Interview with Edward Kirumira

Can an Analysis of Social Identity Contribute to Effective Intervention Against the HIV/AIDS Pandemic?

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This special issue of Transformation examines three themes: Identities, interventions and activism in the context of HIV/AIDS in Africa. In this electronic interview, carried out on behalf of the guest editorial team by Relebohile Moletsane, Edward K Kirumira, Dean, Faculty of Social Sciences, Makerere University, Kampala, Uganda, comments on the role of the social sciences, particularly an analysis of identities, in contributing to a better understanding of, and effective interventions against the HIV/AIDS pandemic.

RM: What do you see as the major issues/problems surrounding social identities and HIV/AIDS in Uganda and the rest of Africa south of the Sahara?

Kirumira: Although evidence exists that challenges the argument of social identities as the determinants for the spread of HIV, strong perceptions continue to exist and to influence HIV/AIDS policy programming. This has not helped to reduce stigmatisation often based on identities.

Secondly, in Uganda just like most of sub-Saharan Africa, the family and community provide the only consistent safety net, in the absence of formal health and general social insurance. The HIV/AIDS pandemic has stretched these safety nets tremendously thus putting in question advantages accruing to social identity(ies). That is, identifying oneself with an extended family, or a community may unfortunately not present the same advantages it presented two decades ago!

RM: How do you see social science contributing to understandings of the HIV pandemic and to the development of effective interventions to combat transmission in the region?
**Kirumira**: When the first cases of what looked like HIV presentation were identified in southern Uganda (current Rakai District), the local population was quick to associate it with unscrupulous traders who had cheated across the Tanzanian border and were therefore bewitched. As the pandemic gained ground the bio-medical explanation gained prominence. However, by 1993, the Uganda AIDS Control Program started looking beyond for behavioural-based approaches to the prevention and control of the pandemic. Today, care and support are presenting themselves as critical in containing the impact as well as a powerful motivating factor in accessing and utilising counselling and testing services for the infected and affected. In all these, it is demonstrated that the individual, the community and the state are major players in the spread, prevention and control of HIV/AIDS.

Relationships, whether social, economic and/or political, are central to the understanding and manifestation of the pandemic in the sub-region. Social Sciences, therefore, present a very strong opportunity for studying, planning and evaluating the incidence, prevalence and most importantly the impact of the HIV/AIDS epidemic in sub-Saharan Africa. Uganda is an example of this where the breakthrough has been associated with factors like political will and commitment, community mobilisation and involvement, and care and support systems. The latter have been characterised by initiatives such as the Philly Lutaya Initiative (PLI) and the Post Test Clubs (PTCs).

The Philly Lutaya Initiative derives its name from a Ugandan singer, based in Sweden at the time, who was one of the first celebrity Ugandans to declare publicly that he had AIDS. He wrote and sang many songs based on and with AIDS prevention messages including ‘Alone and Frightened’. NGOs – including AIDS Information Centre (AIC) and The AIDS Support Organisation (TASO) adopted the approach by having or supporting drama groups that composed songs and plays depicting HIV/AIDS prevention and control messages. The Post Test Clubs on the other hand were formed as support groups for people that had undergone HIV testing, whether or not they were HIV+. People share their experiences and at the same time PTCs are used by agencies and NGOs to channel medical and social support to people living with AIDS. PLI and PTCs have had considerable success.

To consolidate these gains, social scientists will play an increasing role in providing models and frameworks for understanding the individual and group dynamics that make for risk reduction, de-stigmatisation, and the development of responsive policies and programs.
**RM:** In your view, how do different identities (social class, gender, race, sexuality) and resultant relations among individuals and groups contribute to the spread HIV?

**Kirumira:** The incidence of HIV/AIDS cannot be separated from social relationships and therefore the different forms or manifestations of social relationship are bound to have different impacts. From this assumption, one can say that different identities potentially result in varied degrees of the spread of HIV. However, studies in different Ugandan populations or identities show that identities in themselves do not explain sufficiently the spread of HIV, but that the recorded decline in HIV incidence and prevalence in Uganda cuts across all identities (UNAIDS 2000; UAC 2002). It is more the context within which these identities are lived that has significant impact on the prevalence of HIV, in that they influence individuals’ interpretation of their social realities and identities. Studies on differential risk perception among women in Uganda, have consistently shown that women of the same social status perceived risk differently according to their individual life experiences. Evidence from Uganda also shows that identities need be understood from a social network perspective – for instance peer pressure, friendships/relationships, workplace dynamics, and need for self-actualisation driven by the reference groups that are part of the individual’s daily milieu (Kirumira 1996; Bohmer and Kirumira 2000).

**RM:** Do you think critiques or explorations of such identities are useful or do they obscure more important issues and social dimensions?

**Kirumira:** It is certainly important that these identities are recognised because in many ways they form the basis of our self-concept and therefore influence behaviour outcomes. However to assume that they are a priori the determinants of the character of the spread of HIV in sub-Saharan Africa is an over-simplified reality of much more dynamic and often contradictory behaviour and behaviour outcomes – within the parameters of such identities. A critique or explanation of such identities may therefore be useful in as far as they provide a starting point of inquiry but should not be construed as the end of the inquiry.

**RM:** In particular, do you see the HIV pandemic as contributing to a change in gender relations in Africa south of the Sahara? Can you explain what kinds of changes you see taking place?
Kirumira: The HIV pandemic has most definitely impacted gender relations in Africa. First and foremost talking about sex and sexuality was a taboo in many African societies. Information, Education and Communication programs on HIV/AIDS have invaded this private space. Although many HIV/AIDS prevention and control programme have been at pains to find a culturally appropriate language for the messages, they have tested and expanded the permissible sphere for communicating about sex and sexuality.

Secondly, prevention campaigns have used an empowerment discourse. Women, most especially have been encouraged to ‘say no’ to unwanted and unprotected sex – initiation and negotiation of sex is no longer the privy of men. To empower women to say no or to negotiate sex, HIV programmes have also sought to empower women economically thus perceptively contributing to changes in power and therefore gender relations.

Thirdly, the pandemic has moved the realm of sex education from the family – and therefore domestic/private sphere – to the school environment, which is associated more with the public sphere. Such education has challenged sex education for social reproduction and by so doing has interrogated gender relations especially among the young generation. Maybe this is why statistics beginning to come out show a higher level of behaviour change and HIV prevalence decline among the youth than in the older population of 35 years and above (UAC 2002).

RM: What approaches do you think could be used to change the way such relations (eg gender relations) contribute to the spread of HIV?

Kirumira: Initially it was thought that women empowerment alone would tilt the balance in gender relations. Increasingly the realisation is that understanding and addressing social context factors is critical in impacting on relational construction, especially gender relations. Approaches should be seen to go beyond the individual behaviour change models and those that treat women as homogenous and inactive participants in social relationships that predispose them to HIV infection. The pandemic has been demonstrated to be a household, community or/and collective responsibility, and approaches for relations change must therefore be collectively-oriented. The focus should be on the institutionalisation of meaning and value and therefore the construction and reconstruction of identity(ies) in response to or as a result of HIV/AIDS.

RM: Uganda is hailed as a ‘success’ story in curtailing the spread of HIV/
AIDS. In your view, is this an accurate characterisation of the situation? If so, what factors have contributed to this success? For example, how much is this success due to effective interventions and specific gender equity campaigns? How much is it due to people’s proximity to death?

Kirumira: As a social scientist, it is always very difficult to characterise a situation as accurate! Some authors have for instance argued that in a mature epidemic, prevalence may be stable, but this stability simply means that the number of new infections every year equals the number of people dying from AIDS each year (The Futures Group 2000:67). Furthermore, one may argue that only a proportion of people know or are known to be infected and that therefore a significant percentage that is potentially infected is not documented. Having said that however, I think that Uganda has made very strong and visible gains in the fight against the epidemic. Three areas are worth noting:

1) **Political Will and Support**
   In Uganda one of the major reasons for the gains made in stemming the epidemic has been government’s will and commitment to the struggle against HIV/AIDS coupled with the Presidency’s open policy on gravity, incidence and prevalence of the epidemic (Kaleeba et al 2000). It was safe and politically correct to talk about HIV/AIDS to the extent that people were confident enough to declare publicly their sero status.

2) **Financial Resources**
   The country has benefited from tremendous donor (development partners) support for research, program and coordination activities to combat the epidemic.

3) **Community Involvement**
   The involvement of religious leaders, civic and cultural leaders in a highly religious population that Uganda is, has also benefited the fight against the pandemic. The fight against HIV/AIDS has consistently been based on a multi-sectoral approach and cognisant of multi-cultural belief systems. HIV/AIDS has been made a household disease rather than a disease that afflicts a single individual. The prevention and control programmes have addressed and continue to address the afflicted and the affected. As mentioned earlier, Clubs such as the Post Test Clubs were not only for those who tested positive but for everybody that has gone through counselling and been tested for HIV/AIDS.
**RM**: How would you characterise the various forms of social activism linked to HIV in Africa?

**Kirumira**: The first is a form of social activism that deals with the question of identity reformulation. As Butler (1990) argues, it would be wrong to think that the discussion of ‘identity’ ought to precede the discussion of gender identity, for the simple reason that ‘persons’ only become intelligible through becoming gendered in conformity with recognisable standards of gender intelligibility.

A second form of social activism seeks to consolidate the gains from gender equality to the social locale of individual experience of the HIV pandemic—dealing with the need to socialise discussion about the pandemic and thus challenge the dominance of bio-medical discourses around the HIV/AIDS pandemic.

A third form of social activism derives from being HIV positive and addresses itself to issues such as access to ARVs and employment policies responsive to persons with HIV. Especially with the Global Fund for HIV/AIDS, Malaria and TB Control efforts, this form of social activism has become very strong and produced powerful lobbies at HIV/AIDS national, regional and international meetings.

**References**


