

AIDS & ANTHROPOLOGY BULLETIN

The Newsletter of the AIDS and Anthropology Research Group

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AIDS AND
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RESEARCH REPORT: Building Bridges to Drug Treatment: A Role for Applied Anthropology

by Merrill Singer, Michael Duke (Hispanic Health Council), Margaret Weeks (Institute for Community Research)

On any given day, it is estimated that 85% of the injection drug users (IDUs) in the U.S. are not in drug treatment. IDUs now account for over 35% of the AIDS cases reported in the U.S., including 62% of female AIDS cases. To this group of at-risk individuals must be added non-injecting illicit drug users, a heterogeneous set of people who probably are even less likely than IDUs to be in treatment at any specific point in time and whose primary AIDS risk is through sexual transmission, including sex for drugs exchanges. These data are notable because existing research confirms that "treatment works." Participation in drug treatment is associated with a reduction in both drug use and AIDS transmission.

To increase the number of drug users that enter into treatment, our research team, with funding from the Center for Substance Abuse Treatment, implemented a collaborative program called Project CONNECT (the Community Outreach Neighborhood Network for Education, Counseling, and Treatment) in Hartford, CT in 1992. Guided by ethnographic insights about drug users' behaviors and attitudes, individual and structural barriers to drug treatment, and treatment system processes and procedures, this project was

designed to use street outreach and the establishment of a broad referral network to identify out-of-treatment inner city drug users and to recruit them into a process that included: 1) rapport building, 2) health and human service needs assessment, 3) HIV testing and counseling, 4) peer pre-treatment counseling and support, and 5) assisted enrollment in drug treatment. Developed and managed by anthropologists, Project CONNECT exemplifies an important role for applied anthropology in addressing the intertwined AIDS and drug use epidemics.

The community intervention model developed in Project CONNECT was predicated on the idea that individuals are more likely to enroll and stay in drug treatment if they have undergone culturally sensitive pre-treatment counseling. Pre-treatment was seen as a "gateway" to motivate participants to enter drug treatment, provide information on the treatment process, begin the process of socialization into a non-drug user patient role, prepare participants both practically and emotionally for treatment, and provide strongly advocated referral to overcome institutional barriers to treatment. The pre-treatment model developed in Project CONNECT was implemented at four community-based intervention sites across the city and emphasized AIDS risk reduction. In

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RESEARCH REPORT: DEATH AND SOCIAL LOYALTY IN BOTSWANA IN THE TIME OF AIDS

by Fred Klaitz, Ph.D. Candidate, Dept. of Anthropology, Johns Hopkins University

From February 1997 to September 1998, I carried out dissertation research, funded by the Social Science Research Council, in Gaborone, the capital of Botswana, on the problem of how suffering and loss create social belonging. The tragic HIV/AIDS pandemic in Botswana, as elsewhere, has within a very few years killed thousands of people, placing heavy material and emotional burdens on the ill, on caretakers, and on survivors. All those affected must confront difficult issues of moral responsibility: who has an obligation to care for the sick and for survivors, how to treat the ill, how to conduct sexual relations, how to understand and speak about the nature and causes of disease. My study focuses on death as an event which concentrates local attention on such questions of social loyalty, forcing people to negotiate overlapping and potentially competing commitments to members of their households, churches, extended families, and wider communities. I explore the ways in which moral and explicitly religious discourses are used in negotiating these multiple claims, both to diminish the violent rupture of death and to provoke confrontations over its social and emotional significance.

My research has focused on the ways in which the material and ethical dilemmas associated with fatal illness have been shaped by ongoing debates surrounding the morality of kinship, healing, and death. The research shows that persistent local concerns about care and abandonment in the face of various kinds of past and present afflictions -- low and unpredictable incomes, large-scale unemployment, housing shortages, and now AIDS -- are expressed in debates about multiple and coexisting forms of parenthood, childhood, and marriage. This is particularly

the case within independent churches in Botswana, in which the healing of physical and social ailments is commonly seen to create tensions between church participants, often known as "spiritual" parents and children, and non-churchgoing "fleshly" members of their households and extended families. How to negotiate such overlapping social identities in the context of death is a difficult moral issue, in large part because in a context of mass circular rural-urban migration, death forces decisions about where and to whom people ultimately belong. I explore these concerns through a focus on funerals and mourning practices, arguing that the activities of caring for the ill in particular places, paying for burials, deciding on burial sites, speaking and singing at funerals, wearing mourning clothes, and undergoing cleansing all possess the capacity to create and destroy generational and marital ties, as well as relationships within churches. In discussing the emotional, moral, and political implications of death, I concentrate on independent churches as places where the work of faith consists of healing and social transformation. My thesis traces in detail a series of recent losses experienced by members of a particular church, concentrating on transformations in preaching, ritual, and kinship at a time when death has assumed a new centrality.

I designed my plan of research, carried out after two preliminary visits in 1993 and 1995, on the basis of a recognition that the ways in which people experience problems posed by severe illness hinge on their varying social positions. Thus, I set out to

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AARG MISSION STATEMENT

The AARG, an interest group of the Society for Medical Anthropology (SMA), is a network on HIV infection and AIDS. The mission of the AARG is to support anthropological research on AIDS. To this end, AARG

- 1) works to use anthropological research in the fight against HIV and AIDS,
- 2) advocates for AIDS research within anthropology,
- 3) promotes AIDS research by anthropologists within the broader AIDS research community,
- and 4) provides a forum for anthropologists working on AIDS to meet and communicate about their work.

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addition, the program assisted participants to: 1) review personal, life situation, health, motivational, attitudinal, and financial hindrances to treatment entry and participation, 2) select among appropriate treatment options, 3) understand drug treatment entry criteria and procedures, 4) make contact with treatment providers and secure a treatment slot, and 5) obtain the necessary ID or other enrollment materials required. The program also provided transportation to detoxification programs and, if needed, from detox to drug treatment. Pre-treatment was offered by peer counselors who were recovering drug users with a 2-year minimum period of recovery. As peer counselors, recovering drug users were able to offer supportive social pressure for entering treatment that individuals defined as "straight" by drug users could not be able to achieve. Additionally, a primary focus of the day-to-day work of pre-treatment counselors involved negotiating institutional hurdles and obstacles found in what can only loosely be called the drug treatment "system."

During the period of active participant recruitment from February 1993 to June 1996, Project CONNECT enrolled 1,010 participants. Approximately mid-way, the project adopted a new intake and outcome evaluation instrument, after which 586 participants were enrolled. This report covers this latter participant cohort. Of these participants, 68.4% were male and 31.6% were female. The majority (65.7%) was Latino (almost all of which was Puerto Rican) followed by African Americans, and then whites. Education levels of participants were low, with almost 15% of participants dropping out of school during or before the 8th grade. Fifty-three percent of participants had less than a high school education. Most of the participants (58.6%) had never been married and only 20.6% were married at intake into the project. About a fourth (25.8%) of the participants were homeless and 78.9% were unemployed. Less than 2% of participants reported having a full-time job at intake. Most individuals (74.6%) had monthly incomes from all sources below \$500. In short, participants were poor, poorly educated, and primarily members of stigmatized ethnic minority populations.

For a group with considerable drug involvement, 60% of participants said they had been in drug treatment two or fewer times, indicating limited drug treatment experience for individuals suffering from a chronic, relapsing disease. The majority of participants (67.8%) reported

having injected drugs, most before the age of 22 years, while 55% reported having used crack cocaine. The most commonly used injected drug was heroin (reported by 46.6% of participants) followed by speedball (a combination of heroin and cocaine). Injection frequency was high in this population, with over 60% reporting four or more injections per day. About half the participants also reported current crack use and over 30% of these individuals reported using crack four or more times per day.

Generally, participants had a realistic sense of their risk for HIV infection, with about 85% of participants indicating that their behavior could expose them to infection. Almost all of the participants reported they were willing to lower their risk by changing their drug use patterns. However, almost a quarter of the participants indicated they were not willing to change their sexual behaviors to avoid exposure to HIV. Similarly, while almost all participants reported they would need help to deal with their drug problems, about 40% stated they did not need intervention to reduce sexual risk for HIV infection. In sum, while almost all participants admitted a drug problem and desired project help to enter a drug treatment program, desire for HIV prevention for sexual risk was much less common.

Project staff provided a wide range of assistance to participants based on the needs assessments. Services included helping participants to acquire clothing, food, housing, medical financial assistance, legal assistance, medical care, mental health intervention, HIV treatment, and drug treatment. The number of contacts between staff and project clients ranged between 1 and 23, with a mean of 4.4 intervention contacts per client. The most frequently delivered services were assistance getting into drug treatment, provided to 95.6% of participants; referral into a support group, received by 44.6%; transportation assistance, received by 39.4%; referral into case management, received by 16.8%; and referral into HIV treatment, received by 10.9%. In addition, all participants received HIV prevention counseling.

Regarding drug treatment, 79% of participants were initially referred for drug detoxification, while 8.3% were referred directly to an outpatient treatment program and 6.1% to an inpatient program. Of these initial treatment referrals, 74.1% enrolled and began the

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program as scheduled. Sixty-five percent of these individuals completed the initial drug treatment program. During the time they were enrolled, staff completed telephone inquiries about client progress in 88% of the cases. Following completion of the initial drug treatment referral, staff assisted participants to move on for additional drug treatment. Forty-five percent of participants were referred for a second detoxification, often because this was the only type of drug treatment assistance available to the client at the time because of lack of ability to pay, lack of other treatment slots, or past problems with available treatment programs. Additionally, 13% of participants were referred at this point to outpatient drug treatment and 4.7% to inpatient treatment. Fifty-seven percent of participants began the second treatment arranged by project staff. Of these, 60% completed the second treatment. Additionally, 19% of participants were assisted in enrolling in a third treatment program.

In attempting to refer clients into drug treatment, Project CONNECT encountered many obstacles that often led staff to wonder why it was so much easier to get drugs than it was to get drug treatment. Frequently encountered institutional barriers to treatment included: 1) difficulty referring monolingual Spanish-speaking clients because of a lack of Spanish-language counselors at drug treatment programs and a general lack of bilingual capacity in drug treatment programs, 2) lack of specialized programs for non-pregnant women, which constitute the vast majority of women clients, 3) lack of funding for detoxification and treatment of impoverished clients beyond a five day treatment paid for by the city's General Assistance program, 4) long waiting lists at the methadone program, 5) lack of aftercare programs, and 6) lack of coordination among treatment providers that blocked a rational continuity of care approach to treatment planning. Additionally, during the course of the project, several events further complicated staff efforts. First, the City of Hartford announced it would no longer pay for detoxification and residential drug treatment at a hospital-based program located in an adjacent town because services were available at a closer hospital-based program (which, nonetheless, also was located outside of Hartford). The somewhat more distant program—an additional 10 minutes of driving time from Hartford—had become a primary treatment referral site because it offered an array of

services and was very receptive to close coordination with Project CONNECT. Ironically, the City next decided not to pay for treatment at the closer hospital-based program because its services were more costly than those offered by some other providers in the area. However, it had already been the project's experience that there were rarely treatment slots available at these other providers, in part because their drug treatment beds were increasingly dominated by mandated referrals from the criminal justice system.

Several months later, the project was informed that the rules for receiving General Assistance support, including payment for drug treatment, would be tightened. This change followed wide media coverage of the findings of a local judge that many people in Connecticut were using welfare payments and other forms of public assistance to buy illicit drugs. The less-than-sound decision to restrict General Assistance support for drug treatment in order to punish welfare recipients for their drug use provided yet another barrier to Project CONNECT efforts. The final blow to the project came from its federal funder. We were informed in mid-year that Project CONNECT's last year of support would be eliminated because of cuts in Congressional funding. Consequently, the project ended with little opportunity to find alternative funders or even complete the final data analysis for the project evaluation.

The budgetary cut that destroyed Project CONNECT was part of a 20% slash by U.S. Congress of the Substance Abuse and Mental Health Services Administration. At the same time, in 1996, Congress passed and President Clinton signed a bill that eliminated Social Security disability insurance for individuals whose disability was chemical dependency, thus denying these individuals access to Medicaid funding for drug treatment. The public rationale for this slash and burn approach to drug treatment was that the states and the private sector would pick up the difference. This, of course, has not happened. Drug warriors and drug hysteria have blocked even the discussion of a rational drug treatment policy, to say nothing of a research-driven approach to AIDS prevention among drug users. As a result, drug users find it is much easier to obtain drugs than to enter into drug treatment.

Books Available for Review

Complimentary copies of the following books are currently available for review. Please contact AAB Editor, Katherine Fritz, if you would like to write a review for the AAB and receive a free book!

Women, Drug Use, and HIV Infection. Sally Stevens, Stephanie Tortu and Susan Coyle eds. The Haworth Press, 1998.

Putting Risk in Perspective: Black Teenage Lives in the Era of AIDS. Renee T. White. Rowman & Littlefield Publishers, Inc., 1998.

In addition, if there is a book you would like us to order for review, please contact AAB Editor, Katherine Fritz with your suggestion.

CALL FOR NOMINATIONS

AARG is currently seeking nominations for four new AARG Steering Committee Members. Send your nominations for the positions of Chair, Graduate Student Representative, and two general steering committee members by September 10. Ballots will be mailed with the Fall issue of the Bulletin and the results of the election will be announced in November at the American Anthropological Association meeting in Chicago. The new Steering Committee members will take office on January 1, 2000. Please send your nominations to:

Fred Bloom, AARG Chair
4486 Union Church Rd.
McDonough, GA 30252

BRIEF REPORT FROM THE FIELD

by Katherine Fritz, UCSF-Center for AIDS
Prevention Studies

Harare, Zimbabwe -- The HIV/AIDS epidemic in Zimbabwe is currently estimated to be among the most severe in sub-Saharan Africa. In an effort to contribute to Zimbabwe's rapidly expanding HIV prevention program, I am currently in Harare assisting faculty and students of the University of Zimbabwe Department of Community Medicine perform a rapid ethnographic assessment of public drinking venues, most notably, beer halls. Beer halls are abundant in Harare and are locations where men can, fairly cheaply, purchase "chibuku," the very popular maize beer. The goal of the project is to develop a comprehensive AIDS prevention campaign targeted toward the many men who spend much of their leisure time drinking with friends at their local beer hall. Through

Newsletter Submissions Welcome

We encourage all members, especially our colleagues working internationally, to contribute to the AIDS AND ANTHROPOLOGY BULLETIN. Submissions can include announcements of or reports on AIDS-related conferences and events, grants awarded and available, positions available, publications, obituaries of anthropologists and/or AARG members, book reviews, commentaries and letters (at the discretion of the Chair and Editor), research reports, and paper abstracts.

Submissions for the next issue of AIDS AND ANTHROPOLOGY BULLETIN are due April 30, 1999. Please send your submission to:

Katherine Fritz
Center for AIDS Prevention Studies
74 New Montgomery St., #600
San Francisco, CA 94105
email: kefritz@aol.com

(Submissions longer than half a page should be on disk or sent via e-mail)

participant observation at beer halls, as well as informal and structured interviewing of men who frequent these drinking places, we are investigating drinking practices, the role bar attendance and beer-drinking play in men's social lives, the ways in which men think alcohol consumption and sex (especially unprotected sex) are related, and perceptions of HIV risk. We are also asking men to suggest what types of beer hall-based HIV prevention programs would be most effective and popular. The research will continue through October, 1999. For more information, contact Katherine Fritz at kfritz@psg.ucsf.edu

New On-Line Database of Curricular Resources On HIV/AIDS

The Association of American Colleges and Universities, Program for Health and Higher Education (PHHE), is currently constructing a new on-line database of HIV/AIDS-related curricular resources. The PHHE welcomes your contributions to this database in the form of course descriptions and syllabi, bibliographies and reading lists, special program descriptions (Web pages, class listservs), sample writing/laboratory/writing assignments, service learning programs, and information about campus-community partnership projects. The database will be open to the public in September 1999.

With financial assistance from the United States Centers for Disease Control and Prevention, The Program for Health and Higher Education is providing national leadership to increase attention in university curricula to public health and, in particular, to HIV. PHHE serves academic leaders who wish to incorporate the study of these complex social issues into undergraduate studies. PHHE sponsors activities that include: · organizing special conferences · offering a partnership program that extends stipends to institutions to pursue special projects · integrating attention to health in other AAC&U institutes, meetings, and publications · sponsoring a survey research initiative · publishing resource materials · providing individual consultation, upon request. These activities are designed to help leaders improve education and, by including attention to the disease and its many dimensions within course work, to expand their institution's comprehensive HIV prevention efforts.

If you have questions or would like to contribute materials to the database, please contact:

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explore urbanization in comparative terms, as well as church networks, households, and extended families as distinct but overlapping units of analysis. My work was based in two areas: Old Naledi, a high-density urban neighborhood near downtown Gaborone, and Tlokweng, a peri-urban village. In 1993, I came in contact with a small-scale independent church in Old Naledi which has been a central point of reference in all my subsequent research. Along with participating in church activities and developing a relationship with the Bishop as her student and disciple, I traced connections between church members and their families both in Old Naledi and in their home villages elsewhere in southeastern Botswana. I also attended services and conducted interviews focusing on healing, conversion, and kinship in a small number of other "churches of the spirit" in Old Naledi. In addition, I carried out a survey of approximately 25 compounds in Old Naledi, focusing on demographic patterns, resource distribution, and networks of support, such as burial societies, in times of illness and death. In Tlokweng, I worked with members of an extended family who have experienced a large number of recent losses, in particular with a senior woman who practices Tswana medicine, a form of healing disavowed by some Apostolic churches, including the one with which I became most familiar, but accepted by others. Finally, I participated in a local NGO whose aim is to educate young people about sexual and reproductive health, conducting interviews with predominantly middle-class "youth" members about sexuality and relations between parents and children.

In local Tswana terms, the central ethical dilemma in negotiating the multiple commitments surrounding death is the profound difficulty of "loving" without "jealousy." "Love" (*lerato*) and "jealousy" (*lefufa*) are complex concepts referring not to transient emotional states but to moral stances toward social relations, and in particular to the capacity to transform them (Deborah Durham, pers. comm.). For example, church leaders often say that their "love" is demonstrated by the fact that their prayers bring a large number of people to church, and also to live with and help support them. "Jealousy," by contrast, signifies the resentment apt to arise out of preferential "love" for certain people rather than others. "Jealousy" kills, because "jealous" people are apt to

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bewitch or refuse to support their own kin, and to deliberately violate pollution norms involving sexuality and death. Given that the sorrows of death often provoke strong sentiments of both "love" and "jealousy" among the bereaved, moral tension in funerals and mourning derives from the fact that demonstrating "love" for the deceased and for survivors often provokes disputes with particularly long-lasting and painful consequences.

The chapters of the dissertation contextualize in various ways an extended case study, presented at the outset, of a young woman church member's illness and funeral, and of the efforts made by church participants to affirm the value of their faith and community during the AIDS epidemic. Noting that church members consistently cultivated ambiguity in speaking about the nature and causes of their friend's illness, I argue that remaining ambiguous about suffering is a way to contain "jealousy," and also to postpone making definitive statements about a variety of social commitments. The case study concludes with a description of how the contradictory qualities of the deceased's social loyalties became most apparent at her funeral, when church members celebrated her faith and eternal life in preaching and song while some in her extended family expressed sentiments of blame and profound loss, going so far as to state publicly that she had died of a sexually-transmitted disease. I argue that the stigmatization of AIDS in religious, popular, and public health discourse in Botswana must be considered in relation to existing conceptions of pollution in sexuality and death, as well as in the context of widespread concerns about the "obedience" of children to their parents. In reflecting on the implications of the ethnography for health policy, I return to the theme of how cultivating ambiguity about social commitments in general and the nature of illness in particular helps to contain "jealousy." After watching my friends die, I wonder how to create common ground between this legitimate concern and the aims of health education programs, which tend to presume that all refusals to identify AIDS as such reflect moral cowardice.

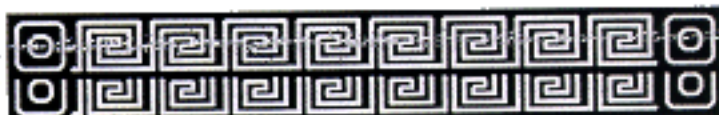


Upcoming Conferences

August 29-Sept. 1, 1999. National HIV Prevention Conference, Atlanta, GA. Sponsored by the CDC. Abstracts must be received or postmarked no later than April 2, 1999. For more information, visit: http://www.cdc.gov/nchstp/hiv_aids/dhap.htm

November 3-7, 1999. Joint Annual Meeting of the Society for the Scientific Study of Sexuality and the American Association of Sex Educators, Counselors and Therapists. St. Louis, MO. Theme: "The Context of Sexuality: The 20th Century." Paper proposals due March 5, 1999. For more information, call Howard Ruppel at 319-895-8407 or email TheSociety@worldnet.att.net

Nov. 17-21, 1999. Annual Meeting of the American Anthropological Association. Chicago, IL. Theme: "Time at the Millenium." Paper proposals must be received by April 1, 1999. For more information visit <http://www.ameranthassn.org> or contact AAA Meetings Dept. 4350 N. Fairfax Dr. Suite 640, Arlington, VA 22203; phone: 703-528-1902



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