critique of the Ugandan success story in The Lancet, in which he suggested that the country's success was "predicated on selective pieces of information, which have been falsely presented as representative of the nation as a whole" in order to "provide the international community with the African success story it wants, or even needs" (Parkhurst 2002: 78, 80). As he explains elsewhere, "The belief that 'Uganda has seen declines in HIV rates from 30 to 10 per cent' is a statement all too common both in the media, as well as in health policy literature. While such a decline was seen

in prevalence rates in one urban antenatal clinic, such a broad generalized statement is not an accurate reflection of the epidemiological situation in the country as a whole" (Parkhurst 2001: 70). Ultimately, Parkhurst concedes that Uganda has been successful in preventing the spread of HIV, "and that there are meaningful lessons to be learned from the way that the government and other institutions have tackled the disease", but he emphasizes that the data have been exaggerated and taken out of context. (Parkhurst 2002: 78, see also Parkhurst 2001: 70).

Not surprisingly, Parkhurst has been heavily criticized by Ugandans for diminishing the scope of their success: "Newspapers splashed Mr. Parkhurst's findings on their front pages. The country's top health officials and AIDS researchers denounced the article as 'slanderous'" (Economist 2002). While many outside AIDS experts agree with Parkhurst that it is unlikely that infection rates could have dropped as precipitously as the data imply, few contend that Uganda has not succeeded in drastically decreasing HIV prevalence through its response to the epidemic. Rather than debating Parkhurst's claims, it is worth looking at some of the reasons why Uganda experienced such a large epidemic in the first place, as well as the factors that contributed to its decline.

According to Barnett and Whiteside (2006), Ugandan's susceptibility to infection was amplified by the breakdown in political order and ensuing economic collapse that took place during a slew of dictatorships from 1970 to 1986, led most notably by Idi Amin and Milton Obote. Amin had come to power as a result of a military coup in 1971, and his rule was characterized by persecution and corruption that drove thousands of Ugandans into exile. Milton Obote, Uganda's ousted president, was given sanctuary in Tanzania, which strained the already weak relationship between the two countries and contributed to what became known as the Uganda–Tanzania War or Kagera War in 1978. In 1979, Amin's regime was overthrown and a

struggle for power ensued until 1980, when Obote regained political control in a heavily contested national election. Many of Obote's opponents united under Yoweri Museveni's National Resistance Army (NRA) and initiated an armed uprising that lasted until 1985, when Obote was overthrown and replaced as President by his general Tito Okello. The conflict, which become known as the Ugandan Bush War, officially ended on January 25, 1986, when the NRA established a new government with Museveni as President (Cooper and Fontanellaz 2015).

Nearly two decades of political turmoil, civil war, and economic demise left Uganda's population impoverished, insecure, and largely without education and health services. Women were particularly socially, economically, and politically disempowered. Some people engaged in risky sexual behavior in order to survive— exchanging sex for money, food, or protection— which exacerbated the transmission of HIV (Barnett and Whiteside 2006: 129-30). What's more, high rates of sexually transmitted diseases such as syphilis, gonorrhea, and herpes further facilitated the spread of the virus. The lack of adequate medical care in the country meant that these common conditions often went untreated (Epstein 2007: 9).

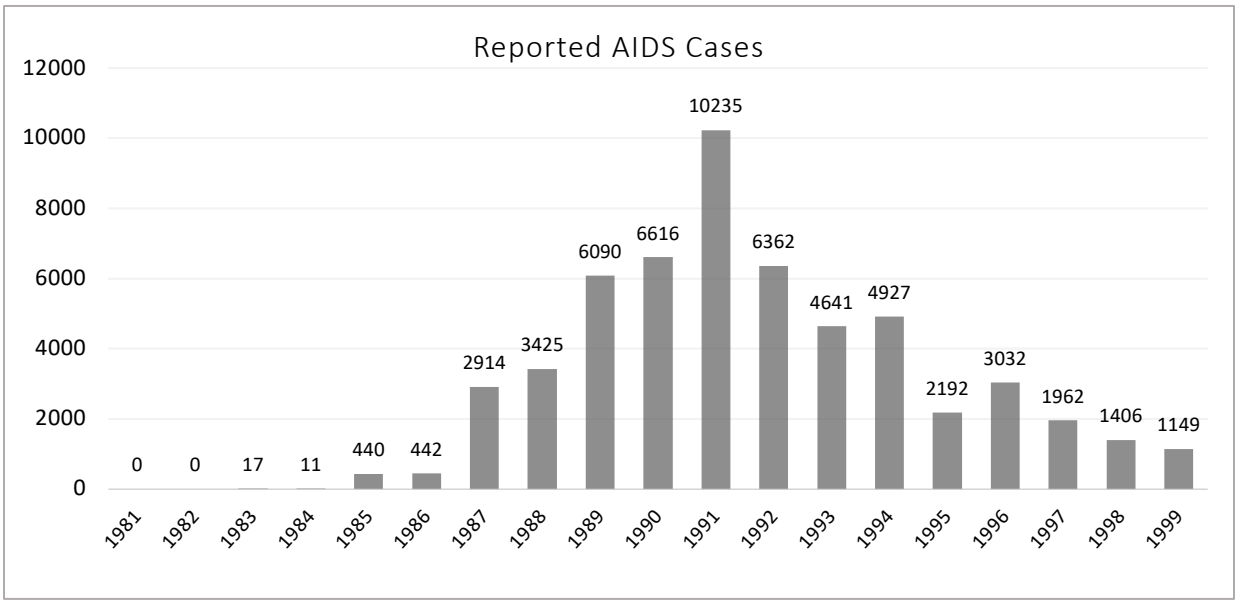

Figure 2: Reported AIDS Cases in Uganda, 1981-1999 (UNAIDS/WHO 2004: 6)

In 1986, when Museveni took power, 442 new cases of AIDS were reported in Uganda. By 1991, this number had peaked at 10,235, and by 1999, it had dropped to 1,149 (UNAIDS/WHO 2004: 6). The numbers of annually reported AIDS cases are shown in Figure 2. What explains the apparent decline in AIDS cases during the 1990's? According to Barnett and Whiteside (2006),

> This success depended on many factors rather than one factor alone—such as promotion of abstinence or condoms. Different factors played a role in different communities and areas of the country. There was considerable selection from a portfolio of HIV prevention methods: AIDS awareness campaigns, community mobilization, targeted behavior change programmes, voluntary counselling and testing, use of condoms and treatment of STI's (Barnett and Whiteside 2006: 131).

Many of these factors will be discussed in more detail below, but it is worth noting that Barnett and Whiteside also credit the Ugandan government's initial speed and candor with which they addressed the epidemic on an international stage (Barnett and Whiteside 2006: 131).

Although AIDS was identified in Uganda in 1982, it was four years before the government established a formal control program. Under Amin and Obote, "the political leadership at the time was also unwilling to allow for any examination of what was happening in the country" (Kaleeba 1993: 128). When the NRM under Museveni came to power in 1986, it established the national AIDS Control Programme (ACP) in the Ministry of Health— "one of the first of its kind in Africa" (Parkhurst 2001: 73). The ACP established a number of sentinel surveillance sites at antenatal clinics throughout the country (particularly in urban areas) to monitor HIV prevalence, which have been praised for producing a large amount of historical data on HIV for Uganda (Parkhurst 2001: 70). Additionally, it began screening blood to reduce the possibility of transmission through transfusions. It also provided AIDS Information, Education, and Communication (IEC) through a number of initiatives, to promote community

education and awareness. Finally, the Ministry of Health promoted and subsidized sales of condoms in order to control the transmission of HIV and other STD's (Parkhurst 2001: 73).

Behind all of the ACP's initiatives was the principle that Uganda would pursue an open policy toward AIDS. President Museveni spoke candidly about the scope of the country's problem, and elected officials at national and local levels were required to discuss AIDS at public meetings. The approach likely reduced stigma around the HIV/AIDS, allowing individuals to more freely discuss the disease on their own (Parkhurst 2005: 575). The open policy caught on around the country. As the new Minister of Health, Dr Ruhakana Rugunda, described, "There is no national pride whatsoever in hiding the prevalence of AIDS … you objectively destroy the standing and pride of your country if you hide such a problem" (Putzel 2004: 23). Adoption of Museveni's approach and the implementation of the ACP was likely incited by the "overwhelming presence" of the NRM regime, which "left little room for open political dissent" (Putzel 2004: 26). But Museveni undoubtedly earned a reputation for tackling the epidemic head-on. As a senior official in the Ministry of Health explained, "the key person was the President, and he guaranteed that the government's position would be open, frank, positive, and proactive in dealing with it" (Kinsman 2010: 71).

By the early 1990's, there was a growing sense that AIDS was an issue that needed to be addressed beyond the health sector. In response, Uganda adopted what became known as the "multisectoral approach," establishing AIDS control initiatives outside of the Ministry of Health (Parkhurst 2001: 73). One of these was the Uganda AIDS Commission (UAC), established in 1992 by a statue of parliament "to oversee, plan and co-ordinate AIDS prevention and control activities throughout Uganda, and in particular to formulate policy and establish programmatic priorities" (Uganda AIDS Commission 1992: 5). The UAC focused on the social and economic

factors involved in the epidemic and coordinated HIV/AIDS stakeholders and activities around the country (Parkhurst 2001: 73). But government initiatives comprised only a small portion of the response to HIV/AIDS that developed in Uganda during the 1990's, in part due to the government's financial constraints and limited capacity to provide services. Numerous programs and organizations—including community support groups, religious associations, and donor-financed international nongovernmental organizations (NGO's)—became involved in the cause (Parkhurst 2001: 76). By 1997, over 1,020 agencies were involved in HIV/AIDS related activities in Uganda, 60% of which were nongovernmental (Parkhurst 2001: 76-77).

Not surprisingly, from the myriad of HIV/AIDS control initiatives came numerous and, often, conflicting messages pertaining to treatment and prevention. However, because initiatives were often tailored to a specific population (such as women or children) and operated on a local level, the diversity of approaches also meant that messages were able to reach diverse groups of people (Parkhurst 2001: 77). What's more, the government did not push any one approach to treatment or prevention too strongly, focusing instead on broadly stated policy. This lack of strong, top-down prescription of response has, in Parkhurst's words, "assisted in providing an enabling environment that has allowed a multitude of interventions designed at the 'grassroots' levels, and thereby more culturally appropriate for the populations they target" (Parkhurst 2001: 78). I will now examine some of these treatment and prevention interventions in more detail.

2. "Living Positively": ART and Social Cohesion

The first form of treatment available for AIDS was azidothymidine (AZT), approved in 1987 (Vella et al. 2012: 1231). However, it was the development of highly active antiretroviral therapy (HAART, now commonly referred to as ART) in the mid-1990s that signified a turning point in the treatment of HIV/AIDS (Palmisano and Vella 2011: 44). With the advent of ART,

HIV infection became a chronic but usually nonfatal condition. In Uganda, ART became available in 1996 (Whyte 2014: 2). However, the average annual cost of up to $20,000 USD per person meant that few people could afford the treatment (Vella et al. 2012: 1234).

The availability of generic antiretroviral drugs in 2002, followed by the development of simplified drug regimens with fixed-dose combinations, meant that ART became increasingly accessible to people in resource-limited settings (Vella et al. 2012: 1236). In 2003, the Uganda AIDS Commission estimated that 10,000 people were receiving ART. Four years later, this number had grown to 115,000—a more than tenfold increase. By 2011, the number of people receiving ART was estimated at 291,000. This rapid expansion was coorinated by organizations like The AIDS Support Organization (TASO), which was founded in 1987 by a group of volunteers, many of whom were living with HIV (Low-Beer and Stoneburner 2017: 178). It was also facilitated by money from two major donors: the multinational Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFTAM), established in 2002, and George W. Bush's President's Emergency Program for AIDS Relief (PEPFAR), established in 2003 (Whyte 2014: 3).

Whyte (2014) describes the "Lazarus effect" that took place in Uganda during the ART "rollout years" from 2004-2007: "AIDS was still known as a fatal disease and the medicine brought resurrection" (Whyte 2014: 3). As Jenkins (2015) illustrates, the use of religious language to describe so-called pharmaceutical "miracles" calls to mind "the blurred conjunction of magic, science, and religion in the production of cultural meaning" (Jenkins 2015: 26). In describing the introduction of clozapine for use in the treatment of schizophrenia during the early 1990s, Jenkins writes that, "the christening of this particular medication as a 'miracle drug' conjured the notion of a substance imbued with the power to bring patients back to life, invoking not only the power of pharmaceuticals but also the religious metaphor of miraculous healing"

(Jenkins 2015: 26). In Uganda, such reports of dramatic restoration through ART offered hope and reassurance for those who were grievously ill (Whyte 2014: 4).

Miraculous or not, the novel form of treatment for AIDS necessitated new forms of healthcare. Whereas healthcare in Uganda had previously been largely decentered and inconsistent, ART required affiliation to one treatment site, where people would refill their medication and receive regular checkups. This was in part to insure adherence to the treatment, which helps to prevent the development of drug-resistant strains of the virus. Thus, people became "clients" of specific healthcare clinics, and many volunteered to provide care to others (Whyte 2014: 4). In fact, most treatment programs required that people starting ART identify a "treatment companion" who will provide support and make sure they take their medication daily (Whyte 2014: 17-18). These practices gave HIV/AIDS treatment in Uganda what Whyte calls an "intensely social character" (Whyte 2014: 17; see also Whyte, van der Geest, and Hardon 2002)

In addition to its social character, two features characterized the expansion of ART in Uganda: "the heavy dependence on donors and the diversity of treatment programs" (Whyte 2014: 7). In promoting an open discussion of HIV/AIDS in the country, Museveni also encouraged international NGOs and donors to become involved (Parkhurst 2005: 575). This increased the legitimacy of the Ugandan government both nationally and internationally, as evidenced in a joint report by the United National Development Program (UNDP) and UNAIDS, which pointed to Uganda as an example of "good governance" (Hsu 2003: 34 n. 21). Parkhurst (2005) describes the way in which such recognition contributed to international aid as follows:

> The concept of state legitimacy has typically referred to the extent to which those in power have domestic support and are recognized as legitimate in their actions by the populace. However, as developing country states are often dependent on the international community for their financial and political stability, a second aspect of legitimacy can be the extent to which international actors recognize and accept the government in power. (Parkhurst 2005: 576).

As a result, Uganda fledgling government relied on substantial foreign aid and support throughout the 1980's and 90's (Parkhurst 2005: 572). This reliance has continued into the past decade, with donors covering 93% of the country's AIDS response in 2008-09 (Whyte 2004: 7).

According to Whyte, the rollout of ART gave people "second chances"—a notion that can be used to better understand the subjectivity of those with AIDS (Whyte 2014: 18). One of the elements present in the idea of second chances, she suggests, is of reprieve: "A reprieve is an extension, a chance to resume and carry on. It is also a kind of recognition of human fallibility… We must give opportunities for new beginnings to continue living with others" (Whyte 2014: 19). Here, as above, Whyte stresses that ART encouraged a kind of sociality by offering second chances. She observes that it is not unlike forgiveness, which involves cooperation and mutual commitment (Whyte 2014: 19) Hannah Arendt also argues for the necessity of forgiveness in social life, noting that there is a "power generated when people gather together and 'act in concert'…The force that keeps them together, as distinguished from the space of appearances in which they gather and the power which keeps this public space in existence, is the force of mutual promise or contract. (Arendt 1998: 244-245). In this way, ART forged a kind of social contract between those who were given the chance to live with HIV.

These contracts also demand change. ART programs promote the idea of "Positive Living," which TASO describes as "understanding the implications of HIV infection and undertaking positive choices to prevent HIV infection and adopt strategies to improve one's health condition as mechanisms to fight the HIV epidemic" (The AIDS Support Organisation). This includes taking one's medication daily, seeking regular counseling, disclosing one's diagnosis to others, engaging in productive work, following a healthy diet, and abstaining from alcohol, tobacco, and sex. As Whyte writes, "You must accept becoming a client" (Whyte 2014:

21). These lifestyle changes are evident in the case of Robinah and Joyce, two sisters in their early forties who are both HIV-positive. Anthropologists Lotte Meinert and Godfrey Etyang Siu worked with the sisters for 18 months beginning in 2005, as part of TORCH—a collaborative project on the changing relation between communities and health systems in eastern Uganda's Tororo district, involving researchers from Danish universities and Makerere University in Kampala, Uganda (Whyte 2014: iv).

Robinah and Joyce grew up in eastern Uganda's Kumi District, where their parents were farmers. Joyce married a soldier from northern Uganda and had four children. But her children all passed away, "one after another," of what she later assumed to be AIDS (Meinert and Siu 2014: 28). Her husband died as well. Joyce said, "I remained alone with a lot of frustration…Many fingers were pointing at me because I had lost all the people consecutively with the same signs and symptoms. It was through these experiences that I started wondering about AIDS." (Meinert and Siu 2014: 28). At the urging of a colleague, who was HIV-positive, Joyce got tested at a local hospital. She found out that she was also HIV-positive. She immediately joined TASO and was started on a program that provided clean drinking water and antibiotic prophylaxis, which helped her avoid infections. Robinah married into a large family of cattle traders and businessmen, most of whom were polygynous. She had five children with her first husband, but, like Joyce's children, they all passed away. Her husband and father-in-law died as well. Robin reflected sadly on that time: "Today, if you went to that home, you would be shocked by the number of graves. I am the only one who survived" (Meinert and Siu 2014: 27). With her sister's encouragement, Robinah, who was living with her mother in Kumi district at the time, also got tested and found out she was HIV-positive (Meinert and Siu 2014: 27-28).

Robinah's health started rapidly deteriorating health. She lost weight, vomited frequently, her hair began to fall out, and a rash covered her skin. People in her community told her mother to isolate her with separate plates, cups, and bedding. When Joyce found out about her sister's health and discrimination, she visited her and cared for her. With the help of an officer from the Home-Based AIDS Care (HBAC) project run by the US Centers for Disease Control, Robinah eventually moved to Tororo to live with Joyce, who was working there as a teacher. Joyce took Robinah to the HBAC clinic the next day, where she was started on ART. The drugs' side effects were difficult to tolerate, and Robinah felt bad that she had to rely on her sister for food and care: "I was staying in the home just like a child…All support had to come from my sister, who earned only 165,000 shillings [at the time, about $94] per month" (Meinert and Siu 2014: 29). Others helped as well: "The HBAC officer brought Robinah's medicine to the house every week on a motorbike. A counselor from the project came to visit Robinah several times to interview her and advised her on feeding, side effects, traveling, involvement in social life, challenges, medications, and sexual relationships" (Meinert and Siu 2014: 30). Three months later, Robinah began to show signs of improvement.

Joyce, however, began to decline. She started on ART as well, and Robinah helped Joyce arrange her pills into daily doses in a small container, like she did. Recalling her sister's help, Joyce said,

> Robinah is like my medicine companion. Before I leave home for school, Robinah makes sure I have swallowed my drugs. But even if I forget to take them, Robinah can come herself or send the children to school to bring my drugs. One time I had forgotten, and I went to school. During break time, I went to the trading center. But I was surprised when schoolchildren ran after me, calling, "Teacher, teacher, we have something for you — your drugs." My sister had sent the drugs to the headmaster, who had sent children out to find me. Most of the time, they are supportive like this" (Meinert and Siu 2014: 32).

When the study ended in 2007, the sisters were doing well. Robinah was busy cultivating corn, beans, and vegetables on their small plot of land, and Joyce was chair of the Post-Test Club,

which provided support for individuals who had tested positive for HIV (Meinert and Siu 2014: 31). Both sisters were involved in activist work and were considered to be local "'AIDS stars' in projects connecting neighbors, relatives, friends, and colleagues with HIV to testing, treatment sources, food rations, and other AIDS programs" (Meinert and Siu 2014: 33).

The case of Robinah and Joyce exemplifies the role that connection to others plays in learning about and gaining access to HIV/AIDS treatment and support. According to Meinert et al. (2004), nearly all of the interlocutors in the TORCH project emphasized "the sociality of decision making and action" (Meinert et al. 2004: 34). Many, like Robinah and Joyce, were encouraged by others to take an HIV test. Others relied on the connections of a friend or relative to get into a treatment program. Anthropologist John M. Janzen coined the term "therapy management group" (Janzen 1987: 73)— "an alliance of kin, friends, and associates who guided a patient to one source of treatment after another in the quest for therapy among alternative possibilities" (Meinert et al. 2004: 35). According to Janzen, "diagnosis and therapy must be seen as a process" that is influenced by a variety of actors and issues (Janzen 1987: 73). As Meinert et al. note (2004), Janzen's idea of a therapy management group (TMG) is not unlike another concept that is common in Ugandan popular culture: "'technical know who' (TKW), which refers to the widespread conviction that it is through personal contacts, and not only through knowledge (technical know-how), that things get accomplished" (Meinert et al. 2004: 35). Both TMG and TKW imply that access to treatment is mediated by the support of others (Meinert et al. 2004: 36).

According to Meinert et al. (2004), "The mediated access to AIDS programs through social connections …underlines the significance of human agency and sociality in making a health system work" (Meinert et al. 2004: 41). Barnett and Whiteside (2006) refer to this

tendency towards collective action based on trust in others as "social cohesion" and note that it influences a population's susceptibility to HIV/AIDS as well as its ability to respond to and mitigate the impact of infection (Barnett and Whiteside 2006: 92-94). They note that Uganda stands out among African countries for uniting in the face of the epidemic (Barnett and Whiteside 2006: 208).

Low-Beer and Stoneburner (2003) also note Uganda's exceptionalism in using social communication channels to share information about AIDS: "Ugandans seemed to communicate about AIDS and people with AIDS differently… in Uganda personal channels predominated in communicating about AIDS in both urban and rural areas, among men and women. (See Figure 3.) In Uganda, 82% of women heard of AIDS from this source compared to 40-65% in other countries" (Low-Beer and Stoneburner 2003: 13). They note that, "This is important as it shows that AIDS issues in Uganda were rooted in discussions in social networks rather than just received from public health and media messages, to which there is widespread skepticism," and credit this with greatly enhancing HIV prevention (Low-Beer and Stoneburner 2003: 13).

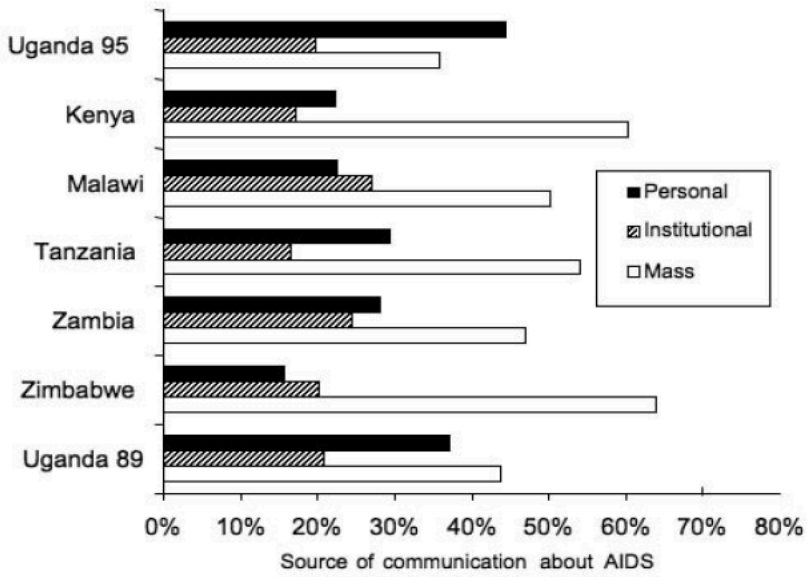

Figure 3: Source of AIDS Knowledge by Communication Channel in Uganda (1989, 1995), Kenya (1998), Malawi (1996), Tanzania (1996), Zambia (1996) and Zimbabwe (1994) (Low-Beer and Stoneburner 2003: 12)

Epstein (2007) suggests that Uganda's social cohesion may be due to the country's history and the "personalized, informal, intimate, contingent, reciprocal nature" of Ugandan society (Epstein 2007: 169):

> while Uganda was terrorized for decades by a series of brutal leaders, they could never destroy the traditional rhythms of rural family life... No large settler population displaced huge numbers of people or set up a system to exploit or humiliate them, as happened in South Africa and in many other African countries. This means Ugandans are more likely to know their neighbors and to live near members of their extended families (Epstein 2007: 135).

Social cohesion was also encouraged by government campaign messages, which emphasized that everyone was at risk and created "a sense of collective urgency that roused people into action" (Epstein 2007: 161). As a result of these factors, community-based AIDS groups, like Joyce's Post-Test Club, were common throughout Uganda during the early years of the epidemic.

3. The Politics of Prevention

As mentioned above, Uganda's policy of openness has resulted in a vast array of AIDS control programs. While is important to emphasize the overall social character of the Ugandan response to AIDS, I would be remiss to ignore a contrasting initiative that has characterized recent decades. Whereas community-based AIDS programs and TMG's draw on longstanding interpersonal connections between friends and relatives, HIV prevention initiatives—especially those funded through the President's Emergency Program for AIDS Relief (PEPFAR)— tend to encourage personal responsibility and individual autonomy as a means of disease control.

Preventing the transmission of HIV is a challenging and ambiguous task. As Parkhurst (2001) puts it, "Unlike polio or smallpox, where a vaccine is widely available and effective—and where there is a generally agreed procedure for prevention methods (mass vaccination campaigns), prevention of HIV still falls to the less clearly defined problem of changing

individuals' sexual behavior" (Parkhurst 2001: 77). In Uganda, behavioral change efforts began in 1990, when the government sponsored campaigns that emphasized two messages: "Zero grazing" (be faithful) and "Don't forget to carry your coat" (always use a condom) (Trinitapoli and Weinreb 2012: 85). To these messages was added the understanding that abstinence was the surest way to prevent infection. These three tenets became what is known as the "ABC" strategy, standing for Abstain, Be faithful, use Condoms (Trinitapoli and Weinreb 2012: 85). (See Figure 4.)

ABC became popular throughout Africa, in part because "it represented a compromise between public health and religious professionals" (Trinitapoli and Weinreb 2012: 86). Religious groups, as we will see, tended to emphasize abstinence and being faithful, while health experts at international agencies such as USAID and the World Bank began promoting condom use through social-marketing campaigns. At the 2004 International AIDS Conference in Bangkok, President Museveni (for whom the issue of HIV/AIDS in Uganda had become increasingly important as part of his international profile) described Uganda's ABC approach during the late 1990's as follows:

> We had to transmit to our people the conviction that behavior change and therefore control of the epidemic was an individual responsibility and a patriotic duty and within their individual means.…Our only weapon at the time [was] the message: "Abstain from sex or delay having sex if you are young and not married, Be faithful to your sexual partner (zero grazing), after testing, or use a Condom properly and consistently if you are going to move around…" With no medical vaccine in sight, behavioral change had to be our social vaccine and this was within our modest means. (Boyd 2015b: 39-40)

By referring to AIDS control as an "individual responsibility" and "patriotic duty," Museveni highlighted the growing belief at the time that avoiding disease risk by following the principles of ABC bolstered Uganda's political and economic image. The hope was that, "As Ugandans became more accountable, empowered, and self-reliant citizens, their nation supposedly also became more economically viable, more democratic, and better able to manage the epidemic

that had ravaged its populace" (Boyd 2015b: 41). This belief represented a shift in Uganda's response to HIV/AIDS. As a Ugandan public health student reflected, "In the eighties there was a sense of communal vigilance [about HIV]. Communities became vigilant and aware of each other. It is not the case anymore. It is more about individual aid. [Prevention], now it's your call" (Boyd 2015b: 41).

Figure 4: A poster promotes ABC as an HIV-AIDS prevention strategy (Twinomujuni 2017)

Partly due to its openness about the epidemic, Uganda was able to attract significant funding for HIV/AIDS activities. In the early 2000's, the United States was the largest single donor, contributing more than 80 percent of the country's funds for HIV/AIDS prevention and treatment through PEPFAR. As Whyte (2014) notes, "In the first three years after its inception in 2003, PEPFAR made Uganda one of its top three recipients; in 2005, it gave Uganda $148 million, more than any other country in the world" (Whyte 2014: 7). While PEPFAR was extolled as "a great mission of rescue" that would save the lives of millions living with AIDS around the world and prevent new HIV infections (Bush 2003: 521), it was also controversial. One-third of the funding it set aside for HIV prevention programs was reserved for programs that

focused on "behavior change" by promoting abstinence until marriage and faithfulness to spouses (Boyd 2015b: 2).

PEPFAR's stipulations were in line with the conservative trends in American policy making, which advanced "neoliberal strategies emphasizing the weakening of state welfare and the expansion of global free-market capitalism" (Boyd 2015b: 2). These tended to underscore an ethic of "self help" and individual will in response to limited state resources (Boyd 2015b: 2). But PEPFAR drew criticism from the United States and abroad. As Boyd (2015) writes,

> President Bush and his advisers argued that empowering individuals to practice better self-control…was the best remedy for an epidemic that had confounded public health officials worldwide. But critics…viewed these stipulations as needless restrictions on aid, siphoning money away from other types of prevention programs, such as access to HIV testing, the promotion of condom use, and broad-based sexual education. More pointedly, others argued that such stipulations were made solely to forward Bush's political agenda, and especially to appease his evangelical Christian supporters, who had newly embraced the AIDS epidemic as the frontline in a battle to reassert religious values in American policy making (Boyd 2015b: 2).

Bush's policies were salient in Uganda, however, where older values predicated on interdependence were being challenged by discourses emphasizing self-empowerment and personal success (Boyd 2015b: 5). As Boyd (2015) articulates, PEPFAR was initiated at an "historical moment" in both the United States and Africa, which was characterized by "neoliberal economic policies that emphasized the individual—rather than the state, kin group, or community— as the central agent in processes of development and social transformation" (Boyd 2015b: 5).

Uganda's born-again churches were at the center of this transformation. As Boyd (2014) notes, "born-again" is the term preferred by Ugandans to describe "a new, Charismatic brand of globally oriented Christianity" (Boyd 2014: 337). Born-again churches have their roots in Pentecostalism and the Protestant evangelical tradition, which has been called "the world's

fastest growing religious movement," in part because it is "very successful at crossing cultural and linguistic boundaries" (Robbins 2011: 51). Throughout Africa, Pentecostal churches are known for opposing traditional practices, particularly those related to family life. While many characterize Pentecostalism on the continent as "a socially corrosive force, a handmaiden of neoliberalism," Haynes (2017), argues that "Pentecostalism is at the heart of a dynamic process of social creativity" (Haynes 2017: 1). Through an ethnographic exploration of Pentecostal expansion in Zambia, Haynes challenges the notion that Pentecostalism is "a mechanism for breaking down relationships that stand in the way of self-realization" (Haynes 2017: 4). She asserts that Pentecostalism can be socially productive by emphasizing "moving by the spirit" through new forms of relationships, such as those between church leaders and lay people (Haynes 2017: 12). Ultimately, the ways in which Pentecostal churches structure the relationships of believers "makes life possible" (Haynes 2017: 2).

In Uganda, the efforts of born-again churches to defend and reform traditional ideas of the home and family are indicative of "broader concerns about the spiritual and social costs of secular modern culture on Ugandan life" (Boyd 2015a: 44). Many of these concerns focus on sexual abstinence and marital faithfulness. According to Boyd (2015b),

> Ugandan debates surrounding abstinence and faithfulness were concerned with questions about the shape of moral obligations to others during a period of rapid social change: What kinds of families and persons are deemed proper and good? What is the social worth (and potential cost) of personal independence or monogamy? What kinds of marriages are moral and worth protecting? (Boyd 2015b: 56).

While these questions became particularly pertinent during the AIDS epidemic, they can be traced back to two historical events that sparked debates over the place of "traditional" culture in the modern state. (Boyd 2015b: 56).

The first event was a disagreement about forms of marriage and the importance of kin relationships in the colonial state, which emerged in reaction to the expanding influence of Protestant Christianity in the British Protectorate of Uganda (Boyd 2015b: 57). Traditionalists argued that kin relationships and the bridewealth ceremonies that reinforced them were necessary for healthy families, while missionaries wanted to enforce Christian monogamy. The second event was the East African Revival of the 1930's, a reaction to the dominance of an elite Protestantism in the region. Revivalists eschewed "traditional" forms of moral authority in favor of new practices of moral reform and asceticism, including the public confession of sexual sin (Boyd 2015b: 57-58). Both historical periods demonstrate that the role of "tradition" in the modern state has long been debated in Uganda. According to Boyd (2015), "The narratives that developed in response to these historical moments, narratives about family life and the moral purpose of marriage, are recognizable in and even central to the arguments presented by born-again Christians today in response to AIDS" (Boyd 2015b: 58).

Born-again campaigns promoting abstinence and marital faithfulness as the primary defenses against AIDS emerged during the early years of Uganda's epidemic (Boyd 2015b: 70). Social protests and education campaigns emphasized the moral superiority of monogamous Christian marriage and warned against the dangers of contemporary sexual relationships. Pastors called attention to the data linking marriage to heightened HIV risk, and "Christian marriage was idealized, spoken of frequently in sermons, and planned for in church meetings and prayer groups (Boyd 2015b: 130-131). In addition to their emphasis on Christian marriage, born-again churches advocated for sexual abstinence, particularly for youth. Abstinence offered youth a means of managing kin relationships and protecting their future (Boyd 2015b: 128). While abstinence was promoted in the context of Christian values, it acquired a popularity that

transcended religious doctrine. In many cases, abstinence became seen as a strategy for "upward mobility and social achievement" (Boyd 2015b: 38). As Trinitapoli and Weinreb note, the message became "more about being 'cool'" than being good (Trinitapoli and Weinreb 2012: 89). Posters proclaimed sayings like "Stay strong, say no to peer pressure," "Not everyone is doing it, we are NOT!" and "Virgin Power, Virgin Pride" (Trinitapoli and Weinreb 2012: 89).

These born-again campaigns dovetailed nicely with PEPFAR's emphasis on conservative, Christian values. With PEPFAR's support, local churches and Christian NGOs became involved in the fight against HIV/AIDS. Religious organizations were encouraged to compete for funding and "to occupy a more central role in the administration of a large range of social services" (Boyd 2015b: 29). As a result, the "C" from the ABC strategy was effectively eliminated, and by 2004, Museveni had ordered the mention of condoms to be removed from school sex-education curricula (Schoepf 2004b: 372).

In 2002, USAID published an influential report affirming the success of Uganda's behavioral change initiatives (USAID 2002). The authors note that this "low-tech" approach to HIV prevention has been adopted by both medical professionals as well as

> people normally not involved in health issues such as political, community, and religious leaders, teachers and administrators, traders, leaders of women's and youth associations, and other representatives of key stakeholder groups… [These] interventions reached not only the general population, but also key target groups including female sex workers and their clients, soldiers, fishermen, long-distance drivers, traders, bar girls, police, and students, without creating a highly stigmatizing climate" (USAID 2002: 5).

They conclude that the most significant factor in reducing HIV incidence in Uganda has been abstinence and marital fidelity, noting that a sample of Ugandan individuals studied in 1995 were "more likely to be married and keep sex within the marriage, and less likely to have multiple partners" than what was reported in 1988-89 (USAID 2002: 9-10). These data are summarized in Figure 5.

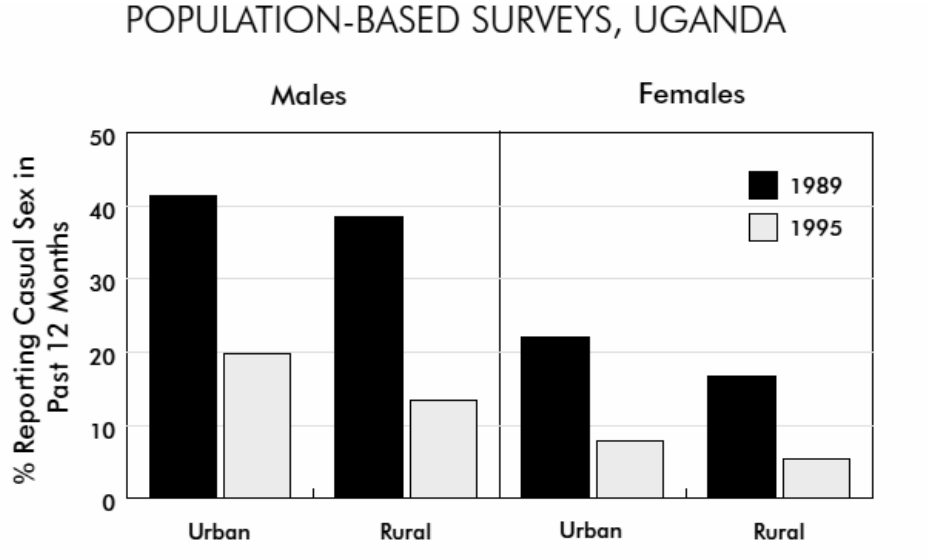

Figure 5: Reported Sexual Behavior, 1989 and 1995 (USAID 2002: 9)

Engrained in the approaches of the Christian activists and NGO's described above is a novel way of thinking about what it means to be a "good" person in Uganda. In this sense, being "good" means being both physically and spiritually healthy, as well as being protective of one's future. Out of this line of thinking emerged what Boyd (2015b) calls "the accountable subject"—a new object of care for the HIV/AIDS response as well as a model for proper behavior (Boyd 2015b: 3). Boyd locates the accountable subject within a broader emphasis on individual accountability in the international public health arena, which was fortified by programs like PEPFAR:

> Accountability was an approach to public health that emphasized individual responsibility for disease prevention; one that envisioned the locus of disease risk in personal behavior and choice, rather than broader structural, economic, and social factors that might also contribute to well-being. It was animated by a Western cultural orientation to health that places value on the virtues of physical autonomy and independence (Boyd 2015b: 3).

By encouraging personal accountability, the Ugandan government and its donors expressed faith in one's ability to change his or her behavior. By doing so, however, they assumed a particular understanding of one's self, community, and personhood (Boyd 2015b: 57). In order to better understand the ways in which HIV/AIDS prevention initiatives in Uganda reshaped these

conceptions, it is useful to examine them in light of anthropological conceptions of the individual and collective self.

4. Conceptualizations of the Self in Uganda's AIDS Response

In anthropological discourse, the concept of the self was not fully articulated until the 1980's (Csordas 1994b: 332). Studies of the self proliferated during the decade (see Hollan 1992: 283), but some questioned the degree to which self concepts were cross-culturally applicable. Many anthropologists argued that conceptions of the self as whole and continuous are culture-bound, a product of "Western spatial categories and individualism" (Ewing 1990: 256). In non-Western societies, they argued, the self is relational and unbounded. Although their point of view has been well received, the means and degree of cross-cultural variation remain unclear:

> The notion that concepts of the self vary by culture is now accepted by many, if not most, social and cultural anthropologists. Yet the theoretical and methodological implications of such a finding remain obscure…Anthropologists are often not explicit on the issue. They frequently fail to clearly and unequivocally address such questions as: To what extent are selves culturally constituted? (Hollan 1992: 284).

In popular discourse, the terms self, person, and individual are effectively interchangeable. In the history of anthropological discourse, they have undergone several transformations that create further confusion, and their use frequently overlaps. Although a complete account of the anthropological use of these terms is beyond the scope of this paper (see Csordas 1994b for an overview of this), I will attempt to disambiguate these terms as they are used in the general anthropological sense.

Harris (1989) asserts that the conflation of the terms person, self, and individual in anthropological discourse has serious theoretical consequences, including but not limited to the fact that it hinders ethnographic comparison and cross-disciplinary study. (Harris 1989: 599).

Harris respectively glosses these terms as "conceptualizations of human beings as (1) living entities among many such entities in the universe, (2) human beings who are centers of being or experience, or (3) human beings who are members of society" (Harris 1989: 599). Let's take these each in turn, beginning with the individual.

According to Harris, the individual is "a human being considered as a single member of the human kind" (Harris 1989: 600). In this sense, the individual is the most basic unit of humanity—that is, one human. Yet it is important to note that this definition relies on the referential collective "human kind." Indeed, the individual has long been anthropologically conceptualized in its relation to the group. Writing in 1932, Sapir noted that anthropologists tend to think of "the individual as a more or less passive carrier of tradition" (Sapir 1949: 140). That is, individuals are of anthropological interest only to the extent to which they share "ideas and…modes of behavior which are implicit in the structure and tradition of a given society" (Sapir 1949: 141). The task of studying behavior that diverged from the social standard falls to psychiatry, which aims to address "those behavior disturbances of individuals which show to observation as serious deviations from the normal attitude of the individual towards his physical and social environment" (Sapir 1949: 143).

The collective "human kind" of which the individual is a part becomes increasingly important when we attempt to define the person. Harris refers to the person as an "agent-in-society" (Harris 1989: 602), drawing attention to the "systems of social relationships whose participants, performing actions and responding to each other's actions, live in a moral order" (Harris 1989: 603). In this sense, personhood it not implicit; it is "structural and processual" (Harris 1989: 604), bestowed according to local expectations. In other words, not every

individual is a person. A person is "assigned some measure of freedom to choose among possible lines of action" and is thus held accountable for those actions (Harris 1989: 603).

Like the idea of the bounded self, this notion of the person has come under attack by those who believe it to be rooted in Western individualism. They contrast it with a non-Western, relational notion of the person. As Schweder and Bourne (1984) assert, many non-Western societies maintain a more holistic view of the world and thus understand the relationship between the individual and society to be "sociocentric organic" in nature (Schweder and Bourne 1984: 193). In these societies, the person is conceptualized as "context-dependent," shaped by interactions with other persons, objects, and events (Schweder and Bourne 1984: 193). Geertz (1984) adopts a similar perspective on the matter:

> The Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgment, and action organized into a distinctive whole and set contrastively both against other such wholes and against a social and natural background is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world's cultures (Geertz 1984: 126).

As Hollan (1992) notes, both Geertz and Shweder and Bourne use the term person "to refer, at least in part, to a locus of subjective experience" (Hollan 1992: 284). In this way, their understanding of the person refers as well to the psychological self, which Hallowell (1955) defines in terms of self-awareness. Hallowell asserts that self-awareness is "a psychological constant, one basic facet of human nature" (Hallowell 1955: 75). Self-awareness is not innate, however. Rather, it is "a cultural as well as a social product" (Hallowell 1955: 81) that emerges in the context of "a culturally constituted behavioral environment" (Hallowell 1955: 87). Within this environment, culture provides the individual with five basic orientations that facilitate his "development, reinforcement, and effective functioning of self-awareness" (Hallowell 1955: 89). These orientations, as summarized by Csordas (1994b), are:

> that of self to others, that of self to a diversified world of objects whose attributes are culturally constituted and symbolically mediated through language, that of self within discrete spatial and temporal frames of reference, that to self toward objects within the behavioral environment with reference to motivations for the satisfaction of his needs, and that of self to values, ideas, and standards that define the normative or moral framework of life (Csordas 1994b: 334).

By defining the self in terms of self-awareness and orientational processes, Hallowell offers an alternative point of view to that of the self as entity which, as we have seen, is problematic for cross-cultural studies. Several authors have followed Hallowell in eschewing the notion of the self as a bounded and integrated entity. For example, Marriott (1976) introduced the concept of the "dividual" in "Hindu Transactions: Diversity without Dualism," in which he illustrates the ways in which the Hindu person is constantly interchanging his or her substance with that of the external world:

> persons – single actors – are not thought in South Asia to be "individual," that is, indivisible, bounded units, as they are in much of Western social and psychological theory as well as in common sense. Instead, it appears that persons are generally thought by South Asians to be "dividual" or divisible. To exist, dividual persons absorb heterogeneous material influences. They must also give out from themselves particles of their own coded substances – essences, residues, or other active influences – that may then reproduce in others something of the nature of the persons in whom they have originated (Marriott 1976: 111).

Hence, by conceptualizing persons as dividuals, Marriot resists the individual-society dichotomy to which Western anthropologists seem to be committed. Because Hindu society does not differentiate between mind and body, dividuals are able to transfer and take in parts of themselves and others through interaction and exchange.

In *The Gender of the Gift* (1988), Strathern follows Marriott in asserting that Melanesian persons are dividual. She writes that there is no conceptual distinction between the social and the individual in Melanesia. Rather, the dividual is a composite of the community. It is a relational composite of actions and exchanges between people. Strathern (2004) writes that "persons grow,

have influence, and maintain their own well-being through detaching and attaching parts of themselves from and to others" (Strathern 2004: 12 n11). Like Marriott, Strathern contrasts the notion of the Melanesian dividual with that of the Western individual, in which the person is distinct from and often opposed to society.

Although conceptualizations of the non-divisible individual and the relational dividual are often characterized as "Western" and "non-Western," respectively, applying both understandings of the self to the examples of HIV/AIDS response efforts described above can allow for a better understanding how Ugandans experience these efforts. In short, by appealing to both understandings of the self, Ugandan treatment and prevention initiatives are able to target particular demographics and, ultimately, reach a larger population.

As described above, PEPFAR was rooted in conservative trends in American politics and international aid policy. These same trends were evident in an emerging shift in Uganda, where older values based on extended kin relationships and interdependence were being displaced by discourses emphasizing self-empowerment and prosperity. Thus, behavioral change strategies, such as those funded by PEPFAR and advocated for by born-again churches, reflect the "historical moment" when neoliberal economic doctrine an ethos of individual accountability began to displace values rooted in family, community, and even the state (Boyd 2015b: 5). Although the term "neoliberalism" is often used in "a wide variety of partly overlapping and partly contradictory ways (Ferguson 2009: 166), it undoubtedly describes the economic policies that governed international aid and structural adjustment programs during the 1980s and beyond.

These programs, supported by the World Bank and the International Monetary Fund, included provisions that sought to "rebalance" the economies of developing countries like

Uganda. Social scientists argue that neoliberalism cultivates a particular approach to self-governance, by which "rational choice is imbued with a moral value" (Boyd 2015b: 8). As Nikolas Rose (2007) writes, neoliberalism reorganizes social behavior "along economic lines—as calculative actions undertaken through the universal human faculty of choice" (Rose 2007: 141). Thus, rational choice—that is, being free to choose for oneself—creates proper conduct through self-regulation. The neoliberal emphasis on self-regulation contrasts with the prominence of social cohesion in Uganda's ART programs described earlier, in which decision making was based on social connections and trust in others. These programs are predicated on an understanding of the self that resembles the "dividual" described by Marriott and Strathern. As Strathern writes, dividuals "have influence, and maintain their own well-being" through interactions with others (Strathern 2004: 12 n11)—not unlike the mediation of treatment access by TMG's and TMK.

The difference between the neoliberal individual cultivated by behavioral change prevention initiatives and the "dividual" who navigates ART treatment programs is not necessarily reason to mourn the loss of Ugandan "tradition," however. Instead, it can be seen as assisting AIDS response efforts in a changing country, where people, particularly young people, are having to contend with new political, economic, and social currents. University students, for example, have been shown to be more attracted to born-again abstinence messages (Sadgrove 2007; Gusman 2009), while older generations may be drawn towards community-based efforts because of their frequent role as caretakers for the sick (Kakooza and Kimuna 2006: 64). As Parkhurst (2001) describes, "what is being seen in Uganda is a diverse number of messages reaching individuals on the ground. The presence of multiple messages from a wide variety of approaches…will have the greatest chance of exposing an individual to that one message (or

combination of messages) which will produce the desired health-promoting changes in behavior" (Parkhurst 2001: 77). Thus, by drawing on multiple conceptualizations of the self, the Ugandan response to HIV/AIDS is well-suited for a period of political, economic, and social change.

Conclusion

In 1848, the German pathologist Rudolph Virchow developed a theory of epidemic disease as a manifestation of unfavorable social and cultural conditions. He wrote, "the history of epidemic diseases must form part of the cultural history of mankind. Epidemics correspond to large signs of warning, which tell the true statesman that a disturbance has occurred in the development of his people which even a policy of unconcern can no longer overlook" (Rosen 1957: 155). Virchow's point of view was adopted by social scientists and community health experts in the early 1990s, as they described the social forces driving the AIDS epidemic in Africa. But their voices were largely ignored in the international biomedical arena, which focused on defining populations that were "at-risk" for contracting HIV. These definitions rested on representations of disease and contagion that reinforced existing gender, class, and national hierarchies. As Schoepf (2004a) writes,

> Full responsibility for moralizing discourses and resulting social demobilization cannot be laid solely at the feet of biomedical policy makers, for the discourses and policy are embedded in the public culture of late 20th-century Western societies and exported to Africa. The currently dominant biomedical model…leaves little scope for understanding how behaviors are related to social conditions, or how communities shape the lives of their members (Schoepf 2004a: 18).

Schoepf appropriately emphasizes that understanding the connection between social conditions and behavior—a connection I have attempted to emphasize in this paper—is necessary in order to reshape the discourse surrounding the AIDS epidemic.

Yet the diverse responses to AIDS that exist in Uganda demonstrate that both social conditions and behavior can vary within a given society. As demonstrated by Uganda's ART

programs, social cohesion within a community can improve and protect the well-being of its members while also reflecting historical and political forces at work. Uganda's behavioral change prevention initiatives reveal that an emphasis on individual accountability can be the direct result of the dynamisms of a changing society. Because these two responses to AIDS draw on conceptualizations of the self and person that differ markedly, they are able to impact a greater number of people in Uganda's rapidly changing society. Ultimately, we must take these and other responses seriously as a reflection of the complex historical, economic, political, and sociocultural factors at work in Uganda.

My approach throughout this paper is not without limitations. For one, as I have previously mentioned, my analysis is informed by existing literature rather than field research of my own. While I have tried to maintain a discerning and objective perspective in relaying data, I realize that I am removed from the immediacy of the material from which I draw. What's more, given the scope of this paper, I do not take into account factors such as indigenous religion and healing in Uganda, nor do I offer a comprehensive account of humanitarian intervention. (For more information on these topics, see King and Homsy 1997, Langwick 2011, and Flint 2011.) Ultimately, I hope that these limitations do not prevent me from demonstrating the dynamic nature of life in Uganda and the particular challenges posed to it by HIV/AIDS. I hope to shed some light on the matter, and I look forward to future research that explores the avenues I could not.

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