

**A CULTURAL APPROACH TO
HIV/AIDS PREVENTION AND CARE**

UNESCO/UNAIDS RESEARCH PROJECT

**SUMMARY OF
COUNTRY ASSESSMENTS**

AN INTERNATIONAL OVERVIEW

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FOREWORD

This is an expanded and more detailed version of the Country Assessments Summary carried out within the UNESCO/UNAIDS joint project “A Cultural Approach to HIV/AIDS Prevention and Care”.

As now widely acknowledged, through the activities of UNESCO and other UN agencies in development issues, the cultural approach provides an overall concept for achieving more efficiency, relevance and sustainability in HIV preventive action, and a more supportive human environment for people with AIDS through: relying on their capacity to understand and appropriate the issue within their own cultural references and resources and building new behaviour norms through new motivations.

The first research-oriented phase of the Project (1998-1999) resulted in nine country assessments, Angola, Malawi, South Africa, Uganda and Zimbabwe for Southern Africa, Thailand for South East Asia and Cuba, Jamaica and the Dominican Republic for the Caribbean followed by three workshops in each sub-region. Moreover seven shorter country papers were devoted to Botswana, RD Congo, Lesotho, Namibia, Mozambique, Swaziland and Zambia.

Each country assessment included, on one hand, an evaluation of the institutional action taken to date, as regards consideration of cultural aspects in prevention and care, and on the other hand, an in-depth analysis of people’s reactions to HIV/AIDS, in relation with their cultural references and resources.

Through showing common societal/cultural trends and differences in situations throughout the world, the present summary report highlights the importance of cultural diversity. More specifically the research findings of the country assessments have been used to identify and formulate basic concepts, guidelines and methods for designing, in a cultural approach, more efficient, appropriate and sustainable strategies, policies and projects.

I take this opportunity to re-emphasize three fundamental principles in UNESCO’s work in the field of culture: the relevance of the definition adopted in the Mexico World Conference on Cultural Policies in 1982; the scope and multiple possible applications of the Resolution on the *Safeguard and revitalization of the tangible and intangible heritage* adopted by the General Conference at its thirtieth Session in 1999; the quality and fruitfulness of the continuing cooperation and interaction between the Organization and its member states.

On these crucial subjects the present publication gives renewed evidence that in HIV/AIDS prevention and care, as in other issues related to continuity and change in contemporary societies, culture is at the core and the forefront for the whole international community.

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EXECUTIVE SUMMARY

Within the framework of the Joint UNESCO/UNAIDS project “A Cultural Approach to HIV/AIDS Prevention and Care” this book presents an expanded and more detailed version of the Summary Report of 16 country assessments and shorter country papers carried out in Southern Africa, the Caribbean and South-East Asia. The goal was to identify the interactions between cultures and the HIV/AIDS issue and to adjust prevention and care accordingly. In this perspective, it can be considered as an international overview of the situation .

Assessment activities were twofold:

- 1) Review of the institutional action taken to date, in as much as it considered cultural aspects in prevention and care policies, programmes and projects;*
- 2) In-depth case investigations of people’s reactions concerning the risk and the need for them to change their sexual and non-sexual behaviour accordingly, in relation to their cultural references and resources.*

In principle, taking a consistent and comprehensive view of the present situation, regarding a cultural approach to HIV/AIDS prevention and care at world level, would need that the geographical coverage of the country assessments provide a balanced and representative view of the issue. However due to limited time and resources, the scope of the project had to be focused on three prioritised geographical areas: South-East Asia, the Caribbean and Southern Africa, where the expansion of the epidemic in the last decade has been spectacular.

This analysis has made it possible to formulate a preliminary set of remarks and to draw up a summary of the major observations thus made. Even though the review was not actually worldwide, on one hand it was large enough to authorize identification of common trends,, and on the other hand cultural and societal diversities, pertaining to more or less specific cultural areas.

Identified common trends are related above all to the perception of the risk: everywhere, there is wide awareness versus insufficient understanding of the epidemic. HIV/AIDS itself is not a purely medical problem, but a complex socio-economic and societal/cultural phenomenon. Socio-economic conditions impact heavily on societal/cultural references and resources and on HIV/AIDS. The impact of the disease as such is multifaceted, whether in the economic and social arena or in cultural and societal systems. In the last analysis HIV/AIDS indicates a globally destabilizing crisis, which hits at the same time family patterns, rural traditional cultures, women’s and young people’s status, primarily via the global urban explosion.

These common issues show the fundamental irrelevance of prevention and care action taken to date, given the diversity met in the field. Large regional societal/cultural areas with specific issues can be identified. Other major cultural diversities are related to traditions, religious beliefs, representations of health and disease, life and death, sexual norms and practices. More or less culturally fragile groups, whether vulnerable or actually risk-taking can be distinguished: from more general - the poor, women, children and young people - to more culturally specific categories: family, men/women in their relations, communities and migrants and, lastly, small

groups specifically at risk: youngsters exposed to street subcultures, homosexuals, mobile workers, sexual workers.

The above mentioned country assessments made it possible to draw major conclusions and recommendations to make more efficient, appropriate and sustainable prevention and care proposals. They were used to identify and formulate basic concepts, guidelines and methods for designing, with a cultural approach, strategies, policies and projects, which will fully take into account the cultural references and resources of the various populations for which the UNAIDS strategy is being developed. The joint UNESCO/UNAIDS project is currently continued on the same basis.

PREFACE

From the mid-eighties onwards, the international campaign against HIV/AIDS gradually mobilized more and more countries, IGOs and NGOs, as the epidemic invaded at an even faster pace, other regions of the world and killed more and more people. During the first fifteen years of the crisis, efforts and means of action for combating the epidemic focused on health and medical care, within the limits of the epidemiological approach. Later, however, information/education/communication became the second major instrument used to prevent the risk itself and to promote the practical protection measures it implies, though still with limited results. Thus serious concern has arisen as to the real efficiency of the prevention campaigns. It becomes more and more patent that in fact, even if prevention messages are received and intellectually understood, too often their content is not appropriated in depth and thus is not followed by behavioral changes.

The establishment of the joint United Nations Programme on HIV/AIDS (UNAIDS) in 1996 inaugurated a new approach to the disease's prevention and care. The first requirement expressed was the need for inter-institutional and inter-partner co-ordination in combating the epidemic. This need in itself opened new possibilities for building a trans-institutional strategy, making it necessary to take a comprehensive approach to prevention and care. For the same reasons, UNAIDS increasingly emphasized the necessity to pay full attention to the multidimensional configuration of the issue and subsequently to take a comprehensive view of strategies to build and "contextualize" the crisis in its environment.

Three recently published UNAIDS methodological documents represent new strategies in the same direction:

1. *The Guide to the Strategic Planning Process for a National Response to HIV/AIDS.*

Two key concepts can be drawn from this document:

- the necessity to adapt general norms to given or changing situations and the specific needs of the given country;
- the acknowledgement that the "unique strength of the country's people and institutions" must be used to build the most effective national response.

2. A *UNAIDS/IMPACT/FHI document* (1999) recommends various data collection methods for setting up efficient national HIV prevention programmes, on the basis of accurate behaviour assessments. Such assessments would provide detailed information on risk behaviour, areas, groups and on opportunities, obstacles and appropriate approaches to prevention. They would be repeated periodically, in order to point to significant changes, improve the delimitation of target specific groups, identify sexual and drug-taking practices and the various stages of the epidemic. The results would be used for populations' appropriate IEC, as well as for policy-makers, in relation with their fields of competence: education, health or public finance.

3. A methodological review entitled "*Sexual Behavioural Change to HIV – Where have Theories Taken Us?*"

Its major assumptions are as follows:

- Sexual behaviour is deeply embedded in individual desires, social and cultural relationships, environmental and economic processes. This makes prevention very complex since it involves multiple dimensions.
- These dimensions must be fully considered in any action designed to build sustainable sexual behaviour change among individuals through altering their community models.

In its conclusion, the document re-emphasizes that building sustainable behaviour change in individual sexual norms and practices will have to be mediated by changes in the community cultures and subcultures within them. This will entail shaping out an environment which will support safer practices. As a consequence, participatory methods will have to be given preference, in order to involve and empower individuals and groups to make this change.

In order to meet this concern and along the same lines, a UNESCO/ UNAIDS joint project was launched in 1998 under the title "A Cultural Approach to HIV/AIDS Prevention and Care", as a new effort to contribute to finding solutions to this apparently insuperable challenge. This project was initiated on the basis of a dual assumption, which points to concerns similar to those of the two UNAIDS documents:

1. In order to overcome possible obstacles in the process of sustainable behaviour change in sexual norms and practices regarding HIV/AIDS prevention and care, it is necessary to tailor action's content and pace to people's mentalities, beliefs and value systems.
2. Any given population's societal/cultural resources, their creativity, self-confidence and motivation should be mobilized for the difficulties of daily life they have to solve. Among these difficulties HIV/AIDS prevention and care should be integrated in the perspective of sustainable human development, as a crucial objective.

The project lead to the following major activities:

1. Sixteen country assessments and shorter country papers in Southern Africa, South East Asia and the Caribbean, followed by three workshops in each sub-region.

Each country assessment was divided into two parts:

- An assessment of the institutional action taken to date, as regards consideration of cultural aspects in prevention and care;
 - An in-depth case analysis of people's reactions to HIV/AIDS, in relation to their cultural references and resources.
2. The present summary report, showing common societal/cultural trends and diversity in situations, conclusions and recommendations for possible solutions, has been established accordingly.
 3. A methodological handbook has been elaborated for:
 - Strategy and project design integrating a cultural approach;
 - Development of culturally-appropriate information/education/communication material and processes;

- Proposals concerning capacity-building systems for training/sensitizing all those involved in HIV/AIDS prevention and care, at all levels, and for integrating a cultural approach to their tasks;
- Further relevant networking, data collection/processing and research.

In this respect, the cultural approach advocated in the project provides an overall concept for achieving more efficiency, relevance and sustainability in HIV preventive action and more supportive human environments for people with AIDS through:

1. Relying on their capacity to understand and appropriate the issue within their own cultural references and resources.
2. Building new behaviour norms through new motivations.

In fact, the lack of motivation for the debated behaviour change is the major obstacle to be overcome, in order to develop pilot projects and sustainable information/education/communication activities accordingly.

This is why there is a need for an in-depth analysis of people's formal cultural references, based on traditions, beliefs, family and power models, value and priority systems. This analysis should also take into account the new emerging cultural motivations and practices linked to survival and gradual adaptation strategies, formal and informal, in the modern/urban environment.

From this analysis, country- and people-centered response methods will have much better chances to grow and reach significant results as regards people's norms and rules, for example in prevention against getting infected and infecting others.

Similarly, new attitudes and behaviours will have to be developed towards infected and sick people, to reintegrate them in the community and give them human support at the final stage of the disease.

Thus, this book must be read as an introduction to a renewed strategy to face the epidemic through making full use of the resources and energy embedded in the core of each culture.

PART ONE: RATIONALE

I. BACKGROUND

Following a proposal made by UNESCO's Culture Sector to the UNAIDS Programme, on taking a cultural approach to HIV/AIDS prevention and care for sustainable development, a joint project was launched in May 1998.

The project originated in the UNAIDS Coordinated Appeal for 1998-99. This proposal was made on the basis of methodological research carried out on taking a cultural approach to development strategies, institutional work, programmes, projects and fieldwork. It was drawn up in the Unit of Cultural Research and Management and proposed as an application for HIV/AIDS prevention and care from the experience gained by the Culture Sector on the interactions between cultures and development.

In order to better understand the present project, it may be of use to recall the first two phases of UNESCO's work on the integration of cultural aspects in development, with a view to contribute to the implementation of the main objective of the World Decade for Cultural Development (1988-97): promoting "the acknowledgement of the cultural dimension of development". This work itself was based on the "broad" definition of culture adopted by the UNESCO World Conference on Cultural Policies (Mexico City, 1982) and the Report of the World Commission on Culture and Development, published in 1996.

The methodological work carried out within UNESCO Culture Sector first resulted in the UNESCO book "*The cultural dimension of development - Towards a practical approach*", published in 1994. This research identified the conceptual foundations of the work to be carried out. It then proceeded to demonstrate the necessity of taking the cultural dimension into account, in order to achieve sustainable human development. Next, it assessed to which extent and in which ways international co-operation has so far evolved in this direction. It then defined the cultural impact and functions of the development process. Finally, it presented in general terms the research needs that should be followed up, in order to help institutions adopt a cultural approach in their action to promote sustainable human development.

The question addressed in the second volume: "*Change in continuity – Concepts and tools for taking a cultural approach to development*", (French version published in November 1999, English version published in June 2000) was more strictly methodological. The aim was to show how the working methods of the organizations and operators involved in development actions can help set in motion a genuinely sustainable process of human development, by basing both their theory and their practice on a cultural approach, at the level of strategy, institutional action, programmes, projects or field work.

This task was carried out with two priorities in mind:

- On one hand, to stimulate reflection and discussion on the need to reconsider existing tools so as to redefine the content and the objectives of the development process.
- On the other hand, on the basis of the methodological indications given in the previous volume, to develop proposals, based on a cultural approach:
 - the strengthening or the modification of existing instruments;

- the use of methods currently adapted in other fields of development, especially in economic and social policies and projects;
- new methods and approaches, on the basis of the observed dysfunctionality of existing methods and the persisting lack of understanding of situations encountered in the field, in their qualitative aspects or in their fundamental diversities.

These proposals were intended to allow cultural aspects to be integrated at all stages of the planning process, and thus to open the way to an entirely new approach in development planning, still too often limited and focused on the search for technical efficiency and, if not economic profitability as such, for short-term “investment return” or visibility.

A series of methodological requirements resulted from this reversal of the traditional perspective:

- Bottom-up planning (already existent , but mostly at the experimental stage).
- Ongoing participation of local development stakeholders, tending to a balanced partnership between local and external actors (participatory development is already admitted, but more often than not to a limited extent, as concerns time spent and decision- empowerment).
- Adaptation and diversification of the modalities and ways towards change.
- Readjustment of every action’s time frame.
- Substitutions of programmes and projects by master plans within which many smaller-scale initiatives emerging at grass roots level (project clusters) can be included.

The progress thus reached in methodological work on the subject now allows that the proposed new approaches may concern more specific subjects ; in the economic sector: savings, enterprise, the informal sector, crop and animal farming; in the social sector: basic education, health policies, food/nutrition, human settlements, urban development, family and, of course, the role of women.

Other specific subjects such as population policies, sustainable management of natural environment, the evolution of traditional systems of land tenure , under the impact of modern productive agriculture, can now be tackled with a cultural approach. This is why the present project was proposed by UNESCO to UNAIDS, with a view to clarifying the ways and means of adopting a cultural approach to HIV/AIDS prevention and care policies and projects. These would then appear both feasible and timely, and thus efficient, relevant and sustainable.

II. MAJOR OBJECTIVES

This project is meant to put people’s cultures at the base of the design and implementation of action taken to:

- Combat the expansion of the virus.
- Evolve a more supportive culturally-based environment for people with AIDS (PWA).

It must be noticed that this project, drawn up between July 1997 and January 1998, could not take into consideration the new developments in HIV/AIDS medical treatment, even if their specific efficiency is still discussed. In spite of the recent decisions concerning prices at which to sell existing drugs and medicine, or production of generic remedies, for economic, social, societal and cultural reasons, these will not be massively used in developing countries in a short-term perspective. Thus, the two major objectives of the project will remain valid during the five to ten years to come.

Besides, by far country assessments to date have shown that a sustainable change in fighting the epidemic is not limited to providing medical treatment to infected and sick people. It is essential both to protect those still uninfected from the virus and to build an enabling environment for the HIV positive people and those who are developing the disease itself or other opportunistic diseases, with a view to building more responsive societies and alleviating the financial burden on public expenditure. Thus, the two major objectives of the project remain fully valid.

III. KEY ISSUES BEHIND THE PROJECT

In the light of the experience gained, it is more and more widely recognized that the HIV/AIDS epidemic is not only a sector-based medical problem, but a multifaceted issue which requires multidimensional strategies. Modern-type information/education/communication, promotion of condom use will not achieve the expected results, if the question is limited to medical considerations and its solution to pharmaceutical treatments. It is, indeed, a complex socio-economic, societal and cultural phenomenon, to be considered in the perspective of sustainable human development. This is why the prevention and treatment of the epidemic require a cultural approach to face the issue in all its aspects.

In order to bring about changes in cultural references and behavioural norms likely to alleviate the task of risk reduction, two prerequisites have to be met:

- For ethical and practical reasons, in every action due attention should be paid to mentalities, traditions, beliefs and value systems, , in order to overcome obstacles, which might arise in the process of HIV/AIDS prevention and treatment.
- The societal and cultural resources of the populations, including knowledge, know-how, modes of economic and social organization and their creativity, self-confidence and willingness to solve their problems, should always be mobilized in prevention and care activities.

IV. BASIC HYPOTHESIS FOR THE PROJECT

As a follow-up to the activities and documents mentioned above, the current project is based on the established fact that culture is the foundation and core of any economic and social transformation, in the perspective of sustainable and human development. It is now well ascertained, thanks to the output of the World Decade for Cultural Development and to the conclusions of the World Commission Report on Culture and Development, that the

interactions between these two realities are the basis for any valuable work in both fields. This is why a cultural approach should be adopted in all development strategies, programmes and projects, whether comprehensive or sectoral.

As regards HIV/AIDS prevention and care, adopting a cultural approach means that populations' cultural references and resources (ways of life, value systems, traditions and beliefs, and the fundamental rights of persons) will be considered as key references in building a framework for strategies, policies and project planning, but also as resources and basis for building relevant and sustainable action. This is an indispensable condition for making in-depth and long term changes in people's behaviours and giving full consistency to medical and sanitary strategies and projects.

Moreover, in socio-economic development, the present spectacular mortality rates among active people in developing countries seriously compromises development efforts in all social and economic sectors. The subsequent lack of available human resources can result in the collapse of the overall development process, at the national or even international level.

This is why sustainability is a key condition for behavioural change and the subsequent success of HIV/AIDS prevention and care, this in turn being a key condition for sustainable development as a whole.

Change in this matter will occur only with overall changes in people's life conditions, thus making human development the second prerequisite to achieving significant results in the fight against the epidemic.

V. GENERAL TERMS OF REFERENCE

On the basis of documentary research and inquiries carried out in academic research institutions, national and international agencies, NGOs, and local networks involved in AIDS prevention and care, country reports aimed to:¹

1. Improve the understanding of the interaction between culture, the evolution of the AIDS crisis and development issues.
2. Identify cultural factors and resources, which play an important role in the expansion of HIV/AIDS prevention and care.
3. Assess the role of these factors and resources in securing the relevance and efficiency of actions carried out in the field of prevention and care and the institutional cultures of the organizations involved.
4. Identify specific needs of disadvantaged risk groups (women, commercial sexual workers, youth, children, the poor, minorities, refugees) and methods of addressing their problems with a cultural approach.
5. Identify and analyze selected cases, in which the recognition of these factors positively affects the results of different strategies and programmes and the conditions for adapting successful initiatives to other contexts (replicability) and identify priority issues for future strategies and research.

¹ Detailed description to be given further from page 26 to page 28.

The research findings were meant to allow the formulation of a set of methodological proposals and guidelines for adopting a cultural approach in:

- Designing, implementing, adapting and evaluating AIDS prevention strategies and programmes.
- Training/sensitizing actors and agents involved in this task, in local communities, administrative structures, education and health institutions, economic and social development policy makers and planners, the media, religious organizations, international governmental and non-governmental institutions.

Special attention had to be paid to **experiences, methods and possibilities** of using a cultural approach in:

- Carrying out innovative programmes and projects through comprehensive, interdisciplinary approaches to prevention and treatment in a multicultural context.
- Promoting participatory processes, community support and care to people with AIDS, PWAs' networking and initiatives, peer education, interactive learning and communication.
- Promoting cultural and behaviour change through enhancing awareness, sense of responsibility, mutual respect, attachment and compassion, up-dating cultural traditions and references, and mobilizing traditional knowledge and spiritual resources in response to the AIDS crisis.
- Adapting the strategies, programmes and planning methods of the organizations and institutions involved to these requirements.

Along these terms of reference, the research had to be carried out in each selected country, at two levels:

- Institutional assessment of the integration of cultural aspects in the action taken to date.
- In-depth analysis of the cultural background of the HIV/AIDS issue and the availability of cultural resources for future prevention and care programmes and projects.

1. Institutional Assessment

- The assessment of institutional action taken to date considers the cultural aspects of prevention and care programmes and projects and the impact of institutions' own culture (concepts and working methods) in understanding and designing appropriate responses to the evolution of the epidemic (HIV infection and PWA) and its societal and cultural impact, in the context and perspective of sustainable human development.
- More specifically it deals with the present situation in HIV/AIDS prevention, detection and treatment within institutions, with special emphasis on institutional consideration of cultural references and resources of the given populations in their programmes and projects.
- Do institutions practice self-evaluation with due consideration of these various cultural issues?

- Assessment should also include success stories and innovative experiences carried out to date and from which lessons could be learnt, pilot projects could be developed and their replicability tested.
- Are further action developments and new proposed policies included in medium and long-term strategy documents?

2. In-Depth Case Investigation

Specific case studies had to be conducted in clearly differentiated situations: for instance those of suburban districts, rural areas, diverse ethno-cultural groups, migrants, refugees etc.

In all cases, due attention had to be paid to the specific situation of girls, women, young people and children, especially orphans.

This type of investigation was aimed at:

- Improving the understanding of interactions between cultures, HIV/AIDS and development issues;
- Identifying cultural references in the given situations, including religious, spiritual and ethical values;
- Emphasizing the specific needs of specially endangered groups;
- Mobilizing cultural resources.

VI. GEOGRAPHICAL SCOPE AND COVERAGE

In principle at the world level, taking a consistent and comprehensive view of the present situation regarding a cultural approach to HIV/AIDS prevention and care, would need that geographical coverage of the country assessments provide a balanced and representative view of the issue in the various geo-cultural areas, countries and regions. Ideally, all UN Regions, North and South, East and West countries, as well as those of broad geographical areas such as Sub-Saharan Africa, Latin America, North Africa and the Middle East, Southern and Southeast Asia, should have been part of the exercise. However, due to limited time and resources, the scope of the project had to be reduced.

On this basis, three geographical priority areas were defined for developing the project: Southeast Asia, the Caribbean and Southern Africa, where the recent expansion of the epidemic has been spectacular.

In each region, national reports based on a cultural approach assessed the institutional action to date, the lessons learnt from the field ranging from HIV/AIDS prevention and care to people with AIDS (PWAs) in different contexts (rural/urban, nomad/sedentary) and at different levels (local, regional, national). In Southern Africa, country assessments were completed in Angola, Malawi, South Africa, Uganda, Zimbabwe and seven short country papers made in Botswana, DR Congo, Lesotho, Mozambique, Namibia, Swaziland, Zambia.

In Southeast Asia, the assessment took place in Thailand and the bordering areas of the neighbouring countries: Myanmar, Chinese Yunnan, Laos PDR and Cambodia. For the Caribbean, country papers were drawn up in Cuba, the Dominican Republic and Jamaica.

VII. EXPECTED RESEARCH RESULTS AND POSSIBLE METHODOLOGICAL OUTPUTS

Research results were meant to enable the drawing up of proposals and guidelines for adopting a cultural approach in :

- Designing, implementing, re-adjusting and evaluating HIV/AIDS prevention strategies and programs, with a view to drawing up practical handbooks for planners, project officers and field workers.
- Carrying out innovative programmes and projects with a holistic, interdisciplinary approach for prevention and care in a multicultural context.
- Adapting strategies, programmes and planning methods accordingly for the institutions involved.
- Promoting participatory processes, community support and care to PWAs, networking and initiatives, interactive learning and communication for education.
- Training/sensitizing all those involved in this task, at the level of local communities, administrative structures, education and health institutions, religious organizations, the media, international and national governmental and non-governmental institutions.
- Promoting among the general population awareness, sense of responsibility, mutual respect, attachment and compassion, cultural and behavioural change, updating cultural traditions and references, mobilizing knowledge and spiritual resources in response to the AIDS crisis.
- Identifying priority issues for further research and strategies.

Other possible proposals and guidelines can be listed as follows:

- Evaluation and remodeling of the existing strategies, programmes and projects and drawing up practical handbooks to this effect, for those engaged in professional action against the epidemic.
- Testing culturally-appropriate methods in innovative projects, conducted with a participatory approach, as well as information/education/communication.
- Networking, collecting and processing all the valuable information on the cultural aspects of HIV/AIDS.

PART TWO:

COUNTRY ASSESSMENTS

SUMMARY REPORT

I. GENERAL CONDITIONS

As explained in the rationale of the project, country assessments and methodological proposals are interdependent in their conception and elaboration. The terms of reference for country assessments could not have been drawn up without previous elaboration of a general outline for the methodological work. Conversely, the latter could not have been elaborated and carried out in a relevant perspective without in-depth assessments of reality (?), thus making it necessary to work in a cross reference and inductive - perspective.

Thus an in-depth assessment of the current situation has to be carried out along two major lines of analysis:

- Accounting of cultural aspects in the institutional action taken to date;
- In-depth investigation of populations' reactions to HIV/AIDS and their behaviour, practices and perceptions regarding prevention and care, on the basis of their cultural references and resources and their daily environment.

Assessing institutional action is relatively easy, since reports, documents and periodical evaluations and publications on the subject are comparatively abundant, even if cultural considerations are on the whole classified under social, educational or informational headings related to HIV/AIDS, and in most cases, considered as obstacles.

On the other hand, the literature on the anthropological, sociological and cultural aspects of the situation is either not well indexed, or these aspects are still insufficiently researched and documented. This is why analyzing people's reactions to HIV/AIDS in connection with their cultures appears particularly timely and relevant. But shifting from a philosophical, somewhat vague, discussion of the concept itself to a concrete representation of its importance in societies and people's conditions requires a systematic, in-depth analysis of its constituents, impact and modes of operation. This is why detailed terms of reference were drawn up before launching the country assessments.

1. Detailed Terms of Reference of Country Assessments

On the basis of documentary research and inquiries carried out in accordance with national and international agencies, NGOs and local networks involved in HIV/AIDS prevention and care, these reports had to address the following issues:

1.1 Institutional Action

These country assessments were first intended to provide relevant information on the institutional action, more specifically as regards the following aspects:

- The present situation in HIV/AIDS prevention, detection and treatment, in which international, national institutions and NGOs are involved;
- The possible self-evaluation exercises taking place;
- Identifying and analyzing selected cases which illustrate the way in which the recognition of societal/cultural references and resources, or their disregard, affects the

results of different strategies and programmes, as well as the conditions for adapting positive initiatives to other contexts;

- Identifying priority issues for future research and strategies.

1.2 In-depth Case Investigation

- Identifying cultural features/references and resources, including religious, spiritual, ethical values, taboos, which interact significantly in preventing or expanding HIV/AIDS, medical and non-medical care to infected and sick people;
- Assessing more specifically the role of these references and resources in securing the relevance and efficiency of the current prevention and care actions;
- Better understanding of interactions between cultures, the evolution of the HIV/AIDS virus, and more general development problems and policies;
- Identifying the specific needs of disadvantaged risk groups as well as methods for addressing their problems with a cultural approach.

2. Expected Research Results and Possible Methodological Outputs

The research results were meant to enable the formulation of a set of concepts, methods and guidelines for adopting a cultural approach in:

- Designing, implementing and evaluating AIDS prevention strategies, programmes and projects for PWAs.
- Training/sensitizing agents and social actors involved in these tasks.

3. Experimental Work, Pilot Projects and Innovative Action

From country papers, other expected outputs deal with testing the cultural approach in pilot projects through the following activities:

- Carrying out innovative programmes and projects in a comprehensive, interdisciplinary, coordinated method for prevention and care, in a specific or multicultural context;
- Promoting participatory processes, community support and care for PWAs', PWA's networking and initiatives, interactive learning and communication between the sick people and between the sick and non-sick;
- Promoting, through all information/education/communication channels, awareness, a sense of responsibility, mutual respect, emotional attachment and compassion, as well as up-dating cultural traditions and references, mobilizing traditional knowledge and spiritual resources.
- Mobilizing traditional knowledge, spiritual resources, empathetic attitudes and customary solidarity towards preventive action, medical and human care for infected

people and for PWAs, in order to gradually eliminate frequent denial, rejection and stigmatization practices;

- On this basis, designing, implementing, evaluating and readjusting or remodeling prevention and care strategies and programmes;

4. Proposals and Recommendations for Adopting a Cultural Approach in HIV/AIDS Prevention and Care

It is also expected that country assessments will result in proposals and recommendations making it possible to adopt a cultural approach in prevention and care activities, more specifically in the following :

- Design, implementation, evaluation and readjustment or remodeling of prevention and care strategies and programmes;
- Launching of innovative prevention and care programmes and projects with a holistic/interdisciplinary approach, in mono-cultural and multicultural contexts;
- Promoting participatory processes, community support and care to PWA, developing PWA networks and initiatives, interactive learning and communication;
- Promoting awareness, sense of responsibility, mutual respect, attachment and compassion, reviewing cultural traditions and references in order to achieve cultural and behavioural change;
- Mobilizing traditional knowledge, spiritual resources and customary solidarity towards preventive action, medical and human care, and empathic attitudes towards infected people and PWAs, as a communal effort to make them feel fully integrated in their family, group and society.

5. Possible Practical Tools and Activities

These proposals can be more specifically translated into practical tools and activities as follows:

- Drawing up practical handbooks for those engaged in professional or specialized action against the epidemic (planners, project officers, field workers) on the basis of evaluation and remodeling of the existing strategies, programmes and projects.
- Training and sensitizing human resources and public opinion at all levels for adopting a cultural approach in preventive action, medical and non-medical care;
- Testing the proposed culturally-appropriate methods and approaches in innovative and pilot projects conducted with a participatory approach;
- Collecting and processing all the valuable information (and indexing existing research centers, researchers and available literature) on the cultural aspects of HIV/AIDS;
- Identifying priority issues to be analyzed in further research programmes.

6. Methodology

At the end of the first year of the project implementation (mid 1998 to mid 1999), country assessments had been carried out in the three pre-selected areas.

In Southern Africa, the most heavily hit region, 5 in-depth country assessments are now available for Angola, Malawi, Uganda, South Africa and Zimbabwe. Seven shorter monographs were carried out for Botswana, RDC Congo, Lesotho, Namibia, Mozambique, Swaziland and Zambia. Thanks to these documents, the situation in the Sub-region can be evaluated on a concrete basis and further development for action can already be outlined. Some of the major issues as regards adopting a cultural approach in Southern Africa were identified and further action recommended by the Sub-Regional Workshop held in Zimbabwe (24 - 28 May 1999).

For the Caribbean, national assessments were carried out in Cuba, the Dominican Republic and Jamaica. The Regional Workshop for the Caribbean - and some Latin American countries - held in April 1999, obtained positive results in the form of an enthusiastic and fully committed interest in the follow-up of the project.

For Thailand and the bordering areas of neighboring countries (Myanmar, Southern China - Yunnan-, RDP Lao, Cambodia and Vietnam), a Conference on Cultural Factors in the Transmission, Prevention and Care in the Upper Mekong Region provided information on the local populations' living conditions, cultural references and resources and culturally-based initiatives for taking care of HIV-infected and people with AIDS.

A total of 16 country papers, more or less extensive, are available to date. This makes it possible to formulate a preliminary set of remarks and to draw up a summary of the major observations made, after one year of in-depth investigation and assessment of country situations in three different regions of the world.

On this basis, the Project Design Handbook, first presented in the three sub-regional workshops, was enriched and amended in order to make it a practical work tool for those engaged in HIV/AIDS prevention and care (policy-makers, planners, specialists in information/education/ communication, field workers and community leaders). It is now furthered by small practical handbooks adapted to the specific needs of the various categories of stake-holders and professionals involved in this task: *Strategy and Policy Building, Project design, implementation and evaluation, Fieldwork and building local response, Appropriate communication for behaviour change.*

II. IDENTIFIED COMMON TRENDS

As should be understood from the outset, describing common trends and differential features in the various issues and possible solutions opens avenues towards the drawing up of methodological proposals for improving the efficiency, relevance and sustainability of HIV/AIDS prevention and care, at various levels: international, regional, sub-regional, national or specific cultural areas. In order to meet these conditions, the prerequisite is to take a balanced view of the unity and diversity involved in building and implementing strategies and projects.

The most comprehensive documents, such as international strategies (UN Five-Year Plans etc.) have to be based on similarities between the various situations, in other terms a common core of issues and joint actions to be taken.

On the other hand , differences and specificities in situations and contexts have to be included from the onset in programmes and project documents, in as much as they concern more limited action areas, at national, sub-national or regional, and/or at the local levels, in order to fully consider cultural and societal diversities and model projects and activities accordingly. This is where adopting a cultural approach towards prevention, detection, medical and non-medical care will fully show its relevance.

In this respect, the results of the country assessments and regional workshops have shown a significant number of common trends and characters regarding the epidemic through populations around the world and the public authorities' concerns and commitment . This makes it indispensable to further develop international thinking and action processes, with a view to identifying agreed upon objectives, shared principles and coordinated - if not unified - strategies and policies.

The emphasis repeatedly laid on co-ordination by the UNAIDS Strategy for 2000-2001 points very relevantly to this necessity, frequently disregarded in field action, where specialized agencies, on one hand, and the multiple NGOs on the other, compete rather than collaborate, thus entailing important breaches, overlapping and ideological competition. UNAIDS Strategy also stresses the need for developing a multidimensional strategy, without explicitly mentioning the multidimensional nature of the cultural approach, in response to a trend towards over-specialized, limited sector-based policy and action.

1. Risk Perception: Wide Awareness Vs Insufficient Understanding

All national reports periodically recall the aggravation in the number of infected people, people developing AIDS and deaths, with special emphasis on children, more specifically orphans. The publication of these figures is impressive in itself, as it emphasizes mainly the irresistible progress of the epidemic, rather than the significant improvement in the prevention and care activities all over the world. Thus, in all countries, people are made aware that the HIV/AIDS threat is not limited to specific groups or regions, but is a worldwide epidemic spreading within and between countries. In this respect, given the increase in international transport and populations' movements, it is frequently regarded as a manifestation among others, of the current globalization phenomenon.

Moreover, since HIV/AIDS is widely discussed by the mass media and other technical communication channels, only a few people in the countries under review have not been reached, with more or less accuracy, by messages concerning the epidemic. In this respect , no other deadly disease has been so massively mediated and publicized, though other fatal diseases are still wide spread in many countries: malaria, TB, typhus, cholera, infants dysentery.... This is all the more obvious as information/education/communication messages are relayed by group or interpersonal oral communication channels. Thus a blurred idea of the threat can be found now in large circles of the populations in most countries, with the exception of certain tribal groups in remote areas.

However, all national surveys have proved that the understanding of the epidemic in more concrete terms, especially its causes and effects and the possible means of protection against the infection, has by far not been reached everywhere. Thus, the impact of the large information campaign has proved at the same time impressive and not efficient enough.

Disseminating very general information, more focused on the risk linked to the disease, illustrated by frightening images, rather than credible and feasible prevention means, has entailed in many countries widely spread and irrational fear of the disease perceived as a punishment or a curse. This makes infected people hide their situation, as they are afraid of being rejected and forsaken by their community and even family (Namibia, Botswana, Thailand and border zones). It also entails stigmatization and massive rejection of anybody suspected to be infected or sick, these attitudes being aggravated by the general rule of silence on the subject and sexuality in general.

Thailand: Negative Cultural Constructions

Since its apparition in Thailand in 1984 AIDS has drawn up three negative cultural images. These cultural images have serious negative impacts on PWAs and their families:

AIDS: A Moral Laxity

The images and interpretations of AIDS which have been developed and transmitted to the general public are highly negative. In these images and interpretations, it is homosexual men who are first infected and then pass the virus on to intravenous drug users and then to commercial sex workers. Heterosexually active men then receive the virus and pass it on to their pregnant wives. Then their children are borne HIV+.

It should be noted that in this explanation of the stages of HIV transmission the initial victims of this disease are already marginalized groups in Thai society. They have already been stigmatized. Once they are infected with HIV/AIDS, they are considered to be the "reservoir" which breeds and passes the virus to other groups. They are even more stigmatized as "sexually promiscuous" groups, whose behaviour is sinful according to Buddhist norms. They are seen as the cause of the misery of innocent victims, i.e., women and infants. This perception of PWAs prevails in the society and has led to the view that they deserve to be punished by their own "karma".

Discrimination and stigma.: PWAs : The 'Dangerous Others'

The bio-medical significance of AIDS has led to a general belief that AIDS is a lethal disease which cannot be cured by any available medicine. AIDS is an infectious disease which can be transmitted through blood from an infected person, needle sharing or by sexual intercourse with an infected person. However, there is no clear explanation for the mechanism of AIDS infection. Therefore PWAs are seen as "persons with a disease which is ready to cause other people's death." Indeed such a perception makes PWAs become "the others" in society. The media spreads this perception throughout society and compare PWAs to murderers or to an enemy which should be entirely suppressed. A cartoon depicting a figure with bloody fangs and a sword and a statement describing AIDS as a "disaster" or

"silent danger" are both commonly used in the government's campaign against AIDS. This reinforces PWAs image as "the other", excluding them from the social and moral space of the Thai society.

Creating such images of PWAs has exacerbated the prejudice and social stigmatization against them. Newspapers that ran an article about a PWA who needed other people in a shopping center became best-selling editions and created more misunderstanding about PWAs. Although there were other sides to the story of PWAs and their families — such as being laid off work before exhibiting any symptoms, the ostracization of members of a PWA's family, or suicides among PWAs and their families — the society's attitude and prejudice remained unchanged.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Thailand's Experience*, UNESCO, 1999.

As a conclusion, national country papers emphasize that the content, language and phrasing of information/education/communication messages should be well adapted to the various populations targeted by prevention campaigns. Moreover, clear information has to be given on the distinction between risk and non-risk situations and behaviour in the context of people's daily life and culturally-based norms and behaviour. More specific understanding of the cultural, societal and human reasons for these types of behaviour requires more in-depth investigation and testing. The research data should be duly integrated in the process of designing prevention strategies and programmes as well as appropriate IEC messages, if significant change is expected in people's motivations, so as to accordingly empower them to act in the interest of their own protection by a change their behaviour.

2. HIV/AIDS Epidemic: a Complex Socio-Economic and Societal/Cultural Phenomenon

The country assessments also made it clear that HIV/AIDS is by far not a sector-based problem. It cannot be put under control through purely medical and sanitary action. It is related with all aspects of human activity, life conditions, the economic and social context, societal and cultural norms, models and value systems. As stressed in UNAIDS policy documents it requires multidimensional strategies, which will bear on various other issues aside from health and education, namely employment, housing, agriculture, industry and trade, rural and urban development, gender issues, family life organization etc. As pointed out also in the various country papers, interactions between HIV/AIDS, culture and development have to be acknowledged. More specifically, the expansion of the epidemic is closely related with major development problems, especially in Third World countries, seriously hit by the current international economic crisis. Consequently, besides UNAIDS and its co-sponsoring agencies, the collaboration of other UN specialized agencies active in these or related sectors, such as FAO, UNHCR should also be included...

The most striking aspects of the current situation are linked to various categories of development issues, which many countries have to face:

- Historical and political issues, for instance in the former colonized countries (Central and Southern Africa, Jamaica and Dominican Republic), the newly independent or self-

governing countries and, in the present South Africa, the heavy heritage of the apartheid period.

- Persisting resource and population imbalance between North and South countries, developing and least developed countries, through the very process of globalization, in fact “asymmetric” internationalization of economy, finance, knowledge, research and information.
- Exclusive quest of short-term maximum profitability in the “emerging” economic systems, resulting in credit and monetary collapse and subsequent social disasters.
- Persisting extreme poverty in certain countries and social groups within national wealth distribution systems, entailing dramatic decrease in life expectancy and infant child life and/or huge imbalance between family growth and income.
- Highly inequitable social development opportunities in education, employment, health and hygiene, and aggravating gender issues for women and girls (even if the greatest number of PWAs are still men).
- Political upheavals and institutional weaknesses: ongoing wars and international conflicts hitting civilian populations and provoking refugee movements, imbalance in internal/external decision-making power in domestic situations, excessive external debt weight and structural adjustment constraints, lack of communication between authorities and society.

All these issues were summed up in President Mandela’s statement at the Davos International Economic Forum in 1997: “The poor, the vulnerable, the unschooled, the socially marginalized, the women and the children, those who bear the burden of colonial legacy - these are the sectors of society which bear the burden of AIDS”.

It may appear that broadening the context of the epidemic to the whole socio-economic system is going too far. However, these economic and social difficulties have, in fact, a direct and serious impact on HIV/AIDS, whether at the stage of prevention, infection or care for the HIV-positive and sick people. If risk groups can be identified through cultural criteria, they are also victims of economic and social injustice: "Where there is poverty, lack of education, mass unemployment, insufficient or absent housing and hygiene, collective and personal life insecurity, these massive risks for getting infected or sick will exist" (Nelson Mandela). These disastrous socio-economic conditions in turn entail serious societal/cultural destabilization crises.

3. Socio-Economic Conditions, their Societal/ Cultural Impact and HIV/AIDS

The scope and weight of economic change and its social consequences, especially in connection with the generalization of market economy, entail dramatic consequences in the overall balance of development, at the international level as well as within countries, whether industrial, developing or least developed. These consequences in turn result in deep socio-cultural crises, introducing new practices and value systems, while previous ones are more and more fragilized and devaluated. Former value systems ruling the various aspect of family and community life, the commitment to solidarity towards their members, the feeling of dignity and ethics are wiped away by new practices linked to self-defense and individualistic

interest or informal group strategies for daily survival as a response to the overwhelming culture of modernity, with its prestige, attraction and demand for instant adaptation, failing which brutal rejection will follow.

South Africa: The apartheid trauma

It should be emphasized that, due to the long-term effects of the apartheid policy, deep traces are still visible in all sectors of the economic, social and cultural life of South Africa. Simultaneously, the present cultural resources are partly linked with these traumatizing experiences, which forged the spirit of the South African population as it is today, whether they maintained their cultural traditions or built, through the struggle for their rights, a culture of resistance and self-assertion in a more equitable society.

Nevertheless, apartheid, though in principle abolished since 1990, has had long-term consequences on the greatest part of the non-White population, which go far beyond medical and sanitary issues. This requires that a comprehensive response be built, if a culturally-appropriate understanding of the epidemic and the strategy to combat it are to be found.

More specifically the former Homelands and Bantustans system also left deep traces on the geographic distribution of populations, entailing socio-economic and socio-cultural imbalances with the inherent consequences on the HIV/AIDS issue.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: South Africa's Experience*, UNESCO, 1999.

Such changes occur for instance due to the urban explosion, which can be observed for instance in Thailand (for example, the large number of immigrants in Bangkok and other fast-growing cities in Northern Thailand like Chiang Mai), South Africa (the huge conurbation in-making between Johannesburg and Pretoria will amount to 11 million people in the next five years) or Santo Domingo in the Dominican Republic.

Simultaneously, rural societies and their traditional styles of life are declining, in relation to the urban attraction, the continuing impoverishment of rural populations and the decaying economic model of family subsistence, faced with large agricultural exploitations, whether in the form of plantations (Dominican Republic) or modern-type export-oriented agro-industry (South Africa, among others).

Both as a consequence and cause of this evolution, young potentially active men emigrate towards big cities and rich countries. This continuously growing trend breaks couples, leaving women and children in the villages or tribes of origin and aggravating the rural world's collapse. This evolution also results in migrants losing their cultural references, family and life models, aggravated gender imbalance, with large numbers of isolated men in big cities and forsaken women in rural areas, where they have to bear the full family load and exhausting work conditions. This leads some of them to also emigrate to urban centres and/ or resort to forced prostitution as a source of income, since opportunities for employment are very scarce, even with very poorly paid work. Such situations are described specifically in country assessments concerning the Dominican Republic, Uganda, or Thailand, where

providing “fresh meat” for prostitution circles, including from neighbouring countries, is a well-organized business.

The cultural consequences of these disastrous economic and social situations can be identified in the new emerging urban sub-cultures, which can be observed in poor suburbs, townships and shanty towns of big cities all over the world. These new practices and “counter-cultural” systems are closely related to private and public violence, drug smuggling and abuse, alcoholism and irresponsible sexuality. As a consequence, they correlate with HIV/AIDS high-risk groups and areas.

4. HIV/AIDS Multifaceted Impact: Socio-Economic Effects, Societal/Cultural Impact

From the first infection to the development of the disease itself, HIV/AIDS produces dramatic consequences on the socio-economic, societal and cultural environment of the infected people and their close family or sexual/emotional partners: loss of job, rejection by spouse or partner, family, community, breaking inter-personal relation systems, for reasons of guiltiness and shame of the infected, taboo, social stigmatization and fear from his/her human environment.

4.1. Economic and Social Impact of the Infection

The economic and social effects of the infection on the national economy can be spectacular. In South Africa for instance, if the epidemic continues to grow, as much as 20% of the economically active population will be HIV positive in 2000. Generally speaking, the strongest impact of HIV/AIDS is felt on business sector productivity and costs, and the national production system as a whole.

Angola: AIDS Economic Consequences

The Household Agriculture Sector

Angola’s main economic sector is agriculture. By affecting people of active age, who are able to work in the fields, the epidemic could exacerbate the existing socio-economic crisis among those families that depend on this sector. The labour force would be reduced not only due to the absence of the sick people, but also due to the absence of those family members who have to take care of them.

The changes in the recruiting and availability of labour could force families to shift from an income activity to mere livelihood production. This situation would reduce their income and further limit the capacity of external labour recruitment. Therefore the utilisation of child labour would force children to drop out of school. Low productivity jeopardises food security within households, causes malnutrition and interferes, above all, with education.

Due to the serious economic crisis and the lack of a structured social welfare system in Angola, the costs of education and health, which should be supported by the state, weigh upon the family budget. The cost of medical assistance and medicines proper to HIV/AIDS

is very high and therefore makes it unattainable, particularly for poorer and underprivileged families.

Recent research, estimated that the cost of hospitalization for a HIV+ child is about three times the father's monthly salary. Transporting the patient and the family members who accompany her/him further increases these costs.

Due to the situation presented above and added to the fact that AIDS does not have a cure, underprivileged people cannot properly assist the patient. They might even ignore the patient considering it useless to spend money on somebody already condemned to die. They might decide to spend their scarce resources on other family members who are healthy.

The reduction of family income could lead to a reduction of food allocations, clothing and education, meaning that children drop out of school earlier. This situation could be more serious among women who, in many cases, lose their right of inheritance from their husbands and are thus forced to return to their native homes with their children.

Informal Sector

Due to the economic crisis, the majority of the population works in the informal sector where commercial activities are predominant. According to some authors, this sector contributes to the development of high-risk behaviour, such as prostitution, drug use and so on. Youth, particularly young women, are the most at risk. However many families depend on this sector for their livelihood. In addition, the mobility across the country of people working in commercial activities could exacerbate the spread of the disease within the country.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Angola's Experience*, UNESCO, 1999.

- a) At the micro-economic level, productivity can be reduced by large absenteeism or loss of morale at work. At the same time, production costs increase through payment by the employer of additional employees' wages. Due to the loss of skilled workers through AIDS, it becomes increasingly necessary to train new workers .
- b) The macro-economic effects of AIDS are more difficult to assess. Undoubtedly, the epidemic will reduce national income and the population will spend money, as little as it may be , on health care and minimum daily expenditure. Over a 20-year period, economic production could decrease by 25%, as a consequence of AIDS. More specifically, as growth slows down, fewer services will be provided and the purchase power will decrease. As regards capital for the private and public sectors, life insurance and pension funds can be dramatically dried up in emerging economies.
- c) Social impact: For the general population, the infection means either the development of free care systems or minimal purchase cost of medicine, not to mention the physical and cultural accessibility to medical centres or specialists. Very frequently also, it results in infected people's dismissal from job, making it impossible for them to make a living for their family or to send money to their native

village or tribe, especially in poorest areas or in emigration countries. This situation is very frequent in Southern Africa or countries bordering Thailand.

In the best of cases if a parent dies of AIDS, the family, more so grandparents, will take care of orphan children within the limits of their own resources. If not, widowed mothers and children may be expelled from their home and/or orphans abandoned **in the streets of big cities**, with all subsequent dangers (malnutrition, dropping into gangs, early prostitution, etc.). Assistance to orphan children is dramatically insufficient, especially in African countries, where AIDS death rates are the highest in the world.

Uganda: Impact of HIV/AIDS on the family

The capacity of the family and the community as a whole to care for AIDS patients is influenced greatly by the income levels and the social networking. In so far that AIDS kills the most productive age group (20 - 50 years) it follows that the disease depletes the most productive members of the family. In some cases these are the very people who are expected to provide care services such as finance, food and housing.

The impact of AIDS on the family is to rob the family of the income support and leave behind large number of dependents (children and the elderly) who become more vulnerable.

Previous studies show that people in high income groups are more likely to attract more prospective sexual partners and they will also be likely to have more money than a person with low income to compensate sexual partners. Hence, the rich have tended to be more at risk than the poor. Similarly, whereas it is expected that the educated will be more knowledgeable about HIV transmission, unfortunately they have ended up being more at risk of HIV infection given the possibility that the educated are also in high-income groups.

Studies have also established that the death of a prime age adult is not only a tragedy for the household, but it has a long-term impact on the survivors in several ways.

First, the psychological and emotional stress and trauma which the survivors have experienced, have largely remained unattended to. In the Ugandan context, there is evidence that in most communities, there are no psycho- treatment and counselling centres specifically established to address this need.

Secondly, AIDS imposes very high medical costs prior to death as well as high costs for the funeral. In the Ugandan cultural context, the family must also find money to finance the funeral rites, which in most cases, cannot be easily afforded. All of these factors combine to make the impact of AIDS on the family devastating.

Thirdly, with the onset of the HIV/AIDS epidemic, women's roles as caretakers and providers have had to be adapted drastically for personal and family support. It is the woman who will take care of a sick husband until he dies. A sick woman may be moved back to her natal home so that her old mother can take care of her. Sometimes, when a woman is sick, a sister or daughter will move to her home to take care of her. When a woman survives her

husband who has died of AIDS she becomes fully responsible for her family. In some places she is shunned and will therefore move away to a place where people do not know her.

She may even remarry in order to support herself and her children or she might exchange sex for money and other favours, especially if she has little education or occupational skills.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Uganda's Experience*, UNESCO, 1999.

4.2. Cultural/societal impact of HIV/AIDS

Many infected people remain unaware that they are HIV-positive, since testing systems are far from being available everywhere. When detected through HIV screening, the societal and cultural effects, in the short and long-term, are generally disastrous for them and their family or group. The professional and social rejection of infected and sick people results most frequently in a serious crisis, destruction of personal and community links and deep moral, cultural and economic distress.

This is why infected people frequently dare not inform their spouses or regular sexual/emotional partner. In other cases, people pay no attention to being infected, because of their disastrous socio-economic situation or, on the contrary, economic and social superiority ("sugar daddies", and even people with authority in business, public order, or education). Among those whose profession entails frequent mobility: truck drivers, peddlers, sailors, soldiers, mercenaries, itinerant merchants, officials, temporary workers in mining, industrial fishing, agriculture or construction many do not realize their responsibility towards an occasional sexual mate. Thus areas of concentration of the epidemic and prostitution correspond with activity zones in these professions, especially along national borders, highroads and in harbours.

In the most extreme situations, the disease can result in an AIDS rage, when the infected person deliberately infects purposely new sexual partners as a vengeance against catching the virus or for a supposed curse. Another possible attitude is to take the risk consciously, as a kind of challenge or gamble, as is the case among certain urban segregated groups of young people. Even worse, for men who do not want to feel responsible is the refusal to be tested.

Finally, in areas where epidemiological risks are high and multiple (malaria, typhus, cholera, sleeping sickness, TB, STDs in general) and deadly dangers frequent (war zones, mined areas), people do not feel the same urge to crusade against a specific disease and one deadly danger more than against others.

But the most serious aggravating factor is the cultural shock generated among the younger generations through brutal immersion into the urban/modern world, where new domestic or foreign migrants from the rural and tribal or semi-tribal zones (see for instance the Upper Mekong region in Southeast Asia), must face at once the world of materialistic interest, individualistic/selfish behaviour, harsh competition for jobs, mass unemployment, poor or no housing, in other terms, daily "struggle for life" in a world with no respected laws.

A particularly spectacular example in this respect is the situation of young girls from the border zones of Thailand, with no other educational and cultural references than those of their communities of origin, thrown by commercial sex businessmen in industrialized prostitution.

The same cultural and human shock occurs for instance in the Dominican Republic with young girls and boys, far below intellectual, moral and even physiological adulthood, forced into prostitution for reasons of mere economic survival, in a context of highly insufficient education, mass unemployment and prosperous tourist sex industry. In such situations, getting infected will be together an economic, social and cultural disaster, the more so as it goes together with drug addiction, as a result of mental depression, cultural dereliction and loss of vital references.

5. A Worldwide Cultural Destabilization Crisis

The present international contradictions in the development crisis are not only economic and political. They are related to the whole system of representations in all societies, even more seriously in developing countries, where cultures are undergoing an overall crisis, in the face of the economic and technological globalizing phenomena and the prominence of international cultural uniformization trends.

This crisis is reflected both at the general level of the societal machinery and in sectoral and even highly specific issues, such as the HIV/AIDS pandemic.

In this respect, the fundamental reasons for people's refusal or reserve against the apparently efficient and rational prevention and care system of HIV/AIDS are also cultural and deeply linked to their deepest convictions. They are reflected among others in the following manifestations:

- Family model crisis: spouses separation, children's and wives' forsaking, due to extreme poverty, loss of morale, weakening of the extended family model as solidarity system.
- Migrations for economic reasons or on account of violent conflict situations: they break people's cultural identity and links with the original group, resulting in situations of economic, social, intellectual and cultural distress.
- Growing aggressivity and xenophobia towards people of other cultural groups, even after long cohabitation, as well as towards recent immigrants .
- Worsening of women's condition, entailing impoverishment, impossibility to take care of children and forced prostitution.
- Prominence of the urban cultural model and city survival culture leading to sexual carelessness, drug addiction, violence and subsequent advocacy, of "no laws for the strong ones", all resulting from the urban explosion and promiscuity due to insufficient housing and hygiene.
- For young people, large cities are viewed as the place for seizing opportunities or losing hope for solutions, especially in matters of education, employment and adult life organization.

6. Common Issues, Field Diversities

As it appears from the various country papers, it can be considered a common trend that HIV/AIDS hits populations in relation to their living conditions and that development disparities and dysfunctionings directly or indirectly aggravate the impact of the disease.

Consequently, a world-wide awareness of the danger is spreading everywhere, however its causes and manifestations remain unclear. Thus, it can entail emotional reactions of fear and rejection, instead of medical and hygienically correct behaviour, which also can be surpassed by pressing daily life issues.

Another common feature, emphasized over and over in country assessments, is the complexity of the HIV/AIDS issue, beyond its purely epidemiological reality, as a socio-economic, societal and cultural phenomenon, interacting in depth with development processes and distortions. This can frequently be noticed in the context of changing from rural, traditional, non-market patterns to the homogenizing urban/modern market- and industry-oriented global model. Thus the HIV/AIDS crisis is at the same time a determinant and an effect of the overall economic, societal and cultural crisis at work worldwide .

As a consequence, a common cultural trend of evolution can be noticed in the three sub-regions under review. On one hand this phenomenon is related to the accelerated disintegration of people's specific cultural references and resources systems. On the other hand, in many cases it is extremely difficult to provide reliable opportunities for new cultural and societal impulse to emerge and allow people's thinking and behaviour models to change, in sustainable and human-oriented ways, built on their own initiatives and action capacity.

Finally, all country assessments come to similar conclusions as regards the insufficient relevance of the current prevention and care strategies and programmes, in relation to the diversity of societal/cultural systems.

In short, common trends deal mainly with the specific issue, its direct causes and effects, in relation to socio-economic overall situations, at the national and international level.

Another common trend is the insufficient relevance of the current prevention and care system, in its interface with societal/cultural systems and its narrowly designed rationale, as opposed to an overall development approach.

III. CULTURAL AND SOCIETAL DIVERSITIES

As mentioned previously, it was decided from the outset that country assessments should be carried out in three prioritized areas: Southern Africa, Southeast Asia and the Caribbean, for reasons directly linked to the epidemic, but also to their overall situation and the populations' response to the action taken to date. In this respect, it was possible, through summarizing the research, to draw up, within each sub-region, societal/cultural and socio-economic similarities, which may be of use in designing regional and sub-regional UNAIDS prevention and care strategies.

Simultaneously, the identification of deeper cultural diversities were makes it necessary to tailor smaller action units that integrate cultural specificities .

1. Regional Societal/Cultural Areas and HIV/AIDS

1.1. The Southern African Sub-Region

In the Southern-African sub-region, where the epidemic is spreading very rapidly, most countries have undergone deep social, political and cultural transformations and/or destabilization crises in the past twenty to twenty-five years. This period corresponds roughly to the traceable history of HIV/AIDS at the world level and, more recently, in Africa itself. Besides, several countries have been subject to important population movements, domestic or originating in neighbouring countries. This might partly explain the remark made in the Report of the Geneva Conference (June 1998), that there is a growing trend of the epidemic - in other terms of infected people - to spread towards Southern Africa through North-South population movements. South Africa appears to be the main attraction area to these movements, mostly for economic reasons. These population movements are probably also related to current or recent armed conflicts in Central Africa, which make it an area from which people tend to flee, thus increasing the number of refugees. On the other hand, infection areas develop along high roads and trade centres, alongside with manufactured goods transportation from South to North.

However, the fundamentals of the education in each country are quite different. A rough approximation would be that in South Africa, HIV/AIDS is an urban/suburban phenomenon, spreading to rural areas, in the country or neighbouring countries (Botswana, Namibia, Swaziland and Zimbabwe), while in Malawi, Zambia and Uganda it is predominantly rural and in Mozambique or Angola, it is closely linked to the consequences of recent or current civil wars or wars in the country. These situations entail periodical flows of migrants and refugees and considerable difficulties for institutional action to cope with the extent and seriousness of the situation.

Another significant difference is that the health and educational systems are by far more developed in South Africa viewed as a whole, though with spectacular internal disparities between the privileged minority, mostly White, and the deprived majority, mostly Black. Given the fact that, starting from the first infection by the virus, an average delay of 5 to 10 years is generally noticed before AIDS declares itself, this means that the detection and prevention system was either non-existent or seriously defective at the end of the 80s and beginning of the 90s. As regards other countries, the rate of infection can be explained by the overall socio-economic situation and the subsequent deficiencies in the educational and sanitary system.

A more culturally based approach of these societies would be to consider whether some of the traditional rules of behaviour and value systems, which might make people refrain from dangerous practices, are still valid and respected. The reverse hypothesis is that the crisis in Southern African countries has destroyed, more or less completely, the norms which, for a long time before, governed relations within the family, group, community, or the society at large. In this case it would be necessary to analyze the content of the emerging new models that tend to replace traditional ones.

Through the answer to this question, it will be possible to determine if it is sufficient and more productive to go on with medical and rationalistic IEC or if the response to the institutional and medical warnings against the spread of the disease have to be secured within

the framework of a general improvement of people's living conditions and rooted in their ways of thinking and behaviour norms.

1.2. The Caribbean Region

If infection rates in the Caribbean are less dramatic than in Southern Africa, the epidemic remains an important concern for countries like Haiti, the Bahamas, Barbados and the Dominican Republic, while countries like Jamaica, Trinidad and Tobago seem less hit and Cuba appears to face the disease with real success.

However, according to the UNAIDS Geneva Conference however, the overall rate of infection is substantially higher in the Caribbean than in Central and South America, with the exception of Guyana, Belize and Honduras. According to the same document, by 1993, 8% of pregnant women in Haiti were infected by the virus and the same prevalence rate was reported from one surveillance site in the Dominican Republic in 1996.

The Conference document gives other information on the situation in the Caribbean. In the French and Spanish-speaking countries of the sub-region, there is a predominance of the infection spread through heterosexual relations. In other countries, a certain number of HIV transmission cases are linked to drug-injection use, bisexual and men-to-men sexual relations. The whole Sub-region is characterized by a high degree of population mobility and prosperous tourist industry, both factors being likely to influence the virus expansion. As in other regions, casual sex relations are more frequent among men than women.

Among societal/cultural references linked to HIV/AIDS risk behaviour, the issues entailed by daily life conditions, economic difficulties among the general population and lack of open relations between men and women have to be emphasized. Other possible causes are country-to-country migrations or migrations from the Caribbean to North American countries (and vice versa) and the importance of the prostitution of young men and women in relation to the tourist industry (Dominican Republic, Dominica and the Bahamas).

Another original feature is the relative public tolerance regarding men-to-men sexual relations. Probably under the influence of the US gay movements, infected gay people have started networking, in order to protect their access to medical care and to promote safe sexual behaviour, thus showing that a certain trend towards solidarity is emerging from the population itself (Jamaica, Dominican Republic). The same solidarity movement can be observed among mothers of infected or even sick young people, among the poorest sectors of society (Dominican Republic). This might be related to the traditional Latin American prominent role of mothers, possibly reflecting Roman-Catholic devotion to the Virgin Mary in Spanish-speaking countries.

1.3. South-East Asia (Thailand and the bordering countries in the Upper Mekong Valley)

Southeast Asian countries, including Myanmar, Thailand and Cambodia, show the highest levels of HIV infection in Asia. However, in Thailand itself, the spread of the infection, especially among sex workers and their clients, has apparently decreased while the number of HIV-infected people through drug injection is rising. The main reason for this decrease in sex-

related infection is the growing use of condoms among heterosexuals and the fact that men are discouraged from visiting prostitutes, while girls are strongly advised not to go into commercial sex to make a living. In Northern Thailand, however, drug injection and men-to-men sexual relations seem to explain the higher figures in recent cases of infection. In Myanmar, HIV infection among sex workers was about 20% in 1996 and 65% among injection drug users, while 22% of pregnant women living in urban areas were infected.

The Upper Mekong Region, the most severely hit HIV/AIDS zone in Southeast Asia, covers inter-related areas in Myanmar, Northern Thailand, Chinese Southern Yunnan, RDP Lao and Cambodia. It is characterized by ethnic diversity, cultural plurality and linguistic complexity. A common feature however is the importance of population movements linked to trade (legal and illegal), job searchers (truck drivers, mule caravans, migrant construction workers) and, more recently, tourism. Many different ethno-cultural minorities live in the area, and are at more risk of HIV/AIDS infection due to their poverty, the degradation and destruction of the natural environment, rural exodus, lack of culturally-appropriate education and information and cultural-societal destabilization and breakdown, massive drug use and active involvement in the sex trade.

The third major component of the HIV/AIDS crisis is the sudden eruption of fast economic growth in the region, not only in big cities like Bangkok and Chiang Mai, but also in smaller towns and rural areas and communities. It appears to have given a new impulse to quick money-making activities and a new demand for industries. This translates into massive trade of young girls from culturally fragile population groups or minorities some of which might even disappear in the near future. The sudden economic and monetary crisis, which exploded in all Southeast Asia in mid-1997, made the situation in the region even worse, due to the even tougher attitudes adopted by traders and businessmen in economic difficulty towards socially/culturally fragile groups and minorities.

Thus, major features that differentiate the situation in Southern Africa (non-pertinence of the current prevention and care system to the socio-economic, institutional and societal-cultural situation), the Caribbean (great economic poverty, prostitution as an informal survival system, versus the North-American model and the mass tourism industry) and Southeast Asia (collapse of the traditional cultures in the face of "wild" market economy expansion) can be identified.

2. Major Cultural Diversities

Beyond regional similarities, a new level of complexity is reached when it comes to national or sub-national diversities. Taking them into account is indispensable if people are to be given a new sense of responsibility and commitment to make the fight against HIV/AIDS one of their highest priorities, as compared to their previous priority systems.

The issue is made even more complex by the importance and nature of cultural diversities, which are at the core of the development challenge. These make it necessary to develop pluralistic strategies and projects, in order to improve efficiency and sustainability in the actions taken, especially at field level.

These diversities are linked to cultural traditions, religious beliefs, health and life/death representations. They also include norms, rites and practices regarding family and societal models, men/women relations, parents/children caring and emotional links.

2.1. Cultural Traditions

The populations' concern for the preservation of their cultural traditions is extremely different, depending on their rural or urban environment, socio-economic conditions, political situation, demographic prominence or inferiority of the given population groups, stability or destabilization in daily living conditions. In cases of external threat or loss of community self-managing power, traditions will be called upon and preserved with the utmost attention. Some of these traditions can be considered as direct or indirect risk factors while other can be used for building positive response in prevention, care and solidarity.

Malawi: Cultural Practices

Widow inheritance

Under this custom a widow is usually inherited by the brother of the deceased, thus exposing either of them to HIV infection if one or the other is infected. This practice is common in Northern Malawi where its traditional name is *kuhara*.

Nursing the Sick

In most Malawian families the role of nursing the sick is left primarily to women, as they evolve socially in support roles associated with production and serving the family. Inevitably, if the person being nursed is an AIDS patient, the woman may be more at risk than the man, who rarely gets involved in practical nursing of the patient.

Property grabbing

Upon the death of a husband, his relatives usually grab property from the widow. Some of the property may be that through which the family was generating income. The woman is thus left to fend for herself, sometimes through 'commercial sex'.

Preference for sending boys to school

Most parents feel that it is better to educate a boy than a girl because the educational returns for a girl will go to her husband and his parents. Parents also see their daughters' roles as independent from education. Such attitudes put girls at a higher risk of HIV/AIDS than their male counterparts, due to the fact that they may not grasp daily life issues as well as those who have attended school.

Many other studies conducted in Malawi on culture and HIV/AIDS prevention and care have come up with similar findings. Therefore suffice it to say that information on culture as it relates to HIV/AIDS in Malawi is not lacking, but badly exploited.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Malawi's Experience*, UNESCO, 1999.

Examples of such attitudes can be found in Southern Africa and Southeast Asia. In the past and present South Africa, Zulu people have put a spectacular emphasis on their culture and cultural traditions to conduct and manage their relations with the former White-only regime and with the present government. In other countries, cultural traditions are mainly maintained among rural people, often threatened for economic, social or political reasons. This is the case for instance among the semi-nomad tribal populations in the Upper Mekong Valley in Myanmar, Thailand, Chinese Yunnan and Northern RDP Lao. In both cases, cultural traditions as such have not enabled these populations to preserve themselves from HIV/AIDS infection and may even have contributed to exposing them more to the disease.

Moreover, certain traditions constitute direct risk factors of contamination through infected blood, whether they relate directly with physical rituals or, more widely with behaviour norms and practices, for instance: ritual violence against women, girls and children, circumcision and excision, ritual scarifications, brotherhood seal through blood mixture, etc. (in certain Central African countries: Angola, Democratic Republic of Congo, Zambia).

Angola: Traditional practices and HIV/AIDS dissemination

Some traditional practices, some of them might be identified and re-evaluated within the framework of HIV/AIDS prevention and care, in order to reduce risks in the dissemination of the epidemic. Among these possible risk practices, the following can be listed as specific examples:

- Learning about sex with or without rites of initiation (i.e. through sexual relations): the traditional way of learning about sex also contributes to the dissemination of the disease since the "adult teachers" (men and women) could be infected without knowing it.
- Scarring, with special attention to the practice of tattooing which is associated to beauty in certain ethno-linguistic groups . This practice could transmit the disease due to the use of infected cutting instruments;
- The practice of blood brotherhood in which two people exchange and drink their blood as a symbol of mutual faithfulness. In general, it is a pact that two individuals or representatives from two groups consolidate through a rite in which they exchange blood. The pact creates brotherhood and a sacred and sound friendship that, demand punishment when betrayed. In Angola, Kikongo young people exchange their blood during the rite of circumcision, *"after soaking a piece of cassava in the blood of their foreskins, they eat "the bread of the Brotherhood"*.
- Circumcision for girls and boys (individual or collective): when practiced as part of rites of initiation, it covers a generation. If the blade is infected, everybody runs the risk of infection.
- When the umbilical cord is cut : the midwife may use infected cutting objects. However, and according to a Kikongo girl, the traditional method does not use cutting objects. *"They tie a knot, then stretch the cord from this knot and it snaps straight away."*
- Polygamy: some participants think that polygamy, practised in the traditional way, protects the man and his wife from STDs and AIDS. Others disagree arguing the man does not have a relation with all his women at the same time. He has "acquired" them through

time and, in some cases, he becomes polygamous through the practice of substitution. The modern patterns of polygamy and possibly, promiscuity, above all among couples that do not share the same house, contribute to STDs transmission, particularly AIDS, if the husband or one of his wives is infected.

- Defloration of girls by their fathers: it is a practice observed in few groups, but which can facilitate the transmission of AIDS.
- Traditional marriage within the same tribe: it is a way in which to protect the group within which the disease could be disseminated, as long as none of its members are infected.
- Traditional healing when infected cutting or sharp objects are used.
- The practice of substitution and similar ones.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Angola's Experience*, UNESCO (1999).

A number of country papers give further evidence that other behavioural norms and practices are also, to some extent, considered as risk factors: for instance, early marriage for girls, sexual promiscuity and violence, early and frequent pregnancies for married women, men's extra-marital sexual relations during young mothers' postpartum period, polygamy, frequently linked with agrarian societal systems and traditional principles among Muslim populations. This last point is however debated by traditionalists in the given examples. Finally, men's deeply rooted feeling of superiority akin to *machismo* in Latin American countries (Dominican Republic and even Cuba) and the principle of giving a privileged status to sons and boys in education and social life, so immemorial and undisputed in many countries (Mediterranean countries, Arabic area, India, Latin America), is in fact considered as conducive to men's sexual unfaithfulness and multi-partner sexuality. Moreover, in Jamaica for example, men's obsessive concern for masculinity is deeply rooted in their memories from the slavery period and subsequent feeling of being fundamentally dominated and powerless, except in sexuality, where the least suspicion from the group that they might harbour femininity would entail deep psychological breakdown.

On the other hand, in other countries, an effort towards reviving cultures and traditions, as testimony of respect to elders in communities and to ancestors in religion and ethics, is attempted by young people, for instance in South Africa, among the Zulu and Xhosa community. In the context of mother/child infection during pregnancy or breastfeeding and, more widely, parents/child relations, these initiatives may appear to be attempts to restore trans-generation responsibility, with possible application to the danger of HIV/AIDS transmission.

From another point of view, the possible inequities towards women in polygamous systems are often substituted in modern life conditions by highly inequitable and sexually dangerous "informal polygamy" or a multi-partner sexual life on the part of men (including bisexuality in the Dominican Republic, Jamaica, Thailand), for example in Uganda, South Africa, Botswana, Zimbabwe and, to a far more limited extent, on the part of women (for instance in Angola).

These observations should also be linked to the issue of prostitution, a traditional practice, but evolving quickly into a commercial sex trade and industry, in countries with high tourist activity, like Thailand or the Dominican Republic. It may also grow for reasons of easy money-making among unscrupulous business people, who may combine it with drug production and smuggling. Concerning Southern African countries, it appears to be linked with the massive emigration of working men towards big cities and mining areas, where they live in isolation from their family and community, to which they will bring back the virus during their rare visits. Female prostitutes often see their activity as the only possible source of income (Dominican Republic, Uganda, Thailand). They may transmit the infection to their family when they return to stay in their native villages, possibly to work as small shopkeepers or street merchants.

2.2. Religious Beliefs

Given the geo-cultural diversity of the countries under review, religious beliefs have been examined in all their diversity: Christianity, Islam, Buddhism, Hinduism, traditional animist or shamanistic religions, and the syncretic trends between several institutionalized religions.

Spiritual beliefs in general can interact closely with the HIV/AIDS issue. Evidence of this was provided by several country assessments (South Africa, Uganda, Thailand, Dominican Republic). But their impact and influence is very different, depending on the intensity of beliefs and religious practice, the plurality in religious references and its consequence in building ethics and behavioural rules.

Religious convictions may for instance develop compassion and concern for moral comfort and care of the infected and even sick persons - an attitude, which is far from general.

More specifically, religious beliefs can develop organized charitable action towards poor people, for reasons of universal love or as a source of gaining merit: charity can be and is practiced by religious people and NGOs towards the poor and sick, including PWA. For example, certain communities of Buddhist monks in Thailand, Christian priests and missionaries in urban centres of Southern Africa (Zambia, Zimbabwe, Uganda, South Africa), Latin America (among others through the liberation theology) and the Caribbean (Dominican Republic) or imams in Muslim countries (Senegal, Sahelian countries and Uganda).

Religious beliefs can also result in new solidarity through associations, movements, NGOs, networks, and may provide rich opportunities for community-based projects, for instance the TASO (The Aids Support Organization) project in Uganda or certain associations of infected or sick people in the Dominican Republic. Thus, they are the basis for altruistic ethical systems, especially as regards duties and responsibility towards oneself and the others (self-dignity and respect towards others, as parents or spiritual “brothers” and “sisters”). More in-depth investigations regarding charitable action linked to the various cultural traditions should be conducted in this respect. Restoring self-esteem through religion should also be more documented.

Concerning life rules and representations, religious beliefs shape people’s feelings regarding fate and the future, through the interplay of natural and supernatural forces. It can lead them to respect certain behavioural norms, with the explicit aim of obeying supernatural or divine authority. In other cases, it can make them judge that life and death are questions of fate, uncontrolled supra-human decision-making processes and life models (life is ruled by

everyone's karma). This can deprive people of confidence in their own capacities to build and control their lives, or elaborate a more complex view of human life issues and their relation with the natural environment (Malawi, Uganda, Dominican Republic). At another level, this type of belief is connected with belief in the power of magic (black and white) and witchcraft (beneficent or maleficent).

Malawi: Traditional medicines and Witchcraft

Many communities believe that HIV/AIDS can result from magic. Some communities distinguish AIDS from two traditional diseases, "tsempho" and "kanyera" which have similar symptoms to AIDS. "Tsempho" and "Kanyera" are what the communities believe to be diseases that affect a person because of the following: -

"Tsempho" - violation of sexual restriction
- extra-marital sex
- promiscuity
- having sex with a woman who had a miscarriage

"Kanyera" - having sex with a menstruating woman
- having sex with a woman who gave birth recently
- having sex with a woman who has had a miscarriage
- having sexual intercourse with a person with "Kanyera"

There is no clear distinction between certain symptoms of "Tsempho", "Kanyera" and AIDS (i.e. thin hair, weight loss, diarrhoea, 'marasmic' attitude), moreover they have in common the fact that they are infectious and fostered by promiscuity. As a result, if members of the community are convinced that someone suffering from an AIDS-related illness is actually suffering from "Tsempho" or "Kanyera", they take them directly to a traditional healer for treatment. This, because they believe the latter to be curable with herbal medicines. Meanwhile the infected person will be exposing others (e.g. spouses) to a high risk contagion.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Malawi's Experience*, UNESCO, 1999.

As regards self-dignity, respecting religious rules of life can also result in specific consuming habits and food taboos, for instance in the Islamic or Hindu tradition, the ban concerning alcoholic drinks or hallucinogenic drugs, the effect of which can aggravate unsafe sexual practices. This might possibly be extended to other aspects of personal dignity: physical and moral health, dedication to parenthood, etc.

A more general question should be raised as regards the comparatively low infection rate reported in Muslim countries in general: are hygiene and overall moderation prescriptions more observed through Islam than through other major religions? Is men's circumcision a positive factor regarding infection through sexual relations?

2.3. Culture, Health, Life and Death

Representations of health, life and death are very influenced by cultural references and consequently highly specific to the various societies and countries reviewed in the assessment exercise.

Good physical condition - and thus good health - is an important social value in all cultures - and thus was verified in all country assessments, in South-East Asia, Southern Africa and the Caribbean. Its importance is linked to work, physical exercise and aesthetic/erotic appreciation. It is mostly manifested in traditional and modern popular sports games (soccer, rugby, basketball, boxing) and manual work, where manpower is synonymous with physical strength and resistance. Physical attractiveness, though a fickle criteria, plays a key role in emotional/sexual relations. This takes more importance in modern life conditions, because it involves personal choice in men-women relations and marriage. In traditional models, the husband can be old and unattractive, provided he is economically and socially important. On the other hand, the bride must be young and "appetizing", according to aesthetic rules that may vary subject to the various cultures.

These considerations can be of interest in advocating preservation of good health in general, more specifically as regards HIV/AIDS. In the matter of sports, the social and cultural impact of which does not need much explanation, interesting initiatives were taken in numerous countries, among which South Africa, in order to preserve young sports fans from infection and to strengthen their motivation, by emulation of their favourite champions, for example. Similarly, famous singers or film stars were invited to become role models.

Another situation where diversities will become explicit, is the attitude towards modern medical assistance or recourse to traditional healing systems. Medical doctors are the regular recourse in social groups with high education and a good economic situation, living mostly in urban centres, for instance in Thailand, South Africa or, for reasons linked to the social and political system, in Cuba. However, traditional healers are highly trusted and frequently consulted by people of all social origins, for their ability to listen and counsel (as a psychotherapeutic recourse), in terms that are understandable to local people, as well as to cure sick people, to an extent which is not well documented or deliberately occulted. In some cases, they can act as cultural-societal intermediaries between populations and the modern medical system (see for instance the Zimbabwean Traditional Healers Association). They are now officially recognized as medical assistants in South Africa. Midwives can also play an important role in counseling and assisting pregnant women and young mothers as regards infant children's care, breastfeeding (Malawi, Uganda...).

Cultural views of life and death are also part of the challenge. They differ according to the various religions practiced in Africa, Southeast Asia or the Caribbean. Depending on specific cultural and religious representations, unexpected death is considered as mere fate, against which nothing can be done, or as divine punishment for mistakes and sins. In other cases, death will be the consequence of errors in observing rituals and offerings, and visiting pilgrimage centres. On the contrary, charitable acts towards poor and sick people (beggars at the entrance of the main sanctuaries) or in day to day situations can mean spiritual progress (gaining merit) towards a happy after-death (sojourn of endless bliss, fusion within the Universe or end of the reincarnation process).

Besides these formal representations, animist or magic beliefs are closely connected with fear of death and the risk of discontenting gods or ancestors. The aftermath can mean further suffering, relief, total disappearance or fusion into the flow of life. In African religions or the voodoo tradition in the Caribbean, it is feared that dead people transmit curses to their descendants (possibly through disease), unless they are properly invoked and celebrated in cult ceremonies. This could be used to illustrate the responsibility of parents in infecting their children and descendants.

Perhaps the notion of “a good” or “a bad” death, which is recurrent in many religions, could be used to persuade people that they should consider the risk involved in HIV/AIDS, as a danger of undergoing a “bad death”. Gaining merit for after-death could also be the motivation for greater compassion and support towards infected or sick people.

These different conceptions of death and the subsequent feeling that life is precious, are presumably of importance when it comes to considering HIV/AIDS as a risk of painful agony and unavoidable death for oneself and one’s loved and cherished. Thus, life and death representations can play a certain role in building a sense of responsibility in the prevention, detection and transmission of the virus. Nevertheless prevention should not exclusively be based on people’s fear, whose effects can be fully counter-productive (for instance, tribal people in Northern Thailand refusing to continue discussing HIV/AIDS).

2.4. Cultural references in sexuality

According to the various country assessments, and as shown through the anthropological research and historical-sociological study of different cultures, sexuality is central to human life. Women’s fertility and trans-generation continuity are major values in traditional societies. They are closely linked to traditional marriage patterns, and are as important as any political or economic agreements. Traditional marriages are still common practice in African countries, especially among rural populations and persist even within Latin American models of sexual and conjugal life (Mexico, Dominican Republic, Cuba). According to the prevailing social model, a regular couple must have children, sterility is seen as a great misfortune, and motherhood is the most significant aspect of women’s life.

Jamaica: Traditional beliefs on fertility and sexuality

Traditional beliefs on fertility and sexuality in Jamaica today are based on centuries of attitudes and practices that are difficult to erode. One example is reflected by the perceptions and negative attitudes towards modern contraceptive methods, that have nothing to do with religion, but rather with traditional culture. This includes attitudes towards the body and belief that the body must be strong and clean. It is held that coitus is essential to the physical and mental health of men, although it is supposed to have a weakening effect. For women, however, coitus is important to avoid the danger of sapping natural vitality. The body’s interior is regarded as mysterious and sacred, thus the “fear of losing things up there” is strong among Jamaican women. Condoms are regarded as invasive objects that could slip off and disappear, causing sickness, sterility and even death by blocking off the tubes.

Sexuality is also seen as a reason for existence in Jamaica. Women, it is held, must have children or must "have out their quota..." in order to rationalize their existence and to release natural vitality. Young men must prove their masculinity by impregnating women. Actually, according to recent research on gender and sexuality in the Caribbean, many of the rituals and characteristics demonstrating a man's masculinity are in fact female characteristics that reflect negatively on the welfare of women.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Jamaica's Experience*, UNESCO, 1999.

In many non-Western societies (for instance in Southern African countries, except South Africa, in Cuba, in Muslim countries), sexual orientations as such, for instance homosexuality, masculine and feminine, or bisexuality, do not have their representative communities, pressure groups and lobbies, as in certain Caribbean or industrial countries, where they may even play a political role. However, in many countries, men-to-men sexual relations may be a more frequent practice than publicly recognized, as an alternative means of sexual satisfaction. This can contribute to spreading the infection in specific places like prisons (South Africa) collective workers' or students' hostels. This can also lead to male prostitution (Dominican Republic). On the contrary, gay communities can raise solidarity movements towards prevention and care as well as build network of infected or sick people in homosexual circles (Jamaica, Dominican Republic, Thailand).

Physical attraction, sexual pleasure and emotional completion for both partners are increasingly recognized as important components for men-women or same gender relationships, within the new practices and value systems linked to the modernization process. The pleasure-only aspect of the relation can even be overemphasized and felt as a justification for giving priority to men's sexual relief and for recourse to prostitution as a vital urgency (for instance in Southeast Asia), while a woman's pleasure will be considered as secondary or even irrelevant.

In some contexts the acceptability (linked to values and principles) and admissibility (relevance and appropriateness) of sexual abstinence, different modes of sexual relief and concern for safe sexual relations raise fundamental issues, far beyond the medical and sanitary approach or moralistic attitudes. Moreover, such directive and intimidating prescriptions do not take sufficient account of people's real life conditions: massive emigration of men, absence of entertainment possibilities, dehumanizing life conditions leading to forms of entertainment involving alcohol, drugs or irresponsible sex.

Uganda: Ritual Sex

Sex can often be linked with other important events as a way of giving these events extra meaning in people's lives. Among the Ankole in the West, there are at least 33 special occasions associated with ritual sexual acts between husband and wife; these include harvesting time, building a new house, and birth of children. In Bunyoro, ritual acts to symbolize sex, and sometimes actual sex, are used to 'leave the dead after a period of mourning. These acts are required of the widow and sometimes other male relatives and are

supposed to be carried out with strangers. Ritual sexual acts are also part of the initiation activities in the Mbandwa healing cult of the Banyoro. During the initiation ritual, the gods are said to get quite stirred up and the initiate is in considerable ritual danger (mahano).

In Buganda, on a wedding night, the presence of the girl's Ssenga (paternal aunt) was required to explain, and sometimes to demonstrate, appropriate sexual activity to the new bride.

Sexual acts are sometimes required as part of the rituals pertaining to death and widow inheritance. Among the Sebei, the legal heir has to have sex with the widow to clean out the ashes, *erandet*, three days after the death.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Uganda's Experience*, UNESCO, 1999.

However, it appears that the acceptability of abstinence is greater in certain Muslim African countries (Senegal, the Sahelian region) or among certain Hindu or Buddhist communities, whether they are monks or spiritual devotees. Motivation for change in sexual attitudes and behaviour also seems more frequent among women than men, partly in relation to religious beliefs and practices, but also in relation with concern for unwanted or too frequent pregnancies.

Depending on the societal and cultural environment, the acceptability of condom use is very diverse. For instance in South Africa, it requires easy, private and anonymous access to condoms through distribution campaigns or distributors. Besides purchase cost, refusal can be motivated by various, sometimes contradictory reasons: reduced pleasure, lack of tight physical contact, risk of masculine impotence, material defectiveness in relation to the supposed penis size (Thailand), suspicion of one's partner, proof of the already present infection, (Malawi, Uganda, Thailand, Dominican Republic). At a more practical level, among the poorest populations, condom use may seem strange and irrelevant, in relation in day to day conditions.

Angola: resistance to condom use

According to an inquiry among young people from Angola, it appears that there is at the most basic level a fundamental lack of understanding of the risk and the need for change in sexual behaviour. Some replies deserve quotation: "Some people say that AIDS does not exist; others say it was made up to break the passion of lovers".

Regarding condom use, despite their knowledge of its pertinence in HIV/AIDS prevention, condoms are hardly used. Boys and girls assert they "*only use them in occasional sexual relations that they consider risky*" and "*when they want to avoid pregnancy*". Often, criteria used to define an occasional sexual relation as risky or not are subjective. Therefore, young people could expose themselves to infection as a result of misjudgement. Male participants reject using condoms because they consider that condoms reduce sexual pleasure and are painful. The female participants said that even when they suggested the use of condoms to their partners, the latter often argued the following:

"They say they like to feel flesh to flesh"

"Going to the bathroom to take a shower and going outside (dressed) when it is raining are two different things."

"When emotion hits there is no room for condoms."

On the other hand, some girls justify the poor use of condoms *"as the fear that the condom could remain in the vagina"*, so that, according to them, *"it would be necessary to have surgery to take them out."* This fear was mentioned by some female students from secondary school.

Others asserted that the price of condoms make them unaffordable to the majority of them. In addition, there is no information on the places where condoms are sold.

Some participants believed that the promotion of the use of condoms among the youth would indirectly motivate "irresponsible" practice of sex since the condom is also a contraceptive.

Taking into account the age and level of education of the participants, the use of condoms should be more effective and accepted. However the answers show clearly the breach between knowledge and daily experience, as well as the cultural pressure of the group on individual behaviour.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care; Angola's Experience, UNESCO, 1999.*

As regards cultural resources which could be mobilized among populations to help change sexual behaviour, with regard to preventive action and infection risks, culturally-appropriate information on safe behaviour should enhance awareness and commitment of person-to-person or person-to-group responsibility and, for the person, the risk of destroying his/her life chances and of dying without sufficient time for preparing a "good death".

Examples of values to be mobilized to this effect are : mutual love between spouses or partners, parents' and especially mothers' love for their children, in order to develop a sense of keeping one's own and others in good health and avoiding the risk of an early and painful death.

Acceptability of faithfulness is linked to the level of value given to the following aspects:

- single partner,
- stability in emotional/sexual links,
- mutual sincerity between the couple,
- importance of children for the parents,
- need of stability in family life.

This acceptability is also linked to respect for others in general, as a religious and ethical rule to be abided by. Cultural aspects of self-esteem and dignity can also be mobilized to protect oneself from the infection. However self-esteem does not exist at the purely individualistic level in traditional societies, where it illustrates the group's judgment of its members, especially as regards young girls and women.

Consequently, the feeling of guilt and shame related to the infection and possible death will be dependent on the group's reaction: for instance the reason for somebody's unexplained death will be hidden by the family or closest friends and AIDS will be given another name (Malawi, Angola). Besides, there is a strong demand for same gender interviews and for confidentiality by people consulting about the infection : for instance men will insist on not being tested by female nurses (South Africa, Malawi, Dominican Republic).

Dominican Republic: Silence and disclosure regarding HIV/AIDS

In most cases when one member of the couple has the disease they inform friends, families and neighbours of their condition, . When the husband is ill, men's groups hide the infection from their in-laws and the majority of their neighbours. Only the family and friends of the wife will know of the infection when the husband is tested positive. In other cases, mothers of deceased positive patients have revealed to their friends and neighbours the condition of their sons, and receive the solidarity and support of many of them, in spite of the general poverty. Women attend the ill and do the housework, while men help to move them from one place to another and contribute money.

Men and women tend to react differently when they discover their diagnosis: resignation among men, panic and depression in the case of women. There is evidence of apathy, family rejection and stigmatization as well as other reactions, which seem to induce people's secrecy .

The economic difficulty of many of those infected, together with the loss of job that occurs as soon as the symptoms appear, makes the purchase of food and essential medicine very difficult. Only a very small minority of those concerned have access to anti-viral drugs. Discrimination has the labels of class and generation. Patients with a low academic level suffer from more discrimination within their family and community, and the less young from the health services. Only one in five persons are not PWAs.

Self-support groups and mutual assistance are crucial for basic education on AIDS, and, in spite of the economic difficulties provide a minimum of emotional support, as well as some supervision, essential medical attention and access to medicine.

Shamans ("medicine men") know they cannot cure the disease, and don't expect anyone to believe this. They feel that their task is to "level" people emotionally, giving them support, advice, more tranquillity and peace of mind. They recommend plants, like cat claw, good luck water, natural products, beverages and tea.

Those who prepare corpses in funeral homes use uniforms, gloves and masks as bio-security measures. They do not think that preparing the corpse of a person who has died of AIDS is different from their normal routine. However the magic beliefs surrounding the infection seem to prevail among them, as they reject carrying the coffins and insist on the fact that these have to be specially covered.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Dominican Republic's Experience*, UNESCO, 1999.

Moreover, there may be important misunderstandings pertaining to people's body representation and semantic stock in the matter of sexuality. This issue has not been well researched and documented up to now. This may lead external prevention and care agents to consider that women are frequently ignorant of their physiological functions (Uganda, Dominican Republic, Thailand). The factual situation should be subject to more in depth investigation. .

IV. CULTURALLY FRAGILE GROUPS

Some of the country assessments carried out within the Project emphasized that it is not appropriate to speak of risk groups, when discussing HIV/AIDS prevention and dissemination, but that one should rather speak of responsible or irresponsible behaviour. This remark is relevant when it comes to designating specific social, societal and cultural groups or minorities as the sole culprits in the dissemination of the epidemic and, as it were, scapegoats.

In fact, the epidemic is disseminated between infected people belonging or not to «risk groups », but also between infected people belonging to the general society and uninfected people belonging to the «risk groups », for reasons of economic, social or institutional power. It actually affects the underprivileged groups: prostitutes, the poorest, homeless, uneducated, who often happen to be women and girls, young people and children, and the unemployed.

This is why these groups need special attention in prevention and care. Such attention must address not only their health situation as regards the virus but, more fundamentally, their societal and cultural fragility when facing economic and social survival situations. In this respect, better knowledge of their cultural references and resources and integration in the urban/modern/competitive world can build the basis for giving them a feeling of necessity and motivation to change their behaviour, including in matters of sexuality, as well as in their relations to others generally speaking.

Similarly, risks are not the same for populations throughout the world, since their socio-economic life conditions and societal/cultural references/resources systems are more or less disturbed in the process of globalization. This remark, which applies to the access to HIV/AIDS health care and advanced medication, is also valid as regards exposure to general basic health and sanitary risks in their daily life conditions.

1. Geocultural Areas of Fragility

At the world level, the most endangered populations, geographically speaking, are those in the Southern African countries, mainly South Africa and her neighbouring countries: Zimbabwe, Botswana, Namibia, Swaziland, Malawi, Mozambique, then follow Central and Eastern African countries (Central African Republic, Congo, Djibouti, Rwanda, Zambia.). In other UN regions, less heavily hit, certain Caribbean countries face a serious situation: Haiti, the Bahamas, Barbados and the Dominican Republic. In Asia, HIV/AIDS expansion is higher in Cambodia, Thailand and Myanmar, while the situation in India is becoming critical. The highest rate of infection is found either in the poorest populations, living in suburban areas of big cities or in the rural or tribal emigration zones, within the borders of the affected

countries, in the neighbouring countries or along the roads of commerce, armed conflict areas, refugee camps and among wandering and homeless unemployed populations.

Thus, as shown in the analysis of common trends, the aggravating factors of the expansion of the epidemic proceed from poverty, unemployment, lack of education, poor or absent housing and health service, migrant and/or precarious labour, threatening most directly the age group between 15 and 35/40, with a currently growing proportion of women getting infected and an age difference between infected women and men.

However the deepest roots of the current evolution are to be found in the overall value crisis brought about by the world shift from traditional, mostly rural societies to the modern, urban/industrial galaxy. This dramatic upheaval in all cultures and societies results in the weakening of cultural identities, networks and family patterns, women's, children's and young people's worsening condition and the growing adoption of a culture of materialistic-self-interest, individualism, violence, alcohol and drug abuse and irresponsible sexuality. In this situation the much-publicized opportunities provided by new technologies are relevant, and for the most part will not even be envisaged.

2. Migrations and the Disintegration of Cultural Identity

An important aspect of the expansion of the epidemic is directly linked to domestic or country-to-country population movements or labour involving high mobility. The presence of refugees, migrant workers in general or, in certain cases, nomad or semi-nomad tribal communities, is a critical factor in the dissemination of the virus and a material difficulty in taking care of – or numbering - possibly infected populations, more so when they have no contact with health services, or are unaware of being infected and, if informed, unwilling to disclose their situation, especially as regards men. The cultural impact of migration will also affect those communities, families, wives and children, left behind in the villages.

Western Zimbabwe: Migrations, local community destabilization and HIV/AIDS

In a poorly developed, semi-arid area with low and erratic rainfall and poor soil, local populations were forced to move from their homes alongside the river onto the escarpment above upon construction of a large dam. This relocation resulted in the local people losing most of their traditional sources of food. To make things worse, fishing and hunting were severely restricted by licensing requirements which were strictly enforced, making people so impoverished that most of the young men were forced to migrate to cities and mines in search of work, leaving their wives behind, without resources or income generating activities. Most of these men may return home once or twice a year. However the long separation from their wives exposes them to the risk of HIV infection as they try to find other sexual partners.

Similarly, the wives left behind, in an attempt to support their families, and to maintain their sexual life, also expose themselves to HIV infection. Extra-marital affairs are rife in the area.

Lack of sexual fulfillment and need for money were mentioned as major reasons for extra-marital affairs, even if people knew that multi-sexual relations entailed higher risk of HIV infection. Polygamous relationships, where one man with two or more wives leaves them

behind for three to six months, places everyone in this relationship at an even higher risk of infection. Moreover, the presence of military camps and construction sites in the area provide a ready source of partners to meet the sexual needs of the wives whose husbands are away for a long time.

Some of the husbands not only go away for a long time, but don't even send money to support their families. Thus wives are almost destitute and forced into extra-marital sexual favours in return for money or fish. Sex for fish barter has been reported in the fishing camps as well as in the beer halls at low-growth points. Interventions to alleviate the impact of poverty and unemployment could very well reduce the incidence of HIV infection and curb its spread, with more enduring effects than mere prevention and care.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Zimbabwe's Experience*, UNESCO, 1999.

Thus professional mobility is a major factor in the dissemination of the virus. Certain professions are subject to risk of contracting - and transmitting - the disease: for instance, long distance truck drivers, occasional farm workers employed in plantations or big farms, for harvesting, fruit or vegetable picking or vintage. Other professions which can be involved in HIV transmission are peddlers and itinerant tradesmen, military troops and mercenaries and, sometimes, poor students of both sexes, living far from home (for instance in Thailand, Uganda).

Uganda: Migration

Migration is an important risk factor and it is precipitated by: pastoral practices, where herdsmen move seasonally with their cattle in search of good water and pasturage. Similarly men and women often migrate to urban areas for employment. Some studies show that women widowed by AIDS migrate to urban areas to avoid stigma or to seek economic survival. Cross-border trade is another factor leading to HIV/STD infections, when businessmen and women travel between countries and within countries, selling or buying merchandise. By so doing, they indulge in sexual relations, thereby creating major risk group. Traders and lorry drivers in the area had a history of multiple sexual contacts. Both men and women in trading centres along the major highways are particularly at risk for HIV/STD infections. Central and southern Uganda have also seen considerable numbers of migrant labourers from Tanzania, Rwanda, Burundi, and other parts of Uganda. Other mobile population groups have included the military, refugees, and teachers.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Uganda's Experience*, UNESCO, 1999.

Similarly, in mining and industrial activities, migrant workers, who may represent the majority of manual labour force, in sectors where work is particularly hard, are specially exposed to losing their societal and cultural norms and rules and thus to contracting the virus. They can be easily lured into any means to find relief and relaxation in the evening.

Moreover, most of them live in collective hostels or dormitories, far from contact with their regular sex partners or wives and turn towards prostitutes, occasional sex mates or practice women sharing. These practices are often accompanied by drug and alcohol consumption, especially among the younger generations, as well as irresponsible sexual practices encouraged by human isolation and permissive urban sub-cultures .

Cuba: Migrant men's behaviour and HIV/AIDS

Migrant men may find themselves involved in difficult situations when adopting a sexually risky conduct as regards getting infected by HIV. Most of them are far away from their family, couple, or are single. Even if they condemn homosexuality, they engage occasionally in substitutive homosexual practices.

Like other risk groups, they are informed predominantly by the overall scientific messages expressing alternatives, such as the necessity to use condoms, through the mass media and social workers. However, they practice other behavioural alternatives, which do not necessarily protect them from STD/HIV (periodical analysis, body hygiene etc.) In this respect, systematic screening is considered as a preferable alternative to other more efficient measures. This is how they conceptualize a "healthy body".

Nevertheless, pleasure and traditional sexual practices are placed above the scientific messages. Thus, even if they consider that each individual is responsible for taking care of their body and realize the danger of getting infected, they accept that, when they find a girl in the streets, and have the possibility of having sex with her, they do not use the condom. The justification for this behaviour is based on the material aspect of the condom. These people also express evidence of socialization limits, such as difficulties for preliminary negotiation, giving way easily to the pressure exerted by the other sexual partner. The proposal for using condoms is considered as an element of defiance, and is the main argument used for disregarding preventive behaviour meant to avoid HIV.

For migrant men, the possibility of a steady couple or of having a relation with only one partner, as per the classical preventive message, even of the religious type, is not accepted as a behaviour option. In this respect, "polygamy" is considered as something natural. As for stability, "religious people can do it, if it's not impossible". It seems there are values and patterns shared by this group, in order to justify the change of partners. There are also justifications such as "material difficulties", which can be the lack of housing or the perceived gender advantage: "there are more women than men in this place". Other excuses are based on the "immaturity due to youth".

As regards the variety of sexual practices that imply safe sex, none are admitted nor accepted. Legitimate practices are concentrated on penetration, whereas others are considered as unimportant or uninteresting.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Cuba's experience, UNESCO, 1999.*

Nevertheless, solidarity networks can survive in the urban world, when people belonging to the same original communities will possibly live in the same areas, build mutual assistance

systems, pressure groups and, in certain cases, semi-delinquent groups. This networking is often present among the poorest groups, where cultural identity remains one of the rare assets of otherwise dispossessed individuals.

3. Crisis of the family model

One of the most important fragilization factors is the crisis of the family model, more so in societies where this model is the cornerstone of the whole economic, societal and cultural system, in African, Asian, Caribbean and Latin American countries. The extended family system can be experienced as an overwhelming responsibility when it comes to supporting one woman or girl, making a livelihood for a number of more or less close relatives without income or, in the case of young women, excessive family control on their activities.

Thailand: Frequent Family Crisis in the Poorest Regions

There are major differences between the North and Northeast that now impact family structure. In the North, cities like Chiang Mai have developed the modern sectors of tourism and industry, while in the Northeast there has been little growth in these sectors. There are no large industrial or mainly tourist-oriented cities like Chiang Mai or Chiang Rai in the Northeast.

This has led to differences between the two areas. In the North, many people still live in rural areas, but they can find work near their home villages. In the Northeast, people must migrate to work in Bangkok or in areas further away. The Northeast is very poor and lacks resources. In many villages there are only old people and children. The people of working age bring their children back home to be cared for by the grandparents, while they work far away. These migrants are the most exposed to risk from HIV/AIDS in the capital city area. In spite of these important differences between populations from the two regions, they go through similar experiences as regards illegal situation, ignorance of their rights and heavy language problems.

Source: *Cultural Factors in the Transmission, Prevention and Care of HIV/AIDS in the Upper Mekong Region* (Chiang Mai Report of the Workshop, June 1999).

At the same time, the extended family model acts as a solidarity system in case of economic or health difficulties and, within its specific style, can be a source of emotional support, counseling and compassion.

The present crisis resulting from the urban revolution and advocacy of the nuclear family model (parents with 2 children) interacts with HIV/AIDS, both as an aggravating factor and as a consequence for the infected and sick people and their spouse and children. Family solidarity is then distorted by the separation of parents, for economic reasons or excessive weight in family power structures.

Along with insufficient nutrition and miserable life conditions, these elements build resistance to HIV prevention messages, leading among others to impossibility of access to sanitary or health facilities. These difficulties of course increase the risk of catching diseases,

among which STDs and HIV/AIDS. The infection increase results in growing work incapacity and aggravated impoverishment, another shock to family life stability.

4. Culture, AIDS and Gender

The most serious consequences of this crisis are clear as regards women's and girls' conditions, their submission to the worst aspects of poverty, and lack of decision power. Seriously aggravating factors are women's and girls' high level of illiteracy, lack of education, promiscuity in housing, entailing risks of incestuous and sexual abuse. Later on, these can result in juvenile work with or without wages (especially in home service), early pregnancy and/or early marriage or forced prostitution, as from a young age for girls and, in certain countries, young boys and men. Opportunities for stable and well-paid jobs are still very rare for women in many countries.

Illiteracy and lack of education result in women's economic dependence, in the present configuration of gender and family models prevailing in most regions, as opposed to the newly emerging urban middle classes, where the nuclear family model is valued. In most cases, women with children depend on men for their economic survival – a situation seriously complicated by men's emigration to find jobs in big cities and foreign countries. Along with unwanted sexual relations and pregnancy, breastfeeding remains a prevalent habit, deeply rooted in the mother-child relation, as an image of life transmission and fertility, an immemorial belief in traditional cultures – but also a necessity when hygienically-safe milk for babies is not available. Mother-to-child infection is likely in such situations.

Angola: women, marriage and informal systems

The traditional marriage system in Angola is similar to that of other countries in Sub-Saharan Africa. Generally, it is a result of family agreements and alliances rather than individual decisions. In many cases, its fulfillment, which requires a long period to be set up, is marked by several ritual stages. Each ethno-linguistic group of the country has got specific rites

The common age for marriage or sexual relations is traditionally very early, especially among girls. Moreover, rites of initiation during puberty contribute to precocious sexual activities geared at reproduction.

Marriage and concubinage may influence individual sexual behaviour. Polygamy can promote extra-marital relations, since polygamous men are more prone to extra-marital experiences than monogamous men.

Some women within a polygamous relation can also be tempted to have extra-marital relations, above all when there is an important age gap between the spouses. These women can consider their husband unable to satisfy them sexually or may feel attracted by younger men.

The new forms of polygamy in Angola, particularly in urban centres, in which the couples do not share the same house and where wives are economically independent, could also contribute to female extra-marital relations. Polygamy could also influence children's sexual behaviour, since they will be inclined to imitate their parents' attitudes and habits.

The polyandry system in which a woman can have more than one husband is a common practice in some groups, but limited to female authority professions. These have the right to choose their husbands. If the chosen man is married, he must leave his home, even if he is polygamous, to devote himself completely to the woman who offered him this honour. This woman has the right to choose occasional lovers.

The marital instability observed today in Angola may also influence individual sexual behaviour. Spouses can have extra-marital experiences during periods of conflict. Thus marital instability and mobility are factors of a greater exposure to STDs, particularly HIV/AIDS. The couple's instability and matrimonial mobility can also influence children's behaviour.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Angola's Experience*, UNESCO, 1999.

5. Homosexual Practices and Communities: Societal/Cultural Acceptability

If women's homosexual practices and communities do not appear to be much discussed in relation to HIV/AIDS, men's homosexuality raises strong discussions in relation to the epidemic, not only for medical reasons, but more for questions of societal and cultural acceptability.

The first reason for this is historical since, due to the sophistication of the medical and health systems, the first cases of AIDS were identified among the gay circles in North America and certain West European countries. Thus, the fear of the disease itself was coupled with the societal and cultural rejection of men-to-men sexual relations in many societies, derived from ethics concerning men/women relations and their aim, especially in Christian societies: human reproduction and trans-generation continuity, and in highly machist societies, where the demonstration of the male identity is permanently exhibited and over-emphasized.

Jamaica: masculinity, colonialism and homophobia

Homophobia in the Caribbean is a central organizing principle of the cultural definition of masculinity. Homophobia is more than the irrational fear of gay men, more than the fear that a man might be perceived gay.... It is the fear that another man will unmask him, emasculate him, reveal to him and the world that he doesn't measure up, that he is not "a real man". In the end, the "fear of being seen as a sissy" dominates the cultural definitions of manhood.

Historical analysis of this construct of masculinity in the Caribbean and especially in Jamaica, describes colonial masculinity as a social form within a culture of violence which embraced all relations of social living and consciousness. It was the principal instrument of all contending parties; it held them together and it tore them apart.... Creole black males were socialized as infants within this crucible of death, blood and suffering. They learned to use it as it was used against them... Thus, implosive community violence remains an expression of subordinate black masculinity.... The favorite streets of communities, the expression of social

discourse, sexual relations, political dialogue and lyrics of popular music, shot throughout with violence, virtual and real..."

The connection between masculinity and violence, which is linked to sexuality and sexual relations, has been further investigated. A 1996 World Bank study found that it was encouraged by the environment of the urban gangs and garrisoned communities. UNFPA-sponsored qualitative studies of adolescents found that aggression was another emphasis among young men in their views of sex, whereas young women reflected fear.

Within this context, Jamaican men must prove themselves, struggling for power and in some cases, for survival, in relationships, in the wider community, and most of all, within their male bonding groups that must judge whether they are men or not.

The subculture of gay men is increasingly permeating manhood, subverting the accepted norms and thriving amidst the very shadow that has been deliberately thrown over the subject of sexuality, in order to increase its clandestine nature in Jamaica. As noted among Brazilian gay men, there was a much larger cohort of bisexual men than at first predicted. The culture itself, or rather the plural culture, with its emphasis on shifting class and race affiliations and denial, allowed bisexual men to move between sexual orientations and be accepted, as long as the rituals of machismo were demonstrated.

Source: *The Cultural Approach to HIV/AIDS Prevention and Care: Jamaica's Experience*, UNESCO, 1999.

From the case study carried out for the Project, it appears that sexual relations between men are much more frequent than publicly admitted, even if they are considered as shameful and unacceptable - and consequently negated - in societies where masculinity appears as a predominant individual and community value. Actually, in many countries sexual intercourse between men is practiced, as a substitute to heterosexual relations, where these are highly controlled by the social and moral power system. Moreover, this tends to develop in situations where young and grown-up men are isolated, for instance in jails, collective housing systems or when women prostitutes are unaffordable. Besides, there is growing social tolerance towards men's homosexuality in urban and modern societies, especially in Western countries, among younger people, or in other societies, where it was historically admitted, for instance in the form of transvestite costuming on the occasion of religious or cultural celebrations, or adolescents' literary celebration.

However in its modern configuration, men's homosexuality has developed into openly claimed ways of life and legal recognition. This evolution, which started in Western countries, is currently extending towards certain developing countries, in spite of the societal/cultural negative image of men's homosexuality, for example in Jamaica, Thailand and certain Latin American countries. As regards HIV/AIDS prevention and care, collective movements, associations and pressure groups, asking for civic recognition and assistance from the current health systems, solidarity movements and projects, especially as regards preventive education, medical and social care and support to the sick people and homosexual communities have developed highly-motivated and efficient medical, social and psychological support systems in a number of mostly Western countries.

Cuba: men-to-men sexual relations , their socio-cultural statute and HIV/AIDS

Among men that engage in sexual relations with other men, there is an acceptance of the factual scientific information on the measures to protect themselves from STD/HIV/AIDS, but with certain limitations. In fact some practices are not explicitly mentioned by the information campaigns, which don't go beyond more general alternatives. Thus there are doubts regarding the ways of transmission in certain practices: "I believe that until the person does not liberate his semen, there is no danger". This includes anal or oral sex. This is an opinion shared among these groups, but they lack reliable information and safety measures.

The perception of risk in such groups is mediated by primitive representations of AIDS, with a great influence in beliefs shared by its members. Many of these beliefs are based on information disseminated, by mass media, during the first period of the epidemic outbreak.

There is also the issue of subjectivity in the criteria expressed on effective measures to avoid the infection (within the couple). The same behavioural alternatives are circulated among them as for the general population. Thus, some types of behaviour are censured by the group, more centered on much rooted habits such as the frequent change of partners. "Currently there are no stable couples, but rather one today and another tomorrow". Having the same sexual partner is tiresome, "changing is modern".

They use identical negative stereotypes of the homosexual "evidence", based on the same construction that society has made about them, and the frequent prejudice against this specific population group.

Personal experiences show poor self-power, based on low self-esteem, the socialized construction of feelings, and a negative self-image: "we are promiscuous, unstable".

Defeatist judgements on the possibility of maintaining stable relations or a mutual loyalty between homosexuals are frequently observed, because of intolerance, as well as the impossibility to build a space for living. The well-known sexologists Masters and Johnson consider that lasting homosexual relations are scarce, because they are less visible than heterosexual ones.

More recent anthropological research shows that the relative instability of homosexual relations is caused in part by the fact that society does not promote the homosexual union. Socialization tends to orient hetero- or homosexual men towards variety in sexual relations, while women of one or the other condition are orientated towards monogamy. As a result, many men prefer to have a higher number of sexual male or female partners. Thus, many homosexuals are unstable because of the lack of experience in social learning, and are guided towards impersonal relations, where the quality of the couple's relation is vague.

According to recent research there is a stereotyped and prejudiced social representation of the homosexual, conveyed by the family system that devalues these groups by principle. Due to this repressive and discriminatory behaviour, it is difficult to struggle against these experiences, including sexual ones, except in groups of homosexual friends, in which one can find support and understanding.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Cuba's Experience, UNESCO, 1999.*

6. Commercial Sex Workers

Women's prostitution – and in some countries, boys' and youngsters'- makes them of course a group at high risk and, more fundamentally, a societally-culturally endangered group, consequently more exposed to the infection, with specific difficulties in avoiding it and having access to consistent medical care.

For girls and women, prostitution often results from being left without support by their husbands or regular partners or, for children and youngsters, being abandoned by parents or forsaken mothers. As regards youngsters, for instance in the Dominican Republic, girls' or boys' prostitution is the obvious consequence of poor families' migration to the big urban areas, structural unemployment, extreme poverty, lack of basic education allowing to find a job, or even the necessity to finance their school or university education.

Besides the societal/cultural stigmatization linked to prostitution, especially men-to-men commercial sex, professional sex workers cannot refuse unsafe sexual practices and very frequently, cannot identify their customers if they get infected. Also endangered are young girls forced into early sexual practices, since older men or “connoisseurs” are keen on having intercourse with virgins. Some young prostitutes may even have been forced into sex within the family group or raped by infected men for reasons of sexual “cleansing”. In addition, among the poorest populations, women can recur to occasional prostitution as a form of informal payment for food or transportation.

Uganda: Commercial Sex

Commercial sex (or prostitution) is used as a generic term to imply sale of sex for cash. However, the term is used for other persons, usually women, who may be known to engage in multiple sexual relationships, even if such relationships are not for cash gains. In Ankole, for instance, a prostitute is a woman who has sex outside marriage, sells local brew, or engages in sex for gain or favours. It can also be used as an indication of stigma or disapproval. For example, adolescent girls may be called 'prostitutes' by older women criticizing them for wanting more than one partner, even if they do not practice sex for money .

Forster (1989) distinguishes between some of the concepts of prostitution and argues that the Baganda and Bakiga women indulge in occasional sex for exchange or receiving gifts from stable partner. However Bennett (1962) found four classes of urban prostitutes in Kampala; the Bahaya who sold sex from single rooms in certain slums areas; barmaids, well-dressed and educated upper class prostitutes; and homosexual males who mostly catered for European clients.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Uganda's Experience*, UNESCO, 1999.

Other types of prostitutes are “thrown” out of their original village or tribe into brothel prostitution, without previous experience of life, against payment to the family or local

procurers, just because sex industry wants “fresh meat”. In such cases, young girls will be unable to understand what happens to them and even less to react to their situation. Procurers, well endowed with money, will place them directly into brothel networks, national or international, from which they will escape only when not “fresh” any more, frequently trapped by debt to their pimps, hard drug addiction and infected by HIV, when they want to travel back to their original village and people (namely in the Upper Mekong Region).

Nevertheless, a feeling of common interest and defense against HIV/AIDS is emerging in certain countries, for instance in some Caribbean or Latin American countries, where prostitutes, including transvestites, strive to build groups and associations in order to develop contacts with public authorities, notably the public health system, to gain access to protection and care opportunities. As regards condom use, they will often advocate it among their colleagues and to their customers. Unfortunately, most of the latter will condition extra payment for unprotected sexual contact, this makes it difficult for prostitutes, who often badly need money for urgent basic needs, or are forced by pimps, to refuse these dangerous practices.

Dominican Republic: male and female sexual workers, the informal world and HIV/AIDS

Youngsters that practiced sexual work were interviewed. The four male sexual workers were minors between 16 and 18 years old. The street workers had been sexually initiated between the ages of 9 and 11 years and those of the “business” (brothels) between 14 and 15. They consider that the situation regarding AIDS is “dangerous, as many persons have died”. They know of 1-4 persons with AIDS. The four older sexual workers were between 22-26 years of age, and had started sexual work between 11-17 years. They know 2-4 persons that have died of AIDS.

As regards what women prostitutes would say to their sons about AIDS, the answers varied from persuasion to prevention (“trust me, protect yourself with condoms, go and take the test”) even the restrictions that contradict their way of living (“beware of the street world, don’t take street women”). To their daughters they would give similar instructions (“use condoms, protect yourself well, defend yourself, don’t be fooled by promises, don’t go to the streets, marry for ever”).

They tended to justify the female workers as a way of earning a living: “It’s not good, but I could not finish my studies”. Others stated: “If I don’t work, nobody is going to give it to me... Each one lives as he can... but they should protect themselves”. The fact that a man lives with a woman prostitute, however, was not well seen: “I think it’s bad, because a man can work... The man is the one who has to provide for the woman... these men should not be in society, and are in fact real pimps”. However others said that “they could also manage to find money” and that they could wear a condom and always be protected”. Concerning a boy that finds his way with another boy, they say “that he should not do so, as it is bad... Men were not created to have sex with other men, but with women”, even if they recognize that many do so because they like it... some are born with it ... and others are not. I am against that”.

On the changes in sexual behaviour, they say that men “go out less”, and that clients used to do it before without protection, but that now the majority use condoms, or they

masturbate while they are engaging in oral sex. Some are afraid, others are not. To have sexual relations with clients, they demand the use of condoms and reject deep kissing, even if some "do it without condom". Some always use condoms with clients, but not with their husbands (steady couples). Others consider that it is better to always use condom "because he can have more than one lady", "nobody knows what he is doing out there", "I don't trust anyone".

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: Dominican Republic's Experience*, UNESCO, 1999.

7. Sub-Cultures, Violence, Drug Addiction and Sexual Carelessness

Whereas in spite of its economic weight, formal polygamy is still frequent in traditional societies for societal/cultural or religious reasons, multi-partner sexuality is much more usual in the urban world, with significantly different situations between men and women in this respect.

The reasons for men to tend towards multi-partner sexuality are complex: isolation from their family, professional mobility, men's group culture and their deeply rooted feeling of superiority, which they want to control through meeting many different girls or women, even in a short period of time. Moreover, in the absence of other interest or leisure time activities, sex will be the most obvious opportunity for recreation among young men, for which multiple sexual conquests are an important prestige factor in front of their peers.

Urban life leads girls and women to some extent, at least in the new middle classes, to an easier approach to boys and men, especially in the context of the "disco" culture.

South Africa: Subcultures, homosexual practices and drug addiction.

Up to now, it does not appear that the use of infected needles in drug injections plays an important role in the spread of the infection. However, the situation in this respect is changing quickly and the diagnosis could be significantly different within a few years.

Another important phenomenon is that homosexual relations between men are considered as a highly taboo subject. It does not seem to be a wide spread practice among the Black population, as far as can be seen from the information that is available on the matter. The only recognized exception is the imprisoned population for reasons of sexual isolation and promiscuity (141.000 prisoners, among which 46% were under 25, in 1997). It should be noticed however that gay movements and lobbies are developing, mostly among the White community, especially in the Capetown area, and are struggling to make the Government take more important measures against HIV/AIDS.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: South Africa's Experience*, UNESCO, 1999.

In many fast growing cities and megalopolis all over the world, especially in shanty-towns and shacks, frequent in developing countries, the role of crime and violence has grown quickly since the 70s, parallel to the “wild” urbanization rush and the disastrous economic situation of most of the new immigrants, in relation with massive unemployment and the new forms of criminality. It evolves more and more towards drug smuggling, street robbery, firearms trafficking and vulgarization of their use among youngsters or hooligan groups.

Drug addiction and smuggling (cannabis, cocaine, hard drugs, amphetamines, and other new chemical drugs) are growing as well as – and possibly together - with alcoholism, mainly among young people. Some of them tend to become at the same time consumers and providers of various types of “daily-life escapism” products. This can also result in the masses of unemployed and insufficiently educated youngsters turning towards highly illegal activities, as the easiest moneymaking means, especially in popular areas where security services are frequently absent or passive.

All these manifestations of violence and the growth of crime (robberies with firearms, rapes, murders etc) can be considered in part as indicators of despair, deriving from the enduring social, economic and cultural exploitation of the poorest by domestic or foreign powerful minorities, and the failure of the educational systems.

8. Young People: Hope or Despair

Given the demographic situation in most developing countries, young people are faced for the most part with incomplete or absent education, unemployment and consequently, total lack of prospects for building their lives towards a better future.

Due to this incomplete, absent or irrelevant education, most of them have no or poor qualification when entering the work market. So their chances to find any first job are very small. Unemployment will be the rule, aggravated by absence of housing, wandering in city streets or miserable shacks, even for teenagers and children, with or without parents.

However, the massive migration of young people to cities continues because the city is the mythic place where many expect to make a living, through regular work or informal sector activities, even at the lowest level and with minimal pay. This results in serious under-proletarianization and corresponding sub-cultures, possibly in the shape of counter-cultures.

Many young people, not finding a job even in the informal sector, will shift to the already mentioned illegal activities. Even those who can find a job live most often in squalid slums or hostels, in promiscuous conditions, isolated from their family, locked in precarious work conditions, heavily exposed to the "wild" urban culture as well as to the modern market-oriented way of life, in other terms restless competition, where making money seems both easy and inaccessible.

All these are subjects that weigh on culture and cultural components and make it difficult for people to take control of their lives. Among the concerns of employees, that of treating infected people and the preservation of confidentiality are considered as crucial, as well as collaborative approaches, discussions, consultations, peer education, commitment and credibility of those involved in prevention and care.

Under such conditions, they will feel segregated, with exclusive day-to-day survival concern. Some of them will gather in small groups, where risk behaviour will appear as part of their overall situation. This of course will make both boys and girls specially endangered regarding HIV/AIDS infection, , in relation with drug taking and the almost unavoidable recourse to prostitution.

South Africa: Young people, a culture of hope or despair

Young people and the city

Two different lines of development can be observed among young people:

- 1- The massive migration of young men to big cities, where they expect to make a living, through official jobs or working in some informal sectors, mostly non qualified and poorly paid jobs.
- 2- The serious under-proletarianization of the urban population and subsequent emergence of a counter-culture among adolescents and youngsters.

The future and the past: hope or no hope

Rather paradoxically, according to opinion polls, among the Black urban population (50% of the total Black community) young people between 18 and 30 years of age show clearly differentiated life and culture patterns:

- 25% of them feel well integrated into the western, urban and industrial cultural model. This can be seen from their value systems, life styles, preferences for the nuclear family and views about the future;
- another 25% feel strongly linked to traditions, in terms of their identity and origins and the need for a respectful attitude towards authority and the elders;
- a third group, though still seriously bruised by apartheid in their socio-cultural values and behavior norms, remains militant-oriented, even with the political changes in the country. This may result in reactions to what they consider to be the unacceptably slow pace of institutional reforms;
- the fourth group feels deeply segregated, with the daily life struggle and with no project for the future; they live in small groups and are receptive to some extent to pop music and some sports, but also highly exposed to alcohol, drugs and violence.

The two latter groups are at the highest risk regarding HIV infection, even more so for girls than boys. Some of these girls will turn early to prostitution.

On the contrary, the first two groups are probably the most likely to find cultural resources in order to prevent the spread of the virus. For the first group, the strongest motivation will be securing their progress towards social achievement: good education, reasonable housing, "Ebony" style of life and good health. These are seen as a set of prerequisites to consolidating their new social legitimacy. However, the pursuit for this free style of life can also lead to risky sexual behavior.

Source: *A Cultural Approach to HIV/AIDS Prevention and Care: South Africa's Experience*, UNESCO, 1999.

V. SUMMARY REPORT MAJOR CONCLUSIONS

Before proposing concepts, methods and guidelines for developing a cultural approach to HIV/AIDS prevention and care, it is important to briefly recall the major conclusions of the country assessments.

1. Common Trends

- a) There is world-wide awareness of the danger, but it does not entail sufficient motivation, among populations, to make them adopt significant change in their sexual and non-sexual behaviour regarding the epidemic's prevention and care, for extra-medical and health reasons, which have to be better understood and integrated in new strategies. Moreover, information methods are frequently unadapted to population's understanding capacity.
- b) HIV/AIDS is in permanent interaction with people's cultures and overall socio-economic development.
- c) These interactions, as any two-way process, develop situations and obstacles which hinder the effectiveness of medical and informative action. These can be summarized as follows:
 - The expansion of the epidemic is greatly influenced by economic and social development issues, as they have major impact on people's life conditions.
 - Socio-economic evolution also seriously impacts on societal/cultural former value systems and life models, especially in developing countries, mainly through population movements, migrations, miserable housing and living conditions, thus aggravating infection risks.
 - HIV/AIDS in turn develops important economic, social/societal and cultural effects.
- d) Thus a reliable prevention and care strategy will have to integrate the relation with populations' cultural references and resources and with mitigating socio-economic development issues.

2. Cultural Diversities

2.1. Regional features

Some specific regional cultural features can be identified in each of the sub-regions in question :

- In Southern Africa, serious economic crisis, situations of conflict and domestic institutional shortcomings entailing considerable population movements (emigrants, refugees, and a societal/cultural destabilization linked to quick change from rural to urban world).
- In Southeast Asia, the aggravation of the AIDS crisis in the sub-region is linked to the side-effects of the fast-growth economic model, which entails upheavals in traditional life models and cultural value systems of the rural and mountain populations, mainly

through the dramatic growth in women's prostitution, "hard" drugs' increasing production and consumption, in spite of the still present Buddhist religious beliefs.

- In the Caribbean, the epidemic remains an important concern for certain countries. The infection is disseminated mainly through heterosexual relations, but men-to-men relations seem more frequent or more tolerated - than in other regions. Another major cause is drug consumption, linked to the role of the Sub-region in drug trade. High mobility of populations for work, whether domestic or foreign, and prosperous tourist industry are two factors of importance to understand the socio-economic development issues. A dramatic consequence is the extensive prostitution of young people, boys and girls, from their teens, for reasons of extreme poverty, lack of education, unemployment and of subsequent economic survival strategies. Solidarity movements of sick people, prostitutes and gay communities are emerging in several countries of the region.

2.2. Cultural Specificities

The major cultural specificities do not necessarily correspond with national entities. In the short term, cultural references are too easily considered as obstacles when in fact they illustrate styles of life, value systems, ways of thinking which are liable to undergo a process of change, through self re-evaluation. Besides these, numerous cultural resources can be found and mobilized among populations, in order to involve them fully in HIV/AIDS prevention and care.

Both cultural references and resources are linked to the following categories:

- Cultural traditions, mostly related to rural societies, through initiation and marriage rites and models, women's status, traditional mutilations and courage trials, traditional leaders' power and influence, etc.
- Religious beliefs, in relation with ethics and moral rules as regards oneself, others, poor and sick people, with traditional, sometimes magic beliefs and practices and traditional healing systems, which are of use in an apparently fully epidemiological problem like HIV/AIDS.
- Health, life and death representations.
- Cultural norms and practices in sexuality.
- All these aspects have to be taken into account not only in HIV/AIDS prevention and care policies and action, but also fully integrated as part of the conditions and means to build an efficient, relevant and sustainable response to the challenge.

3. Motivations for Change

The core of the issue is the identification and mobilization of people's motivations, which could make them change their behaviour on their own initiative and in their own style. Unfortunately, according to observations and judgement of high-level medical and IEC

specialists, including teachers and communicators, the current content of messages, devised to give people clear understanding of the infection origins and manifestations, reaches them in intellectual terms, which pupils and students can well memorize, but is not integrated and appropriated by them for application in their own life. Thus understanding the message does not entail inward conviction which could make people modify their sexual and non-sexual practices regarding HIV/AIDS. This is of course where cultural references and resources intervene for communities, groups and individuals.

4. Mass-Mobilization: from Duty to Consensus

At this stage, a fundamental distinction has to be clearly made between institutional action and reaction and the society's response.

- a) Institutional networks and agents, through their professional culture, play a certain role in interpreting decision-makers' instructions. To this end, institutional echelons and their staff are used to implement instructions from above, which they understand and integrate through their training and experience, in other terms their institutional culture, including HIV/AIDS prevention and care policies and projects. Thus it would need a fundamental reform to shift from carrying out plans and instructions in a top-down process to adapting their working methods to people's cultures and life habits. Innovative training/sensitizing methods and curricula have to be developed in this respect.
- b) On the other hand, as proven through many examples given in country assessments (and quoted in various insertions of the present document), the civil society needs to recur to its own cultural references and resources, before modeling its response to the challenge and the institutional pressure to change behaviour. Thus, the reply will have to be built on the basis of group and personal consensus, acceptance, conviction, motivations, more precisely people's cultural references and resources: knowledge and perceptions, traditions, beliefs, and behaviour norms - and new cultural practices responding to the constraints and evolution of the socio-economic environment.

This is why community-based project clusters will have to be built on a fully participatory basis, with local key leaders, informants and families, including the HIV-positive and even sick persons. People will feel mobilized only if they are reached where they are and on an equal footing.

As a consequence information, education and communication will have to be tailored to people's knowledge, value systems and cultural acceptability of messages meant for them. Efficient IEC will be secured only as a bilateral information system where people's values, and corpus of knowledge will be integrated with those inherent to modern medical data and explanation system. These will be phrased and conveyed in their local language and semantic stock, . As regards the role of the media, mass media have only a limited impact, because too general and sometimes contradictory with some aspects of their programming. Thus local radios are much better adapted to specific needs.

- c) Concerning mobilization, the role of religious communities, social movements (women, young people, sports associations, etc.), trade and business unions will be essential. Of course, they convey their own value systems and will consider if HIV/AIDS prevention

and care activities fit with what they deem to be their spiritual, ethical and practical mandate and duty. These should not prevail and use the epidemic as an opportunity to advocate ideological positions.

- d). Along the same line, traditional cultural leaders, more specifically traditional healers might be consulted to envisage co-operation between themselves and the modern medical and educational system. It is indispensable to consider their role in prevention and care, since many people consult them, when afraid of being infected or effectively HIV-positive, not only as medical experts, but also as social and psychological advisers.
- e). As regards individuals, advocating abstinence, faithfulness in couple and condom use raises complex practical and moral issues. These of course will be accepted only if people's principles, sexual culture and real life conditions fit with such requirements. The same difficulty arises as regards the transmission of the infection and disease to sexual partner (or partners). Notification in this case means breaking taboos, models and losing prestige. Moreover, traditional family rules can impose silence on the subject.
- f). Finally regarding risk groups or, more relevantly, culturally and socially endangered groups, it is obvious that socio-economic, educational and cultural factors interact dramatically with medical and health issues per se. These groups are endangered by various types of difficulties simultaneously, all of them with seriously destabilizing and segregating effects: massive unemployment, poor or absent housing, economic distress, lack of education.
- g). Each of these factors are aggravated by a general societal/cultural destabilization linked to migrations, rural decline, instability in certain countries and regions, prominence of short-term economic strategies in production activities, rapid urbanization, as opposed to the much lower pace needed for cultures and societies to build new configurations responding to change.
- h). In this context, unsafe practices, refusing condoms, drug abuse and smuggling, alcoholism, sexual or other forms of violence, prostitution and procuring are all aspects of the emerging sub-cultures, linked to mere survival concerns in a world of brutal power and materialistic interest. They may create serious obstacles to HIV/AIDS prevention and care, and therefore, must also be addressed, in order to reach significant results in fighting the epidemic.

Against this background that major lines of strategy have to be defined and qualified:

- Initiating mass mobilization in institutions, the society, families and people;
- Raising public awareness towards behaviour change;
- Developing proximity relations between the prevention/care system and populations;
- Elaborating and diffusing culturally-appropriate IEC messages and processes;
- Co-operating with the civil society, religious communities and traditional leaders;
- Building community-based prevention and care projects;
- Elaborating or adapting training systems for planners, civil servants, media correspondents, school and non-school educators, social workers and medical staff;

- Supporting new creativity linked to HIV/AIDS (preventive/informative creative material, literary and artistic creations on the subject) and better correlation with sports;
- Giving preference to specially endangered groups;
- Investigating more in-depth the “grey zones”.

VI. LESSONS AND RECOMMENDATIONS

1. In-Depth and Long-Term Issues to Be Addressed

The country assessments carried out in Southern Africa (Angola, Malawi, South Africa, Uganda, Zimbabwe), in the Caribbean (Cuba, Dominican Republic, Jamaica) and in Southeast Asia (Thailand), have achieved, more or less completely, the assessment of national situations as regards the consideration of cultural aspects and factors in institutional action towards HIV/AIDS prevention and care. For some of these countries, in-depth case investigations showed interactions between cultures, HIV/AIDS and development, identification of culturally fragile target groups and the significance and power of cultural references and resources that could be mobilized for building relevant prevention and care action.

From these documents, a certain number of conclusions can be drawn. These are summarized in the following sections of the present overview. Many recommendations have also been made at the conclusion of the major country papers. Conclusions and recommendations will make it possible to propose consistent and reliable methodological tools.

1.1. Interactions between culture, HIV/AIDS and development as a basis for efficient relevant work

- **The expansion of the HIV/AIDS epidemic is closely related to major development problems**__, especially in developing countries and countries seriously hit by the international economic crisis, **and the complex interactions of these problems, in terms of value systems crisis or dynamic responses, with the cultures of the populations in these countries** (see above a more complete description).
- The most striking features are the following :
 - For Africa, long-term consequences of apartheid in South Africa, multi-secular slave trade and colonization in the whole region and, during the last thirty years, conflicts and the lasting and aggravating unbalance in North/South relations;
 - In all Regions, economic, social and sanitary inequities, health policy shortcomings;
 - In certain countries, sexual tourism, entailing a high level of prostitution, especially among young people (Dominican Republic, Thailand, certain Southern-Mediterranean countries, among others).

- Another major issue is extreme poverty:
 - Life expectancy and child mortality rates are still critical;
 - Demographic growth versus great inequality in income per family;
 - Large disparities between regions and communities (for instance, the White versus the Black community in South Africa), the privileged minorities and underprivileged majorities in many countries, as well as cultural minorities (for instance, tribal populations in South-East Asia).
 - Growing flow of migrants from poor regions or countries to large cities and rich industrial countries.
- Inequitable social development:
 - Differences in access to education (girls and boys, primary/secondary and higher education teaching and schooling);
 - Health inequities regarding major diseases (infectious and other health issues due to malnutrition) and lack of hygiene security;
 - High level of unemployment, especially among young people and women;
 - Persistent fundamental gender issues.
- National institutional systems' shortcomings :
 - Continual wars, civil wars and other violent conflicts;
 - Unbalance in external/internal economic and domestic socio-political decision-making process ;
 - Excessive weight of structural adjustment constraints in national policies for social development, including health;
 - Insufficient communication between public authorities and the society.
 - unbalance of certain national budgets (health policies insufficiently budgeted).

Conclusion:

All these disparities raise serious obstacles in combating HIV/AIDS, whether due to the need of a conducive environment in terms of well structured and budgeted policies as well as a consistent and respected legal system, the availability of free and easily accessible medical services, the obvious prevalence of daily survival concerns, educational and cultural difficulties in understanding and appropriating modern medical and sanitary information.

However these factors alone cannot fully explain the expansion of the epidemic. This is why it is necessary to examine the role of specifically cultural aspects in their interaction with the overall development problems.

1.2. Societal and Cultural Impact of Socio-economic Change: An Aggravating Factor in the Expansion of the Epidemic

The prominence of short-term maximum profitability strategies in the context of the global market economy entails deep changes in the balance of multi sector-based development. It results among others in important population movements from the economically poor towards more prosperous regions and countries. This introduces new cultural practices and value systems. The most striking examples of this cultural impact are the following :

- **Rural decline**, through the growth of large production farming systems and the impoverishment of small peasantry becoming more and more fragile (subsistence agriculture) and subsequent young men's emigration towards large cities and foreign countries, resulting in the migrants' loss of cultural references, family and life patterns.
- **Urban explosion**, favouring poor or absent housing, proletarianization of immigrants and workers generally speaking, and new urban subcultures: violence, delinquency, alcohol and drug addiction, forced prostitution and sexual carelessness.
- **Aggravated gender unbalance**, with a growing number of isolated men in large cities and, of forsaken women in rural areas, frequently left by themselves with the full household responsibility (grand-parents and children) and little resources , thus entailing the destabilization of family structures, growing promiscuity and further emigration of women to cities, without job perspectives.

1.3. Socio-economic, Societal and Cultural Impact of HIV/AIDS: The Vicious Circle

- Loss of job: personal and family economic weakening and even collapse.
- Social exclusion: rejection from the group, breaking family, social and cultural links.
- Lack of person-to-person and person-to-group communication: difficulty in informing of the infection for many reasons (taboos, reputation, privacy, irresponsibility, guilt towards partner).
- Difficulty in access to medical staff or centres: these problems are both material (facilities and staff are often remote from people's living areas) and cultural (modern medicine is felt as alien and unreliable, while traditional healing is considered to be more understandable and securing).

2. Cultural References and Resources to Be Considered

2.1. Cultural Traditions

- They build the feeling of belonging to the community and the subsequent self-esteem (no purely individualistic approach in non-Western countries).
- However, some traditions can be considered as risk factors, for instance:
 - Circumcision and excision;

- Polygamy, often linked to agrarian societies, gradually disappearing because of stronger economic constraints and modernization, but growingly replaced (more among men than women) by multi-partner sexual practices, especially in the case of migrants and mobile professions, thus increasing permanent or occasional prostitution;
- Sexual violence against women, girls and children, sometimes within the family (as an initiation ritual, a practice of sexual disease “cleansing” or “a wild” demonstration of masculine power, especially in urban subcultures);
- Men’s feeling of superiority and ostentatious machismo (specially in Latin American countries, where it goes together with misogyny and homophobia);

2.2. Religious Beliefs

- They may develop compassion and moral comfort for the sick people, among the devotees and religious leaders: for example, certain monks’ communities in the Buddhist countries, Christian missionaries and priests in certain countries of Southern Africa or Latin America and Imams in Muslim countries.
- They shape people’s feelings regarding their fate and future, through belief in the inter-play of supernatural forces: does this make them lose confidence in their own capacities or build a more complex view of life issues?
- They enhance new solidarity, through associations, movements, networks (NGOs among others) and may provide rich opportunities for community-based projects.
- They are the basis of ethical value systems, especially as regards duties and responsibility towards oneself and others. More in-depth investigations regarding the various religious traditions might be conducted in this respect.
- They may also result in different consuming habits and food taboos, for instance alcoholic drinks or hallucinogenic drugs, in the Islamic or other religious traditions.

2.3. Culture and Health

a) Traditional Healers:

- People trust them for their ability to listen and advise (as a psycho-therapeutic practice) as well as to cure (to which extent?);
- In some cases they can act as cultural intermediaries between people and modern medical action;
- In the same way midwives can also play an important role.

b) Good physical condition (and thus good health) is a traditional value: traditional and popular sport games, need for physical strength in manual work, physical attractiveness in emotional/sexual relations.

- c) The existing and possible interactions between culture and health could give rise to a significant follow-up in the matter of research and pilot projects.

3. Recommendations

A wide range of recommendations for further development of the project were made within country research work as well as at the end of the regional workshops held in Southern Africa, South-East Asia and the Caribbean. Some of these recommendations were very broad while, on the other hand, others were very specific and technical. Despite certain differences they show, the recommendations can be summarized under five main headings: context of the issue and the action to take, policy and project design and implementation (institutional action), information/education/communication, training/sensitizing and capacity building, data collection and research needs.

3.1. Context

All recommendations emphasized the need to go beyond purely medical limits, to take a consistent and realistic view of the HIV/AIDS issue. In this sense, all of them insisted on the importance of analyzing the cultural, social and economic environment of the disease and the context.

Thus the proposal for taking a cultural approach towards prevention and care activities was fully recognized as indispensable to the better understanding of situations and subsequent improvement in the efficiency and sustainability of policies, programs and projects to come.

Special mention was made of the interactions between risk behaviour, for example prostitution, cultural destabilization, unemployment, and the need for informal systems to develop face to institutional deficiencies.

3.2. Policy and project design and implementation

The basic recommendation in this respect was to tailor policies and projects to situations, population groups, specific cultural references and resources. "One size does not fit all", as was said in the South-East workshop report.

In order to define the work itself, a number of indispensable conditions were listed:

- In-depth understanding of people's situations, HIV/AIDS determinants and effects, possibilities for mobilizing communities in fighting the disease;
- Relevant targeting of risk factors, unmet needs, risk groups (young people, rural populations, girls and women, the poorest, minorities);
- Implication of networking institutions, either for research purposes (universities, other research centres), public institutions or NGOs;
- Delimitation of HIV/AIDS specific preventive and care action within wider projects concerning for instance water supply, sanitation, housing, education and health policy in general;

- Participation as a basic rule for designing and implementing reliable and mobilizing projects involving traditional or modern movements and associations, local authorities and communities, local NGOs, PWAs, prostitutes and homosexual groups and associations;
- Rational coordination at the national level of action taken for prevention and care, between public institutions, the private business sector and NGOs;
- Enhancing multipurpose initiatives at the local community level, for instance through debates, advocacy or counseling, in full co-operation with community leaders and cultural "custodians" (to whom the necessary information might be given also in the perspective of capacity-building).

3.3. Information/Education/Communication

- Special IEC activities should be developed for risk groups.
- Other types of IEC should be directed to the general population.
- As regards education, activities should be developed both in and out of school. Co-operation between schools and families should be enhanced. Religious education's role in this respect should be taken into account, with the possible harmonization of spiritual and ethical discourse as regards HIV/AIDS, men-women relations, marriage, solidarity and compassion. Traditional leaders and healers should be involved in this effort. PWAs sensitizing activities should also be part of the overall action for preventing, as far as possible, further infection.
- HIV/AIDS education should not be exclusively medical, but also ethical, including the teaching of life skills, balanced gender roles, integration of school learning and teaching in daily life for those learning and their human environment.
- Further more media should develop culturally diverse programmes, preferably through radio. They should also use the impact of popular music and sports stars as role models advocating responsible behaviour.

3.4. Training

- Capacity building should be initiated or strengthened at all levels, from grass-root to decision and policy making centres.
- As regards public authorities, whether civilian, military or religious, they should be sensitized to the cultural approach of the epidemic and the cultural implications of their tasks in this respect.
- At the local level, local leaders and traditional healers should be given the necessary information in a bilateral communication process.
- As regards health workers, they should respect people's demand for confidentiality and avoid detrimental discriminations between infected and sick people based on the differences in their sexual behaviour.

3.5. Information and Research

- Existing data should be made better known and more accessible for researchers and programmes or project designers.
- Information should be made as accurate and up-to date as possible.
- Comprehensive country profiles should be designed and made available to policy and programmes designers.
- Compendia of cultural traditions enhancing HIV/AIDS prevention and care should be drawn up and published.
- In-depth research should be carried out on the building and evolution of sexual behaviour models and current practices.

4. Methodological Implications

The basic principles are as follows:

- Bottom-up planning procedures (instead of the current top-bottom system);
- Participatory processes at all stages: preparation, implementation and evaluation;
- Adaptation and tailoring of projects to the context;
- Realistic time-frame for reaching significant and sustainable results;
- Substitution of conventional planning documents by institutional master plans and project clusters from the field.

At the instrumental level, these principles should result in the following changes:

- Overall, multidimensional, trans-institutional and, consequently, more coordinated and integrated strategies and policies, at the international and national levels (already mentioned as a basic principle in UNAIDS proposed Strategy for 2000-2001).
- Better adapted methods for designing, implementing, readjusting, and evaluating strategies, programmes and projects in matters of prevention and care.
- Relevant training/sensitizing of all professionals involved in such strategies and projects, from decision-makers and senior officers to junior and field workers.
- Building of culturally-appropriate information/education/communication material and methods, through combined elaboration/ delivery systems.
- Collection and processing of data meant to enlighten choices and behaviour, through better information on the societal and cultural context of actions taken, through development of appropriate indicators and enrichment of the measures taken by decision centres via rich feedback from the field.

- Assessment of the present information and research on the subject (repertories of relevant documents and research centres) beyond the medical field, in areas such as anthropology, sociology, history, geography, etc.
- Identification of further research needs, for example with regards to other necessary national assessments other critical issues to identify and research, complementary concepts and tools to draw up and pilot projects to design and implement.

Implementing these tasks with view to better coordinating and improving the efficiency and relevance of the action taken to date, within the framework of UNAIDS and national HIV/AIDS prevention and care policies, requires that several basic principles be recognized and put into practice.

ANNEXES

ANNEX 1: NATIONAL CULTURAL ASSESSMENTS (NCA)

National Cultural Assessments (NCA) should be a prerequisite for any strategy that intends "to make development a true servant to culture, considered as the permanent spirit of a society, and reinforcing this interaction".

There are two ways to address this challenge:

- Secure this function in the school and media systems;
- Carry out national cultural assessments to :
 - Serve as diagnosis exercises;
 - Take stock of major cultural values, knowledge and practices, and up-date this information as appropriate;
 - Open opportunities to promote within society the necessary interactive and consultative process.

The possible major items of national cultural assessments could be:

- Evaluation of the cultural corpus, as a basis and source of information for nation-building and economic development, prior to any further undertaking;
- Mistakes to be avoided: lip-service to culture; changing dances, drama, music, in a "cultural animation", changing names, dress codes, policy statements, resolutions etc. , without sustained and in-depth follow-up.

NCA's would help to design a number of substantive principles and policies based on a culturally-sensitive approach to development, as well as more specific actions for cultural development:

- Identify and analyze the cultural corpus underlying individual and collective life;
- Take hold of emergency cultural issues;
- Establish cultural values affecting positively or negatively the success of development programs and projects;
- Initiate popular consultation processes on which consensus can be built;
- Keep the interactive consultation process open within a long-term perspective (trans-generation), with permanent follow-up and updating of findings.

The possible results of such assessments would include:

- Establishing a framework of cultural references for the endeavours for national development;
- Securing that culture remains a sound basis for **democratic life** and **human development** and not a tool for political domination and repression;
- **Adapting cultural institutions** to the local needs and realities.

Source: UNESCO World Decade for Cultural Development, *Culture and Development*, Harare, Zimbabwe, 1994, Contribution by P. Damiba.

ANNEX 2: CULTURAL AND SOCIAL COST/BENEFIT ANALYSIS

The socio-cultural costs and benefits of development have not hitherto been much studied, although similar analyses have been carried out for other non-economic sectors (health, education, habitat, environment, leisure). The socio-cultural sphere can sometimes be hard to pin down, but it corresponds to a concrete reality that is affected by development, and as such is amenable to analysis from a cost/benefit point of view. The cost/benefit analysis itself can also help bring to light certain social differences which have indirect socio-cultural implications.

This method aims at enabling the local community to fully assess the economic, social and cultural cost of an action undertaken to improve the situation in some specific area. The community alone is in a position to undertake this work, but they can be given technical support from external initiators if they need it.

Systematic assessment of the socio-cultural costs and benefits of development requires the elaboration of specific methods of analysis which have to be defined with precision.

1. Work to be Carried Out

Work activities to be carried out in this area are the following :

- In depth identification and measurement of observable effects, areas in which they are manifested, in particular the socio-cultural area (ways of thinking and doing);
- Definition of the types of communities concerned by the positive and negative results of the project (target group, other groups affected by the project, local or external actors);
- Similarities and differences (linked to socio-professional group, gender, age, urban/rural, etc.) in the ways cost/benefit balance is perceived (sacrifices to be made, response to needs, interests, preferences);
- Quantitative/qualitative evaluation methods for project results (by officials, by the community);
- Short, medium and long term change of conditions and content of this kind of evaluation.

This kind of analysis should result in recommendation of practical proposals for the formulation of objectives, implementation modalities, and anticipated results of development programmes, projects and policies. The complexity of this work means that it must be envisaged with sufficient time for significant results.

2. Difficulties of Cultural Cost/Benefit Analysis

This type of analysis should not be confused with cultural development cost/benefit analysis. These costs and benefits can be measured by the quantification of access conditions to certain goods, services and activities considered to be cultural in nature. Similarly, social cost/benefit analysis and the identification of preferred changes draw on data that are known, measurable and widely accepted, such as increase in literacy rate, life expectancy, or improved housing.

Analysis of the socio-cultural costs and benefits of development, on the other hand, is concerned with fundamental cultural features: e.g., identity, systems of signification, feeling of belonging to a place or to a community. In these cases, it is difficult to identify tangible evidence, even though these features are of capital importance. It is also difficult to define people's aspirations, and, even more so, their needs (or demands) for cultural change.

For example, should **traditional behaviours** be seen as a benefit, since they help to protect identity and give security, or should they be considered as a cost as they hinder social mobility and the development of the individual? Subjective choices will inevitably have to be made about the relative values of change and preservation/continuity in the cultural sphere. Here, the "developer" runs the risk of replacing the community's values with his/her own views. This danger is all the greater, since the community lives its own culture, and will not spontaneously feel it as relative.

A number of issues linked to measurement and evaluation must be addressed. Many forms of cultural change are intangible by their very nature: e.g., changes in beliefs, attitudes, and social norms, even though some aspects of culture e.g. clothing, or local forms of artistic expression, are very tangible.

Carrying out socio-cultural analysis must begin by identifying, preferably in relation to concrete cases and in a diachronic perspective, the impact, on different aspects of the culture of one or more particular communities, of such factors as economic and technological innovation in their most visible manifestations. Thus, transition to a money-based economy, and even more so to a market economy, will have an impact on previous systems of production and trading, and will lead to changes in the organization of activities and power relations within the group, and even within families. At a deeper level still, such innovations can weaken the underlying cultural and ethical structure of life styles, replacing it with an economy-based value system and thus destroying old forms of communal solidarity. The impact of these changes may affect different socio-economic groups within the community in different ways.

Conversely, innovation may impart a new impetus to a society, giving the population more confidence in their own ability to cope with change. The community may take a selective approach to novelty, choosing to enrich its vision of the world and make use of certain new types of economic and social organization, if it feels that in this way it can redynamize its existing values, restore its strength and thus come to play an active role in its own development.

In the same way, the introduction of new technologies can have a positive impact on living standards. Here too though, it is important not to let innovation simply suppress or repress older practices, that were important in maintaining balance in society and in the family, and on which the status of local skills and know-how depended. New technology can, on the other hand, help resolve problems that are potentially destructive for the cohesion, and even the survival of the society. It can also be useful in giving women a broader role to play in society and in improving their status within the group.

It is clear however, that one can only make definite conclusions from observations such as these drawn from in-depth analysis of the causes, effects, and retroactive consequences that are operating in all areas and among all the development actors involved in the situation. In order to ensure the analysis is sufficiently rigorous, it must be supplemented by identifying and formulating indicators for, on the one hand, the fundamental characteristics of a culture, on the other hand, for the models of behaviour and activity most directly implicated in change.

Indicators should also be able to reveal significant modifications in these fundamental characteristics and models.

Thus one can see that analysis of the socio-cultural costs and benefits of development requires both the creation of indicators of initial situations and of change observed, and the representation of the interaction of actors, factors, sectors and levels, as performed by certain types of system analysis or modeling.

ANNEX 3: ELABORATION OF A PARTICIPATORY PLANNING METHOD

1. General Conditions

- Awareness within the given development agency of its failures and agreement on the need to modify its programming procedures.
- Setting-up of a pluri-disciplinary group (specialists in social sciences among others) to elaborate a new approach;
- Institutional support at the highest level.
- Commitment to field experiences, risk-taking, self-evaluation of results of the action taken.
- Acceptance of the necessary time to extend social experiment and to subsequently reform the institutional procedures.

2. Necessary Commitment and Know-How

- Integrating practitioners' and researchers' knowledge.
- Allowing sufficient time for researchers to observe the validity of their methodological proposals, so as to identify scientific weaknesses and to adjust these proposals accordingly.
- Pre- and in-service training in social innovation.
- Firm commitment from political decision-makers in order to counter-balance bureaucratic habits and pressure from lobbies.
- Rapid institutionalization after completion of the experimental phase.
- Availability of organizational and administrative means for putting new methods into practice.

Source: Cernea Michael, *The Building Blocks of Participation: Testing Bottom-up Planning*, World Bank Discussion Papers, Washington, 1992.

ANNEX 4: CRITERIA MATRIX OF THE LOMÉ CONVENTION

Within the framework of the Lomé Convention (a wide-ranging agreement between the European Union and African, Caribbean and Pacific countries), and in the light of its experience under this Convention, the Union has developed a criteria matrix to help adapt aid to the specificities of different geographical and cultural areas within the Convention's beneficiary countries (CEC, 1990). Four groups of factors are described in this matrix. In spite of this subdivision, cultural connotations are also patent in Section 2, 3, and 4.

1. Social Organization

2. Structuring by ethnic, age, religious and linguistic groupings.
3. Status of and relationships among groups and hierarchies (by age, sex, lineage, property, etc.).
4. Decision-making processes and powers within the group and in relation to those outside the group.
5. Demographics (fertility rate, life expectancy, anticipated changes) and mobility (migration patterns, direction, duration).
6. In cases of migration: number, reasons, origin, destination, duration, sex and age of migrants, consequences, methods of travel, cost.
7. Basic needs situation (nutrition, water, hygiene and health, habitat).
8. Employment (type, level, conditions).
9. Social prestige and value criteria.

2. Family Organization

1. Family size and organization (for various representative groups).
2. Interpersonal relationships, authority and subordination relations, distribution of power within the family (budget, decision-making, etc.).
3. Distribution of tasks within the family and specific position and role of women.

3. Economic Organization

1. Forms of ownership, transmission and inheritance of land, personal property, etc.
2. Role of money, relationship between wealth and social value.
3. Activity (agriculture, livestock husbandry, cottage industries, commerce, transportation, child and family care) and agents of production (specify: food crops to be marketed or consumed by grower, other crops and activities).
4. Main products and modes of production.

5. Organization of work, calendar of workload at key periods of the year, labour wage rules: specify working and living conditions, terms of payment for men, women or youth.
6. Instruments and tools, equipment, technologies.
7. Trade, transportation and processing of products, prices at various stages.
8. Income (monetary and non-monetary), debt and savings. If credit exists: terms of access and repayment, interest rate.
9. Propensity to consume, invest or save, distribution and use of income (for example, the purchase of metal sheet, bicycles, millet beer).
10. Access to agricultural advice and results of scientific research.

4. Cultural Factors

1. Professional and general knowledge (specify how and how long to acquire, training structures), level of literacy, ability to manage accounts and keep books for a cooperative.
2. Beliefs, customs, value systems.
3. Taboos (related to food, resources, interpersonal relationships).
4. Attitudes toward modernization, attachment to traditional know-how.
5. Typical behaviour (for example, the use of leisure time, hospitality, aspirations).
6. Relationship to authorities (central or regional) and institutions.
7. Self-development efforts: collegiate organizations (for example, village committees), collective endeavours. Possibilities in this regard, in particular innovation processes, initiative (individual or collective, private or public), obstacles (such as social inequality), and dissemination (processes of imitation, persuasion, etc.).

Source: Commission of the European Communities, *Recueil d'instructions et directives concernant la coopération culturelle*, Brussels, 1990.