

THE GLOCALIZATION AND ACCULTURATION OF HIV/AIDS: THE ROLE OF
COMMUNICATION IN THE CONTROL AND PREVENTION OF
THE EPIDEMIC IN UGANDA

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Grounded in the social constructivism tradition, this study examined the role of communication in the glocalization and acculturation of HIV/AIDS by a section of sexually active Ugandans then living in Rakai district during the advent of the epidemic in 1982.

Sixty-four women and men participated in ten focus group discussions in Rakai and Kampala districts. Five themes emerged from the data highlighting how individuals and communities made sense of the epidemic, the omnipresence of death, how they understood the HIV/AIDS campaign, and how they are currently coping with its backlash.

The study concludes that HIV/AIDS is socially constructed and can be understood better from local perspectives rather than from a globalized view. The study emphasizes the integration of cultural idiosyncrasies in any health communication campaigns to realize behavioral change.

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CHAPTER 1

INTRODUCTION

Background of the Study

This exploratory study examined the role of communication in the understanding of the global human immune virus (HIV) and acquired immune deficiency syndrome (AIDS) by a section of the sexually active Ugandan population then living in Rakai district where the epidemic was first identified in 1982. The study demonstrates how the knowledge acquired during that sense-making process was used by the section of the population now aged between 40 to 50 years to adapt new life skills to cope with the epidemic in their continuously changing social environments.

Grounded in the social constructivism perspective, the introductory chapter of this study begins with an explanation of the basic assumptions of the constructivism perspective and describes the glocalization process through which the new global HIV/AIDS pandemic was localized and understood by a section of high risk Ugandans then living in Rakai district, the epicenter of the epidemic in the country. The chapter also describes the acculturation process to demonstrate how a section of the Ugandan population then aged between 17 to 27 years adjusted to the HIV/AIDS epidemic and adapted strategies that are gradually leading to the integration of the disease in their culture.

Next, the chapter presents an overview of the status of the HIV/AIDS pandemic with statistics that highlight the human crisis orchestrated by the devastating pandemic in Uganda and elsewhere in the world. This is followed by a statement of the problem and the rationale for the study. Finally, the chapter includes an explanation of the theories replicated in the research and concludes with a statement of the research questions.

The Constructivism Perspective

The constructivism or the social constructivism perspective (e.g., Berger & Luckmann, 1966) has led to a growing body of literature from social science researchers in the health field who contend that reality is a product of human action which constantly creates and recreates within a given social context. Proponents of this sociological tradition (cf. Engelhardt & Spicker, 1974; Eisenberg, 1977) argue that the world does not exist only in our heads but also is collectively constructed through constant human interpretative activity. According to Engelhardt and Spicker (1974) and Eisenberg (1977), health communication scholars from the constructivism tradition argue that any society interprets and assigns meanings to all forms of illness according to its cultural values, social norms, and culturally shared rules of interpretation. Although this position is a sharp contrast to the biomedical or western scientific diagnosis of disease, it does not negate completely the former but rather views it as part of a social process that is initiated and perpetuated through human interaction.

This study has adopted and applied the view as expounded by Engelhardt and Spicker (1974) and Eisenberg (1977) which recognizes disease as a biomedical reality and acknowledges alternative interpretations based on nonmedical or cultural theories of illness. Clearly, the emergence of local names and alternative interpretations to define and understand the HIV/AIDS epidemic by a section of the population in Uganda (Kolsrud et al., 1989; Hampton, 1990; Seidel, 1990; Bond & Vincent, 1991; Obbo, 1991; Lyons, 1997) is evidence of the globalization of the pandemic and is consistent with the social constructivist tradition. In addition, the social changes adapted by the 40-50 year old members of the Ugandan population from Rakai district to cope with the HIV/AIDS epidemic on a daily basis reflects a gradual integration of the disease in their culture as one of the alternative outcomes of the acculturation process.

The process of redefining and reframing the HIV/AIDS pandemic and the subsequent changes and adjustments in the daily lives of a social community to cope with the epidemic, (Bond & Vincent, 1991; Moodie, 1991; Lyons, 1997; Singhal & Rogers, 1999; Hogle, 2002; United Nations AIDS monitoring agency (UNAIDS), 2003; World Health Organization (WHO), 2003; World Bank, 2004a; Parkhurst & Lush, 2004; Stoneburner & Low-Beer, 2004) is a clear manifestation of the pivotal role communication plays in the reconfiguration of cultural norms in a community. What makes individuals aged between 40-50 year from Rakai district a compelling group for investigation in this study is their unique experience as surviving members of the most vulnerable section of the sexually active Ugandan population then aged between 17 to 27 years (Sewankambo, Wawer, Gray, Serwadda, Stallings, 1990; UNAIDS, 1998; Kamali et al., 2000; Medical Research Council (UK), 1998). In addition, the group is a part of the population in Uganda that witnessed the onset of the epidemic, the unprecedented deaths of their peers, the decline in the death toll due to changes in high risk sexual behaviors, and the availability of anti-retroviral drugs (Uganda AIDS Commission (UAC), 2003; UNAIDS, 2003; WHO, 2003; Singh, Darroch & Bankole, 2004; Stoneburner & Low-Beer, 2004).

Furthermore, this age group was sexually active when the country went public about the presence of the HIV/AIDS disease in 1987. At the same time, the age group lived through the period when the Uganda government launched a national multi-sectoral campaign against the epidemic in 1992 that emphasized abstinence, be faithful, and condom use (A, B, & C) (UAC, 2003; Ministry of Health (MOH), 2003). Members of this age group also witness, in less than ten years, a dramatic reduction in the HIV/AIDS infection rates from 30% in the worst hit urban areas, mostly in Rakai district, to a stable national average of 6.1% by 1995 for almost ten years (UNAIDS, 2002; WHO, 2002; UAC, 2003).

Therefore, this study investigated the role of communication in the glocalization of the HIV/AIDS pandemic among a section of the Ugandan population aged between 40-50years who hail from Rakai district, the hotbed of the epidemic in Uganda. At the same time, the study investigated the gradual acculturation of the disease in the mainstream culture of the age group.

The Glocalization Concept

According to Stroupe (1990), the term glocalization was conceptualized by globalists at the end of the cold war in the late 1980s during the height of a global debate on the cultural and economic impact of globalization on developing countries and their poor local communities. Stroupe states that the term glocalization is attained through combining the words globalization and localization. Glocalization refers to a process through which localities develop direct economic and cultural links to the global system through information technologies and other unconventional channels of communication. Traditional power hierarchies like national governments and sometimes markets are bypassed and/or subverted in order to reach diverse populations across the globe.

Walsh (1990) and Friedman (2002) add that glocalization is a process through which cultures encounter other foreign and world cultures or phenomena but use their internal and local mechanisms to adapt influences that naturally fit into and can enrich their respective cultures and resist those aspects of other cultures that would erode their cultural identity.

Other scholars of glocalization (Kozłowska, 2003; Roudometof, 2003; Thornton, 2000; Satyavrata, 2004; Randeria, 2003) contend that global products, phenomena, trends, services, or norms that transcend national boundaries are localized, customized, or transformed to suit the local culture of a specific destination. However, the scholars warn that some global cultures or phenomena are too strong to be resisted by communities with fragile or weak economic, cultural,

or political systems resulting in the destabilization of their social and cultural structures and core values.

Thus, this exploratory study applied the glocalization concept to understand how a section of the Ugandan population that was sexually active and living in Rakai district during the onset of the HIV/AIDS epidemic communicatively glocalized the pandemic. Specifically, the study investigated how the group socially constructed and assigned local meanings to comprehend the new disease and how they adapted new traits to cope with the challenges posed by the scourge. In addition, the present study examined how the section of the population transformed some of its cultural institutions to respond to the pandemic. Indeed, despite the growing transnational diseases that keep popping up in the global village, the glocalization concept has yet to be replicated in any studies on health related issues to understand how afflicted local communities frame and make sense of new global diseases and adapt strategies to cope with the unfamiliar health hazards.

The Acculturation Concept

Furthermore, the present study extended the acculturation concept to assess whether communication about HIV/AIDS within the section of the Ugandan population that was sexually active in Rakai district by 1982, has resulted in any of the predictable outcomes of acculturation for the disease that include assimilation, separation, integration, or marginalization.

Acculturation research refers to assimilation as a consequence of acculturation which entails a complete loss of original identity of an individual or group of individuals leading to total absorption into another culture (Redfield, Linton & Herskovits, 1936; Social Science Research Council, 1954; Graves, 1967; Smith, 1969; Berry, 1980; Kim, 1988).

On the other hand, the research describes separation as an outcome of acculturation in which acculturating individuals or encountering phenomena or cultures remain distinct from one another while marginalization is defined as a state which entails isolation and rejection of acculturating individuals or new cultural phenomena.

Finally, acculturation research describes integration as the most desirable outcome of the acculturation process because it involves the loss of some cultural traits and adaptation of new cultural attributes that competently negotiate the new and changed cultural environment. This exploratory study tested the integration outcome of acculturation to explain how the then sexually active population in Rakai district changed some of its cultural norms and adapted new traits to competently negotiate the new cultural environment imposed on it by the advent of the HIV/AIDS epidemic.

Originally developed in anthropology, the concept of acculturation was replicated in intercultural communication to refer to a process of resocialization for individuals who have come into contact with another culture (Kim, 1988, 1995). Anthropologists had earlier defined acculturation as a “process of cultural change experienced by an individual or a group of people as a result of an encounter with a different cultural group” (Redfield, Linton & Herskovits, 1936, p. 149).

The Social Science Research Council (SSRC) (1954), proposed a more comprehensive definition of acculturation by referring to it as a cultural change that is initiated by the conjunction of two or more autonomous cultural systems. The Council adds that acculturation may be the consequence of direct cultural transmission or may result from other social phenomena or non-cultural causes such as ecological or demographic modifications caused by impinging culture regardless of the origin of such phenomena. The council states that such

phenomena may include or result from short term or accidental encounters between individuals or diffusion of ideas or values over long distances through the mass media or other non conventional channels of interaction.

Researchers in psychology (Graves, 1967; Smith, 1969; Berry, 1980, 1992, 1995; Berry, Kim, Power, Young & Bujaki, 1989; Searle & Ward, 1990; Ward & Kennedy, 1993; Rogler, Cortes, & Malgady, 1991) described acculturation as a complex process occurring on two separate but related levels: behavioral and psychological. They explain that the first dimension, behavioral acculturation, is associated with acquiring new and recognizable cultural traits such as language, social skills, and the ability to function within the changed cultural environment. The second dimension, which the researchers termed psychological acculturation, is depicted as a more complex process that reflects invisible changes in the culture of acculturating groups, such as adaptation of new cultural values, ideologies, beliefs, attitudes, and other norms.

Expounding on the psychological perspective of acculturation, several authors (Graves, 1967; Smith, 1969; Berry, Portingan, Segall, & Dasen, 1992; Berry, 1997) point out that acculturation at the population level should be considered as changes to social structures, economic base, and political organization of the groups involved in the acculturation process. Since previous research on acculturation focused exclusively on cross-cultural contact between groups of people, this exploratory study extended the more comprehensive definition of acculturation as advanced by the Social Science Research Council (1954) to investigate the encounter between HIV/AIDS as a social phenomena and the sexually active population then living in Rakai district in Uganda.

Furthermore, since there are conflicting theories on how the HIV/AIDS epidemic reached either side of the Uganda-Tanzania border (Kolsrud et al., 1989; Bond & Vincent 1991; Obbo,

1991; Kiluwo et al., 1993; Lwihula, Dahlgreen, Killewo, & Sandstorm, 1994; Mutembei, Emmelim, Lugalla, & Dahlgren, 2002), this study applied aspects of the definition advanced by the Social Science Research Council (1954). This definition acknowledges that the origin of the phenomena notwithstanding, acculturation can take place as a result of an encounter between a new phenomena and a population through formal and informal channels of interaction.

Based on the foregoing definitions, this study examined the linear and psychological impact of HIV/AIDS on a section of the Ugandan population that was sexually active during the outbreak of the epidemic to a point of influencing and changing their communication and sexual behavior, adapting new attitudes, norms, and values to cope with the new challenge. The study also investigated how the reconfiguration of the social, economic and political landscape changed to acculturate the epidemic. Thus, both glocalization and acculturation concepts were deemed appropriate for application in the present exploratory study to explain how the target population socially reconstructed the global pandemic, how it responded to the unprecedented deaths of their peers, and how it adjusted its way of life to deal with the on-going humanitarian disaster.

Overview of the HIV/AIDS Status

Twenty three years since the outbreak of the epidemic in Uganda, this section of the population has witnessed a massive and relentless destruction of life by AIDS unparalleled in the country's history (Museveni, 1991, 1998; Alun & Tumwekwase, 2001). According to UNAIDS (2003), WHO (2003), and the World Bank (2004a, 2004b), a national cumulative total of over 2.4 million Ugandans have been infected since 1982 with the human immune virus (HIV), the virus that causes AIDS. The three organizations estimate that out of the cumulative total, over one million people have been killed by HIV/AIDS. The organizations estimate that

approximately 1.4 million people in Uganda are living with HIV/AIDS. The three international organizations report that, by 2002, a staggering 1.7 million children were orphaned by the disease.

The total number of people estimated to have died of AIDS and those living with AIDS, represent almost 10% of the country's population estimated at 26.7 million people, (Uganda Bureau of Statistics (UBOS), 2004). The cumulative and widespread deaths and communal grief has left deep and permanent scars in the psyche and lives of the entire population regardless of age, social status, ethnicity, or creed (Seeley, Wagner, Mulemwa & Kengeya-Kayondo, 1991; Twaddle & Hansen, 1998; Alun & Tumwekwase, 2001; Kaleeba et al., 1997).

Unfortunately, 24 years after the HIV/AIDS disease was first diagnosed in the United States in 1981 (National Center for HIV, STD and TB Prevention, 2000; Centers for Disease Control and Prevention, 2004; Gilen et al., 2001; Crosby, Yarber, Diclemente, Wingood & Meyerson, 2002) neither vaccine nor known cure has been developed to eradicate the pandemic that is gradually but systematically threatening to wipe out sections of humankind. In Uganda, while the devastating cultural and political impact of the epidemic is apparent in all communities, the traumatic effects of the tragedy are glaring in most families across the country.

More specifically, since HIV/AIDS is transmitted invariably through heterosexual intercourse in Uganda and most of Africa, the section of the population that was sexually active at the advent of the epidemic in Rakai district, suffered the worst brunt of the disease (UNAIDS, 2003; WHO, 2003; World Bank, 2004a). Accordingly, due to the havoc wrecked on the country by the epidemic, the government of Uganda declared the HIV/AIDS a security and development crisis (Museveni, 1991, 1998; Twaddle & Hansen, 1998; UAC, 2003). Ten years later, the World

Bank declared the HIV/AIDS epidemic a global development crisis in 2002 because it was decimating the most productive and reproductive sections of the global population.

In Uganda, unlike other short-term disasters that come and go, the HIV/AIDS epidemic has been an on going crisis for the last twenty three years emotionally and physically traumatizing the population by indiscriminately killing children, adults, the elderly, the rich, the poor, the illiterate, and the educated alike (Bond & Vincent, 1991; Obbo, 1991; Lyons, 1998; Seeley et al., 1991; Kaleeba et al., 1997). In Rakai district in particular, large numbers of deaths and burials became a common feature of daily life leaving some families and villages completely wiped out by the epidemic which turned death into such an ordinary burden and common occurrence that even ceased to shock children (Alun & Tumwekwase, 2001). The authors (Alun & Tumwekwase, 2001) graphically explain the omnipresence of death as a result of the widespread and cumulative deaths in Rakai district: “Children of today know who is ill, who is dead and who is weak. They go to burials at a young age and are used to them. They may have seen the body of an aunt, and then the father dies and they see his corpse, then the mother and a stepmother, so they are used to it, and used to dead bodies and large graveyards” (p. 232).

However, the catastrophic effects of HIV/AIDS and the alarming figures on the evolution and status of the epidemic in Uganda are not in isolation. They reflect a relentless and disastrous pandemic that is afflicting the entire world. According to UNAIDS (2003) and WHO (2004), approximately 28 million people have been killed by AIDS worldwide, and an estimated 50 million people are living with HIV or AIDS. Despite the high figures of HIV/AIDS infections around the globe, sub-Saharan Africa has suffered the worst brunt of the pandemic with a death toll standing at about 24 million people while those living with the virus are estimated to number 28.2 million (UNAIDS, 2003; WHO, 2003). The two global health organizations (UNAIDS,

2003; WHO, 2003) state that while multiple causes account for the spread of HIV in other parts of the world, the primary cause of HIV/AIDS in sub-Saharan Africa is through heterosexual relationships.

Despite the rapid growth in the numbers of HIV infection rates in other regions of the world like Asia, Latin America, and in the former Soviet Republics, (UNAIDS, 2003; WHO, 2003), the effective management of the AIDS symptoms with cocktails of antiretroviral drugs and relatively better health facilities compared to Sub Saharan Africa, the fatalities in those regions have been considerably reduced. Although successful management of the AIDS symptoms has resulted in prolonged lives for people living with AIDS, the catastrophe still looms and the AIDS threat to humankind is still real across the globe. Under the prevailing circumstances, effective education to equip the world population with life skills to protect itself against infection with HIV and to care for both the infected and affected individuals with AIDS, remains the only practical and plausible solution to control the unprecedented spread of the virus, (UNAIDS, 2003; WHO, 2003).

Thus, since Uganda was among the first front-line states to sustain AIDS casualties and endured the challenges of experimental and protracted HIV/AIDS education and prevention campaigns, this study investigated how the global pandemic was explained and localized among the sexually active individuals in the area where the epidemic was first reported. Accordingly, to understand the process of HIV/AIDS glocalism in Uganda, the present research examined the role of communication from the onset of the epidemic through its evolution and how communication is reinforcing the gradual acculturation of the disease among a section of Ugandans who were sexually active during this time period.

Statement of the Problem

Previous social scientific research on HIV/AIDS in Uganda (Bond & Vincent, 1991, 1997; Kolsrud et al., 1989; Hampton, 1990; Seidel, 1990; Moodie, 1991; Obbo, 1991; The AIDS Support Organization (TASO) (1992), Lyons (1997, 1998), and Twaddle and Hansen (1998) traced the history of the epidemic and discussed the community response to the HIV/AIDS epidemic. The research also examined the language used to describe the HIV/AIDS disease in its early stages. The studies explained how the stigmatization of people living with AIDS was reflected in the rural and urban discourse. In addition, the research discussed the social, physical, and emotional impact of the epidemic on selected groups of the Ugandan society especially in Rakai and Kampala districts.

Epidemiological and bio-cultural research on HIV/AIDS in Uganda (Musinguzi, 1996; Konde-Lule, Tumwesigye, & Lubanga, 1997; Hogle, 2002; Parkhurst, 2002; Stoneburner, & Low-Beer, 2004; Parkhurst, & Lush, 2004; Singh, Darroch & Bankole, 2004) focused on how the HIV/AIDS infection rates were reduced and evaluated the levels of knowledge about the disease among the population in the country. The research also examined the campaign strategies against the epidemic and assessed some of the changes in the behavior and attitudes among the groups of the population observed.

However, overlooked in this line of research was the application of some salient communication concepts in the globalization of the pandemic among a section of the population in the country and how globalization is reinforcing the gradual integration of the HIV/AIDS disease into their culture. Thus, the present exploratory study builds on previous research on the epidemic by focusing specifically on how a section of the population that was sexually active

during the advent of the epidemic made sense of the pandemic. Specifically, the section of the population, then aged between 17 to 27 years and living in Rakai district where the disease was first identified in 1982, presents a unique generational perspective on HIV/AIDS.

Members of this age group have lived through the entire 23 years of the epidemic in the country. This group, now aged between 40 to 50 years and living either in Rakai or Kampala district, possesses first hand knowledge and experiences as a result of its encounter with the pandemic. In all previous studies, the knowledge and experiences of this unique group have not been specifically investigated.

The purpose of including respondents from both Rakai and Kampala districts is multifaceted. First, the inclusion ensured that both rural and urban members of this section of the population then living in the Rakai district between 1982 and 1986 during the genesis of the epidemic are represented. This enriched the study through the various stories and perspectives the diverse sample provide on the evolution of the HIV/AIDS epidemic. Second, Rakai and Kampala are both districts in Uganda's central region called Buganda whose majority belong to the same ethnic group called Baganda and speak the same mother language called Luganda (Uganda Bureau of Statistics (UBOS), 2005).

Third, since most of the elite in the country live in Kampala city, the capital of Uganda, most national policy and opinions are formulated here before they are filtered to the rural areas. The inclusion of the Kampala members of this age group from Rakai district provided the study with insight into the elitist and urbanite perspectives and responses to the epidemic. Furthermore, this study addresses how the target group is communicatively responding to the emerging health consciousness that has resulted from the impingement of their culture and the reconfiguration of

the social, economic and political structures in their environment. The study illuminates the various disparities that emerge between the two sample sets.

Since the cornerstone of this study is that communication changes from time to time according to prevailing conditions in a society, special attention is given to how members of the age group locally adapted the new concepts that have constantly emerged during the global HIV/AIDS crisis. In addition, the study assesses how communication among the age group is reinforcing the acculturation of the disease in their culture. By examining the role of communication among a section of the population that was sexually active during the last 23 years and has adapted new strategies to cope with the disease, findings of the study may be modified, replicated, and applied to other environments that are similarly afflicted.

Already, over 25 million people have been killed all over the world and close to 50 million are infected with HIV/AIDS, a challenge that demands a reevaluation of how global communities derive lessons from the ravages of the pandemic within and outside their environments and use them to control and prevent the scourge. Indeed, the astronomical numbers of people killed by the disease, those that are already infected, and the global magnitude of the crisis suggest the need for supplementation of the bio-medical solutions to mitigate the relentless pandemic. Therefore, understanding the role of salient communication concepts in the campaign to sensitize global communities to protect themselves against the scourge of HIV and AIDS can no longer be overlooked.

Rationale

Since Uganda was one of the first three countries along with Senegal and Thailand to register a breakthrough in the fight against the global HIV/AIDS pandemic (UNAIDS, 1998a, 1998b, 2000, 2001, 2003; WHO, 2003), it is important to understand the factors that contributed

to this success. The recognition by UNAIDS and WHO that neither a vaccine nor a cure exists for HIV/AIDS, the explanation for Uganda's success in the reduction of the spread of the epidemic lies in the massive education and prevention campaign launched in the country almost twenty years ago. The Ugandan record in the campaign against the HIV/AIDS epidemic presents a strong case for investigation. For example, in 1987, Uganda went public about the existence of HIV/AIDS in the country. But in less than ten years, after the adoption in 1992 of the multi-sectoral approach to respond to the epidemic, the country was able to reduce the HIV/AIDS infection rates from 30% in the worst hit urban areas to a stable national average of 6.1% by 1995 for a period of ten years (UNAIDS, 2002; WHO, 2002; UAC, 2003).

Yet, to date, there have been inadequate studies to apply, understand, and explain the concepts of communication that have contributed to the reduction of the HIV/AIDS infection rates in Uganda. In addition, insufficient attention has been given to the role of communication in the glocalization of the pandemic and in the gradual acculturation of the disease among a section of the population that lived in Rakai district by 1982. Therefore, the purpose of the present study was to understand how communication was used in the glocalization and acculturation of the pandemic among a group of Ugandans who were sexually active and lived in Rakai district by 1982.

While there has been a growing line of research in the bio-medical field to enhance the scientific understanding of HIV/AIDS: The characteristics of HIV 1 and 2, the transmission and incubation period of the virus in the developed and developing countries, and the management of the symptoms of HIV/AIDS Kriss, 2004; (Whitworth et al., 2000; Sewankambo et al., 1990; Nunn et al., 1997; Medical Research Council (MRC), 1998; Asiimwe-Okiror et al., 1997; UNAIDS, 1998; Kamali et al., 2000; Morgan, Mahe et al., 2002; Shabbar, Alison, Whitworth,

Smith, & Whittle, 2003), there has been a disproportionate growth of research in the communication field to explain and understand the communication concepts that have contributed to the reduction of the HIV/AIDS infection rates in Uganda.

In addition, little focus has been paid to the constantly changing communication behavior of the population in shaping and reshaping people's lives. Overlooked in Uganda for more than two decades of HIV/AIDS existence is research that is specifically focused on the role of communication in fostering some of the far reaching changes in the cultural, social, economic, and political structures among the different social communities in the country. Bio-cultural, epidemiological, and social scientific research conducted on the HIV/AIDS epidemic in Uganda have focused primarily on degrees of knowledge about the disease during specific phases of the epidemic (Bond & Vincent, 1991, 1997; Obbo, 1991; Konde-Lule et al., 1997; Lyons, 1997, 1998; Twaddle & Hansen, 1998; Stoneburner & Low-Beer, 2004; UAC, 2005). The studies concentrated on anthropological, epidemiological, or scientific outcomes of the epidemic.

Noticeably missing in this line of research are the more salient and complex communication features that highlight the evolution of the epidemic and the continuous reconfiguration of the cultural, economic, and political landscape in the country and how they affect different social communities and age groups. Hence, this exploratory study provides some fresh insight into the role of communication in the globalization of the HIV/AIDS pandemic, its impact on a section of the Ugandan population, and how those communication outcomes are gradually being integrated into the daily lives of that group. At the same time, the study explicates how communication oriented outcomes are shaping the emerging health-conscience culture among a section of the population that was sexually active when the epidemic reached the country in 1982.

Theoretical Framework

Two separate but related theories that have been widely replicated in research on social change have been applied in this exploratory study. The theories: symbolic interactionism (SI) developed by George Herbert Mead as cited by Morris (1934) and the diffusion of innovations (DOI) (Rogers, 1962) have had a tremendous heuristic impact on both natural and social science research (Littlejohn, 2000). This exploratory study builds on that tradition to understand how a section of the Ugandan population made sense of the HIV/AIDS epidemic to freely and publicly talk about the disease and set a gradual course to acculturate it into its culture.

Symbolic Interaction (SI) Theory

Extending the line of research in the social construction tradition, this study draws from the symbolic interaction theory developed by George Herbert Mead and published by Morris (1934) to explain how a group of Ugandans made sense of the HIV/AIDS pandemic. In addition, the theory is used to explain how the group locally and continuously named and understood the disease, how they thought about the disease and changed their lifestyles to cope with the epidemic and how they have gradually set a course to integrate the disease in their daily lives.

Symbolic interactionism (SI) refers to a dynamic process of interaction through which individuals use significant symbols or labels to assign shared meanings to objects, events, or any other social reality within their environment (Morris, 1934). Symbolic interactionism suggests that people make decisions and act in accordance with their experiences from their ever changing environment. According to Mead as cited by Morris (1934) individuals or groups of people use language to interact, create, and establish shared meanings, interpret and understand social reality in the world around them.

Hence, symbolic interaction theory suggests that human actions are impulsive and spontaneous unless moderated by some other factors. This study applied the “I” concept as suggested by the theory. The “I” is the driving force behind all human action. The “I”, which is very fluid and susceptible to change in response to the whims of the individual, has been extended to understand how sexually active individuals in Rakai district responded to the advent of the epidemic.

The theory also presents the concept of “Me” as a stable factor that represents a moderating effect on the “I” and has been applied to this study because it represents significant or particular others who are looked upon as role models in society. At the same time, the “Me” represents the generalized other, the larger social network of customs, norms, values, and culture that always prevail upon the excesses of the “I” by providing guidance to conform to social norms. In addition, the concept of self that enables individuals to reflect on themselves and think about those communication symbols that enhance their images has also been extended to this study to explain how individuals related to the significant labels that were used over time to describe the HIV/AIDS epidemic in their localities.

Furthermore, the present study applied the concept of “Mind.” Symbolic interactionism theory refers to “Mind” as a person’s ability to construct, understand and use shared meanings assigned to objects, events, and any other social reality. The concept of “Mind” also refers to the ability of an individual to understand how other members of society think about him or her. Finally, this study applied the role playing concept as suggested in symbolic interactionism which refers to individuals as actors and performers of various roles in society in accordance to the established and shared norms. The implication of this concept is that there are social expectations an individual must accomplish without deviating from the established conventions.

This study examined whether individuals in the age group acted in conformity with the demands of the anti-HIV/AIDS campaign to avoid contracting the disease.

According to Littlejohn (2000), symbolic interaction theory was further developed by the Chicago school under Herbert Blumer who supported participatory inquiry in which researchers observe or interact with respondents in order to understand their social relationships rather than quantify their creative and dynamic human interactive experiences. Following the Chicago school tradition, the present study applied concepts in the symbolic interaction theory to understand how the section of the Ugandan population communicatively responded to the HIV/AIDS epidemic since it was first identified in its district 23 years ago. In this study, this application was accomplished through the use of focus group discussions to tap the diverse and unique experiences of the participants.

Diffusion of Innovations (DOI) Theory

The diffusion of innovations theory (DOI) suggests that the diffusion of an innovation occurs when the adoption of an idea, practice, or object spreads by communication through a social system (Rogers, 1962, 1973, 1976, 1994; Rogers, & Kincaid, 1981). The diffusion of innovations theory was deemed most appropriate for this exploratory study because it effectively examines and explains the communication flow of new ideas into a community and how targeted communities respond positively or negatively to the ideas disseminated to them through both formal and informal communication networks.

The diffusion of innovations theory was originally conceptualized as a basic mass communication model depicting the functions and goals of communication involving a source or sender of a message, through a channel or medium of transmission to a receiver of the message (Lasswell, 1948). The model was further developed by Lazarsfeld, (1955) with the two-step flow

hypothesis which underscored the importance of interpersonal communication in authenticating and spreading media messages through some opinion leaders to other members of society.

Several researchers in various fields of study across the world have replicated the theory to understand social changes triggered by the diffusion of innovations in societies (Littlejohn, 2000).

This study applied the more comprehensive model of the theory as expounded and reviewed by Rogers (1962, 1973, 1976, 1994) and Rogers and Kincaid (1981), who argued that the dissemination of ideas require more than just a two-step flow process. They contended that information distribution demands that multiple networks are used to spread information through the mass media and by word of mouth to members of society who in turn discuss the idea and eventually adapt or reject it according to its relevance to them. The theory suggests that often, but not always, the dissemination of information results into the adaptation of an innovation.

According to Rogers (1962, 1973), the diffusion of innovations (DOI) is essentially a social process consisting of people talking to others about a new idea and they gradually shape the meaning of the innovation. He posited that although adaptation may be gradual at the beginning, more and more people adapt the innovation when they start observing its benefits to early adapters then the rate of adaptation increases until a critical mass is achieved before the process levels out. In addition, Rogers (1962, 1973, 1976, 1994); Rogers and Kincaid (1981) and Backer and Rogers (1998), acknowledged that if an innovation is to be successfully spread and adapted, it must initially attract the attention of key members of a community to champion its cause by elevating it to prominence on the public agenda and help to secure resources for its promotion in society. They also noted that adaptation of an innovation will largely depend on its

relevance, its perceived advantages, its relative simplicity to adapt, understand, and its applicability to community life.

Based on the foregoing concepts, this study examined how the new HIV/AIDS pandemic was socially reconstructed to acquire a local cultural dimension that was diffused to the sexually active section of the Ugandan population then living in Rakai district and how the HIV/AIDS messages made sense to them. At the same time, the study investigated how the socially constructed meanings of the disease were spread to the targeted age group in education and prevention campaigns for easy comprehension and adaptation to register the desired change in sexual practices.

Research Questions

Based on the foregoing background and purpose of the study, the following research questions were investigated to assess how a section of the Ugandan population then aged between 17 to 27 years and living in Rakai district by 1982 made sense of the epidemic and globalized the HIV/AIDS pandemic. At the same time, the present exploratory study examined the degree to which the disease has been acculturated in the culture of the same age group.

Previous research (c.f. Trudgill, 1974; Lwihula & Dahlgreen, 1993; Mutembei et al., 2002) suggests that initial response by a community to an encounter with a new phenomenon is to draw from its cultural experience to describe, explain and define the phenomenon. Consistent with that observation, this study raises the first research question to understand how a section of sexually active Ugandans made sense of the global HIV/AIDS when it emerged in their midst.

RQ 1: How did sexually active Ugandans aged between 17 and 27 years then living in Rakai district where the disease was first identified adapt local meanings and definitions to communicate about HIV/AIDS?

Stroupe (1990) and Friedman (2000) state that when a global phenomena encounters a local culture, a transformation process is set in motion to customize both the foreign and indigenous ideas, services, institutions or products to blend into the changed local environment. Thus, the intersection between the global and the local systems may create some instability in a local context. While previous studies on global and local encounters (e.g. Stroupe, 1990; Friedman, 2000; Randeria, 2003; Kozłowska, 2003; Rafalovich, 2005) focused primarily on trade, education, law, and religion, this study extended the concept to health communication to investigate how sexually active Ugandans in Rakai district negotiated the impingement on their culture by the global HIV/AIDS pandemic and posed the second research question.

RQ 2: How was the global HIV/AIDS communication campaign transformed in the local environment to be understood by a section of the Ugandan population now aged between 40 to 50 years then living in Rakai district by 1982?

The reconfiguration of the Ugandan social structures (e.g. Kolsrud et al., 1989; Museveni, 1991, 1998; Bond, & Vincent, 1997; Allan & Tumwekwase, 1998; Twaddle & Hansen, 1998; Lyons, 1998) as a result of the HIV/AIDS pandemic left the entire population in the country emotionally, physically, and economically scarred. Despite the grave affliction, individuals and communities had to devise new strategies to competently negotiate the new HIV/AIDS infested social landscape. The ability to cope in such a changed environment is the subject of the third research question.

RQ3: How did Ugandans now aged between 40 to 50 years then living in Rakai district 23 years ago integrate the changes brought about by the epidemic in their mainstream culture to effectively cope with it?

CHAPTER 2

REVIEW OF LITERATURE

This chapter presents a brief history of the human immune virus (HIV) or acquired immune deficiency syndrome (AIDS) pandemic. It provides a synopsis of the scientific description of the virus, and highlights the evolution of the epidemic in Uganda. A review of the relevant research on the HIV/AIDS epidemic that illuminates the multi-dimensional nature of the HIV/AIDS crisis in the country is also presented.

A substantial body of literature on the global HIV/AIDS pandemic has been generated in the natural and social sciences to understand the multi-dimensional nature of this modern day health crisis. Even long before the World Health Organization (WHO) declared HIV/AIDS a global epidemic in 1981, research into the history and nature of the human immune virus (HIV) and the acquired immune deficiency syndrome (AIDS) had already begun. The American National Institute of Health (NIH) started tracking the virus in the 1950s, 30 years before the first HIV case was diagnosed in the United States in 1981 (NIH, 2004; CDC, 2004).

History and Origin of HIV

According to the United States based Centers for Disease Control and Prevention (CDC) (2000), the earliest known case of HIV-1 in a human was from a blood sample collected in 1959 from a male patient in Kinshasa, Democratic Republic of Congo. The CDC adds that it is not known how the man got infected but results of a genetic analysis indicated that the type of virus he was carrying could have been around from the late 1940s or early 1950s. According to the CDC, although the HIV virus existed in the United States since the mid 1970s, rare types of pneumonia, cancer, and other illnesses associated with compromised immune systems were not

prevalent until 1979-1981 among male patients who had sex with fellow men in Los Angeles and New York.

The CDC report that the first cases of AIDS were identified in 1981 in Los Angeles. According to the CDC (2000), public health officials started to use the term "acquired immune deficiency syndrome," or AIDS, to describe the occurrences of opportunistic infections, in previously healthy people in 1982.

Later research into the history and geographical origin of HIV by a team of international scientists confirmed earlier reports that the source and origin of HIV-1, the predominant strain of HIV in the developed world came from a subspecies of chimpanzees native to west equatorial Africa (Gao, Bailes et al., 1999). The researchers reported that the virus was introduced into the human population when hunters in West Equatorial Africa became exposed to infected blood from the chimpanzees. The World Health Organization (2003) and the United Nations AIDS monitoring agency (2003) have since confirmed these findings.

Scientific Description

There are two conflicting theories from the United States and France on the scientific discovery of the human immune virus (HIV), the virus that causes acquired immune deficiency syndrome (AIDS). Both the United States based National Center for HIV, STD and TB Prevention (2000) and the CDC (2000) report that the virus that causes AIDS was discovered by a group of international scientists in 1983. The two organizations claim that the virus was originally named "HTLV-III/LAV (human T-cell lymphotropic virus-type III/lymphadenopathy) but later renamed human immune deficiency virus (HIV) prevalent in chimpanzees found in Equatorial West Africa.

However, French scientists from the Pasteur Institute claim that it was not until 1985 that the human immune deficiency virus (HIV) was isolated from associated viruses rather than merely being discovered that it was then confirmed that HIV1 prevalent in primates caused AIDS, the acquired immune deficiency syndrome (Montagnier, 2002). Despite the conflicting theories, the scientists have since overcome their differences and focused on the devastating impact of the virus on human life.

Scientists from both countries have also confirmed the existence of an associated virus classified as HIV-2 as related to HIV-1 in terms of origin and ability to cause the acquired immune deficiency syndrome (AIDS). However, the HIV-2 virus is reported to be less lethal than HIV-1 which is most prevalent in sub-Saharan Africa. The World Health Organization (2003) and the United Nations AIDS monitoring Agency (2003) have since confirmed the existence of the two types of viruses that cause AIDS.

Thus, the present purview will now focus on the evolution of the HIV/AIDS in Uganda and the relevant line of research that has emerged during that period. However, for purposes of establishing the appropriate context in which the study was conducted, a brief background on Uganda will be presented. The information will create an understanding of the social and economic indicators of a country that has been ravaged by the HIV/AIDS epidemic. Despite its early encounter with the epidemic, the country managed to reduce the HIV/AIDS infection rate from 30% in the worst hit urban areas to a stable 6.1% within a period of less than ten years (UNAIDS, 1998a, 1998b, 2000, 2001, 2003; WHO, 2003; USC, 2003). The modest gains against the epidemic have since made the country a model to be emulated by other nations similarly afflicted (UNAIDS, 1998, 2000, 2001, 2003; WHO, 2003; Twaddle & Hansen, 1998; Lyons, 1998).

Background Information on Uganda

Uganda, a former British colony, is a land locked country in East Africa with Kenya to the East, Sudan to the North, the Democratic Republic of Congo to the West and Rwanda and Tanzania to the South. According to a Uganda government official website (1995), the majority of Ugandans, estimated at 87%, live in rural areas where subsistence agriculture is the major source of food and income. The United Nations Development Program (UNDP) Human Development Report of 2002 classified the country as least developed and resource constrained with a real gross domestic product (GDP) per capita of about \$300.

The UNDP Report and the UNAIDS Health Report of 2002, state that because less than 51% of the population have access to health facilities, HIV/AIDS is the leading cause of death in the country. The reports add that although AIDS is also responsible for the reduction in the average life expectancy of Ugandans from 54 years to 43.2 years, only 10,000 out of 150,000 people with full blown AIDS access the anti-retroviral therapy. Consequently, according to the Uganda AIDS Commission (2001), the government declared the AIDS epidemic a security and development crisis.

Timeline of the HIV/AIDS Epidemic in Uganda

This section describes the timeline of the HIV/AIDS epidemic in Uganda from 1982 when the disease was first identified in Rakai district, on the shores of Lake Victoria, along Uganda's southwestern border with Tanzania. Table 1 below shows the 23-year timeline of the epidemic in Uganda.

The author demarcates the timeline of the epidemic into four landmark phases to underscore the globalization and acculturation of the disease among a section of the Ugandan population then aged between 17 to 27 years and living in Rakai district by 1982.

The four phases include: (1) Genesis of the disease (1982-1986), (2) Upsurge in infection rates and deaths (1987-1995), (3) Decline in infection rates and deaths (1995-2000), and (4) Mainstreaming of the disease in community life (2000-to-date).

Table 1

Timeline of HIV/AIDS Evolution in Uganda

Period	Elements
Genesis of epidemic:	1982 First HIV/AIDS case identified along the shores of Lake Victoria in Rakai district bordering Tanzania.
1982-1986	1982-1986. Spontaneous treatment of clinical symptoms. Government silent about the disease. Confusion and despondence in the population because of the strange disease. New National Resistance Movement government announces the existence of HIV/AIDS in Uganda to the World Health Assembly in Geneva. National campaign spearheaded by President Yoweri Museveni. First Aids Control Program launched in ministry of health.

(Table continues.)

Table 1 (Continued).

Period	Elements
Upsurge of the Epidemic 1987-1992	<p>Peak of infection recorded at over 30% in most hard hit areas. National average prevalence rate of 18%.</p> <p>Unprecedented death toll across the country.</p> <p>Establishment of AIDS Support Organization (TASO). Formation of the AIDS Information Center (AIC) for voluntary testing and counseling.</p> <p>Government launches a Multisectoral Approach to the Control of AIDS (MACA) emphasizing abstinence, faithfulness, and condom use (AB&C).</p> <p>Massive nationwide campaign to prevent further spread of disease.</p> <p>1992 Parliament establishes Uganda AIDS Commission (UAC)</p> <p>HIV/AIDS declared an epidemic with cultural, social, economic, political, and security implications.</p>

(Table continues.)

Table 1 (Continued).

Period	Elements
Decline in infection rate 1992-2000	<p data-bbox="363 411 1438 516">Government and international partners announced decline of HIV infection rate from a national average of 18.5% to 8.3%.</p> <p data-bbox="363 558 1438 663">Decline attributed to intervention at all levels, information dissemination, abstinence, faithfulness, and condom use.</p> <p data-bbox="363 705 1438 884">Uganda awarded an excellence prize by the Society of AIDS in Africa, and Bristol-Myers Squibb in recognition of its work in the campaign against Sexually Transmitted Diseases (STDs) and HIV/AIDS.</p> <p data-bbox="363 926 1438 1031">Establishment of the Drug Access Initiative to advocate for reduced prices for Anti Retroviral (ARV) drugs.</p> <p data-bbox="363 1073 1438 1104">Stagnation of national average prevalence rate at 6.1% since 2002.</p> <p data-bbox="363 1146 1438 1251">Fears that rates are higher in Northern Uganda where an 18 year old insurgency has been going on.</p>

(Table continues.)

Table 1 (Continued).

Period	Elements
Mainstreaming of HIV/AIDS in Communities.	Uganda HIV/AIDS Control project launched emphasizing mainstreaming HIV/AIDS in workplaces and communities.
2000-to-date.	<p>Mandatory requirement of integrating HIV/AIDS in public sector budgets and sensitizing workers to become AIDS competent, and turning workplaces into AIDS sensitive sites.</p> <p>Demanded provision of Antiretroviral drugs to workers.</p> <p>Integration of mainstreaming HIV/AIDS in the 6000 community-based World Bank funded Poverty Eradication Action projects.</p> <p>Mainstreaming has accelerated the integration of the disease in all communities.</p>

The next section briefly describes the phases as shown in Table 1 starting with the genesis of HIV/AIDS in the country followed by the general response to the outbreak of the “strange disease” (Obbo, 1991, p. 86). A synopsis of the overwhelming upsurge in the epidemic will be given, highlighting the sense of hopelessness and despair among the population that culminated in a sustained decline in the rates of infection in the country. This will be followed by a description of the renewed sense of hope and confidence as the population came to terms with the reality that HIV/AIDS had come to stay and demanded radical changes in their ways of life to manage and cope with it in their midst.

The importance of emphasizing landmark phases in the timeline of the epidemic and underlining the key events that characterized them creates a better understanding of the critical turning points in the evolution of the epidemic in Uganda. Furthermore, delineating the phases enhances the examination and understanding of the changing communication patterns that highlighted the progression of the epidemic. Finally, spotlighting the phases assists in identifying emerging human communication behaviors used to negotiate the new and changed social environments.

Genesis of the Epidemic

According to Uganda's Ministry of Health (MOH) (2003), the Uganda AIDS Commission (UAC) (2003), Kolsrud, Amanyire, Landbo, Jareg, Byangire, and Wathne (1989), and Bond and Vincent (1991), the first HIV/AIDS case was identified by medical doctors in 1982 along the shores of Lake Victoria in Rakai district. This area is located on the country's Southwestern boarder with Tanzania. The MOH (2003) and the UAC (2003), a statutory agency set up in 1992 to coordinate all HIV/AIDS related activities in the country, report that the initial response to the disease by medical practitioners between 1982 and 1986 was spontaneous treatment of clinical symptoms of the infection carried by the patients. The MOH and the UAC, which have traced and documented the evolution of the epidemic into the country, state that despite all efforts to effectively treat and manage the symptoms, infected persons eventually died because most of the opportunistic symptoms were resistant to the available drugs. The result was frustration and despair to both health workers and the general community leading many citizens to turn to faith healing and witchcraft in a desperate attempt to find a cure or a solution to the multiple ailments (Kolsrud et al., 1989; Bond & Vincent, 1991; Obbo, 1991; Ankrah, 1993). The MOH (2003) and the UAC (2003) report that matters were not helped by the then

government which pursued a policy of silence about the disease. The two government agencies state that the uncertainty resulted in a state of hopelessness and despondence for the entire population across the country.

However, in 1986, Uganda went open and launched a national and international HIV/AIDS awareness campaign with the announcement of the existence of the disease to the World Health Assembly in Geneva by the then Minister of Health of the new National Resistance Movement government. The two governmental agencies contend that the announcement marked the beginning of an era of political openness about the epidemic that created a friendly environment for mass campaigns spearheaded by President Yoweri Kaguta Museveni. In the same year, the AIDS Control Program (ACP) was established in the MOH with a primary focus on safe blood, prevention of HIV infection in health care settings, information, education and communication. Similar programs have since been set up in all government departments.

The UAC (2003), states that the government also established The AIDS Support Organization (TASO) to offer the much needed psycho-social support for the infected and affected. In addition, the AIDS Information Center (AIC) for voluntary testing and counseling services was formed in 1990 followed by the adoption of the Multi-sectoral Approach to the Control of AIDS (MACA) as a policy and strategy for responding to the epidemic. According to UAC (2003), Uganda was given an award for excellence by the Society of AIDS in Africa, the African Union against sexually transmitted infections, and Bristol-Myers Squibb in 1997 in recognition for its work in the campaign against sexually transmitted diseases (STDs) and HIV/AIDS.

Upsurge in the Infection Rate and Interventions

Compared to other countries, Uganda was, as early as 1982, in the firing line of the devastating attack launched by HIV/AIDS, and by 1992, the infection rates had reached epidemic proportions and was undermining and decimating the social, economic, and political foundation of the nation (Museveni, 1991, 1998; Bond, & Vincent, 1997; Twaddle & Hansen, 1998; Lyons, 1998; WHO, 2003). The MOH (2003), and the UAC (2003), reported that by 1988 the average prevalence rate of HIV/AIDS was at 9% and reached its peak in the hardest hit urban areas, registering a prevalence rate of over 30% in 1992. The two government departments state that the escalating infection rates heralded a high morbidity rate unprecedented in the country's history and triggered a national campaign to prevent further spread of the killer disease through education. The agencies report that as a result of the high morbidity rates, the multi-sectoral approach was formulated and adapted in 1992 as a strategy to combat the rapid spread of the epidemic. This approach emphasized abstinence, be faithful, and condom use commonly referred to as A, B, & C (MOH, 2003; UAC, 2003). The massive campaign strategy involved all stakeholders in the public, private sectors, and the international community with a strong emphasis on the role of the individual, the end point of all services to ensure success of the campaign.

Decline in the Infection Rates

From 1995, results from the annual monitoring of the HIV/AIDS infection rate indicated a declining trend with an average national prevalence rate among the adult population dropping from an estimated 18.5% to 8.3% by 2000 (UNAIDS, 2000, 2001, 2003; WHO, 2003; UAC, 2003). Since 2002, the greatest challenge has been that the country has been unable to reduce the figures beyond 6.1%. Indeed, UNAIDS, (2003) reports that by the end of 2002 there were some

indications that the rates had climbed to 6.5 percent. Although the rate stabilized at 6.1 % for two years, the recently published results of the National HIV/AIDS Sero survey indicates that the prevalence rate has risen to 7 % (MOH, 2003; UAC, 2005).

However, the dramatic decline in the prevalence rates of HIV in Uganda was attributed to openness about the disease, a later average age of sexual initiation, and a reduction in the number of sexual partners, reinforced by a consistent message from the government and high levels of awareness communicated through formal and informal channels (Okware, Opio, Musinguzi, & Waibale, 2001; Hogle, 2002; Parkhurst & Lush, 2004; Stoneburner, & Low-Beer, 2004; Darroch & Bankole, 2004). However, the figures may be higher, due to inadequate monitoring and surveillance services coupled with the 18-year old insurgency that has ravaged the northern part of the country (Ciantia, 1998; UNAIDS, 2003). These studies indicate that programs in the north are not as effective as in the south, largely because of the insecurity and the war situation. Secondly, they report that the majority of rescued teenage girls from rebels are HIV positive because they were reportedly turned into sex slaves during their time in captivity.

Despite some setbacks, a World Bank Mid-term Review Report (2004) underscored the effectiveness of the openness about the disease and the multi-sectoral approach in the reduction of HIV/AIDS rates in the country because at most levels there is some intervention, especially in areas that have been peaceful. In addition, the MOH (2003) reports that the tens of millions of condoms imported into the country annually, have supplemented the abstinence and faithfulness messages. However, no concrete information is available as to how many condoms are actually used effectively and consistently.

Mainstreaming AIDS in Community Life

In 2000, the government of Uganda adapted a policy of mainstreaming HIV/AIDS in all workplaces and communities across the country. The policy is contained in the Uganda HIV/AIDS Control Project (UAC, 2003) which required all government ministries and programs to integrate HIV/AIDS into their budgets, workplaces, and community activities. It demanded that all workers are AIDS competent, with workplaces enforcing policies that are sensitive to AIDS. According to the provisions of the project, employers were required to support those infected and affected by providing antiretroviral drugs (ARVS), care and support, participating in HIV/AIDS activities, and having programs to respond to AIDS related issues.

The process of mainstreaming HIV/AIDS in all community level activities was also integrated in the country's Poverty Eradication Action Plan both in the public and private sectors. The World Bank Mid-year Report of May 2004 states that there are over 6000 community level projects involved in the mainstreaming of AIDS at grassroots levels. The mainstreaming process is already showing signs of consolidating the knowledge and awareness about HIV/AIDS in the population which is now standing at 99 percent (MOH, 2003). This consolidation of awareness and knowledge about HIV/AIDS in Uganda is reflected in two comparative studies by Parkhurst, and Lush (2004) and Stoneburner and Low-Ber, (2004). The researchers found that there was a high level of knowledge about HIV in the Ugandan population with 82 percent of women aware of HIV, compared to only 40-65 percent of women in Malawi and Kenya respectively.

The authors (Parkhurst & Lush, 2004; Stoneburner & Low-Ber, 2004) also found that Ugandans had a higher level of personal contact with individuals living with AIDS standing at over 95 % by 1995 compared to Malawi and Kenya whose knowledge of HIV/AIDS and contact with persons with AIDS stood at between 68 to 71 % respectively in 2002, while less than 50

percent of the South African population knew a person with HIV/AIDS. Therefore, this indicates that the mainstreaming of AIDS into community activities in Uganda is an acknowledgment that integration of the disease into the diverse cultures of the country provides the most effective weapon to combat and manage the disease. This study examines how a section of the population that was sexually active at the beginning of the epidemic communicatively reconstructed, redefined, and gradually integrated the disease into its culture. Based on the foregoing description of the critical phases in the evolution of the HIV/AIDS epidemic in Uganda, a review of the relevant studies along this line of research follows.

The Nature of Epidemics

Because epidemic outbreaks are “generally caused when biological forces encroach on specific cultural environments resulting in a destabilization of the social systems, the spontaneous reaction by living species to such threats in their environments is to seek explanations and answers from within their own experiences to overcome the new uncertain situation” (Dahlgreen & Lwihula, 1993, p. 1). This statement holds true for the dilemma experienced by the population in Uganda, most especially in Rakai district, the epicenter of the HIV/AIDS epidemic on the shores of Lake Victoria of Uganda’s southwestern border with Tanzania.

The uncertainty in Uganda was no less than that in neighboring Tanzania where the “unknown disease was equally killing young men and women by draining their blood and consuming their bodies to the bones,” (Mutembei et al., 2002, p. 12). Trudgill (1974) argues that human beings have a predictable and patterned reaction to epidemics and any new phenomenon: “When a new phenomenon turns up, there is need to identify it, understand and cope with it, and

of course, a need to name it” (p. 54). Uganda appears to have followed a similar pattern when the epidemic broke out in Rakai district in 1982.

HIV/AIDS Research on the Ugandan Campaign

The existing social scientific research on the HIV/AIDS epidemic in Uganda emerged in the 1990s following a sequential pattern mapped by the evolution of the disease as predicted by Dahlgreen and Lwihula (1993). For example, available literature on the socio-cultural impact of HIV/AIDS epidemic in Uganda focused on the way communities labored to linguistically name, explain, and make sense of the strange disease (TASO, 1992; Hampton, 1990; Seidel, 1990; Obbo, 1991; Lyons, 1997). The studies examined the metaphors used in the multiple languages used in the HIV/AIDS discourse in Uganda.

The literature provides the initial insight into how different communities used significant symbols to talk about AIDS. For example, an information booklet published by the AIDS Support Organization (TASO, 1992, p. 6), indicates that all languages spoken in Uganda have adapted the word *siliimu*, meaning thin or slim, as a name to describe the AIDS disease. This name has since been adapted and used in all HIV/AIDS education and prevention campaigns in the country and has been established nationally as a standard definition for the disease.

The research also identified some non-discriminatory words that were used to refer to People Living With AIDS (PLWA) without stigmatizing them. The euphemisms like “client instead of victim or sufferer” (TASO, 1992, p. 7) have previously been used to describe individuals living with the disease. The literature underlined the process of how communities distressed by a troubling new phenomenon construct shared meanings by assigning symbols and labels from their experiences to identify objects or ideas in order to enhance and sustain communication. National HIV/AIDS education and prevention campaigns to promote the

abstinence, be faithful, and condom use (A, B, and C) strategy adapted many of those words to package their messages (UAC, 2003).

However, Lyons (1998) notes that because of inconsistencies on some policy positions by key stakeholders in the HIV/AIDS campaign in Uganda, the language used by the politicians, church leaders, interventionists, and the media is sometimes contradictory and leaves the population confused. For example, the author points out that the discourse on the condom in the country is unclear because at one time the president speaks in support of the condoms and then changes his position after a few days or months. The researcher points out that political expediency should not be privileged over the right to life.

Subsequent bio-cultural and epidemiological research, conducted to evaluate the effectiveness of the Uganda HIV/AIDS campaign, reported initial resistance to the use of condoms because they were reportedly associated with promiscuity in the Western countries. The condoms were also initially resisted because the powerful Catholic Church and Christian evangelists were vehemently opposed to them on the grounds that they contradicted Christian teachings that emphasized natural methods of family planning like abstinence (WHO, 2003; UNAIDS, 1998a, 1998b, 2000, 2001, 2003; Musinguzi, 1996; Konde-Lule et al., 1997; Cohen, 2003; Green, 2004). At the same time, the researchers found that communities were very suspicious of condoms because they were associated with a western conspiracy to depopulate Africa and perpetuate their domination of the continent.

Research also found resistance to abstinence because of cultural factors which socialized individuals, especially men, to engage in sex at an early stage to demonstrate their manhood (WHO, 2003; Musinguzi, 1996; UNAIDS, 1998a, 1998b, 2000, 2001, 2003; Konde-Lule et al., 1997). The researchers also report that the idea of being faithful to one partner was viewed with

suspicion because it was contrary to cultural practices which encouraged polygamy and widow inheritance. The studies concluded that cultural norms and customs were the biggest stumbling blocks in the campaign against HIV/AIDS.

Expounding on the role of culture in the HIV/AIDS campaigns, Moodie (1991), Campbell and Rader (1995), and Kaleeba et al. (1997) underscored the challenges faced by HIV/AIDS interventionists in rural Uganda and other African settings in developing a sustainable and community based counseling program. The authors noted that developing a participatory counseling program that was acceptable to PLWA, their families, the community, and the counselors was a frustrating and sometimes futile venture because cultural and ethical factors would sometimes become incompatible.

However, longitudinal research that followed found that individuals' behaviors and attitudes had started to change positively towards the HIV/AIDS campaign largely because of the many people who had been killed by HIV/AIDS, coupled with the consistent HIV/AIDS education and prevention campaign messages that were disseminated through formal and informal communication networks (Konde-Lule et al., 1997; Ciantia, 1998; MRC, 1998; WHO, 2002; UNAIDS, 2003; Hogle, 2002; Cohen, 2003; Stoneburner & Low-Beer, 2004; Muyinda et al., 2004; Green, 2004; Parkhurst, 2002; Singh et al., 2004). The researchers report that during the period between 1992 and 2002, Uganda registered a reduction in the national HIV/AIDS infection rates from as high as 30% to between 6% and 7%. The research also suggests that an observable change in people's sex behavior was underway as individuals freely talked about the disease and the use of condoms became widespread.

Researchers (Konde-Lule et al., 1997; MRC, 1998; WHO, 2003; UNAIDS, 2003; Hogle, 2002; Cohen, 2003; Green, 2004; Stoneburner & Low-Beer, 2004; Muyinda et al., 2004;

Parkhurst, 2002; Singh et al., 2004) also report that groups observed in their various longitudinal studies were reporting fewer cases of polygamy and a reduction in involvement in sexual intercourse with multiple partners as earlier research had indicated. Furthermore, the researchers reported that there were fewer cases of STDs being reported in medical centers and hospitals attended by the groups studied.

In addition, the research indicated that a growing number of teenagers monitored were reporting delayed sexual activities for fear of contracting the disease and eventually dying. Finally, Muyinda et al. (2004) report that high risk sex behavioral change was observed among teenage girls and boys in rural areas like Rakai and neighboring Masaka districts due to sex education provided by the “modern *Ssengas*”; the modern version of paternal aunts. The researchers note that traditionally, paternal aunts command special positions in most Ugandan communities to prepare pre-teenage girls to strictly avoid sex before marriage but that out of necessity, their roles had been diversified to undertake HIV/AIDS education.

The present study builds on this research to underscore the critical role communication played in fostering cultural change among the sexually active adolescents during the evolution of the epidemic in the country. Secondly, this study extends this line of research by demonstrating that the different phases experienced by sexually active Ugandans during their encounter with the HIV/AIDS epidemic are evidence of an acculturation process as a result of an impingement on their culture by the new HIV/AIDS phenomena.

Regarding the social-economic impact of the epidemic on the population, research indicated that many marriages collapsed as a result of one of the partners contracting the deadly HIV/AIDS disease (Porter, Hao, Bishai, Serwadda, Wawer, & Lutalo, 2004). However, the researchers note that in most cases, when the wife showed the symptoms of the disease first, the

men abandoned their wives or sent them back to their parents to provide them the opportunity to remarry. On the other hand, the researchers report that if the men contracted the disease first, the women persevered and took care of their husbands until they died. Some research has suggested that the burden of the HIV/AIDS epidemic imposed on women in Uganda has gravely affected their quality of life (Obbo, 1998; Porter et al., 2004; Mast et al., 2004). The authors observe that in most communities women have to shoulder the physical and the psychological strain of the disease when either of the spouses is infected. Extending that line of research, Alun and Tumwekwase (2001) report that the epidemic has imposed an unbearable strain on grandparents especially the women who have over time assumed the role of caring after orphaned children when their parents die.

Other studies that focused on the snowballing cultural, social, and economic impact of the humanitarian crisis in Uganda illuminated the disruption of the life cycle, the economic insecurity to both families and communities, and the erosion of cultural norms as a result of the disintegration of the traditional extended family (Kolsrud et al., 1989; Seeley et al., 1991). The researchers highlight the failure of the traditional support system to cope with the huge problem of orphans in the rural areas, some of whom migrate to urban areas and become street children or degenerate into criminals.

Specifically focusing on the macro economic impact of the epidemic, Museveni (1991, 1998), Twaddle and Hansen (1998), and Lyons (1998) observed that the epidemic has overstretched the country's infrastructure which can barely sustain itself as a result of the World Bank/International Monetary Fund-sponsored Structural Adjustment Programs (SAP). In addition, the authors claim that since the epidemic is killing the most productive and reproductive members of the population, the country's population would decline to a level that

agricultural production would fall by 30 percent by 2015 resulting into a food crisis in the country.

The present study builds on those findings to examine the role of communication in the social construction of gender roles during the globalization of the HIV/AIDS pandemic and acculturation of the disease in the culture of a section of the Ugandan population. In addition, the present study goes beyond the mere naming of the disease and demonstrates that through communication, names change from time to time to reflect the changes taking place in society.

Furthermore, the study shows that both changes in the social system of any community influence the naming of any phenomena which in turn shapes attitudes, thoughts, and actions of individuals and cultures of social communities. In addition, this study explains some of the positive and negative globalization of other new concepts associated with the HIV/AIDS pandemic in the reconfiguration of the social, economic, and political landscape as experienced by the targeted group in the two locations in the country.

The contention that changes in time influence how communities define, understand, and communicate about disease and illness is consistent with the works of Sontag (1983, 1990) and Morris (1998) who argued that perception about illness is rooted in a changing cultural environment of a particular community living at a particular time in history. Sontag and Morris argued that every era in human history has been characterized by a particular epidemic or illness that was defined, named, and understood using appropriate metaphors drawn from within that cultural environment. More specifically (Morris, 1998), traces the history of epidemics and diseases including bubonic plague in the middle ages, tuberculosis in the 19th century, syphilis in the 20th century, cancer, heart disease, and HIV/AIDS in the present era and concludes that

every epidemic and disease reflect the cultural values, norms, customs, and communication patterns of a community.

However, the author (Morris, 1998) cautions that viewed in isolation from other cultural correlates, names of epidemics and diseases may not reflect a total picture of the fluid communication trends in social contexts. The author adds that even within a particular era in history, there could be generational differences in the communication behaviors of individuals living in the same cultural environment.

This study builds on that line of research by examining the role of communication in the globalization and acculturation of the HIV/AIDS epidemic among a section of the Ugandan population that was sexually active during the outbreak of the epidemic. Members of this age group present a unique generational perspective on HIV/AIDS because they have lived through the entire evolution of the epidemic and possess first hand knowledge and experiences as a result of the encounter between the Ugandan population and the pandemic.

Research on Symbolic Interactionism

Extending the symbolic interaction theory developed by George Herbert Mead as cited by Morris (1934), in health research, Belgrave, Allen-Kelsey, Smith, & Maritza, (2004), Rafalovich, (2005) and Lombardo, (2004), highlighted the constant conflict between the “I” and the “self” on the one hand and the “Me” and the “Mind” concepts that characterize health campaigns. They observed that while health campaigners target individuals to change their behaviors and adapt the generally acceptable norms established by society, individuals also have to contend with their internal voices urging them to either abide by external demands or contravene them. The researchers point out that a reconciliation of the two competing voices by the individual determines the success or failure of a health campaign.

The running contradiction between the individual and society is captured in a longitudinal study on African American patients of dementia and their caregivers, (Belgrave, et al, 2004). The researchers found that while society the (“Me”) which reflects the bio-medical perspective, has labeled people with symptoms of dementia as “sufferers” who must live and act as such, people with such conditions believe (the “I”) that their fate has been sealed by a conspiracy between science and society yet they are living meaningful lives.

Rafalovich (2005); Foley (2005) and Nack (2002) also found that undue social pressures from society (Me, and Mind) on the individual (“I” and “self”) can frustrate the success of a health campaign. This, they argued, is because social expectations are communicated through symbols or labels that may undermine the self esteem of individuals in society. Consistent with the symbolic interaction theory, they contended that common ground solutions need to be found between the medical perspective and cultural environments in which individuals are socialized to ensure effectiveness and success of health campaigns.

Elaborating on the moderating effect of the “Me” on the “I”, Crossley (2004) and Crooks (2001) state that persons who feel that their self identities are put on the spot by society will struggle to manage and create impressions that are compatible with social expectations to maintain and restore face. The authors state that the negotiation of social obligations by individuals is consistent with the role playing concept suggested in the symbolic interaction theory and is identified as a critical factor in enhancing behavioral change.

This line of argument is expanded in the work of Lombardo (2004) who studied HIV/AIDS patients in Canada and argued that society constantly establishes and imposes labels, norms, beliefs, values, and customs that could be parallel to the thinking of the individual. The author argued that in this process, the individual perceptions are discounted and if he or she

violates the “normal” way of life, he or she is rendered a misfit by the social system. The Lombardo (2004) stated that the running conflict between the individual and society is a critical factor in explaining and understanding how individuals make personal decisions and engage in anti social sexual behavior that leads them into contracting HIV/AIDS and other sexually transmitted diseases.

Furthermore, Airhihenbuwa and Obregon (2000), Mishler (1981), Best and Kellner (1991), and Sonja and Flora (2000) underscored the centrality of culture in shaping individuals communication behavior in health related issues. The authors extensively reviewed literature in health communication that extended the symbolic interactionism theory. They concluded that there should be an intersection between culture and medicine because such dual perspective enhances appropriate interpretation of communication behaviors of individuals and promotes effective health care delivery and successful health campaigns.

Since the transmission of HIV/AIDS in Uganda and almost everywhere in the world is through actions between individuals in private environments, the conflict between the “I”, the “self” on the one hand, the “Me” and the “mind” on the other, are always at play to influence peoples’ behavior. At the same time, the multiple roles individuals play in society also come into play when assessing how individuals acquired or failed to gain social skills to avoid or contract HIV/AIDS. This study tests those social-cultural concepts in examining the role of communication among a section of the Ugandan population that was sexually active during the glocalization and acculturation of the HIV/AIDS epidemic in the country. In addition, the study focuses on how Ugandans drew from their socialization process to interpret scientific concepts associated with the HIV/AIDS pandemic.

The Glocalization Connection

Following the line of research that emphasizes the centrality of culture in health related issues, the next section of this chapter reviews literature on the concepts of glocalization and acculturation. The purpose of this purview is to build a background on which the present research draws to replicate the concepts in the Ugandan context. Because the concept of glocalization is relatively new in the academic arena, the existing body of literature around the subject remains small (Kozłowska, 2003; Roudometof, 2003).

Therefore, available research on the concept of glocalization has focused on international trade, culture, education, politics, law, religion, environment, and the transfer of other global phenomena across borders through the mass media and other non conventional channels of communication (Ritzer, 2003; Thornton, 2000; Satyavrata, 2004; Randeria, 2003). The common ground shared by most researchers on the concept of glocalization is that since the end of the Cold War and the ultimate collapse of the Soviet Union, the physical world has come closer together in terms of trans-national movement of people, goods and services (Friedman, 2002; Thornton, 2000; Satyavrata, 2004). The authors argue that globalization has opened up most areas of the world to share common ideas that were previously an exclusive domain of a few privileged individuals. This, the author's state, has exposed most people across the world to a continuous flow of foreign ideas from all over the world creating a semblance of cultural uniformity across the globe.

Discussing the impact of glocalization on the European unity, Kozłowska (2003) argues that the phenomena has rekindled a tremendous interest in local cultures and promoted the concept of unity in diversity that had previously been debunked by the balkanization of nation states with diverse historical experiences and incompatible cultures. The author states that

glocalization has empowered smaller communities to forge a sense of identity and cultural stability amidst large and powerful communities.

This view is supported by Roudometof (2003) who posits that glocalization is much more sensitive to indigenous cultures than modernity because it emphasizes the power of local communities to transform any new global ideas to suit their local conditions without necessarily abiding to rules and regulations previously imposed on communities by modernity as had earlier been driven by globalization. Roudometof states that glocalization has enabled healthy Eurocentrism to thrive granting each community that seeks to retain its unique characteristics to do so as the case was before the First World War.

Reinforcing this view, Satyavrata (2004), argues that glocalization has enabled Christianity to flourish in the Hindu-dominated India because local communities have been afforded the latitude to develop their own mission leadership based on their traditional ways and transform them as they conduct worship and fellowship in the communities. The author contends that glocalization has even enabled them to broaden their mission to facilitate education in international trade and evangelism.

However, some researchers have argued that glocalization has come at a huge cost in terms of dismantling existing sovereign laws of nation states, threatened the fundamental human rights of indigenous people, and infringed on their natural habitat to a point of threatening their very livelihood and existence (Randeria, 2003; Roudometof, 2005; Ritzer, 2003). Randeria (2003) argues that the relatively flexible manner in which international capital crosses borders for investment has brought local communities into direct collision with foreign investors who sometimes neglect the enforcement of international law to protect the interests of local people. The author argues that although glocalization empowers local communities, they are still too

weak to challenge foreign investors who may sometimes collude with international finance organizations and officials in central governments to violate the rights of local people whose social movements may not be strong enough to advocate for them in international courts of law.

Roudometof (2005) and Ritzer (2003) have also argued that glocalization basically benefits the privileged groups in the developed world who enjoy the reconfiguration of the international trade at the expense of the less privileged majority in the poor countries. The two authors also point out that even the benefits of democracy are never realized by the poor because they are too weak to influence decisions in the distribution of global wealth.

Based on the foregoing observations, this exploratory study replicates the glocalization concept in the evolution of HIV/AIDS in Uganda and explains how the process of localizing the global AIDS pandemic has transformed the Ugandan society. Special emphasis is given on whether the reconfiguration of the social systems in the country has overwhelmed the population to a point of losing their core cultural values or the process has given them a soft landing.

The Acculturation Link

This study also extends the acculturation concept to the HIV/AIDS epidemic in Uganda and explains the degree to which the disease is gradually being integrated in the culture of a section of the Ugandan population. In the process, the study illuminates the different perspectives expressed in the country about the disease.

A growing line of research emerging from a psycho-social perspective has replicated the acculturation concept in research on HIV/AIDS transmission and in mental health. Several researchers (Marks, Cantero, & Simoni, 1998; Tschann, Gomez, Barbara, & Kegeles, 1993; Schneider, 2004) have associated HIV/AIDS infection among Latino immigrants in the Diaspora to alcohol consumption as an escape route from the stressors and hassles of adaptation. The

authors also argue that, since most immigrant sex workers are forced into the business to survive the harsh realities of acculturation in foreign countries, they become too psychologically unstable to avoid risky sex behaviors. In addition, the researchers state that cultural factors in home countries that socialize women to obey men also accounted for HIV/AIDS transmissions during the acculturation process.

Contrary to stereotypical beliefs, some studies that have extended the acculturation concept in social groups have found that acculturation into minority cultures like the gay community protects acculturating individuals from contracting HIV/AIDS than in dominant groups (Seibt & Ross, 1995). In a longitudinal study on the gay community in Dallas, Seibt and Ross (1995) found that existing members of the community routinely encouraged new members to read gay magazines, newspapers, listen to gay radio programs, and attend community meetings that constantly advised members to engage in protected sex and avoid risky sexual behaviors.

On the other hand, other scholars who have extended the concept of acculturation in health research have associated illness with failure to adapt to new conditions in foreign culture by immigrants (Mehta, 1998; Noh & Kaspar, 2003; Yunjin, Koeske, & Sales, 2002). In longitudinal studies on Asian immigrants in United States and Canada, the researchers found that failure to socialize with members of the host cultures resulted in feelings of marginalization and separation that gradually caused psychological stress and mental illness for some individuals. However, the researchers viewed acculturation from a traditional perspective which only views the process of acculturation as strictly for human beings who must experience specific outcomes. Overlooked in that line of research is the possibility that social phenomena can also undergo or trigger off a process of acculturation.

The present exploratory study goes beyond the classic view of acculturation and explains that the development of social skills by a section of the Ugandan population to cope with the challenges posed during their encounter with the HIV/AIDS epidemic is a form of acculturation because of the degree it has been integrated in their daily lives. Indeed, Morris (1988) thoroughly reviewed the history of global epidemics and provided insights into how afflicted communities adopted traits from within their past and present experiences to cope with the new maladies imposed on them by the new reality

In a benchmark study on global epidemics entitled *Illness and Culture in the postmodern Age*, Morris (1998) analyzes how human beings reconstruct their perceptions to interpret new phenomena and integrate it into their culture and effectively deal with it. Although the author does not explicitly state that the process of integrating illnesses in social culture is indeed acculturation, the graphic description of how cultural norms, values, and customs are changed to accommodate the epidemic is a clear recognition that acculturation is taking place.

For example, Morris (1998) explains that although the bubonic plague in the Middle Ages was spread by rats as a result of changed living conditions in Europe, it was interpreted in spiritual terms as a punishment from God according to medieval doctrine. The author states that the medical explanation for the plague was out of question and sufferers considered themselves as sinners who had to atone for their sins by flogging through the streets. In addition, tuberculosis, popularly referred to as “*consumption*” in 19th century Europe, was integrated into the then culture and it assumed some mythic force. Rather than consider it a serious health problem, patients were associated with artistic cultural values like creativity, beauty, romance, temperament, and anxiety experienced by spiritual beings.

Morris (1998) adds that when tuberculosis reached the United States, it became a revered disease of the middle class. “Tuberculosis was, in short, a lifestyle, a parable, a theater of illness complete with tacit rules, recurrent images, and complex social meanings that came to dominate the imagination of an entire century” (Morris, 1988, p. 34). The author identifies other diseases like cancer, heart disease, and obesity as diseases that have become cultural fits in our present times. This study builds on that line of research to show that the competence with which a section of the adult population in Uganda is negotiating the HIV/AIDS epidemic is indeed a form of acculturation for the disease in their culture.

Application of the Diffusion of Innovations Theory

The diffusion of innovations theory (Rogers, 1962) is perhaps one of the most replicated theories of communication with an estimated 5000 studies extending some of its key elements to explain and understand the process of how communities adapt innovations or new ideas (Littlejohn, 2000; Muhiuddin & Kreps, 2004). A short review of some of the research that has applied the theory to health communication in the evaluation of health campaigns and behavioral change at both community and individual levels is in order.

Most research in this area emerged in the 1990s to investigate the dissemination of new health concepts promoting family planning and HIV/AIDS control and prevention messages through formal and informal communication networks (Backer & Rogers, 1998; Bertrand, 2004; Kriss, 2004; Muhiuddin & Kreps, 2004; Singhal & Rogers, 1999; Singhal & Svenkerud, 1998; Vaughan & Rogers, 2000). These studies were consistent with the diffusion of innovations theory in confirming that observable social change can only be realized in longitudinal studies because behavioral change at both community and individual levels takes place over time. Results of the studies indicated that time affords late adopters of an innovation an appreciation of

the benefits being enjoyed by early adopters, an incentive that persuades late adopters to change and adjust to the new condition.

Indeed, findings from studies on short-term campaigns indicated failure to make any observable changes in the behaviors of the targeted population were due to the old adage “old habits die hard” (Elford, Sherr, Bolding, Serle, & Maguire, (2002), p. 8). The researchers studied a peer-led education program for HIV/AIDS positive men attending several gyms in London and found that the main cause for the failure of the program lay not only in its inability to attract peer educators but also in its duration of only six months. They recommended that if change is to be realized, a campaign should last for at least one year.

Another element found to be critical in any campaign aimed at social change is the identification of highly placed individuals in societies to champion the dissemination of an innovation by placing it at the top of the community agenda for implementation (Bertrand, 2004; Backer & Rogers, 1998; Kriss, 2004; Rogers & Dearing, 1988). The authors observe that if a campaign does not identify a champion who can mobilize resources for its promotion and dissemination of the innovation through multiple channels, chances for its success will be minimal.

In addition, the researchers found that for innovations to be diffused, their champions should be influential enough to prioritize their implementation against other issues on a community agenda. Backer and Rogers (1998) studied the implementation of HIV/AIDS education and prevention in some of the major airlines and other corporations in the United States and reported that it had to take total commitment and personal involvement of the corporations’ top executives for the campaigns to succeed. Furthermore, the researchers note that

before the United States' White House took a special interest to promote the implementation of the HIV/AIDS campaign in the country in 1984, almost nobody was paying attention.

Consistent with the diffusion of innovation theory, other studies evaluating HIV/AIDS prevention and control campaigns found that adaptability of safe sex practices by high risk groups took into consideration their cultural norms, beliefs, customs and values to avoid a backlash in the dissemination of messages (Bertrand, 2004; Kriss, 2004; Singhal & Svenkerud, 1998). The researchers note that opinion leaders were especially effective as role models and change agents in collectivist cultures and were fully utilized to initiate the dissemination of new ideas that eventually filtered to the entire community through word of mouth.

Later, Singhal and Rogers (1999) and Vaughan and Rogers (2000) introduced the concept of entertainment education in HIV/AIDS and family planning campaigns in Tanzania, Bangladesh, and Mexico. They found that dissemination and adaptation of an innovation was enhanced through locally produced soap operas on radio using traditional folklore, proverbs, puppetry, dance, and music. Their research suggested that targeted groups easily identified with the characters in the drama and used them as role models to adapt family planning practices and safe sex behaviors. The authors report that the campaigns resulted into quantifiable reductions in sexually transmitted diseases, birth control and HIV/AIDS infections. This study applied the diffusion of innovation theory to explain the process through which the new concepts about the global HIV/AIDS were glocalized by a section of the Ugandan population resulting into the observable social and cultural change in the group.

CHAPTER 3

METHOD

This chapter describes the method used in conducting the study. First, the process of getting the research approved by the Institutional Review Board (IRB) of the University of North Texas is presented. Second, the chapter explains the process of selecting participants in the study. Third, the procedure utilized in the conduct of the focus group discussions in Uganda is discussed. Finally, the methods used to analyze the data are presented including the decision rule or plan of analysis.

A case study approach was adapted to comprehensively answer the research questions raised in this exploratory study to provide an understanding of how one section of the Ugandan population coped with the HIV/AIDS pandemic over time. According to Yin (1984) and Dutton and Dukerich (1991) a case study approach is effective in rendering an in-depth and thorough investigation into most of the underlying elements inherent in a new social phenomena that may otherwise not be illuminated through empirical examination.

Consistent with that approach, a focus group methodology was utilized to collect data from participants in the Rakai and Kampala districts of Uganda. The strength of focus group discussions lies in the empowerment of participants to share their respective experiences and supplementing each others perspectives by contributing incremental pieces to the collective understanding of a research problem that has not yet been empirically examined (Fontana & Frey, 1994). Fontana and Frey (1994) also state that focus group discussions are useful in exploratory studies because they generate broader perspectives on the research problem not available through individual interviews.

Tanno and Jandt (2002) have argued that focus groups are especially productive in intercultural communication and cultural research because they provide participants a forum to freely share experiences as a group and offer their own insights on a particular subject. The researchers also contend that although most studies on acculturation have used survey methodologies, participatory methods of inquiry are most appropriate and effective in probing new social phenomena in cross-cultural encounters because they empower participants to freely put their experiences into their own words, not the words of the researcher.

Procedures

The data for this study were collected from Rakai and Kampala districts in Uganda. It primarily included transcriptions from focus group discussions of participants from the two districts. The law in Uganda does not require researchers using methods of data collection like administering surveys, conducting interviews, or focus group discussions with human subjects to seek permission to conduct their studies. The law only requires researchers involved in conducting drug or vaccine trials on human subjects to seek permission before carrying out their experiments.

However, for the purpose of protecting participants and ensuring compliance with research ethics, the researcher applied for permission from the Institution Review board (IRB) at the University of North Texas for permission to conduct the research. The application was duly approved by the IRB and is attached as Appendix A. The researcher ensured that the laws governing the research process in both the United States and Uganda were followed for maximum protection to all participants in the study. Abiding by the two sets of laws eliminated any bottlenecks that would have hindered the progress of the study.

The researcher informed IRB that the study was strictly for academic purposes and did not have any anticipated risks to the participants. Through the moderators of the focus group discussions, a translated version of the IRB approval was presented to the participants. It was translated into Luganda, the first language of all the participants, and it outlined their rights during the course of the study. A copy of the translated version is attached as Appendix B. The approval note introduced the researcher and the moderators of the focus group discussions in Uganda to the participants. The form requested the respondents to participate in the study as volunteers and restated the academic purpose of the research. The form provided the contact information of the researcher and emphasized that the anonymity of the participants would be strictly observed throughout the period of the study and in the final paper. Consent forms were also distributed and explained to the participants by the moderators on behalf of the researcher. Both the moderators and participants signed the consent forms before the focus group discussions began. The English version of the consent form is attached as Appendix C, while the translated version in Luganda is attached as Appendix D

Owing to the high air travel costs from the United States to Uganda, the researcher did not travel to Uganda but appointed and trained two moderators to conduct the focus group discussions. The two moderators were selected on the basis of their experience in health journalism and coverage of HIV/AIDS related issues. The two, a female 44 years and a male 33, are broadcast journalists holding bachelors and masters degrees respectively. The two moderators, currently working with Radio Uganda and Uganda Television have moderated and presented health programs on the two national media channels and have conducted focus group discussions for local and international non-governmental organizations (NGOs) on various health

topics in the country. One of the moderators, a journalism graduate had already carried out research work and was familiar with focus group methodology.

However, for purposes of this study, the researcher designed specific instructions for the two moderators on how to facilitate the focus group discussions to generate the relevant data. The researcher conducted several telephone discussions with the moderators and sent step by step directions to them via e-mail. The researcher also dispatched guidelines that were followed during the transcription and translation of the data from the local Luganda language in which the discussions were held into English. The transcription and translation of the material was supervised by the moderators but carried out by qualified and experienced Luganda Newscasters at Radio Uganda who are highly proficient in both Luganda and English languages. The researcher paid all operational costs incurred during the data collection process including fees for the moderators and charges for transcription and translation services.

Research Participants

A total of sixty-four women and men participated in ten focus group discussions held in Kampala and Rakai districts. Before the focus group discussions began, each participant completed a questionnaire titled section one of the interview schedule that evaluated their demographic characteristics, and their knowledge about HIV/AIDS. Such information included their age, sex, ethnicity, religion, occupation, level of education, where they lived in 1982, whether they were sexually active by 1982 and their knowledge level of HIV and AIDS by 1986.

According to the demographic information, all the participants were aged between 17 and 27 years in 1982 and sexually active when the HIV/AIDS disease was first identified in Rakai district. Presently, twenty three years since the onset of the epidemic in Uganda, the surviving youngest members of this vulnerable age group is 40 while the oldest of the group is 50.

According to Sewankambo et al. (1990); Stoneburner, Low-Ber, Tembo, Mertens and Asimwe-Okiror (1996); UNAIDS (1998); Kamali et al. (2000); the Ministry of Health (MOH, 2003); and the Uganda AIDS Commission (2003); the national average age for the onset of sexual activity for both males and females is 15 years. However, the researchers note that the average age in some regions varies from the national estimate. The researchers claim that in some areas, the average age for onset of sexual activity is between 13 and 14 years for girls.

The researchers also point out that in rural areas like Rakai district where school drop-out rates are high coupled with strong cultural beliefs in the institution of marriage and motherhood, most girls become mothers at 13 or 14 years. In addition, the Ministry of Health and the Uganda AIDS Commission have consistently found in their annual reports of 1988 to 2002 that the most vulnerable and worst hit age group to HIV/AIDS is between 20 to 24 years because they are the most sexually active section of the population. However, the national mapping for HIV/AIDS for 2003 and 2004 indicated that the age group most affected by the disease is between 40 to 50 years (MOH, 2003; UAC, 2005).

Thus, based on the above studies, at between 17 to 27 years when HIV/AIDS broke out in Rakai district, participants in the present study were sexually active with reasonable experience in sexual activities. Currently, at between 40 to 50 years, this age group is the worst affected with HIV/AIDS and participants in this study are assumed to be the survivors of a relentless epidemic that has killed hundreds of thousands of their peers and can vividly recollect the traumatic experiences of that period. Therefore, they are presumed to be seasoned individuals of the HIV/AIDS evolution in Rakai and Kampala districts because they have weathered serious challenges posed by the epidemic to their sex lives. Similarly, it is assumed that the same age group has over the last twenty three years adapted strategies to cope with the disease.

All the participants belonged to the same ethnic group, Baganda, the largest group in Uganda that occupies the entire central and parts of the south western region of the country geographically referred to as the Buganda kingdom (Government of Uganda, 1995; UBOS, 2002). All the participants were born and raised in various parts of Rakai district and were living in the district between 1982 and 1986 during the period when the HIV/AIDS epidemic was first reported in the area. Twenty-eight women and thirty-six men participated in the focus group discussions in both Kampala and Rakai districts. In Kampala, a total of twenty-six participants including fourteen men and twelve women took part in the discussions.

In Rakai district, a total of thirty-eight participants including sixteen women and twenty-two men participated in the focus group discussions. The average age of the participants was 44.7 years, with a range of 40 to 50. In both districts, the women participants were the youngest with an age range of 40 to 48 with an average age of 44.25. The range between the men was 41 to 50 years with an average age of 45.08 years in both districts. The information indicated that all the participants were aged between 17 and 27 years and sexually active by 1982. All the participants identified themselves as believers in one of the three predominant religions in the country. The majority of the participants, 68.75 percent, identified itself as Catholics, 18.75 percent identified itself as Muslims, and while 12.5 percent reported that it was Protestant.

All the participants had heard about the HIV/AIDS disease by 1986 and had physically seen patients with AIDS. Indeed, all the participants disclosed during the discussions that by 1986, they had either lost a parent, a sibling, a relative, a friend, or a village mate to HIV/AIDS. The educational levels of participants, their occupations, and current residence reflected a great diversity in the sample that enriched the study with unique experiences from different perspectives. For example, 23 percent of the participants in the four focus group discussions that

were held in Kampala had only completed their secondary school education, the equivalent of Junior high school in the American education system. Half of those participants were self-employed while the rest were working as attendants in various businesses in the city. The genders of those participants were also evenly distributed.

Over forty two percent (42.3 percent) of the respondents in Kampala held either high school diplomas or various qualifications below college degrees and all held blue-collar jobs in the city. The majority of those participants, 77.7 percent were female. Participants who possessed college degrees were 23.07 percent and were all in professional employment; holding various positions in both the public and private sectors. Only one of these participants was a female. Out of the 26 participants who attended the focus groups in Kampala, 11.5 percent possessed Masters degrees and held white-collar jobs in the city. All of them were men. Besides the foregoing diversities in this city sample, there was also a disparity in the education levels of the two genders. The men had the highest levels of education with only one of the women participants possessing a college degree and none had a graduate qualification.

Although diverse in their professed occupations, the participants who took part in the more rural Rakai district nearly shared similar demographic characteristics. Unlike the urbanites in Kampala, all thirty-eight respondents owned plots of land and grew their own food. Out of the thirty-eight participants in Rakai district, 78.9 percent had almost attained the same level of education. They had either completed primary school education or had dropped out of school. Despite their low levels of education, all could read and write and were well informed about the HIV/AIDS epidemic. Among the thirty, 66.6 percent identified themselves as peasant farmers while the remaining 33.4 percent engaged in various occupations like trade, fishing, carpentry, taxi driving, and waitress. Only 21.1 percent of the total sample in Rakai district had completed

secondary school education and held teaching, clerical, administration, health, and security jobs in the district. Even these, lived off the land just like the other 66.8 percent of the participants.

Participants in this study were recruited using three methods. First, moderators of the focus group discussions who were designated representatives of the researcher in Uganda, contacted the local health workers and community leaders in Rakai district to invite volunteers aged between 40 and 50 years to come forward and participate in an HIV/AIDS-related study. The prospective participants were told that the study aimed at gathering their knowledge about the disease and discuss the campaign against the epidemic since 1982. The local health and community leaders used their networks to identify the participants. The moderators then randomly divided participants into six focus groups although some preferred groups attended by their acquaintances. Others preferred to attend groups designated for same sex participants. The participants were recruited from all the five counties in Rakai district where the HIV/AIDS epidemic was first reported in 1982. Some of the district leaders together with the moderators volunteered to transport the participants in the two locations where the focus group discussions were held.

The participants who took part in the focus group discussions in Kampala, were identified through the executive committee of Rakai District Development Association based in Kampala. Most of the people who hail from Rakai district and are resident in Kampala city, are members of the association. Other participants were recruited through using a snowballing technique in which those who were recruited through the Rakai district development association were used to identify other Baganda residents in Kampala from Rakai district that fitted the demographic profiles of the study.

The Focus Group Discussions

At the beginning of each focus group discussion, the moderators reminded the participants of the topic and reiterated their right to confidentiality, voluntary participation, and rules of procedures that allowed them to decline answering any question or withdraw from the discussion. The interview protocol, whose English and Luganda versions are attached as Appendix E and F respectively, included two sections that were used to guide the facilitators and participants through the discussions.

The first part of the protocol required participants to complete demographic information about themselves, where they lived in 1982, whether they were sexually active then, and their brief knowledge about HIV/AIDS by 1986. The second part of the protocol included open-ended questions divided into four broad categories representing the critical phases in the evolution of the epidemic in Uganda. The phases were delineated as Genesis (1982 to 1986), Upsurge in infection rates and deaths (1986 to 1995), Decline in infections and deaths (1995 to 2000), and Mainstreaming of HIV/AIDS in community life (2000 to-date). (See also Table 1). However, the moderators were allowed to pose follow-up questions for deeper insights into an issue under discussion.

The ten focus group discussions were held on three consecutive days in three separate locations convenient to both participants and moderators. Each focus group discussion lasted approximately one hour and ten minutes. All of the focus groups were conducted in a local language called Luganda, the mother tongue for all participants. Four of the ten focus groups comprising twenty six participants were held on the same day and audio-recorded in Radio Uganda studios in Kampala, where the two moderators and translators are currently employed.

All the focus groups were facilitated by either of the two moderators, a female and male, who are also Baganda. Two of the focus groups held at Radio Uganda had seven participants each while the other two had six respondents each. One of the groups consisted of seven men and the other had six women. The other two groups comprised three men and three women while the other had four men and three women. The group with three men and three women was referred to as focus group number one and the participants randomly assigned numbers one to six.

The group that comprised four men and three women was classified as focus group two with respondents assigned numbers one to seven. The group that had seven men was referred to as focus group three with respondents assigned numbers one to seven. The last group with six women was classified as focus group four and the respondents designated numbers as participants one to six. [See Tables 2 through 5 below showing details on the Kampala Focus groups.]

In the study, the participants are referred to using numbers designated to their focus group and to each of them. In some specific cases, participants' levels of education, occupation or sexes are disclosed if deemed relevant. The same criteria were used to classify the focus groups held in Rakai district and to designate participants. In both Kampala and Rakai, one group was exclusively attended by participants of the same sex. These are four in total and are numbered last in either location. The purpose of having same sex groups was to find out whether any unique experiences specific to that gender would emerge much more easily than in mixed gender groups. Indeed, some participants preferred same sex groups but the majority were comfortable in the groups assigned to them.

Table 2

Participant Demographic Characteristics for Focus Group No. 1- Kampala

Participant:	Age	Sex	Education	Occupation	Ethnicity	Religion
#1	42	Male	Secondary Education	Self Employed	Muganda	Catholic
#2	49	Male	Secondary Education	Taxi Driver	Muganda	Catholic
#3	48	Male	Degree	Lawyer	Muganda	Catholic
#4	48	Female	Diploma	Women/HIV/ AIDS Activist	Muganda	Protestant
#5	45	Female	High School	Hair Dresser	Muganda	Muslim
#6	41	Female	Diploma	Nurse	Muganda	Catholic
<i>Summary:</i>	Total (6)	<i>Male (3)</i>	<i>Female (3)</i>			

Table 3

Participant Demographic Characteristics for Focus Group No. 2- Kampala

Participant:	Age	Sex	Education	Occupation	Ethnicity	Religion
#1	47	Male	Masters	Journalist	Muganda	Protestant
#2	49	Male	High School	Hotel Employee	Muganda	Muslim
#3	45	Male	Masters	Politician	Muganda	Catholic
#4	41	Male	Degree	Economist	Muganda	Catholic
#5	40	Female	High School	AIDS Activist	Muganda	Catholic
#6	43	Female	Diploma	Government Employee	Muganda	Protestant
#7	45	Female	Secondary Education	Midwife	Muganda	Catholic
Summary:	Total (7)	Male (4)	Female (3)			

Table 4

Participant Demographic Characteristics for Focus Group No. 3- Kampala

Participant:	Age	Sex	Education	Occupation	Ethnicity	Religion
#1	42	Male	Degree	Politician	Muganda	Catholic
#2	45	Male	Degree	Social Worker	Muganda	Catholic
#3	44	Male	High School	Shop Keeper	Muganda	Catholic
#4	44	Male	High School	Musician	Muganda	Catholic
#5	48	Male	Secondary Education	Ex-Soldier	Muganda	Protestant
#6	48	Male	Masters	Doctor	Muganda	Catholic
#7	42	Male	Degree	Artist	Muganda	Catholic
Summary:	Total (7)	Male (7)	Female (0)			

Table 5

Participant Demographic Characteristics Focus Group No. 4- Kampala

Participant:	Age	Sex	Education	Occupation	Ethnicity	Religion
#1	40	Female	High School	Self Employed	Muganda	Protestant
#2	46	Female	Diploma	Nurse	Muganda	Catholic
#3	43	Female	Secondary Education	Market Vendor	Muganda	Catholic
#4	46	Female	Secondary Education	Office Clerk	Muganda	Catholic
#5	47	Female	Diploma	HIV/AIDS Educator	Muganda	Muslim
#6	41	Female	Degree	Journalist	Muganda	Catholic
Summary:	Total (6)	Male (0)	Female (6)			

The six focus group discussions held in Rakai district were conducted on two consecutive days after the Kampala discussions. The Rakai discussions were held in two separate locations in the district, the epicenter of the HIV/AIDS epidemic. Thirty eight participants including sixteen women and twenty two men participated in the discussions that were held in two separate local health centers. The discussions were tape-recorded by one of the two moderators while the other conducted the discussions. In the first location, one group consisted of seven men. The other two

groups: the one with seven participants had five men and two women while the other with six respondents included four men and two women. In the second location, one focus group comprised only six women. The other two groups also consisted of six participants each with either group composed of three women and three men.

Focus group one in Rakai district was held in the first location and included five men and two women. The respondents were assigned numbers from one to seven. Focus group number two was also held in the first location attended by four men and two women. The participants were assigned numbers from one to six. Focus group three was held in the second location attended by three men and three women and participants were assigned numbers from one to six. Focus group four was also held in the second location with three women and three men assigned numbers from one to six. Focus group five was held in the first and was exclusively attended by seven men who were assigned numbers from one to seven. Focus number six was held in the second location and was attended exclusively by six women who were given numbers from one to six. [See Tables 6 through 9 below showing demographic characteristics for focus groups held in “Rakai.”]

The questions in the interview protocol enabled participants to share their knowledge and unique experiences about how their sexually active age group understood, defined, and responded to the advent of the HIV/AIDS epidemic. The participants discussed how members of their age group adapted strategies to cope with the challenges posed to their sex lives by the epidemic on a daily basis. Focus group discussions were particularly useful in this research because participants were afforded the opportunity to explain the multi-dimensional aspects of the evolution of the HIV/AIDS epidemic in Rakai and Kampala districts.

Table 6

Participant Demographic Characteristics Focus Group No. 1- Rakai

Participant:	Age	Sex	Education	Occupation	Ethnicity	Religion
#1	50	Male	Primary	Peasant	Muganda	Catholic
#2	45	Male	School Drop out	Peasant	Muganda	Catholic
#3	43	Male	Primary	Fisherman	Muganda	Catholic
#4	41	Male	Primary	Trader	Muganda	Catholic
#5	44	Male	Secondary Education	Local politician	Muganda	Muslim
#6	43	Female	School drop-out	Peasant	Muganda	Catholic
#7	46	Female	Primary	Community Counselor (Ssenga)	Muganda	Catholic
Summary:	Total (7)	Male (5)	Female (2)			

Table 7

Participant Demographic Characteristics Focus Group No. 2- Rakai

Participant:	Age	Sex	Education	Occupation	Ethnicity	Religion
#1	45	Male	Primary School	Trader	Muganda	Catholic
#2	47	Male	Primary	Fisherman	Muganda	Muslim
#3	44	Male	Primary	Peasant	Muganda	Catholic
#4	43	Male	Primary	Carpenter	Muganda	Protestant
#5	40	Female	Primary	Birth Attendant	Muganda	Catholic
#6	47	Female	Drop out	Peasant	Muganda	Catholic
Summary:	Total (6)	Male (4)	Female (2)			

Table 8

Participant Demographic Characteristics Focus Group No. 3- Rakai

Participant:	Age	Sex	Education	Occupation	Ethnicity	Religion
#1	50	Male	Primary	Peasant	Muganda	Catholic
#2	44	Male	Primary	Trader	Muganda	Muslim
#3	46	Male	Primary	Local Defense	Muganda	Catholic
#4	43	Female	Secondary	Clerk	Muganda	Catholic
#5	44	Female	Secondary Education	Nursing Aid	Muganda	Catholic
#6	49	Female	Primary	Community Counselor	Muganda	Catholic
Summary:	Total (6)	Male (3)	Female (3)			

Table 9

Participant Demographic Characteristics Focus Group No. 4- Rakai

Participant:	Age	Sex	Education	Occupation	Ethnicity	Religion
#1	45	Male	Drop Out	Peasant	Muganda	Muslim
#2	44	Male	Primary	Civic leader	Muganda	Catholic
#3	43	Male	Primary	Fisherman	Muganda	Catholic
#4	48	Female	Primary	Bar Maid /Waitress	Muganda	Catholic
#5	43	Female	Secondary	Teacher	Muganda	Protestant
#6	41	Female	Primary	Peasant	Muganda	Catholic
Summary:	Total (6)	Male (3)	Female (3)			

Table 10

Participant Demographic Characteristics Focus Group No. 5- Rakai

Participant:	Age	Sex	Education	Occupation	Ethnicity	Religion
#1	47	Male	School drop out	Fisherman	Muganda	Muslim
#2	44	Male	Primary	Trader	Muganda	Muslim
#3	45	Male	Secondary Education	Teacher	Muganda	Catholic
#4	49	Male	Primary	Peasant	Muganda	Catholic
#5	43	Male	Primary	Taxi Driver	Muganda	Catholic
#6	45	Male	Primary	Fisherman	Muganda	Catholic
#7	42	Male	School drop out	Peasant	Muganda	Protestant
Summary:	Total (7)	Male (7)	Female (0)			

Table 11

Participant Demographic Characteristics Focus Group No. 6- Rakai

Participant:	Age	Sex	Education	Occupation	Ethnicity	Religion
#1	46	Female	Secondary school	Health Educator	Muganda	Catholic
#2	42	Female	School drop out	Peasant	Muganda	Muslim
#3	45	Female	Primary	Community Counselor (Ssenga)	Muganda	Catholic
#4	45	Female	Secondary Education	Midwife	Muganda	Catholic
#5	48	Female	Primary School	Housewife & Community Counselor	Muganda	Muslim
#6	43	Female	Primary	Peasant	Muganda	Muslim
Summary:	Total (6)	Male (0)	Female (6)			

Besides discussing the overall impact of the epidemic on their age group, participants were able to share how their respective communities made sense of the epidemic and are gradually integrating the disease in their daily lives. The discussions contributed to a clearer understanding of the glocalization process of the HIV/AIDS pandemic among a section of the

Ugandan population that was sexually active during the onset of the epidemic to the present day when the disease is undergoing a process of acculturation.

At the end of the focus group discussions, the participants were served refreshments and each of them received two thousand five hundred shillings equivalent to one dollar and fifty cents as a token of appreciation for participation in the study. All the data from the ten focus group discussions were transcribed and translated by qualified and experienced Luganda Newscasters at Radio Uganda who are highly proficient in both Luganda and English languages. The transcription and translation processes were supervised by the two moderators following the guidelines provided by the researcher. The translated material was then e-mailed to the researcher in the United States for analysis while the rest of the materials were sent by mail.

Analysis

Drawing from the grounded-theory approach (Glaser & Strauss, 1967), a thematic analysis was utilized for interpretation of the data generated from the focus group discussions. The grounded-theory approach is particularly useful because it provides a thorough procedure for analyzing data and makes sound and plausible conclusions about phenomena under investigation. Consistent with the grounded theory, thematic analysis employed in this study was especially effective because the themes that emerged from the data reflected the replication of the concepts of glocalization and acculturation of HIV/AIDS among the sexually active section of the population then living in Rakai district in Uganda. Secondly, the analysis enhanced the comprehensive answering of the research questions raised in the study. Finally, thematic analysis contributed to a better understanding of the role of communication in the control and prevention of HIV/AIDS in Uganda, an area of research that had been previously overlooked.

The process of analysis began with the researcher thoroughly examining and reviewing all the transcribed statements in order to identify emerging themes. The researcher coded the transcriptions according to corresponding patterns to allow categories to emerge identifying and classifying pertinent ideas in the data. In the process, the researcher labeled themes that emerge from the data for final analysis. The process of open coding and constant comparison of the data enhanced the emergence of categories that enabled the classification of the ideas in the transcriptions.

This process of coding and labeling data into categories and themes is also supported by Spradley (1979) who states that thematic analysis focuses on identifiable themes and patterns of experiences that emerge from interviews or conversations. The author notes that themes can be developed from direct quotes or paraphrasing common ideas highlighted by respondents during an interview or discussion. Reinforcing that view, Taylor and Bogdan (1989), contended that "themes are defined as units derived from patterns such as "conversation topics, vocabulary, recurring activities, meanings, feelings, or folk sayings and proverbs" (p.131). In addition, the authors stated that themes are identified by "bringing together components or fragments of ideas or experiences for analysis because, when viewed alone, they are meaningless" (Taylor & Bogdan, 1989, p. 60).

In this study, special focus was placed on how participants shared their knowledge and experiences from the first time they heard about the HIV/AIDS disease to their initial reaction to the epidemic. Their attitudes towards the infected and the subsequent changes they have experienced in their perceptions about the disease were highlighted. Emphasis was also placed on how the participants recalled the initial communication about the disease, how it has changed, and how those changes resulted into the globalization of the pandemic and gradually leading to

the acculturation of the disease in their culture. Focusing on those elements in the data helped the author form a comprehensive picture of the participants' collective experience about the pandemic. Five primary themes emerged from the data and will be discussed next in the following chapter.

Decision Rule

The data generated from the focus group discussions comprehensively answered the three research questions raised in this study. The data were also consistent with the communication concepts applied to explain the dynamic communication processes that unfolded during the 23 years of the HIV/AIDS epidemic in Uganda and Rakai district in particular.

To effectively and adequately analyze the data and answer the research questions, the author divided the timeline of the epidemic into four phases delineating the critical events that highlighted the evolution of the epidemic from 1982 to the present day. Table 1 shows the 23-year timeline of the epidemic and the four phases that were used as landmarks in the globalization and acculturation of the disease among a section of the Ugandan population then aged between 17 and 27 years and living in Rakai district.

Richardson and Gray (2000) argue that spotlighting critical events that characterize a protracted historical event enhances the systematic examination of the changes reflected in the communication during those critical turning points and contributes to the categorization and analysis of the emerging themes from the data. This study is divided into four critical phases that provided the basis for analyzing the role of communication during the evolution of the epidemic in Uganda.

The four phases include: (1) Genesis of the disease (1982-1986), (2) Upsurge in infection rates and deaths (1987-1995), (3) Decline in infection rates and deaths (1995-2000), and (4)

Mainstreaming of the disease in community life (2000-to-date). Participants in the focus group discussions shared their knowledge about the HIV/AIDS epidemic and their experiences on how communication during the four phases of the evolution of the epidemic resulted into the glocalization of the pandemic

More specifically, for research question one, the data reflected how the 17-27 year-old sexually active group and their respective community's then living in Rakai district made sense of the new HIV/AIDS phenomena. The data showed how they established and assigned common or shared labels or symbols to describe, explain and name the disease. Data from questions in the Genesis phase also showed how participants constantly created, recreated, and adapted new definitions or names to explain the HIV/AIDS phenomena from their social environment.

This process of socially and collectively reconstructing a new phenomena to enable members of a social community to understand it, is consistent with the social constructivism perspective Berger and Luckmann (1966); Pearce (1995) and the symbolic interaction theory advanced by George Herbert Mead as cited by Morris (1934). Similarly, assigning culturally bound labels, symbols, or names to describe and explain a scientific phenomena like HIV/AIDS, is also consistent with the bio-cultural model as advanced by Engelhardt and Spicker (1974) and Eisenberg (1977).

Data generated from the critical phases: Upsurge in infection rates and deaths and Decline in infections and deaths were used to answer research question two. The question related to the glocalization of the global HIV/AIDS campaign into the local environment and how it was transformed to be understood by the targeted populations. The data show that global HIV/AIDS concepts were localized through the modification of traditional institutions and local resources in

order to achieve the desired changes in the high risk sexual behavior of participants to avoid contracting HIV/AIDS.

Data from these two phases, which were characterized by intensive HIV/AIDS education and prevention campaigns reflected the process of the diffusion of innovations through multiple communication networks that eventually resulted into the reduction of HIV/AIDS infection rates and deaths in the country. But the adaptation of the new strategies to avoid HIV/AIDS came after a long period during which many lives were lost due to skepticism at the beginning of the campaign.

The data also showed how the HIV/AIDS issue gained national recognition because the president took it upon himself to spearhead the campaign and secured resources that helped the national campaign to filter down to the grassroots through various formal and informal communication networks. The data also provided information on who championed and participated in the campaign against the epidemic, and how the HIV/AIDS education and prevention messages were disseminated to reach members of their age group and other Ugandans.

The globalization of the HIV/AIDS global campaign in the previous two phases and the resultant diffusion of innovations about the new disease, set the pace for the gradual acculturation of the disease in the mainstream culture of the participants. This is reflected in the mainstreaming of the disease in all public and community activities aimed at destigmatizing HIV/AIDS and making communities and workplaces sensitive to the infected and affected. Data from all the three phases answer research question three regarding how the participants integrated all the changes brought about by the epidemic and accepting HIV/AIDS as the disease of the moment (Morris, 1998).

The data show that the participants competently coped with the new social, economic, political and cultural changes imposed on them as a result of the epidemic. The data also reflected the reconfiguration of the entire social structures in the community that moderated the social roles and conduct of participants irrespective of their own personal views or wishes as posited by George Herbert Mead in Morris (1934). The data showed that the changes came with new social norms that the participants had to adapt to function effectively in their culture (Graves, 1967; Smith, 1969; Berry; 1980; Kim; 1998).

CHAPTER 4

FINDINGS AND DISCUSSION

This chapter presents the results of the data analysis in which five major themes are identified and discussed to demonstrate how the research questions raised in this study were answered. The emergence, categorization, and subsequent labeling of the themes were enhanced by the delineation of the epidemic into linked phases that featured landmark events that sequentially followed one another. The elaboration of the themes shows how the communication concepts applied in this study effectively explain the glocalization and acculturation of HIV/AIDS among a section of the Ugandan population then living in Rakai district by 1982.

Five primary themes emerged from the data analysis. These themes were labeled as follows: Genesis and Sense-Making Process; Desperation, Stigmatization, and Sensitization; Enlightenment and Change; Transformation and Integration; and Institutionalization and Backlash. The themes will be discussed next.

Genesis of HIV/AIDS and Sense-Making Process

The first major theme emerging from the data revolved around participant recollection of the advent of the HIV/AIDS epidemic in Rakai district and how their respective communities and members of their age group made sense of the new disease. Data for this theme were constructed during discussions that revolved around the critical events that illuminated the first phase in the evolution of the HIV/AIDS epidemic in Uganda designated as genesis of HIV/AIDS (see Table 1). Data in this theme date back to the 23-year history of the HIV/AIDS epidemic in Rakai district, the epicenter of the epidemic, as experienced by the participants.

The two categories comprising this theme included: “Advent of HIV/AIDS,” and “Confusion and Sense-Making Process.” Each of the categories will be discussed momentarily.

Advent of HIV/AIDS

This category describes the prevailing health conditions in Rakai district as recollected by the participants immediately before the advent of the HIV/AIDS epidemic as it is known today. In their recollections about the advent of the epidemic, participants aged over 46 were predictably more retrospective than their younger counterparts in articulating the pre epidemic conditions in their respective areas. When asked to share any immediate stories that came to their mind when the words HIV/AIDS are mentioned, the participants were striking in their detailed comments that went back to the late 1970s before the liberation war that overthrew Ugandan dictator Idi Amin Dada's regime in 1979 by a joint force of Ugandan exiles and Tanzanian People's Defense Forces (TPDF).

Participants aged over 46 across all the ten focus groups were unanimous in their statements that they had heard a story or at least seen an individual with symptoms similar to those of HIV/AIDS patients long before 1982. Ugandan medical authorities and subsequent epidemiological studies have documented 1982 as the year when the first cases of HIV/AIDS were reported in Rakai district (Bond & Vincent, 1991). Participant number [1] in focus group number [3] held in Rakai district who also claimed to have been 27 years by 1982 recalled with certainty,

I personally lost an Uncle in early 1978 before the Tanzanian "Bakombozi" (a Swahili word meaning "Liberators") invaded Uganda. He was a very rich man operating businesses on the shores of Lake Victoria on both sides of the Uganda-Tanzania border. He was such a huge man but by the time he died, he was just a skeleton with sores in his mouth, all over his body and his private parts and hair had dropped off before he died. He had all the other symptoms similar to those of AIDS patients as we know them today. Because nobody in the area had ever seen or heard of such a disease, some elders claimed he had died of a severe type of gonorrhoea or syphilis.

Participant number [1] in focus group number [1] held in Rakai district reinforced the statements of the previous participant when he said,

Before 1982, some people had actually died of ailments similar to those suffered by AIDS patients in busy trading centers like Kasensero and Mutukula in Rakai district. The first victims I personally saw were men who used to drive trailers from one country to another. The women were the “malayas” (a local name for “sex workers”) who fell prey to the Tanzanian soldiers because they gave them a lot of money looted from fleeing Amin's soldiers and businessmen. Both the men and women who died during this period, displayed similar symptoms described by the locals as “Kisununu ky'Abakombozi” (a Swahili word meaning lethal gonorrhoea from Tanzanian liberators). Since we were all ignorant about AIDS, we could not have rightly named the disease. However, all of us thought kisununu was the closest name that could describe the symptoms. But I strongly think AIDS existed long before 1982 and 1986 when we first heard of the name. Unfortunately, by the time we knew what it was, it was too late and many people had already been infected.

The comments by the respondents reflect the mysterious advent of the HIV/AIDS epidemic in Rakai district in Uganda. That it subtly crept upon an unsuspecting and oblivious community about its cataclysmic nature portended a humanitarian crisis. For its ignorance and lack of awareness about the disease, the community simply regarded the disease as a temporary health hazard that would be overcome like any others that had existed before. Besides, as the statements imply, there were just a handful of victims whose death, although painful, were no cause for alarm. Tragically, the affected communities neither understood nor imagined the magnitude of the disaster that loomed in their midst. Obviously, going by the comments made by the participants, none envisaged that the disease would develop into a relentless plague to wipe out families, villages, and a productive section of the population.

Morris (1998) observes that unlike other epidemics which pop up and wreck sudden havoc on humankind, the evolution of the HIV/AIDS epidemic is more covert and gradual. More specifically, this implies that for individuals infected with HIV 1 that is most prevalent in Uganda, by the time a person starts showing symptoms of The acquired immune deficiency syndrome (AIDS), the human immune virus (HIV) would have completed its long incubation

period which lasts between seven to thirteen years (Whitworth et al., 2000; Sewankambo et al., 1990; Nunn et al., 1997; Morgan et al., 2002; Shabbar et al., 2003).

Thus, the retrospective observations by the participants that HIV/AIDS might have existed before 1982 are not without scientific support. However, the inability by the community to detect the looming danger of the epidemic confirms the covert and gradual development of the HIV/AIDS epidemic. Nonetheless, by describing and interpreting the symptoms of the disease and assigning a meaning to it however rudimentary, marked the beginning of the sense-making process to understand the new affliction on the community. The initial conceptualization of the disease as explained by the participants is consistent with claims by health communication researchers who argue that HIV/AIDS manifests itself through or by association with other diseases that prevailed in the previous experiences of individuals or exist currently in the social environments of the affected communities (Eisenburg, 1977; Mishler, 1981; Best, & Kellner, 1991; Morris, 1998).

Furthermore, while the community did not discern the magnitude of the calamity that was to afflict it in future, their collective construction and understanding of the new health phenomena based on their shared cultural experiences is in concurrence with the social constructivism perspective (Berger & Luckmann, 1966; Pearce, 1995). At the same time, the use of shared symbols from within their historical interaction with the Tanzanian forces to communicate about the new disease reinforces the symbolic interaction theory developed by George Herbert Mead and cited by Morris (1934) which refers to a dynamic process of interaction through which individuals use language to interact, create and establish shared meanings, interpret and understand social reality in the world around them..

Confusion and Sense-Making Process

The second category comprising this theme was labeled “Confusion and Sense-Making Process.” This category represents accounts made by participants on how their respective communities grappled with the confusion that surrounded the increasing number of deaths from a strange and horrifying disease that had no cure because nobody understood it. Statements from the participants indicate that as a pattern of deaths developed, anxiety and uncertainty heightened in the community which triggered off a process of soul searching to understand, explain, and name the destructive disease with multiple symptoms.

Across all the ten focus groups held in Kampala and Rakai districts, participants recalled the period between 1982 and 1986 as one marked with both fear and concern in the community about the incurable disease that devastated patients before they died. Participant number [3] in focus group number [1] held in Kampala district echoed the sentiments expressed by other participants regarding the confusion and dilemma experienced by the community about the strange and incurable disease:

Confusion and uncertainty was rampant in many villages and trading centers across Rakai district where some people had died of the strange disease. No cure was available from local healers and in hospitals. The lack of a cure from traditional medicine, hospitals, and subsequent deaths of the patients heightened the anxiety among the population. The disease had no name and could not be easily explained because patients suffered from many painful ailments at the same time.

The statements by the participant underscore the initial perplexity that communities in Rakai district experienced when the HIV/AIDS epidemic broke out. It appears that the failure by all known remedies to cure the multiple ailments aggravated the situation and overwhelmed the communities. Participant number [1] in an exclusively women focus group number [6] in Rakai district who claimed to have personally nursed six of her dead family members between 1982

and 1986 graphically described the horrifying symptoms of the disease that confounded the population:

AIDS symptoms were very severe and shocking to us all. Patients suffered painful deaths and the symptoms were difficult to treat. ...Intermittent fever (locally known as omusujja ogw'Olutentenzi), vomiting, sores or a rash all over the skin, a pale and rough skin like that of a frog, coughing or akafuba (meaning Tuberculosis), prolonged diarrhea and oral thrush ...red lips, wounds around or inside private parts, or total loss of sexual organs, thin and falling hair on their heads, excessive loss of weight or total erosion of the body that left them to die as skeletons, and total lack of menstruation in young women...And the incubation period took one to two years for one to catch AIDS and die. I do not think it takes eight years....Those were very, very hard times for us all.

The statements by the participant indicate the gravity of the HIV/AIDS symptoms that patients, relatives, and the communities had to contend with. They further emphasize the novelty of the disease and the budding confusion that characterized the genesis of HIV/AIDS epidemic in Rakai district in Uganda. Based on the statements from the two participants, it becomes apparent that from the onset of the epidemic, the local perception and interpretation of the disease was shrouded in a cloud of mystery.

The inability to appropriately name the disease, trace its origin and understand its transmission contributed to the confusion and anxiety in the community. In addition, the failure to cure the disease by either home remedies or western medicine, fueled all sorts of speculation and generated numerous conspiracy theories about the strange disease. Participant number [1] in focus group number [2] held in Kampala district observed:

During the confusion, doctors gave no clear explanation of the cause of the disease and if you were lucky, they treated the symptoms with available drugs but nobody recovered because patients eventually died. No government official or religious leader gave any explanation or solution to stop the disease. People felt abandoned and left to suffer and die a miserable death.

Participant number [5] in focus group number [3] held in Rakai district stated:

Because of the confusion, various names started to emerge to define, describe and explain the new disease and its symptoms. Bereaved families shared their experiences about the

ailments of the deceased and the people started inventing names that everybody understood. People were seriously concerned that nobody could explain the disease to them. They were interested in understanding the disease and quickly find a cure for it.

The description of the confusion by the participants and the subsequent involvement of the entire community to seek an interpretation of the new malady and solution to it, points to an onset of a collective process of creativity to make sense of the new social reality and overcome the confusion and uncertainty. Berger and Luckmann (1966) and Pearce (1995) state that communities use knowledge from their shared experiences to create and construct meanings and interpretations of phenomena even when such reality were previously unknown to them.

Hence, uncertainty and confusion in the communities about the mysterious disease, imposed an emergency need on the people to simultaneously name the disease, explain its origin, and eventually find a cure to it. Berger and Calabrese (1975) and Gao and Gudykunst (1990) argued that since uncertainty causes anxiety, fear, loneliness, and frustration, it motivates individuals to monitor their environments and seek ways and means to reduce its levels.

Reinforcing this view, Trudgill (1974) states that because local languages are a product of a continuous creative process, they empower societies to think and reflect over a new phenomenon when it turns up. “In such situations, there arises a need to identify and understand it, cope with it, and above all, name it “(Trudgill, 1974, p.56).

Recollecting some of the stories about HIV/AIDS that were typical during the advent of the epidemic, participant number [2] in focus group number [5] attended by men only in Rakai district mimicked some of the stories told by other participants:

When AIDS is mentioned, I associate it with death and the name “Mukenenya” (meaning the drainer or that which saps both flesh and blood from the person and leaves him or her as a pack of bones). That was one of the first local names that were given to AIDS during its early stages and some people in my community still use it.

The metaphor implied that HIV/AIDS was a debilitating disease that incapacitated the victim and left them for dead. Participant number [6] in focus group number [2] held in Rakai district observed:

For me, AIDS is nothing but death and in my village, we used to call it “Lukonvuba.” This means that the disease was not only incurable but also crippling because of the extended period of unbearable suffering patients endured before finally dying.

Participant number [2] in focus group number [4] held in Kampala said:

In my village, people called AIDS “Olukusense” (meaning “Measles”) because its symptoms of a generalized skin rash, fever, oral thrush, vomiting, weight loss, and diarrhea were similar to the new disease. Although it mostly infected children under five years, it used to kill almost as many people as malaria.

Across all the ten focus groups held in Kampala and Rakai districts, recollections of the discourse on HIV/AIDS by participants were distinctly similar and were a plethora of ominous metaphors and sounded like a chorus from mourners at a death match or a recitation from a textbook on the history of the devastating HIV/AIDS in Uganda. Their use of metaphors that equated HIV/AIDS to death reflected “a common style of naming something new with the help of something familiar” (Trudgill, 1974, p. 54).

Participant number [1] in focus group number [5] held in Rakai district recalled:

I remember AIDS was called “Nnamusuna” (meaning “Small pox”) and “Nnawookera” (meaning “The destroyer”). The two types of diseases are both deadly and devastating to the human body and they torment the victim for an almost indefinite and agonizing period of time.

Participant number [6] in focus group number [4] held in Rakai district recalled that:

In my village, AIDS was referred to as “Kawumpuli” (meaning “Plague”) because it affected the community by killing most of the productive and reproductive people. We also used to call AIDS “Akaveera” (meaning “Polythene material”) because it as deadly to humans as swallowing polythene material is to a cow.

The descriptions of HIV/AIDS using various metaphors by the participants underscored the destructive nature of the epidemic to humankind. However, despite the harrowing narratives about AIDS, participants stated that some of the names used to give meaning to the disease were

peppered with local humor. Most of such names emerged by the end of 1986 after government had publicized the scientific name of the disease as HIV/AIDS, and explained to the population that the virus is transmitted and caused by a virus. Participant number [2] in focus group number [3] held in Rakai district identified one of the commonest names associated with HIV/AIDS that had a humorous touch to them but also maintained the lethal effect of the virus:

In most villages, AIDS was referred to as “Akawuka” (meaning a small insect). The villages said that just like a tiny worm, pest or weevil finds its way into beans or maize cobs and make them so hollow inside that they rot and die was similar to the way the AIDS virus (akawuka) finds its way into the human body and destroys it from within.

Participant number [1] in focus group number [3] held in Kampala and attended by men only explained that:

The local people named AIDS “Siliimu” (meaning “Slim or Thin”). The name was used to define and describe the condition of an AIDS patient as a result of excessive weight loss and erosion of the body leaving only bones.

According to Obbo (1991), the name “Siliimu” also meant that the disease was foreign and resistant to local treatment on top of depicting it as a White man's glorification of thinness as a distinct feature of beauty. Unlike other names given to HIV/AIDS in Uganda, the name “Siliimu” has endured the evolution of the epidemic in the country and has to the present day, been adapted by all local languages as standard definition of the disease and is used in both informal and national discourse (TASO, 1992; MOH, 2003; UAC, 2003; Ankrah, 1993; Lyons, 1997). Today most people recognize the symptoms of AIDS and have local terms for them even if their explanations differ from those of health professionals.

To the present day, the process of creating new definitions, assigning meanings, and interpreting HIV/AIDS still continues. Participant number [4] in focus group number [1] held in Rakai district identified other names such as “Akantu kaffe” (meaning “Our thing”), “Obwaja” (meaning “That which came”), and “Obulwadde” (meaning “The disease or sickness”). It is

called “Obulwadde” or “The disease” because it is so common and has supplanted all the “other diseases” in killing people.

Participant number [2] in focus group number [3] held in Kampala and exclusively attended by men echoed the impressions of the predominantly elitist participants held in the four focus groups in the city:

The HIV/AIDS epidemic is “A weapon of mass destruction” because it has killed more people in the world than any modern weapon to my knowledge. It is even more than “A Tsunami” because it has killed close to 30 million people and almost 50 million are infected with the virus all over the world.

Using metaphors that captured a sense of destruction mirrored the attitude the people of Rakai had towards the evil in their midst. The names also captured their sense of siege from AIDS, a disease that was foreign and imposed on them from outside without a local explanation or cure. Besides capturing the destruction of the epidemic in the variety of names assigned to it, the names helped create an understanding of the magnitude of the problem. The use of shared metaphors from the social environments of the communities enhanced the sense-making process.

It also provided the community with the preliminary knowledge to communicate about the disease, cope with it, and negotiate their changed social environment. For every new manner the disease manifested itself, communities found a metaphor to describe, explain and name it. For example, participant number [2] in focus group number [6] held in Rakai district recalled that because Herpes Zoster appeared as a generalized rash and spread around the waistline of a patient, it was named “Ekisipi,” meaning “a wide belt.”

Sontag (1991) stated that metaphors are crucial bricks in people's social schemas because they are used to cope with new and frightening situations and help them generalize from previous experiences to rationalize and understand their new environments. The sense-making process elaborated in the theme is consistent with the symbolic interactionism theory developed

by George Herbert Mead as cited by Morris (1934), which suggests that societies have inherent social processes in which unfamiliar phenomena are rendered familiar by naming them using known and shared symbols that enable individuals to recognize, understand, and also evaluate them.

Furthermore, the data lend credence to Mead's theory of symbolic interactionism as cited by Morris (1934), which contends that the way people use symbols, words or language to assign meanings to things or objects is a continuous and creative process that is not isolated from their social context. Put succinctly, data explained in this theme reflects the innovative concept expounded in the symbolic interactionism theory which suggests that people's continuous interactive activities contribute towards the establishment of shared meanings, definitions, and interpretations that are assigned to any social reality within a given cultural context at a particular time in history.

Although the community assigned shared symbols to interpret, define and explain the strange disease, it had to simultaneously make-sense of the origin and cause of the incurable ailments suffered by the patients. Responding to questions requiring them to share what they considered to have been the most important features of HIV/AIDS epidemic in their own knowledge and experience at the community level, all answers from respondents clustered around the notion of witchcraft. Witchcraft was identified as the single factor advanced in their respective areas as the number one cause of the disease.

Across all the ten focus groups, not a single participant gave a contrary view to the idea of sorcery as the source of pain and suffering to the community. For example, participant number [1] in focus group number [1] held in Rakai district that was also one of the oldest of all participants observed:

Since I was old enough and living in the worst hit area of the district, I saw more and more people dying and others showing symptoms of the disease. We then realized that most victims were rich young men and their many girl friends. The young men belonged to a fast-growing group of rich traders engaged in a daring but profitable smuggling of essential goods called “Magendo” mainly across (Nalubaale) meaning Lake Victoria, for sale on the black market on either side of the Uganda-Tanzania border. They used to charge very high prices on grounds that they risked their lives over the lake and that they were always at the mercy of Iddi Amin's soldiers who patrolled the common border.

Participant number [2] in focus group number [1] held in Kampala collaborated the account and echoed statements from other participants when he said:

Based on the pattern of deaths, we started to suspect that the traders had cheated their Baziba counterparts in Tanzania and had been bewitched. Because we could not find any better reason or other convincing explanations, we attributed the origin of the mysterious disease and deaths of the young businessmen to witchcraft.And you know, the Baziba ethnic group in Tanzania are famous witch doctors and have a reputation in punishing thieves.

Participant number [4] in focus group number [1] held in Kampala added:

The Baziba were assumed to be very powerful sorcerers that we all believed that they could inflict death on whoever cheated them in business. A few unscrupulous businessmen and double dealing female sex workers from my village who suspected they had AIDS returned to the border on the advice of local medicine men, to appease Baziba traders or repay debts if only to survive death.

The statements indicate the strong cultural beliefs that prevailed in the area alongside the professed beliefs in Christianity and Islam. In addition, the statements reflect the magnitude of the problem and the extent to which the community was prepared to find explanations and solution to the devastating epidemic which was threatening to annihilate them. Ironically, although all the participants were believers in at least one of the three of the predominant religions in the country, there is no indication to show that they hesitated to attribute the unusual sickness to witchcraft as the most plausible source of the disease.

Furthermore, the stories recounted by the participants across the focus groups underscore the elements of the constructivism perspective as extended by Engelhardt & Spicker (1974);

Eisenberg (1977) in their bio-cultural models which emphasize that communities interpret their health conditions alongside their cultural beliefs and local surroundings. Mishler (1981), Ankrah (1993), Morris (1998), Airhihenbuwa and Obregon (2000), and Sonja and Flora (2000) also contend that the socialization process of a community greatly influences its perceptions about any new phenomena that impinges their health.

Responding to what they considered to have been the most important feature of HIV/AIDS epidemic in their own knowledge and experience at the national level, participants recalled the national HIV/AIDS control and prevention campaign that emphasized the cause of the disease as a virus transmitted through sexual intercourse, contaminated blood, unsterilized sharp objects used by infected persons, and transmission from mother to child. Participant number [3] in focus group number [2] held in Rakai district recalled:

Although some people did not immediately believe the scientific explanation by the government, others accepted that the virus is the cause of HIV/AIDS but it was too late. I think by that time, many people had already got the disease through sexual activities and the “small insect” virus had already entered their bloodstream. Many people were dying including the Baziba across the border in Tanzania. It was hard for some of us to continue believing that witchcraft caused AIDS.

Participant number [6] in an all-women focus group number [4] held in Kampala summed up the state of affairs that was repeated in other focus groups:

It was not possible to change people in just one year. Many people still quietly believed it was sorcery and even continued to visit traditional healers to consult them about their different ailments. A lot of skepticism still existed. We were even told that the disease was brought to Africa by the Americans using a polio vaccine in the 1960s and that all of us who got immunized would die.

Coincidentally, most of the participants and the majority of the people dying at the time were in their mid and late twenties and had been born in the 1960s. They had also been immunized against polio. However, this theory was eventually countered by the massive campaign information that followed.

However, the early perception that the first victims of the disease were either thieves or Malayas (prostitutes), coupled with the frightening and horrifying symptoms that they exhibited, resulted in the early stigmatization AIDS patients suffered (Obbo, 1991; Lwihula, Dahlgreen, Killewo, & Sandstorm, 1994; Kaleeba et al., 1997). The stigmatization and the massive deaths and infections rates that followed the genesis of the epidemic is the subject of the next theme that emerged from the data.

The data used to illuminate the foregoing theme comprehensively answers the first research question which sought to understand how sexually active Ugandans aged between 17 and 27 years then living in Rakai district where the disease was first identified adapted local meanings and definitions to communicate about HIV/AIDS and eventually cope with it. The data demonstrated how the initial response by the community to an encounter with new phenomena drew from its shared cultural experiences to describe, explain and above all, named the disease. Twenty three years after the community's first encounter with the HIV/AIDS epidemic, some of the first names given to the disease are still being used in both local and national discourse. One of the names, "Siliimu" has even been adapted in the national HIV/AIDS control and prevention campaign (MOH, 2003; UAC, 2003).

Similarly, the data highlighted in this theme reflects the hassles and stressors that are characteristic of the conjunction between two autonomous cultural systems as they set on a process of acculturation (Redfield, Linton & Herskovits, 1936; Social Science Research Council, 1954; Graves, 1967; Smith, 1969; Berry, 1980; Kim, 1988). Thus, the responses to the advent of the HIV/AIDS epidemic by the people of Rakai district lends credence to research on the acculturation process that the initial continuous contact between two different cultural norms,

values, or systems may sometimes generate anxiety and apprehension before either of the four outcomes of acculturation; assimilation, integration, marginalization or separation is attained. .

Finally, the initial response by the people of Rakai to the global HIV/AIDS pandemic supports claims by Roudometof (2003, 2005); Friedman (2000); Randiria (2003) who argue that the process of glocalization of a foreign norm, product, service or value in another cultural environment encounter some initial skepticism and indifference. The authors argue that unless the new phenomena are customized to suit the new conditions and expectations of the indigenous populations, then there are likely to be rejected in preference to the local items, values, or norms.

Desperation, Stigmatization, and Sensitization

The second major theme constructed from the data was labeled: Desperation, stigmatization, and sensitization. Data for this theme were constructed from discussions that clustered around events that highlighted the Phase delineated as upsurge in infection rates and deaths during the evolution of the HIV/AIDS epidemic in Rakai district in particular and Uganda in general (see Table 1). Although some of the data in this theme are a spill over from the genesis phase, most of it is drawn from the period between 1986 and 1995, the period that witnessed the design and implementation of a comprehensive national HIV/AIDS education and prevention campaign that resulted in the reduction in the infection rates in the country.

This theme is characterized by statements that depict the degree of frustration and fatalism as a result of the increasing number of AIDS-related deaths and infections in Rakai district. Furthermore, the theme is illuminated by statements that portray the high level of stigmatization against people living with AIDS and the resultant denials and suicidal tendencies displayed by some individuals.

The theme highlights statements that expound on the education and prevention campaign to control the spread of the epidemic. The theme is divided into three categories: “Desperation and fatalism, stigmatization and denial, sensitization and dissemination. These categories are discussed next.

Desperation and Fatalism.

This category highlights the level of desperation reached at the height of the HIV/AIDS epidemic in Rakai district between 1986 and 1995. In addition, the category captures the sense of fate expressed by the people as a result of the unprecedented deaths witnessed in the district. Participants recalled that during that period there was a lot of fear of death as hundreds of sexually active people perished while others suffered from the disease.

Participant number [2] in focus group number [2] held in Rakai district observed: Because of the fear and desperation, patients still visited local healers for traditional remedies called “Budomola.” (These were liquid medicines in plastic containers administered to patients with the hope that it would cure the disease.) But the patients eventually died. In the absence of anything more effective, that was the last resort. I also administered “Budomola” to my brother and two sisters but all died. It was a terribly desperate situation.

Participant number [7] in focus group number [1] held in Rakai district recalled what most participants emphasized:

During that time, quack doctors and traditional healers thrived on the desperation of the patients and their relatives. Many bogus healers appeared on the scene claiming to have a cure for the multiple ailments. They fleeced the patients and their relatives of their meager resources and provided hoax remedies to patients in villages but the end result was death. Some of the very affluent patients and their relatives traveled as far as Congo, Nairobi, London, Germany and the United States in search of a cure. But they were all returned dead or to wait for their death.

The statements reflect a high degree of desperation and hopelessness that gripped the entire community as they helplessly witnessed a living tragedy that threatened to exterminate them. The accounts also indicate that this was a community torn between two worlds of

maintaining their faith in the potency of traditional remedies to disease and confidence in western explanations of sickness. Because none of the two worlds offered a cure for AIDS, despair drove them to try out whatever offered the slightest promise of alleviating pain and avert death. Lyons (1998) states that the HIV/AIDS epidemic in Uganda brought out the worst of business with regard to human life as local and international seekers of fortune scrambled to cash-in on the humanitarian tragedy in the country. The author notes that in the absence of a cure for AIDS, desperate patients fell prey to their hoax and toxic remedies they hawked.

Across all the focus groups, respondents referenced their visit in 1989 to Lutunku, a remote village in neighboring Masaka district, to collect “blessed soil” from an elderly woman called Nanyonga. They recalled that she claimed to have received a vision from the Virgin Mary to scoop soil from her courtyard and freely dispense it to AIDS patients, mix it with water and drink it as a cure from God!

Participant number [2] in focus group number [2] held in Kampala recollected the episode in the following words:

It was simply madness. Almost the entire nation trekked to that wasteland to get a share of the soil. I joined the thousands in the “frenzied pilgrimage” for a portion of the soil. AIDS patients drank bucket-fulls of the soil to recover and others took it for prevention! Even the rich who could afford to go abroad and “change their blood” drank the soil! Of course, it did not cure the disease as people continued to die. But we were so desperate that we could take anything that offered the slightest hope of life.

The statements portray a community that was emotionally and physically tormented by the viciousness of an affliction that was beyond their scope of control and left them vulnerable to any form of manipulation that would ensure their survival. Accounts that even those who were not infected took portions of the soil demonstrate the extent to which nearly everybody in the community lacked the self-confidence and resigned to the fate that awaited them just like those who had perished. Similarly, the omnipresence of death from AIDS across the land instilled fear

and a sense of fatalism in the minds of both the deserving and the innocent. Participant number [5] in focus group number [4] held in Rakai district captured the thinking of the many people in the community at the time: “Nobody was safe from the terrible disease. The young and the old, the rich and poor including Priests, Nuns, and Sheikhs were also dying.”

Participant number [4] in focus group number [4] held in Rakai district added:

AIDS was no longer a disease for traders and prostitutes but everybody was dying. Nobody thought they would survive the plague, “Ffena twafa dda” (meaning “all of us died long ago”). Everybody just has to wait for her or his day to die. What an inescapable fate!

The above statements reflect sentiments of a community under siege from phenomena previously unknown to them. They depict the difficult process of a transition from the old to the new order. Friedman (2000) posits that the process of glocalization is sometimes “stressful to a local population as it negotiates a common ground between the “lexus” (new phenomena) and the “olive trees” (indigenous culture), (p. 148). Friedman argues that healthy glocalization prevails when the local population can function competently in a changed environment by adjusting to the new order and retaining some elements of the old and absorbing some elements from the new. The category of desperation and fatalism clearly illustrates that period of transition.

But the highest level of fatalism and desperation were more prominent in the statement of participant number [3] in focus group number [1] held in Kampala who graphically captured the imagination of the community at the time. He hinted at the complete extermination of an entire family, clan, community, and tribe because all the most productive and reproductive members of the population were dying without offspring. He stated:

All members of our neighboring families died. Not a single one was left. It is the same story in all villages. Most of the people left are either grandparents, orphans or migrants to the district. So, what is left of us? Orphans are now the family heads in most

homesteads and most of them are infected. Is there any hope left for us? Most of my peers, siblings and others died without children and left nothing behind. Fathers and sons were dying. Nobody was going to survive to uphold the family tree and clan name for all those people? The majority of the people died and others fell sick. Only old people were left. Who would look after them? The coffee, banana, and other crops were never attended to in the gardens. It did not even matter because everybody was going to die. Why did death come through a channel in which life was created? The simple answer is that life was no longer important and worth living. You cannot destroy what brings life and expect to have life. It was all over for us. That was the mood in the community at the time.

The long statement sums up the thinking across all the communities in Rakai district. The concern was that the natural cycle of life had completely been disrupted and a sense of continuity was lost. At the time, helpless grand parents were burying their grandchildren and were left with nobody to look after them as the natural course of life existed before. In addition, the bitter recollections by the participant reflect the collapse of the rural economy of agriculture on which the communities relied.

Stigmatization and Denial

The second category comprising this theme was labeled *Stigmatization and denial*. This category represents statements that reflect the high stigmatization and discrimination suffered by AIDS patients, a humiliating and dehumanizing attitude and practice that motivated most patients and those who suspected to have the virus to go into denials or display suicidal tendencies. Because AIDS was originally perceived as a disease that afflicted thieves and prostitutes, it was considered shameful and abominable.

Participant number [2] in focus group number [3] held in Kampala district and attended by men only recalled that he together with his friends stigmatize and discriminated PLWAs until he lost his father to the disease. He stated:

When I was in high school, I used to join my friends to gossip and laugh at people with AIDS. I also openly shunned or avoided them. At my first job, I found two employees with AIDS in the same company. Like other employees, I used to dodge shaking hands

with them or sit next to them. Everybody avoided them and they were isolated. It was so bad then. I feel so sorry and regret whatever I did to them. God forgive me. Before my father died of AIDS, I told him about it and he forgave me.

Participant number [6] in focus group number [5] held in Rakai district and attended by men only recalled that he also discriminated PLWAs in the village. He said:

In my village, most of us nursed our patients in the back rooms of the house and never allowed visitors to see them. That was because we knew that if they saw them, they would go spreading rumors and gossip all over the village about our patients' conditions. We only brought them in the living rooms when we knew they were left with a few days or hours to die. Sometimes I never even answered their requests for help because I was fed up with their unending demands.

The statements reflect the attitudes and practices of the community which condemned People Living With AIDS (PLWA) as social deviants, outcasts, dirty, unclean, and contagious. Furthermore, the descriptions indicate that sometimes, family members would ignore the welfare of their relatives because of “compassion fatigue,” (Obbo, 1998, p. 214). The statements also indicate that the prejudice AIDS patients endured from some of their family members and the community during this period made their fragile lives almost unlivable.

Although all the participants had nursed relatives and friends, statements from female participants indicate that they least stigmatized patients and provided the much needed care to patients even at the expense of their own lives. Participant number [6] in an all women focus group number [6] held in Rakai district who also claimed she personally took care of nine relatives recalled:

While I passionately loved my late relatives and did everything to nurse them, I always had a lingering fear and concern for my own life. Having direct contact with the patients like washing their sore and stinking bodies, cleaning their messy clothes, linen, and feeding them drove me almost to breaking point. But because they were my blood relatives, I had no choice. But many people in the villages abandoned their relatives in houses or hospitals to die without any care. I must admit that I felt a sigh of relief whenever the patient I was nursing died. Both the patient and I had suffered enough and God had brought it to an end.

Participant number [3] in focus group number [4] held in Kampala district reinforced the observation with the following statement:

I nursed my brother, mother, and father. They all died in my hands and I will never forget the experiences. My brothers only looked for money and we the girls and women provided all the care that was needed. In my village in Rakai and here in Kampala where I live today, I see the women suffering with their sick husbands, children, and parents. Even when they are sick, they still provide the care. This epidemic has tormented so much and it is still continuing.

The statements by the two women participants highlight the enormous burden placed on their shoulders to ensure that the sick are well attended to. But more importantly, the statements bring into focus the gender imbalances in the provision of care to AIDS patients. While the women physically and emotionally invest and stake everything they have to offer to nurse children and their husbands, more often at the expense of their lives, there is no equal investment in the care for the sick by the men.

Kaleeba et al. (1997); Obbo (1998) and Porter et al. (2004) state that the inequities suffered by the women in the provision of care for AIDS patients in most developing countries like Uganda seriously affects their own health and their investment in nursing the sick is not reciprocated by society but rather used to perpetuate a hegemonic structure that confines them to a state of powerlessness. This state of affairs prompts Obbo (1998) to declare that the HIV/AIDS epidemic has been feminized. Obbo goes ahead to pose the pertinent question, “If the women provide all that care, then who cares for carers?” (p. 215)?

Ironically, participants reported that the worst forms of stigmatization that prevailed in workplaces were practiced by employers, medical staff in hospitals, and by religious leaders in places of worship. Several participants stated that although not all employers dismissed HIV/AIDS patients from their jobs, some denied them insurance coverage and other privileges. But all respondents reported that most nurses and doctors never wanted to touch AIDS patients.

They claimed that patients were kept in dirty, isolated and labeled wards that appeared more like condemned cells than hospital wings. Participant number [5] in focus group number [1] held in Rakai district summed up the sentiments of the others across the ten focus groups:

Doctors and nurses wore gloves and other protected gear during routine visits to wards with AIDS patients. They kept patients at arms-length and if they noticed a patient was in terminal stages, they would dismiss him or her from the hospital. Eventually, some hospitals stopped admitting AIDS patients all together. The religious leaders branded all HIV/AIDS patients as sinners who were condemned to go to hell. “Because they lived immoral and satanic lives, they will never enter the Kingdom of God,” the religious leaders declared!

The explanations by the participant on the degree of stigmatization that prevailed in the communities at the time left patients with no hope of surviving under such circumstances. It is therefore not surprising that many went into denial by falsifying their identities and moving to other parts of the country to avoid stigma and labeling (Kaleeba et al., 1997). Participant number [3] in focus group number [1] held in Kampala stated:

Individuals who suspected they were sick self medicated themselves to death because they feared to come out in the open. Their actions were caused by the stigmatization from the public and medical staff and their deaths were never recorded as caused by AIDS. Others became suicidal and engaged in reckless sexual behaviors in search of death partners. Their mentality was to “fight back” because they claimed: “Ate oba naffe batusiiga, naffe katusiige abalala. Tujja kufiira mumiguwa” (meaning: “Since we were also infected by some people, let us also infect others). We will die in the ring doing battle!” Others claimed, “Akawuka kasiima musaayi. Buli muntu tagenda kufa Siliimu” (meaning: “The virus thrives in friendly blood. Not everybody will die of AIDS.”). Some patients committed suicide by taking poison or “swallowing a battery of a digital watch” which “killed the patients instantly.”

Clearly, the narratives in this category lend credence to claims by Kaleeba et al. (1997) who state that because the epicenter of the HIV/AIDS crisis in Uganda was in Rakai district, high levels of ignorance, stigma, and discrimination were extremely visible. They argue that if the community was to survive the disruption of its structures, by the epidemic, there was urgent need for psychological and social support to restore some form of social cohesion.

Sensitization and Dissemination

The third category derived from the data was labeled “sensitization and dissemination.” This category illuminates statements from participants regarding the national response to the HIV/AIDS epidemic and the impact it had on their age group in Rakai district. Participants recall that up until 1986, there had never been any government statement on the strange disease that was killing most of productive and reproductive members of their communities.

Participants across the ten focus groups in Rakai and Kampala recall that from 1986, their district was literally swamped by government officials, health workers, members of local and international Non Governmental Organizations (NGOs) to explain the cause of the new disease and how it could be avoided. Their accounts coalesced around the fact that for the first time, the new disease, previously known as *Mukenenya* meaning the drainer or slimmer, was given a scientific name called: acquired immune deficiency syndrome (AIDS).

Participants recall that the “wise men and women from Kampala and abroad” told them that the disease was caused by a virus or a tiny worm, insect or *akawuka* called the human immune virus (HIV) which was transmitted primarily through sexual intercourse with an infected person. Participant number [3] in focus group number [2] held in Kampala district who had an advanced degree graphically described the most memorable day in the HIV/AIDS education and prevention campaign in Rakai in 1986 that was corroborated by other participants. He stated:

It was a huge HIV/AIDS awareness rally at the district headquarters and the main speaker was President Yoweri Museveni. He told the crowd that AIDS was the easiest disease to prevent and manage because we now know how it is transmitted and spread. Speaking in Luganda, he warned: “*mulekeraawo okungenda nga mulozaloza ku buli muntu. Musobole okugwa kukyokya. Abafumbo, mubeere kumuntu omu. Ate mwe abavubuka, ebintu ebyo temubikola okutuusa nga mufumbidwa. Ebya girl friend ne boyfriend byabazungu. Mubiveeko.*” (Meaning: “I want to advise all of you to stop the habit of promiscuity or going around tasting everybody. You might fall in danger. Those of you who are married, stick to your partners. For the youth, avoid those things until you get married. This girl friend and boy friend thing is for White people. Just leave it to them.”)

He took the same message all over the country. Although it sounded funny in his faltering Luganda, it made sense and guided me to the present day.

The participants recalled that after the presidents' rally, the Kabaka or King of Buganda, politicians, religious leaders, local musicians, drama groups, health educators, civic and traditional leaders embarked on a massive intervention campaign to sensitize the community against high risk sex behaviors that would expose them to HIV infection. The participants also recalled the campaign launched by Swedish based Ugandan pop star Philly Bongole Lutaaya who was among the first Ugandan to go public that he had AIDS.

Participants recalled that although he inspired many people to avoid high risk sex behaviors, some people were skeptical alleging that “He had been bought by Europeans to lie to Ugandans!” He later died.

Across all the focus groups, participants recalled the anti-HIV/AIDS messages on Radio Uganda before and after every news broadcast which started with a sound of the drum “Ggwanga Mujje” locally sounded to mobilize the population to warn them against any danger or gather for a meeting. Participant number [3] in focus group number [5] held in Rakai district recalled:

That radio message was very scary and terrifying. While it restrained some people, others just switched off their radios whenever they anticipated it. But when radio Uganda started broadcasting recorded programs educating people to protect themselves against contracting HIV and other sexually transmitted diseases, people started listening because the programs were interesting. When Radio Uganda started broadcasting plays in local languages to encourage individuals to change their high risk sexual behaviors, I remember a very interesting play in Luganda throughout the late 1980s and early 1990s called kadiidi that advised people how to say NO to AIDS by either abstaining, being faithful, or using a condom. I never used to miss this play on Radio Uganda's blue channel every Tuesday evening after the Luganda news broadcast. I remember many of my peers gave themselves nick names of the characters in the play. I was personally nick named Kadiidi, after the main character in the play because of my strong interest in the drama.

Participant number [4] in focus group number [6] held in Rakai who said she regularly visited her relatives in Kampala said:

Even Uganda Television (UTV) showed some programs on HIV/AIDS education and also screened thrilling local dramas called “That's life Mwattu, and Bibaawo” which had HIV/AIDS messages. Luganda newspapers in Kampala regularly published exciting columns and features on HIV/AIDS education and counseling either called “Senga” (Aunt) or highlighting testimonies and profiles of HIV/AIDS patients advising sexually active individuals to avoid HIV. The New vision Newspaper started a prolific publication with AIDS Control Program (ACP) called “Straight Talk” which was inserted in the newspaper every Tuesday and exclusively focused on educating young people like us on how to protect ourselves from HIV.

The recollections by the participants confirm that the HIV/AIDS control and prevention campaign was so comprehensive that it covered most of the sexually active individuals who needed the information to protect them against infection. However, participants noted that earlier radio programs alienated the listeners rather than mobilizing them to change their sexual behavior. The fact that radio Uganda changed the message that was preceded by the sound of the drum to dramas every Tuesdays indicates that the initial campaign was poorly designed and suffered a backlash because it only scared listeners instead of persuading them to change.

Participant number [5] in focus group number [1] held in Rakai district recalled the role of drama and music in the HIV/AIDS education and prevention campaign and stated:

Philly Bongole Lutaaya's album “Alone and Frightened,” inspired me. Even the play “Ndiwulira” (a weevil, worm, or pest that infects maize) by Bakayimbira Drama Actors sponsored by the AIDS Control Program and staged in most parts of Buganda was extremely exciting and educative.

Participant number [4] in focus group number [2] held in Kampala also echoed the usefulness of video and films in the HIV/AIDS campaign and stated:

During workshops on HIV/AIDS conducted by health educators, videos and films with HIV/AIDS information and messages helped to sensitize sexually active individuals to avoid behaviors that were showed as dangerous to life. Although the messages were serious, the videos and films were interesting. They featured AIDS patients from Uganda and other parts of the world recounting their experiences and advising young people to protect themselves against the disease. I think the videos and films were useful in sensitizing me about HIV/AIDS. For those who were already infected, I think the videos inspired them to live positively by changing their attitudes towards life to adapt new behavioral practices to prolong their lives.

Statements by the participants that the global HIV/AIDS campaign was adapted to the local conditions by using a variety of media networks to disseminate new concepts about HIV/AIDS is consistent with claims by Walsh (1990); Thornton (2000); Kozłowska (2003); Roudometof (2003); Satyavrata (2004) who argue that if the glocalization process is to be successful, new ideas, products or practices are customized or tailor-made to suit and conform to the local conditions.

In addition, the dissemination of the new concepts on HIV/AIDS through entertainment using the popular local media and language understood by the participants also supports the contention by Singhal and Rogers (1999); Vaughan and Rogers (2000) who contend that the most effective method to diffuse new innovation is through entertainment education. The authors argue that through entertainment, targeted groups identify with local heroes or characters in a drama on radio, television, or in newspapers to absorb the message and gradually change their behavior.

Mbowa (1998) states that theater in Uganda was particularly effective in empowering and educating individuals to change their irresponsible sexual behaviors and contributed to the reduction in the infection rates in the country. Furthermore, across all focus groups, participants recalled that they were bombarded with HIV/AIDS messages disseminated through a multiplicity of formal and informal communication networks. Respondents noted that messages highlighted potential areas through which the virus could be transmitted. Participant number [7] in focus group [3] held in Kampala stated:

People were advised to avoid having a network of sexual contacts, to stop inheriting widows of their dead relatives, to avoid social gatherings like market places, weddings, Bachelors' parties which could tempt them to indulge in excessive drinking and unplanned sex, to avoid having sex with strangers, and for HIV positive mothers not to breast feed their children.

Participant number [2] in focus group number [4] in Rakai district also recalled:

Other potential areas of transmission to be avoided were identified as sharing razor blades, safety pins to extract jiggers, unsterilized needles, or syringes, sharing circumcision knives, exchanging blood to cement or bond relationships among friends locally known as okuta omukago and ensuring that blood transfusion to patients is well screened by hospital staff.

The statements by the participants demonstrate that the HIV/AIDS campaign had put to full use all the existing forms of communication to ensure that all the people who needed the information about the epidemic got it. At the same time, the statements indicate that the messages communicated in a way that was understood by the targeted populations. Participant number [6] in focus group number [4] held in Kampala recalled and shared the number of new concepts that were introduced during the campaign:

New words and ideas were introduced in the vocabulary like Zero grazing or sticking to one partner, AIDS kills, love carefully or faithfully, practice safe or protected sex by using a condom, Be Faithful or avoid multiple sex partners by sticking to one partner or abstinence. The messages clarified that AIDS is not transmitted by mosquitoes, bed bugs, or through sweat of infected persons, handshakes, or caring for the sick.

Participant number [5] in focus group number [3] held in Rakai district said:

The educators told us that HIV/AIDS affects everybody and is not only a White man's disease or a disease for homosexuals in America. They advised individuals who were already HIV positive or living with AIDS to live positively by not infecting others and the rest of the community were advised to provide care and support to People Living with AIDS (PLWA).

Participant number [3] in focus group number [2] held in Rakai district recalled:

From 1988, counselors from an organization in Kampala called The AIDS Support Organization (TASO) visited all parts of the district advising community members to go for a blood test and ascertain our HIV status to enable us live positively. They advised that if one tested HIV positive, he or she should feed well, keep away from sex, and treat all sexually transmitted diseases (STDs) and any other opportunistic infections to keep immune system strong.

The accounts by the participants on the campaign indicate that every sector of the social and political structure was involved in the control and prevention to ensure that all intervention

gaps were filled. The statements imply that the participants were growing more and more aware of the mode of transmission of HIV and were increasingly developing a degree of confidence due to the constant exposure to information from a multiplicity of media channels.

The data highlighted in this category represent some of the major communication concepts that characterized the globalization of the HIV/AIDS control and prevention campaign to the then sexually active Ugandans aged between 17 and 27 years living in Rakai district by 1982. Specifically, the data are consistent with the diffusion of innovations theory because it effectively examines and explains the communication flow of new ideas into a community and how targeted communities respond positively or negatively to the ideas disseminated to them through both formal and informal communication networks (Rogers, 1962, 1973, 1976, 1994; Rogers, & Kincaid, 1981).

While the data do not yet suggest that participants had already adapted the innovations or new ideas about HIV/AIDS, it lends credence to the suggestion by the theory that the diffusion of an innovation occurs when an idea, practice or object is introduced to a community and spreads by communication through a social system before it is adapted over a period of time. There is evidence from the data that new ideas about HIV/AIDS were introduced and communicated to the targeted group through multiple networks.

Similarly, the data support the contention by Rogers and Kincaid (1981) and Baker and Rogers (1998) that if an innovation is to be diffused and adapted, it must attract a champion; a key figure in society who will elevate it to prominence on the public agenda and help to secure resources for its promotion and diffusion in society. The launch of the HIV/AIDS awareness campaign in Rakai district by president Museveni which is referenced by the participants is consistent with the claim.

On the other hand, data illuminated in this theme largely answers the second research question which sought to understand how the global HIV/AIDS communication campaign was transformed or glocalized in the local environment to be understood by a section of the Ugandan population now aged between 40 to 50years then living in Rakai district by 1982.

Stroupe (1990) and Friedman (2000) argue that when a global phenomenon encounters a local culture, a transformation process is set in motion to customize both the foreign and the indigenous ideas, services, institutions or products to blend into the changed local environment. The authors contend that when the global and the local systems intersect, some instability is experienced in the local context as the two systems get transformed to achieve compatibility. Thus, the desperation, sense of fatalism, stigmatization, and other attendant responses to the onset of HIV/AIDS in Rakai district, reflect the logical process of globalization.

Finally, the adoption of local methods and institutions to disseminate the new global concepts on HIV/AIDS is in tandem with the globalization process. Hence, data in this theme support the rationale of this study that a global health phenomena, just like others previously glocalized; trade, education, law, and religion, can equally undergo a globalization process.

Enlightenment and Change

The third theme that emerged from the data was labeled: “Enlightenment and Change.” Statements that characterized this theme demonstrate that over time, the massive HIV/AIDS campaign launched in Rakai district resulted into a high degree of enlightenment and changed the perceptions of the participants towards the generalized epidemic. This theme was constructed from data generated during discussions that centered on landmark events that highlighted the phase designated as decline in infection rates and deaths during the timeline of the HIV/AIDS evolution in Uganda (see Table 1).

Part of the data illuminated in this theme emerged during the previous phase classified as upsurge in infection rates and deaths. However, most of the data discussed in the theme is drawn from the period between 1995 and 2000. The statements also reflect how the respondents used the information disseminated during the intervention campaign to adapt safe sex practices to survive the epidemic. The theme breaks down into two categories: “Enlightenment and Change,” “Adaptation and Compliance.” The categories are discussed below.

Enlightenment and Change

This category reflects a high level of awareness and a thorough understanding among participants and the community about how HIV is transmitted and how previously erroneous views and myths about transmission and infection were overcome. Statements from participant number [2] in focus group number [4] held in Rakai district represent a remarkable shift in perceptions about HIV/AIDS expressed by a majority of the sixty four participants interviewed for this study. The participant stated:

The information we received from all the experts convinced us beyond any doubt that indeed Siliimu or AIDS was an incurable disease mainly transmitted through sexual intercourse by (akawuka) or a virus from an infected person or infected blood. The original notion that Siliimu was caused by witchcraft was now laughable and discarded because it was no longer sustainable. The deaths from Siliimu were indiscriminate, massive and affected everybody including witchdoctors who should have treated and cured it.

The statements reflect fundamental changes in the participants' perceptions and attitudes towards HIV/AIDS as a result of the continuous exposure to the pervasive education and prevention messages from a multiplicity of media networks. The statements also reflect a sharp increase in the level of enlightenment about HIV/AIDS attained by the respondents.

Observations by the participant that they believed a virus rather than witchcraft was responsible for the cause of AIDS indicate that a major shift in the perception of the community had taken

place. The admission of a scientific rather than a cultural explanation shows that a cultural change was underway as a result of the impingement on the society by the HIV/AIDS epidemic. This major shift in paradigm does not only reflect a linear outcome of acculturation, but also a complex cognitive change in the thinking about the disease and patients by the participants.

The knowledge about HIV/AIDS and subsequent changes in perceptions of the participants are consistent with the findings by Stone burner and Low-Ber (2004) who note that the increase in awareness of the transmission and consequences of HIV infection was achieved because the overwhelming majority of the population knew somebody with the disease. The researchers found that by 1995, 91.5 percent of Ugandan men and 86.4 percent of women knew somebody with AIDS. Reinforcing the evidence that enlightenment and change were indeed underway, participant number [4] in focus group number [1] held in Kampala observed:

There were no more scapegoats to blame for causing the disease. It was not caused by mosquitoes, bedbugs or sweat from infected persons. Even religious leaders and medical practitioners changed their attitudes and acknowledged that condemning and stigmatizing AIDS patients were not helpful because their colleagues were also dying. The consensus was that HIV/AIDS was a collective and growing crisis that needed everybody in society to join hands and fight it. There was no more time for skepticism and cynicism. Experience had taught us that Siliimu was a reality to be contended with and could not be wished away.

The statements reflect a universal recognition by the participants and the community that HIV/AIDS was a reality in their midst that had to be collectively controlled and prevented. At the same time, the observations by the participant demonstrate the level of knowledge and awareness attained by individuals regarding the transmission of HIV, how to protect themselves from infection and how to treat the infected and affected with care and compassion.

Responding to questions that required the identification of some specific obstacles which they had to overcome during the campaign, participant number [5] in focus group number [5] held in Rakai district echoed the sentiments expressed by other participants. He observed:

Besides overcoming the problem of witchcraft which was deeply rooted in the culture of the community, widow inheritance and other myths about transmission were big stumbling blocks that were gradually defeated. The Catholic Church was and still is against the use of condoms saying that humans are naturally capable of restraining themselves from sex until marriage. They claim that promoting condoms encourages immorality ...that is despite the fact that many priests and nuns have reportedly died of the disease. For me, although I am a strong believer, I consistently use condoms whenever I am not sure of my partners' HIV status. Most of my friends do the same. Afterwards, I go to church and repent!

The ingenious decision taken by the participant to adapt the use of a condom to protect himself against infection contrary to his faith and deep-rooted cultural beliefs demonstrates the level of fit individuals had attained to competently function in a changed cultural environment.

UNAIDS (2001); Hoogle (2002); Singh, Darroch and Bankole (2003); Cohen (2003); and Green (2004) note that in a country like Uganda where infection rates exceeded 30% and funerals for family and friends were held several times a week, changes in perceptions about the cause of AIDS were inevitable. In addition, the researchers state that with such high rates of morbidity, abstinence, faithfulness and condom use were irresistible options to death.

Stories by the participants on their level of knowledge about HIV/AIDS, their changes in perception, and new traits acquired by individuals and the community to cope with the disease are all evidence of an acculturation process. Redfield et al. (1936), Social Science Research Council (1954), Graves (1967), Smith (1969), Berry (1980), and Kim (1988) state that when individuals and communities lose some cultural traits and adapt new attributes to effectively negotiate new cultural landscapes, then the process of acculturation has taken place.

Kim (1988, 1995) describes acculturation as a resocialization process in the scripts of individuals and communities resulting into changes in perception and communication patterns. For example, the new names, concepts and social skills acquired by the participants to communicate about HIV/AIDS are evidence of a change in their original scripts about the

disease. Furthermore, the cultural changes experienced by the participants are consistent with claims by Berry (1980, 1992, 1995), Berry et al. (1989), Searle and Ward (1990), Ward and Kennedy (199), and Rogler et al. (1991), who posited that acculturation is a complex process occurring on behavioral and psychological levels. They argued that at a behavioral dimension, acculturation is associated with acquiring new and recognizable cultural traits such as language, social skills, and the ability to function within the changed cultural environment.

Hence, the degree of enlightenment about HIV/AIDS expressed by the participants like the language used in the campaign, its transmission, avoidance, and how to care for the sick, are traits associated with behavioral acculturation and support claims made by the researchers. On the other hand, the researchers argue that that at a psychological level, acculturation is more complex because it manifests less observable changes in the culture of transforming communities like adaptation of new values, ideologies, beliefs, attitudes, and other norms. Therefore, abandoning widow inheritance, destigmatization of AIDS patients, the belief in a scientific explanation that a virus rather than witchcraft and other erroneous myths caused HIV/AIDS was a major paradigm shift.

The changes in attitudes, norms, and shift in perceptions lend credence to psychological acculturation as elucidated by the researchers. At an individual level, Graves (1967) and Smith (1969) argue that psychological adaptation is a state during which persons in an acculturating group attains a degree of competence that enables them to individually negotiate and overcome the challenges in a new cultural context. Thus, adaptation of the use of the condom by participants to protect themselves against infection from HIV is proof that psychological adaptation was underway.

Adaptation and Compliance

This category describes the communication strategies used in the diffusion of new ideas about HIV/AIDS to the high risk groups, how they received and discussed them and eventually adapted the new concepts to protect them against infection. In addition, this category describes how participants overcame various challenges in their sex lives by complying with the new social norms, values and attitudes imposed on them as a result of the HIV/AIDS epidemic. Statements in this category also highlight the reasons that led to the decline in infection and death rates in their respective communities.

Responding to questions about how information on HIV/AIDS directly reached them in their respective communities, a female participant number [4] in focus group number [6] held in Rakai district captured the ubiquitous nature of the campaign in the following statements:

The campaign started by government in 1992 brought civic society, faith based organizations, government agencies and international organizations together to fill the intervention gaps and enlighten us on how to protect ourselves against contracting HIV/AIDS. The campaign, which emphasized abstinence, be faithful, and condom use, (A, B, & C) reached every corner of Rakai district. The information about how to protect ourselves from HIV/AIDS was now less alarming and scary. The information was simple, clear, and delivered in the local Luganda language we understood very well. Everybody everywhere was freely talking about the dangers of HIV/AIDS, the advantages of protecting oneself from contracting the virus and the risk of dying young if one caught the disease.

The statements by the participant vividly illuminate the comprehensiveness, inclusiveness, and relentlessness of the HIV/AIDS campaign that effectively reached all communities in the areas that were worst hit by the epidemic. In addition, the observation by the participant that the campaign was conducted in the local language that was easily understood by key sections of the population underscores one of the major elements that contribute to a successful campaign.

Similarly, the statement by the participant that the campaign enabled the respective communities to acknowledge and appreciate the severity of the disease and the advantages of avoiding it, highlights another key component of an effective health campaign; the empowerment of targeted population to make rational and informed decisions to protect themselves against infection. Supporting the observations made by the previous participant, another female participant number [6] in a focus group number [4] held in Rakai district observed:

Siliim or HIV/AIDS was freely and openly discussed among my age group, parents, fellow villagers, in homes, in churches, in schools, at community gatherings, on radios, in local songs, and plays. Siliimu was no longer a taboo subject talked about in whispers. That openness greatly helped me to survive. I think it also contributed to the level of awareness about the disease and reduced the infection rates and deaths.

The statements by the participant indicate the extent to which HIV/AIDS was demystified, simplified, and given a face among community members. The observation that parents, community members, and other social institutions could freely and openly talk about HIV/AIDS to children both in their homes and in public, reflects the positive reception to the campaign messages by the community to ensure its survival. Furthermore, the observation that HIV/AIDS was discussed in churches, schools, in songs, plays and among peers is evidence that a variety of channels were used to ensure that the necessary information reached all key members of the population with minimum difficulty through a variety of social support systems and traditional networks.

Cohen (2003) and Stoneburner and Low-Ber (2004) state that Uganda's HIV/AIDS campaign strategy was to a large extent bolstered through filtering information to the ordinary people not only through conventional western media but by word-of-mouth through social and

familial networks. A male participant number [4] in focus group discussion number [3] held in Kampala observed:

The language used by health educators and in other messages was graphic and straight forward “Silliimu atta. Welekereze ebyobukaba. Wewale obwenzi, beera kumuntu omu oba buli lwoba tosobodde kukyesonyiwa, kozesa akapiira” (meaning: “AIDS kills. Avoid multiple sex partners. Stick to one person or love carefully and faithfully. If you cannot abstain, or love faithfully, always use a condom consistently and correctly.”). Rather than continue with high risk sex behaviors and die, my girlfriend and I decided to stick to one another until we got married.

The recollections by the participant highlight the simplicity with which new and complex concepts about HIV/AIDS were packaged and disseminated in the most effective language that resonated with the unique population targeted by the campaigners. Secondly, the statements indicate that indeed the targeted population was adapting to the recommended behavioral changes. That the participant and his girl friend postponed sexual intercourse until they had an HIV test is evidence that they had attained a degree of efficacy to deal with the risks associated with HIV/AIDS; ultimate death. A female participant number [6] in focus group number [4] held in Kampala who said she moved to Makerere university in Kampala in the early 1990s recalled:

Radio Uganda was no longer the only channel in the country disseminating HIV/AIDS messages. Many private commercial FM stations opened in Kampala and started live phone-in-talk shows and discussed everything about HIV/AIDS openly. The programs were very educative, interesting, participatory, and the guests and hosts were well informed, persuasive, and very friendly to young people. I regularly called in with my friends to ask questions about HIV transmission and how to care for AIDS patients without exposing myself to risk of infection. These programs together with stories about HIV/AIDS in newspapers and on television in Kampala helped to clarify many issues about the disease and enabled me to abstain from sex until I got married.

A male participant number [1] in a focus group number [3] held in Kampala who also said he moved to Makerere university in Kampala in the 1990s said,

The talk shows on the FM stations were very lively. Sometimes the guests on the programs gave personal testimonies on how they had adapted responsible sexual behaviors and had completed Doctoral degrees, got highly paying jobs and were happily married. The programs usually sparked off prolonged debates with my fellow students on

the many theories we had about HIV/AIDS. Although I am typically a “doubting Thomas” or skeptic and cynic, I was eventually persuaded to start using the “gumboots” as the condoms were called in campus slang to protect myself from infection. The “Engabo (meaning shield) or Protector” local brands of condoms became my daily companions. Having buried many relatives and seen many of my peer’s die of AIDS, I realized it was better to live than die and miss out on a better life in future.

The recollections by the two participants who actually attended university at the height of the epidemic in both Rakai, Kampala and other parts of the country provide a deeper insight into how the HIV/AIDS campaign was implemented using a multiplicity of media outlets focusing on different age groups in the population. Specifically, the reference to talk radio that enabled listeners to participate in the discussions and voice their fears, anxieties, and have their questions answered by experts and persuasive hosts created a conducive learning environment that helped sexually active individuals adapt the recommended strategies by behavioral interventionists.

In addition, the allocation of time and space on television and in newspapers to disseminate information and educate participants about the dangers of HIV/AIDS and how to protect themselves against infection enhanced the diffusion of new ideas in the community using alternative electronic media rather than relying on the old-fashioned government-owned radio Uganda. At the same time, giving condoms local brand names enhanced the adaptation process because users easily related to the names drawn from the local language and made the condom more of a local rather than a foreign product.

Participant number [6] in an all men focus group number [3] held in Kampala summed up the sentiments expressed by the other participants when he stated:

The multi-media health programs that encouraged sexually active and high risk groups to abstain from sex to be faithful to their partners or use condoms helped to cater for the interests of everybody including those who were already infected. Sex is a difficult thing to keep away from if you have started. However, those who got too scared to continue with sex like me abstained until marriage after my partner and I had an HIV negative test result and married.

The recollections by the participant point to a shift in the campaign strategy from a generalized audience to a more coordinated focused and audience-specific approach that targeted high risk and low risk groups by different intervention partners. The statements also highlight an increasing appreciation of the appeal in the intervention messages for participants to acknowledge the severity of the disease and make informed personal choices and decisions that ensured their protection from infection and subsequent death. Thus far, the observations by all the participants in this theme indicate that they were indeed persuaded to change and adapt the innovations diffused in their communities through all the available media.

Hence, the accounts by participants on how information on the control and prevention of HIV/AIDS was disseminated through a multiplicity of media networks to every participant support claims by Singh, Darroch and Bankole (2003); Green (2004) who assert that a key factor in the decline in prevalence of HIV in Uganda was the government's uniquely creative and strategic policy approach to enable non-state actors in their individually targeted messages about prevention, and specifically highlights the importance of the comprehensive approach implemented in the country. Singh et al. (2003) observe that the community was mobilized “using behavior change programs, emphasizing abstinence, be faithful, and condom use, or (A, B, & C) that resulted in Uganda making unparalleled progress in reversing its potentially catastrophic epidemic” (p. 5).

The accounts by the various participants on how the new ideas on HIV/AIDS reached them individually and collectively to a point of adapting them, are consistent with the diffusion of innovation (DOI) theory which suggests that the diffusion of an innovation occurs when the adoption of an idea, practice, or object spreads by communication through a multiplicity of channels to a targeted group or a community (Rogers, 1962, 1973, 1976, 1994; Rogers &

Kincaid, 1981; Baker & Rogers, 1998. The researchers explain that for innovations to be thoroughly diffused, the communication flow should comprise the mass media and filter down to the targeted group by word of mouth.

Rogers (1962, 1973, 1976, 1994), Rogers and Kincaid (1981), and Baker and Rogers (1998) add that for the innovation to be understood, targeted groups should discuss the innovations and may choose to adapt or reject them depending on their perceived relevance, simplicity to understand and adapt, their applicability to local conditions, and perceived benefits to the group. The researchers state that although adaptation may be gradual at the beginning, more and more people adapt the innovations when they start observing their benefits to early adapters then the rate of adaptation increases until a critical mass is achieved before the process levels out.

Thus, the description of the massive campaign by the participants, the diversity of channels through which the information about HIV/AIDS reached them, the simplicity with which it was conveyed, and their subsequent discussion of the new concepts, supports the concepts in the diffusion of innovations theory as advanced by Rogers (1962, 1973, 1976, 1994), Rogers and Kincaid (1981), and Baker and Rogers (1998). Similarly, the eventual adaptation of new safe sex practices like abstinence, faithfulness to one partner, and the use of condoms were perceived by the participants as relevant and advantageous because they were better alternatives to death.

In addition, the data are in concurrence with findings by Elford et al. (2002) who report that unless targeted sections of a population are afforded enough time to understand, internalize and relate the innovations to their local conditions, adaptation will hardly take place. Thus, it is not surprising that it took almost ten years in Uganda for any form of adaptation to behavioral

interventions was reported in 1995 (UAC, 2003; MRC, 1998; UNAIDS, 1998a, 1998b, 2000, 2001; WHO, 2003; MOH, 2003) (see also Table 1).

This study was also interested in finding out exactly how sexually active men and women then aged between 17 and 27 years then living in Rakai district by 1982 survived the epidemic and are still alive today. When asked to explain how they handled any sexual temptation and survived, participant number [4] in focus group number [5] held in Rakai district which was exclusively attended by men recalled:

Because most of my age mates had died and some were sick, I was under constant surveillance by my family members and some people in the community to detect whether I was complying with the new sex norms recommended by HIV/AIDS educators. My moves and those of my age mates in the village were monitored by the suspicious public whose members would discreetly warn you against “sleeping with that man or that woman because he or she may already be dead.” We were under a lot of pressure to act and behave correctly in the eyes of a watchful and wary community. “Embulire teffa yonna” (meaning, “Once warned, always act cautiously”). We would always be cautioned and reminded with that local proverb.

The statements imply that the HIV/AIDS epidemic affected the entire community and that controlling and preventing its spread had become a communal undertaking. Sonja and Flora (2000) and Airhihenbuwa and Obregon (2000) observe that in collectivistic cultures like those in Africa, Latin America, and Asia, the well-being of individuals is a community responsibility which voluntarily assumes the role of guardian and moderating influence on the social conduct of all its members. A woman participant number [4] who attended an exclusively female focus group number [4] held in Kampala said:

I was 22 years when Silliimu was identified in my village. When I learned that it was caused by a virus through sex, I simply “buckled-up” and ignored all advances from men. But I could not abstain for ever. Nature is like that. “Ekitalya mmere okiwa ki” (meaning “If you have something that does not eat food, what do you give it”)? Ten years later, I found a man who was ready to deliver me from the nightmare and was prepared to undergo an HIV test. Both of us were negative and got married immediately.

The statement by the woman participant indicates that she had to abide by the new social norms and expectations that prevailed in the community as a result of the HIV/AIDS campaign. That she had to endure abstinence until she found a man she “immediately” married after an HIV blood test, demonstrates the amount of pressure placed on sexually active individuals by the new sex norms vigorously enforced by a vigilant society. Crossley (2004) and Crooks (2001) observe that in health campaigns, societies are very critical in holding individuals accountable for their actions and almost always compel them to negotiate social obligations to maintain and restore face. Another participant number [3] who attended focus group number [5] held in Rakai district recalled how he survived to the present day:

I lost my parents, and all my brothers and sisters. Almost my entire family was wiped out. I look after my children and other orphans who need school fees, food, and medical care. I took up the responsibility of looking after my family when I had just married at 18 years. If I risked my life and died, who would have cared for the children? Secondly, age is not on my side. Sexual adventures are no longer fashionable and given the risks it involves, it is not the exciting and adventurous game of the past. I think that partly explains why a few others and I who changed their ways survived.

Participant number [2] who attended focus group number [1] held in Rakai district shared why he has also survived to the present day:

I divorced my wife after proving that she had an extra marital relationship with another man. I had already lost seven brothers and sisters to that terrible disease. I had to make a choice between life and death. I chose life. After I divorced my wife, I never remarried. I have looked after my three children and all the 24 orphans left behind by my siblings. Every time I look at the graves of my relatives, see my children, nieces and nephews I become more determined to stay a bachelor and alive. I have lived like this for 15 years.

The recollections by the participants indicate that besides the HIV/AIDS education and prevention campaign, the social responsibilities they shouldered as a result of the death of their relatives was a strong inducement to change their sexual behaviors to ensure the continuity of the life cycle. Green (2004) observed that living in a community of high HIV/ AIDS prevalence with

funerals for family and friends held several times a week, abstinence and faithfulness are attractive alternatives to death.

A female participant number [5] who was already in a polygamous marriage at the advent of the epidemic and attended focus group number [6] held in Rakai district said:

Since we were already three wives married to one man, we became sisters each catering for the interest of the other. We always sat down with our husband and freely talked about how to preserve our lives and raise our children and grandchildren. Fortunately, our husband remained loyal to us and that is how we have survived. Our local Imam had four wives and they are still together. He always gave us advice as a family and we looked up to him as our model. My co-wife and I are now local health educators and counselors (modern “Ssengas” or Aunties) to the young people in our sub-county.

The revelation by the participant that she has survived in a stable polygamous marriage as a result of grounding their marriage in religious values shows that if followed strictly, religion can be a source of strength and endurance in relationship. Indeed, Gray et al. (2000) found that there was relative stability among Muslim couples in Rakai district compared to their Christian counterparts on top of recording fewer cases of HIV/AIDS prevalence among circumcised Muslim men.

On the other hand, participant number [1] in a focus group number [2] held in Rakai district observed:

I attended several seminars and workshops for members of my age group in Rakai and neighboring Masaka districts where facilitators used “Bogaya” (meaning “A Banana”) to demonstrate to us how to put on a condom, use it and how to remove it safely without endangering ourselves. Since I could not abstain and I sometimes got tempted, I never “went live” (meaning “never had sex without a condom”). I have always used “obupiira” (meaning “condoms”) correctly and consistently. Actually, ever since, I use two condoms for every adventure for full proof protection!

The recollections by the participant demonstrate that there were a variety of strategies used by community members to survive the epidemic as long as they were applied correctly and consistently. The option to use a condom and not to abstain or be faithful to one partner

highlights the need for behavioral interventionists to emphasize all protection strategies equally without privileging one over the other. Indeed, several participants confessed that it is only God's mercy that has spared them up to the present day. Participant number [5] in a focus group number [2] held in Kampala recalled:

After school, I dropped my first boyfriend and got another one and got married to him without testing ourselves for HIV/AIDS. If any of us was infected, we would now be part of the statistics. We just ignored the advice to go for the test before marriage because we were already doing it!

A male participant number [2] in the same focus group number [2] held in Kampala added:

One time I had a bottle too many and I only sobered up in the morning in the same bed with my female workmate! It is five years since then but each time I see any “Kyaana” (meaning “Beautiful woman or girl”), I remember that incident and I become frigid and cannot get my “member” to salute!

The stories from the two participants echoed throughout the ten focus groups held in both Rakai and Kampala districts. But more importantly, the accounts show the difficulties with health campaigns that target changes in sexual practices and behaviors that are not only sensitive but also secret and closed to public scrutiny. Lombardo (2004) argues that because of the running conflict between individual perceptions and the envisaged health norms poses the greatest challenge to behavioral interventionists and health communication research because there is always a need to establish a common ground between the parallel needs to avoid a boomerang effect from the campaign.

The submissions by the participants on how they dealt with challenges in their sex lives during the last 23 years since the advent of HIV/AIDS in Rakai district in 1982 reinforce concepts advanced in the symbolic interaction theory developed by George Herbert Mead as cited by Morris (1934). The theory suggests that human actions are impulsive and spontaneous unless moderated by external factors. The implication is that most human action driven by the

“I” is very fluid unless moderated by role models in society or customs, norms, values, and culture which are represented by “Me.”

Stories shared by participants that they had to change their high risk sexual behaviors and either abstain from sex completely or wait until marriage, or those that practiced monogamy (faithfulness) because of the new social pressures imposed on them by HIV/AIDS, strengthen the arguments advanced in symbolic interactionism as cited by Morris (1934) that a network of social norms, values, and attitudes stabilize or provide guidance to erratic human actions. For example, the adaptation of the condom by participants as a new invention to protect themselves against HIV infection and subsequent death, confirms the suggestion in the theory that new cultural norms, practices, and attitudes can regulate some erratic actions of individuals to comply with acceptable social behavior.

The use of the newly created language of HIV/AIDS to reflect on their own lives, adapt the appropriate social skills and engage in social discourse enhanced their self images in their respective communities as suggested in the theory. For example, data show that participants were able to use the new vocabulary on HIV/AIDS to competently communicate and function in the changed social environment. In addition, statements by the participants that they had to comply with new responsible sexual behaviors as was expected of them by right thinking members of society validate Mead's concept of role playing. That participants had to adapt the new sex norms in order to maintain the cycle of life by raising their children, look after orphans, become role models in society, and care for the sick corresponds with the role playing concept as advanced in the theory.

Thus, the continuous process of interpretation and assigning of shared meanings and symbols to the new HIV/AIDS concepts by participants as reflected in the data discussed in this

theme reinforces the answer to the first research question which sought to understand how this age group adapted local meanings and definitions to communicate about HIV/AIDS.

Furthermore, the description by participants of how the HIV/AIDS campaign was implemented in their respective localities to enable them receive the new information and adapt it to cope with the epidemic is evidence that the globalization process was well underway. That data bolster the answer to the second research question which was interested in ascertaining how the global HIV/AIDS communication campaign was transformed in the local environment, understood and applied in the daily lives of a section of the Ugandan population now aged between 40 to 50 years then living in Rakai district by 1982.

At the same time, the adaptation of new strategies by individuals and the community to competently function in an HIV/AIDS infested social landscape and ensure continuity of life respectively, is evidence that the process of acculturation was in progress. Hence, the data partly answered the third research question which sought to understand how Ugandans now aged between 40 to 50 years then living in Rakai district 23 years ago integrated the changes brought about by their encounter with the HIV/AIDS epidemic in their mainstream culture.

Transformation and Integration

The fourth theme that emerged from the data was labeled: “Transformation and integration.” This theme was constructed from data generated during discussions that clustered around critical events that highlighted the mainstreaming phase of HIV/AIDS in community activities and in the public sector (See Table 1). Statements that feature in this theme demonstrate how individuals, communities and government, simultaneously took practical steps to localize the global HIV/AIDS campaign by transforming indigenous institutions to control and prevent the spread of the epidemic. The theme illustrates a fundamental change in the attitudes of

the community and individuals towards HIV/AIDS and how social resources were invested to provide care and support to the infected and affected. The statements by participants also depict how communities modified their social institutions by adapting and integrating new roles and norms to cope with the disease.

Furthermore, the theme describes how the integration of the new HIV/AIDS norms into the mainstream culture of the participants and the greater society support the position assumed by the present study that through communication, both glocalization and acculturation of HIV/AIDS is well underway among the section of the Ugandan population who were sexually active and living in Rakai district by 1982. The theme breaks up into two categories labeled: Transformation and Destigmatization, Pragmatism and integration.

Transformation and Destigmatization

This category demonstrates how individuals and communities increasingly came to terms with the existence of the unbidden HIV/AIDS epidemic as a result of the pervasive communication campaign. Statements in this category indicate how individuals and communities disbanded dysfunctional cultural values, customs, and practices by adapting and integrating new social norms, life skills, and attitudes to mitigate the snowballing impact of the epidemic in their midst.

Across all the ten focus groups, participants no longer referred to AIDS as a strange disease but as a water hyacinth. The following statement by participant number [5] in focus group number [2] held in Kampala mimicked the sentiments made by other participants on the same subject. He observed:

AIDS is like “Ekiddo. Kyajja kasirise nekitwetolola. Naye, kati twamumanyiira nga ekiddo kuba talina jalaga. Abalwadde tebalina musango. Tulina kubalabiliira so ssi kubasosola.” (Meaning: “AIDS is like the exotic and resilient water hyacinth. It came

quietly and surrounded us. We are now used to it because it is going nowhere. Patients are not guilty. We need to care for them not to stigmatize them.”).

Participant number [1] in focus group number [2] held in Rakai district echoed the observations of the other participants regarding their shift in perception towards HIV/AIDS and People Living With AIDS (PLWA), when he added:

AIDS is now part of our lives. Experience and education have taught us how to live with it. There is hardly any family or village that has not come face to face with AIDS. We have to help each other. AIDS IS no longer a personal but a national tragedy.

The statements from the two participants highlight a reasonable degree of awareness and efficacy that enabled and motivated individuals and the community to reconceptualize HIV/AIDS as a communal responsibility by taking practical steps to collectively care and support both the infected and affected. In addition, while respondents perceived HIV/AIDS as synonymous with death during its initial stages, their accounts in this category reflect a remarkable shift in their perception of the disease and attitude towards People Living With AIDS. Rather than equating AIDS to death and condemning the patients to their ultimate deaths, participants now describe HIV/AIDS as a normal feature in their daily lives and PLWA as faultless members of society who should not be stigmatized but supported to live longer and quality lives.

The foregoing data support claims by Museveni (1998), Okware et al. (2001), and Green (2004) who state that a community-oriented, timely, and consistent awareness HIV/AIDS campaign backed by unwavering political support yields changes in high risk sexual behavior and attitudes towards patients. They argue that Uganda’s gains in reversing stigma against HIV/AIDS was a result of enlisting multiple behavioral interventionists who disseminated focused messages to general and specific population groups using formal and personal communication networks.

Elaborating on the extent to which HIV/AIDS had pervaded social discourse in their respective communities, participants reported that HIV/AIDS had become an issue of public concern and was openly discussed in society to alert individuals about its dangers. Participant [4] in focus group number [2] held in Rakai district stated:

It is not a taboo to talk about AIDS anymore. We freely and openly talk about siliimu to increase awareness about its danger and reduce infections...AIDS patients and its other effects like orphans are visible everywhere... we cannot hide it, hide from it or shun it anymore.

Participant number [6] in focus group number [2] held in Kampala said,

In most workplaces, schools, and public places walls of stigma have broken down. Demonizing HIV/AIDS and stigmatizing AIDS patients has greatly declined compared to the 1980s... with the new wonder drugs, AIDS is no longer a death sentence.... patients are living purposeful and longer lives, have become more productive, and cannot even be singled out from other people for discrimination.

The statements by the participants indicate that communities had come to a conclusive reality that AIDS was a dangerous disease whose consequences had to be constantly exposed to save the vulnerable. In addition, the statements indicate that the communities had collectively resolved that stemming the spread of HIV/AIDS and mitigating its grave impact demanded a new approach that would create a credible and sustainable dialogue to foster social change.

Thus, it is logical to assume that the severity of the generalized epidemic compelled the community to participate in a candid conversation about the disease rather than perpetuate the futile victimization of AIDS patients. The observations also imply that even before the availability of the Anti Retro Viral (ARV) therapy, destigmatization of HIV and AIDS patients was already underway as a result of the cumulative impact of the epidemic and the HIV/AIDS control and prevention campaign. However, the data show that accessibility to ART drugs by AIDS patients boosted their quality of life, self esteem, and enhanced the destigmatization process. The restoration of hope in life as a result of the accessibility to the new therapy also

strongly emerges from the data as the drugs are depicted as having provided a new lease of life to patients.

The openness with which HIV/AIDS was discussed and the gradual change from the negative to a positive attitude towards AIDS patients was no accident because the epidemic had scarred everybody and nobody could claim any form of insulation from it (Bond & Vincent, 1991, 1997; Obbo, 1991; Kolsrud et al., 1989; Alun & Tumwekwase, 2001). In addition, the comprehensive and sustained communication campaign by government and a network of local and international organizations that demystified HIV transmission as preventable if appropriate precautions are taken, inspired individuals and communities to destigmatize people living with AIDS (Musinguzi, 1996; Hogle, 2002; Singh et al., 2004).

The data are also consistent with claims by Crossley (2004), Crooks (2001), and Lombardo (2004) who extended the symbolic interaction theory in health communication research and found that perceptions and attitudes of individuals and the multiple roles they play are largely shaped by the changing social norms in a community. The researchers note that for individuals to escape sanctions from the community, they almost always abide by the prescribed universal behavior and model their social identity along the prevailing acceptable health norms and values. The current study was also interested in finding evidence of how the HIV/AIDS communication campaign had resulted in the modification of indigenous institutions to adapt new roles and integrate new norms to empower sexually active individuals to competently function in a generalized epidemic environment. Participants noted that the advent of the disease caused widespread changes in several Ganda customs, beliefs, attitudes, practices, and norms. For example, participant number [3] in focus group number [6] exclusively attended by women in Rakai district said:

In my sub county, NGO representatives trained several women volunteers of good social standing in villages to provide sex education to teenage girls including preserving their virginity and preparing them for marriage by advising them on labia elongation. These women advised us against high risk sexual behaviors that could result into pregnancy, HIV infection, and to promptly report sexually transmitted diseases for treatment.

Participant number [2] in the same focus group number [6] held in Rakai district added:

The women volunteers have become so popular and are now well established in villages as “Ssengas” (meaning “Aunties”) locally providing condoms, counseling both teenage girls, boys, and married couples to go for HIV testing. The women together with some men visit orphanages and AIDS patients in their homes to provide them with care, emotional support and counseling.

The comments by the participants illustrate how a community transformed and recreated an indigenous institution by assigning it a new status and more roles to provide HIV/AIDS education and counseling to susceptible individuals in society. The transformation enabled community members to benefit from a reconstructed institution to protect them against unwanted pregnancy, HIV infection and competently manage the impact of the epidemic.

In tradition Ganda culture, the institution of “Ssenga” (meaning “Aunt” or father’s sister) is held in the highest of esteem and is used to educate and sensitize teenage girls on matters of sex and sexuality to ensure satisfactory consummation of marital relationships. To the extent that village women were selected to provide sex education, counseling services to both boys and girls, married couples, orphans, AIDS patients, and locally distribute condoms, demonstrates the readiness of the community to accept and integrate change to cope with the epidemic.

The data are in concurrence with findings by Muyinda et al. (2004) who state that the transformation of the traditional “Ssenga” institution in Buganda into “Modern Ssengas” meaning “Modern Aunties” (p. 5) was a logical and practical response to the impact of the epidemic in the worst hit areas like Rakai and neighboring Masaka district. Muyinda et al (2004) argue that because the modern ssengas were also charged with the traditional tasks of specifically

advising teenage girls on how to elongate their labia, culturally believed to be a pathway to safe motherhood and a safety net against sex dissatisfaction to prospective husbands, quickly gained influence and confidence in the community. The authors add that the “Modern Ssengas” gradually became effective sex educators and counselors in the community and their roles were extended to cover churches and schools.

Thus, the diversification and modernization of the roles of the Ssenga institution to engage in the campaign against HIV/AIDS illustrates the extent to which the community transformed indigenous institutions and reinvested their social capital to systematize new structures to stem the tide of the epidemic. Muyinda, et al (2004) state that currently, “modern Ssengas” are part and parcel of the HIV/AIDS education and prevention campaign in Uganda through a multiplicity of media outlets” (p. 8).

On the other hand, Seeley et al. (199) and Campbell and Rader (1995) observe that the training of local villagers in the absence of relatives to provide care, counsel, and emotionally support the infected, reflects the big vacuum that had been created by the HIV/AIDS epidemic in the traditional extended family system. The authors note that since the epidemic had become a community concern and responsibility, the use of local villagers as counselors was not only culturally sensitive but also the best available alternative to the beleaguered extended family.

The Social Sciences Research Council (1954), Graves (1967), and Smith (1969) state that acculturation at a population level should be considered as transformation to social institutions, economic structures, and political systems of the groups involved in the acculturation process. Unlike previous research on acculturation (e.g. Marks et al., 1998; Tschann et al., 1993; Schneider, 2004) which exclusively focused on negative health outcomes as a result of cross-

cultural contact between groups of people, the present exploratory study investigated the encounter between a section of the Ugandan population and the HIV/AIDS phenomena.

The present study found evidence that impingement on a community of people by social phenomena results in the reconfiguration of the community's indigenous cultural institutions to cope with the new social landscape. Thus, findings in the present study demonstrate that an acculturation process at a population level can be triggered off by a health malady or an epidemic when biological forces encroach on cultural environments resulting in a destabilization of the social systems.

Pragmatism and Integration

The second category constructed from the data was labeled "Pragmatism and integration." Statements in this category reflect a generalized pragmatism adapted by individuals and communities in response to the cumulative impact of the epidemic in their midst. Statements by participants demonstrate how they readily took practical decision to maintain a delicate balance between protecting their lives and preserving their culture in the face of the onslaught from the HIV/AIDS epidemic. The adaptation and integration of new social traits are explained by participants as inevitable life saving strategies to survive the epidemic.

Responding to questions seeking to identify new social norms, customs, practices and habits that have been integrated as a result of the HIV/AIDS epidemic, participant number [4] in focus group number [5] exclusively attended by men in Rakai district echoed the sentiments of the male participants:

When the Rakai project was established, the counselors advised us to get circumcised to reduce the chances of catching HIV. Although they originally targeted youths, many of my friends and I have been circumcised... you know it is not a Ganda custom and Catholics do not circumcise but I did to escape the virus.

Participant number [2] in focus group number [3] held in Kampala attended by only men stated,

The health educators helped us but also created problems for us...You know, there were so many rumors. Many of my uncircumcised Christian agemates lost their wives to Muslims and circumcised boys...Women claimed that sex educators told them that circumcised men were cleaner, did not spread AIDS, and that they were better performers! So, we had to circumcise and escape HIV infection and protect our marriages.

The recollections coincide with findings by Gray, Kiwanuka, Quinn, Sewankambo, Serwadda, Wabwire-Mangen, et al. (2000) who states that while Muslim men in Rakai district had a lower incidence of HIV infection and mortality, they seemed to maintain stable marriages than their Christian counterparts. Hence, the adaptation of circumcision as a new norm to minimize the infection with HIV reflects the level of flexibility the respondents had attained in coping with the epidemic. The statements are also consistent with the contention by Graves (1967) and Smith (1969) who observe that the ability by individuals to competently function in a changed cultural environment is evidence that psychological adaptation, an outcome of an acculturation process, has taken place.

Responding to questions demanding whether there had been any changes in traditions relating to deaths and burial ceremonies since the onset of HIV/AIDS, participants reported that AIDS-related deaths had become so common that communities responded by changing some of the funeral rites to balance between continuity of life for the living and treatment of the dead with the dignity and respect they deserved under the changed circumstances.

For example, four participants in focus group number [1] held in Rakai district shared their experiences in the following dialogue to underscore the changes that had occurred as a result of frequent deaths from AIDS.

Participant number [1] said:

...These days, the bereaved no longer cut off their hair to mourn the dead as it was in the past. Frequent deaths of close relatives within a short time made it practically unreasonable to expect bereaved family members to shave off their hair simply to abide by burial norms. It simply stopped.

Participant number [2] observed:

With time, villagers started going to their gardens in the morning to tend to their crops and go for burials in the afternoon. Villagers no longer spend three days and nights on mourning vigils because if they did, they would starve to death.

Participant number [3] stated:

Today, some mourners no longer give “mabugo” (meaning “cash donations”) during funerals claiming they would run bankrupt if they were to make donations for every dead person in the village. Secondly, grave diggers in villages demand money, food, and beer to do the job. In the past, it was a voluntary community service.

Participant number [4] stated:

These days, carpenters freely display coffins and bark-cloths along village paths because they know that a ready market exists as a result of frequent deaths. If they had done that in the past, they would be called witches.

The dialogue by the participants indicate that confronted with new realities, cultures become dynamic and not immutable (Obbo, 1991). The dialogue demonstrates that out of necessity, the threat from HIV/AIDS compelled community members to adjust their ways of life to optimally function within the new environment and survive the epidemic. The abandonment of some traditional burial customs considered detrimental to the survival of the community and the adaptation of new funeral practices and attitudes towards death is evidence that HIV/AIDS had resulted in the reshaping of the cultural landscape among the participants.

The cultural changes enumerated by the respondents clearly point to a form of behavioral and psychological acculturation as conceived by Berry, 1980, 1992, 1995; Berry et al., 1990; Ward & Kennedy, 1993; Rogler et al., 1991) who posit that the two dimensions of acculturation

involve the adaptation of both recognizable human behavior and less observable norms, values and attitudes that fundamentally differ from the original core cultural values.

Although statements by participants from the urban Kampala focus groups reflect relatively sophisticated new trends, they nevertheless highlight changes in attitudes towards deaths and traditional burial customs and ceremonies. Their accounts represent newly evolved conventions that have come to symbolize elitist and urbanized funeral etiquette like hiring funeral services, abiding by a dress code, and scheduling time spent at burials.

While participants from both rural Rakai and urban Kampala exude a rational approach to death and funerals, the degree of their exuberance reflects the disparities between the two changed lifestyles. Statements by participants in the Kampala focus groups emphasize these variations and underscore the new norms that have come to be associated with burial ceremonies among the urbanized elite.

Participant number [6] in focus group number [2] held in Kampala observed:

Deaths from AIDS no longer surprise us. We expect and prepare for them long before they happen. If one dies, we just do the needful and go ahead with normal life. The only deaths that shock us are those that are caused by accidents, and other unknown causes.

Participant number [3] in a focus group number [1] held in Kampala added:

Shopkeepers stock black pants, shirts, suits, textiles or silk materials for the bereaved to buy as soon as they lose their relatives. In the past, it was not a big deal to dress in black but these days, all mourners endeavor to dress in black in order to appear conventional.

A female participant number [2] in a focus group number [4] held in Kampala which was only attended by women said:

These days, if a relatively famous, rich, or educated person dies in Kampala, relatives, friends, and employers hire funeral services for about two million shillings (equivalent to USD \$1200) to cover all funeral rites including weeping for the dead! Journeys by mourners from Kampala to and from the villages for burials in hired omnibuses, are opportunity for binge drinking, merry making, and touring the countryside. They leave immediately after the body has been put in the grave and eating the “fresh and tasty rural

food” prepared for them by villagers in appreciation for accompanying the deceased. Kampala mourners do not even have time to condole with the bereaved because they must return to the city for work... In any case, the only person they knew was the deceased.

The foregoing statements by participants from Kampala focus groups reflect a sharp contrast between the lifestyles of the urban and rural participants in this study. While the changes in the social lives of the participants in the rural Rakai district are economically modest and less elaborate, HIV/AIDS-induced changes among the city residents are more drastic, affluent, and serve to accentuate the education and economic gap between the two communities. In addition, the differences in the degree of adjustment and adaptation to new norms between the two communities suggest that urbanized and educated individuals are more exposed to foreign influences and are highly likely to adapt them more expeditiously than their rural and poor counterparts.

Bond and Vincent (1991, 1997), Museveni (1991), Twaddle and Hansen (1998), and Alun and Tumwekwase (2001) state that while the HIV/AIDS epidemic has killed the most productive members of the rural population on whom the agricultural economy revolved, survivors migrated to urban areas to escape the scourge and thus widening the social and economic rift between the two communities. The authors further observe that the economic disparities yielded variations in the response to the epidemic from the two communities and exacerbated the levels of cultural change between them.

The data are also in concurrence with insights by globalization researchers (Randeria, 2003; Roudometof, 2005; Ritzer, 2003; Randeria, 2003) who postulate that external forces on indigenous cultures consistently elevate the economic and social stature of urban populations over the rural people and perpetuate a hegemonic structure that oppresses the underprivileged.

On the other hand, while describing other changes that they have adapted in their ordinary lives to protect themselves against HIV infection from contaminated blood and to ensure healthy lives, participants in both Rakai and Kampala sounded unanimous in their precautionary measures. In addition, across all focus groups, participants noted that there have been changes adapted in courtship and marriage to ensure that neither of the couples spreads HIV to the other.

Participant number [3] in an exclusively male focus group number [5] held in Rakai district observed: “Even traditional doctors now demand that clients come with their own razor blades for skin incision while circumcision is now mostly done in clinics with sterilized equipment.”

Participant number [7] in focus group number [2] held in Kampala added: “Today, parents and churches demand an HIV blood test with a negative result before formal introductions and holy matrimony for young partners are approved.”

Participant number [5] in focus group number [6] attended by only women in Rakai echoed the sentiments expressed by others across the ten focus groups: “Expectant mothers buy gloves and other disposables needed while in labor and all patients in clinics and hospitals buy their own syringes. Use of sterilized needles has almost died out.”

The statements indicate that both rural and urban participants had adapted and integrated the new social skills introduced in their lives to enable them avoid infection with HIV. The statements show that the new life skills were a direct response to the onset of HIV/AIDS and never existed in their lives before. However, despite the similarities in the foregoing social skills among participants, healthy living behaviors contrasted sharply between the rural and city participants. While the Kampala participants adapted a middle class healthy regime to build

immunity to any infection, the rural participants were restricted to the basic survival skills disseminated in the HIV/AIDS control and prevention campaign.

Participant number [2] in focus group number [2] held in Kampala who also had a professional job in Kampala captured the totality of the change in the health lifestyles of most elite and city participants. He observed:

Unlike in the past, my peers and I are very mindful of their health and quick to seek medical help whenever we feel unwell. We seek jobs with full health insurance, regularly get medical check ups, many of us have stopped smoking, others have joined the mushrooming sports clubs with gyms, yoga, saunas, massage, and other activities that keep bodies healthy and resistant to disease.

A female participant number [5] in the same focus group number [2] held in Kampala added:

These days, urbanites feed very well and healthy to develop immunity against all common infections that could trigger the onset of AIDS. They have a common saying that goes, “Kaneliise bulungi nwanise akawuka nga tekannakuba wansi” (meaning “let me feed well and fight the virus before it puts me down”).

The statements underscore the emerging healthy consciousness among the city participants as a direct response to the onset of the HIV/AIDS epidemic. Because they have access to recreation facilities and have acquired knowledge about how to guard against opportunistic infections, they have developed the efficacy of functioning competently in a changed health landscape. However, lack of similar recreation facilities and the benefit of a middle class environment in the rural Rakai district, further accentuate the disparities in opportunities to attain equitable levels of efficacy between the rural and city participants.

The changes recounted in the health behaviors of the participants and the communities in which they live reinforce the concepts in the diffusion of innovations theory (Rogers, 1962, 1973, 1976, 1994; Rogers & Kincaid, 1981; Baker & Rogers, 1998). The current study applied the concepts in the theory to understand how the spread of new ideas through a multiplicity of

communication networks can result into changes in health lifestyles of communities. The data provide evidence that the spread of new ideas on health resulted in a new health consciousness among the participants.

However, despite the discrepancies in the health facilities and consciousness, there is a remarkable similarity in the contemporary language of HIV/AIDS among the rural and urban participants. Previous research on the language of AIDS in rural and urban Uganda had found clear distinctions between the two communities largely because the epidemic was still restricted to the rural Rakai district and had not spread throughout the country (Obbo, 1991).

The researcher found that the language of AIDS in rural Rakai district was more prolific, ingenuous and creative while the language in urban areas lacked profound imagination and credulity. At the time, the language of AIDS in rural Rakai was that of anger and bitterness. The feelings in Rakai then were that they were shouldering an unfair burden of the epidemic compared to the rest of the country.

However, because the HIV/AIDS epidemic has become generalized, education and prevention messages almost standardized and disseminated through similar networks using the same language, linguistic similarities have emerged across the two communities. Changes that are underscored by the contemporary language of AIDS among the rural Rakai and Kampala city participants cut across all the ten focus groups interviewed for this study. The changes highlight the shared meanings and attitudes towards illness and death that have evolved over the 23 years of HIV/AIDS in Uganda.

Participant number [1] in focus group number [3] held in Rakai district graphically described the new understanding of sickness and illness as expressed by other participants across all the focus groups. He said:

If somebody is sick and you ask: “What is he/she suffering from?” If the person is suffering from such ailments like a cold, malaria, stomach ache, or any other infection, the ailment is directly named. However, if there is suspicion that the individual is suffering from ailments similar to AIDS symptoms, then that person “alabika mulwadde” implying “the individual has AIDS.

Explaining how the communities subtly distinguish between AIDS–related deaths from other deaths, participant number [1] in focus group number [4] held in Kampala stated: “If one dies from what society clearly believes are AIDS symptoms, then that individual has died of ‘obwajja oba obulwadde’ (meaning ‘that which came’ or ‘the disease’).”

Participant number [2] in focus group number [4] held in Kampala added:

In more friendly and humorous environments, if a person dies of AIDS and those not in the know seek to find out the cause of death, they receive such responses as; “Iiii!! Awo babuliizaawo” (meaning “Must you query the obvious”)!

The statements imply that HIV/AIDS is now “the disease” of the moment that routinely kills while any other ailments are simply named and deaths caused by such named diseases are qualified or clearly delineated. In addition, the exclamation in the observation heavily loaded paralanguage indicating that death from AIDS is too obvious to warrant any question and can be shrugged off as normal and ordinary.

However, that understanding of death is qualified. Untimely deaths from other extraordinary causes like accidents, robberies, and others still draw the spontaneous and deserved emotions. Participant number [1] in focus group number [3] held in Rakai district clarified: “If a person dies of a motor accident or other type of death, reactions are markedly different from those expressed if one dies of AIDS.”

The emergency of a shared language of AIDS as a result of the continuous interactive and interpretive human activity about HIV/AIDS over the last 23years of the epidemic is consistent with the symbolic interaction theory developed by George Herbert Mead as cited by Morris

(1934). The data discussed in this category highlight the widespread cultural changes experienced by the participants and is evidence that the integration of HIV/AIDS in their lives is already underway.

The data are consistent with claims by (Redfield et al., 1936; Social Science Research Council, 1954; Graves, 1967; Smith, 1969; Berry, 1980; Kim, 1988) who describe integration as the most desirable outcome of the acculturation process because it involves the loss of some cultural traits and adaptation of new cultural attributes that enable individuals to competently negotiate the new and changed cultural environment. Thus, the data negate the other three outcomes of acculturation; assimilation, separation, and marginalization neither of which sufficiently explain the experiences as narrated by the participants.

Therefore, “participants” adaptation of new and observable social traits like the new language of HIV/AIDS, the dress code, eating habits, life skills and practices, other overt behaviors to cope with the generalized epidemic is evidence that acculturation had taken place. The findings are consistent with previous acculturation research which posited that acculturation is a process of cultural change resulting from a continuous contact between two different cultures (Redfield et al., 1936; Social Science Research Council, 1954; Kim, 1988).

The data are also in tandem with the contention by Berry (1980) who states that acculturation at a behavioral dimension is associated with acquiring new and recognizable cultural traits that enable acculturating individuals to cope in a changed cultural environment. Similarly, participants’ adaptation of new norms and values like circumcision, destigmatization of AIDS patients, a new consciousness about health living, pragmatic attitudes about deaths, new beliefs and customs with regard to burial ceremonies and funeral rites is evidence that

psychological acculturation and the process of glocalization of the global HIV/AIDS pandemic had taken place.

Thus, the data discussed in this theme shows the continuous and dynamic process of interpreting and assigning of shared meanings and symbols to HIV/AIDS within the changing contexts in which the participants live. This pattern of appropriating meanings and definitions to HIV/AIDS reinforces the answer to the first research question which sought to understand how this age group adapted local meanings and definitions within their cultural environments to communicate about HIV/AIDS.

In addition, the pragmatic approach assumed by the participants to adapt new life skills, norms, practices, and lifestyles as a result of the exposure to the global HIV/AIDS campaign is evidence that the localization of the pandemic is clearly underway. Hence, the data in this theme reinforce the answer to the second research question which was interested in ascertaining how the global HIV/AIDS communication campaign was transformed in the local environment to be understood by a section of the Ugandan population now aged between 40 to 50 years then living in Rakai district by 1982.

Finally, the adaptation and integration of recognizable and less observable cultural norms, values, habits, practices, customs, attitudes and perceptions by the participants in their day-to-day lives demonstrates that acculturation at both individual and population levels is already underway as a result of communication. Thus, the data in this theme bolster the answer to the third research question which sought to understand how Ugandans now aged between 40 to 50 years then living in Rakai district 23 years ago integrated the changes brought about by HIV/AIDS in their mainstream culture.

Institutionalization and Backlash

The fifth and last theme constructed from the data was labeled: “Institutionalization and backlash.” Like with the previous theme data for this theme emerged during discussions that centered on events that marked the mainstreaming phase of HIV/AIDS in community activities and in the public sector (see Table 1). Although most of the data in this theme are contemporary, some of it dates back to the 23-year history of the HIV/AIDS epidemic in Uganda as experienced by the participants.

Statements that highlight this theme reference a deliberate policy by the government of Uganda to systematize and mainstream HIV/AIDS in community life and in the public sector. The statements also demonstrate how individuals and communities joined hands with government and the international agencies to ensure the consistent visibility and omnipresence of HIV/AIDS control messages in daily life as a constant reminder to the population that the AIDS crisis still endures.

However, recollections in the theme also expose the underlying setbacks and contradictions that have characterized the HIV/AIDS campaign and history in the country. In addition, the statements depict the boomerang effects of the campaign on the culture of the participants and on the greater Ugandan society. The theme is divided into two categories labeled; “Institutionalization and visibility” and “The AIDS paradox and campaign backlash.”

The Institutionalization and Visibility of AIDS

This category highlights efforts by the government of Uganda and the community to consolidate the gains made in the HIV/AIDS control and prevention campaign by institutionalizing HIV/AIDS awareness strategies in all community and public activities. Statements in this category demonstrate how government pursued policies that empowered

People Living With AIDS to participate in the formulation and implementation of HIV/AIDS policies in the country.

Observations in this category also highlight the proliferation and integration of HIV/AIDS activities in community and public life all over the country to ensure that the population was consistently reminded that the HIV/AIDS scourge still loomed.

Participant number [6] in focus group number [3] held in Kampala who possessed a graduate degree and held a white collar job in the capital described the institutionalization of HIV/AIDS in the public sector when he stated:

People Living With AIDS are now actively involved at all policy and implementation levels in the country. PLWA are also represented on the board of the Uganda AIDS Commission and are involved in the formulation of the national policy on HIV/AIDS; a major responsibility that puts them at the top of the decision making process in all HIV/AIDS related issues in the country.

A female participant number [2] in focus group number [4] held in Kampala and attended by only women added:

Since the launch of the mainstreaming policy of HIV/AIDS, a lot has changed in Uganda. Stigmatization has declined, PLWA now contribute equally to economic development. Government ministries are now AIDS sensitive, funds are budgeted to provide drugs to the sick, workers are sensitized to become AIDS competent, and there is care and support for the infected and affected.

The statements by the participants reflect a strong political commitment by the government to initiate inclusive policies that entrenched the HIV/AIDS education campaign in all government ministries. Furthermore, the remarks indicate that government policies created space for PLWAs to undertake more responsibilities in designing and implementing policies that directly affected their lives.

Hogle (2002), Cohen (2003), Parkhurst and Lush (2004), and Stoneburner and Low-Ber (2004) state that the government of Uganda played a leading political role in restructuring and

reorienting the bureaucracy to respond to the HIV/AIDS epidemic because the traditional health facilities were poorly equipped and lacked the expertise and manpower to sustain a comprehensive HIV/AIDS awareness campaign across the country.

The researchers note that the restructuring of government departments to undertake new roles of addressing HIV/AIDS needs for employees in workplaces, was a strategic move to sustain and consolidate the presence of the epidemic in daily life. Kalibala, Rubaramira and Kaleeba (1997) observe that the involvement of HIV-positive persons and PLWAs in the prevention and care was a historic and positive milestone in the campaign because it provided credibility to the process and proved effective in fostering positive attitudes and behavioral change among the targeted populations.

Hence, the bureaucratization and perpetuation of the HIV/AIDS campaign in the public sector, budgeting of funds to procure drugs for the sick, and creating a friendly working environment for People Living With AIDS, is consistent with observations by Friedman (2000) and Satyavrata (2004) who argue that health glocalism should involve the customization or adaptation of foreign norms or products to the prevailing local conditions to guard against overwhelming indigenous social systems.

Elaborating on the institutionalization of HIV/AIDS in other public places, participant number [5] in focus group number [6] attended by only women in Rakai district observed:

Unlike in the past, all sub counties and many villages in Rakai have local HIV/AIDS projects conducting education, counseling and testing blood, distributing condoms, and treating sexually transmitted diseases. HIV/AIDS education is now part of the school curriculum in the district.

Participant number [3] in a focus group [2] held in Rakai district added:

Today, there are so many local and international organizations providing medicine, caring and supporting the sick, looking after orphans and widows. Some of the

organizations are religious; others belong to People Living With AIDS, and some are affiliated to hospitals like TASO.

The statements by the participants imply that the intensity of HIV/AIDS activities in their respective communities had increased and appears to have become a permanent feature in their ordinary lives. Lyons (1998) states that “by 1993, there were over 800 registered NGOs engaged in HIV/AIDS-related activities in Uganda, some of which were neither supervised nor coordinated, others even operated without registration” (p. 194).

On the other hand, UAC (2005); Okware, Opio, Musinguzi and Waibale (2001) observe that although Anti Retro Viral therapies became available and accessible to People Living With AIDS in Uganda, intensification and normalization of the HIV/AIDS campaign in the people's daily lives had to be entrenched as a precaution against complacency and a reversal to the old practices.

Commenting on the extent to which HIV/AIDS had become a common feature in their daily lives, the participants were unanimous in their responses which emphasized the omnipresence of the images and messages about the epidemic in their lives.

Participant number [1] in focus group number [3] held in Rakai shared his impressions on the regularity of HIV/AIDS in the traditional media in the following observations:

If you listen to any radio which reaches Rakai, whether it is a government station, commercial or small religious station, you can hardly take an hour before you hear a message on HIV/AIDS, a program, a song or a news item about the disease. It is a big thing and is everywhere.

Participant number [5] in the same focus group number [3] held in Rakai district added:

If you walk outside your house, you may meet an orphan on the way, a coffin or backcloth displayed along a village path or an AIDS counselor riding to or from a visit to an AIDS patient or a neighboring orphanage. All those things remind you of the existence of HIV/AIDS.

The accounts by the participants indicate that HIV/AIDS is now a common feature in their daily experiences both as reflected in its physical symbols and in the messages transmitted on the airwaves. The observations about the omnipresence of HIV/AIDS in the rural environment are also supported by comments from city participants.

Participant number [1] in a focus group number [2] held in Kampala district stated:

You cannot go anywhere and you do not get confronted with an HIV/AIDS image, message, or literature in Kampala. On television, commercials are transmitted in-between programs, if you buy a newspaper; you cannot miss HIV/AIDS messages, adverts, stories or question and answer columns strategically placed in the paper. When you drive along streets or on highways, HIV/AIDS billboards glare at you on either side of the street. If you take a taxi, you are certain of listening to an HIV/AIDS message either on the radio on cassette. If you go to the theater or for any form of entertainment or a church service, you will certainly hear something about AIDS.

Participant number [5] in a focus group number [4] held in Kampala and attended by only women observed:

The most visible images of HIV/AIDS are HIV-positive individuals and PLWAs who openly and regularly speak out about their status and have formed organizations to conduct HIV/AIDS education to their members. They are very outspoken advocates for their rights and needs of patients to secure life giving drugs, accommodation in workplaces, and the general society through demonstrations and media campaigns. They even manage some of the funds extended to the country by the AIDS global fund.

The comments by the participants demonstrate the hyper visibility of HIV/AIDS images that contribute to the omnipresence of the epidemic in the culture of the participants. The optimum utilization of multi-media channels to publicize and promote HIV/AIDS information enhanced the institutionalization and visibility of HIV/AIDS campaign across the country.

Twaddle and Hansen (1998); Lyons (1998); Cohen (2003); Parkhurst and Lush (2004) observe that the latitude extended to organizations involved in HIV/AIDS campaign to design messages and disseminate them using a variety of communication networks greatly enhanced the proliferation and consumption of new HIV/AIDS norms and ideas by everybody everywhere.

Thus, data in this category bolsters the rationale of this study which extended the diffusion of innovation theory which suggests that if a critical mass adapts and embraces a new idea, it becomes a social norm and easily spreads and takes root in society (Rogers, 1962, 1973, 1976, 1994). Furthermore, the reorientation of the government bureaucratic structure and the reconfiguration of the social landscape to create space for the HIV/AIDS campaign in community life is evidence that acculturation of the epidemic at population level had taken place.

Graves (1967); Smith (1969) describe changes to social structures and political systems to integrate new cultural norms following an encounter between different cultural forces, as a form of acculturation at a population level.

The AIDS Paradox and Campaign Backlash

The last category constructed from the data was labeled: “AIDS Paradox and Campaign Backlash.” This category highlights the contradictions that have characterized the 23-year old HIV/AIDS epidemic in Uganda and illuminates the commercialization, weaponization and politicization of the epidemic. While respondents acknowledge that the HIV/AIDS campaign was a blessing in disguise, their observations expose the missed opportunities to combat the epidemic in the name of upholding cultural norms of modesty and decency.

Statements in this category also highlight the parallel moral structures that have emerged in the country as a result of the pervasive HIV/AIDS campaign that liberalized public discourse on sex and sexuality. The following dialogue among four participants who attended focus group number [3] held in Rakai district highlights the dilemma caused by the cultural double standards used during discourse on AIDS-related deaths.

Participant number [6] stated:

The way we publicly speak about deaths caused by AIDS is confusing and misleading. During HIV/AIDS campaigns, everything is talked about openly but when someone dies

of AIDS, it is never announce that AIDS is the cause. Instead, the mourners and the public are told that the deceased has died after “a long illness.” Although the mourners understand that “after a long illness” means AIDS, covering up or disguising AIDS in sweet words negates the gravity from the problem and denies the living and campaigners a clear deterrent from irresponsible sexual behavior.

Participant number [4] stated:

This talk that stigma towards HIV/AIDS has disappeared is simply not true. Stigma towards AIDS is still with us. While HIV/AIDS is part of our daily lives, we do not want to publicly associate with it. Families prefer to attribute the deaths of loved ones to such terminal diseases as cancer, pneumonia, stroke, diabetes or malaria because they fear that if the death is attributed to AIDS, they will be stigmatized.

Participant number [5] observed:

Among the Baganda, the dead are always treated with respect and their spirits are appeased by not passing judgment over their lives or embarrassing them because all of us are going the same way. It would sound insensitive if the living attributed the death to irresponsible sexual behavior.

Participant number [3] said:

Even postmortem reports from doctors do not help matters because they always attribute the death to opportunistic infections. This lack of clarity sustains stigma in society causing many deaths especially among the rich and famous who are afraid of being labeled as AIDS patients if seen going to HIV/AIDS clinics in broad daylight.

The foregoing dialogue exemplifies the ambiguity and double standards that have characterized the HIV/AIDS era in Uganda and among the various ethnic groups including the Baganda, the largest ethnic group in the country to which the participants belong. While Uganda has been roundly hailed internationally as a model of success in the campaign against HIV/AIDS, cultural factors still continue to shape and influence the course of the campaign among the different social communities.

Although the data indicate that both mourners and the public understand the shared euphemism used to moderate the stigma associated with HIV/AIDS, the deliberate effort by society to couch the disease in culturally accepted discourse serves to inadvertently perpetuate

the stigma that is still responsible for a number of deaths in many communities. Thus, the criticism of the discourse on AIDS-related deaths by respondents highlights the continuous tension between new phenomena and the prevailing cultural norms before a common ground position is attained.

Ankrah (1993), Bond and Vincent (1991), Obbo (1991), and Kolsrud et al. (1989) state that stigma towards PLWA in Uganda is no longer overtly expressed because everybody has suffered from the multiple impacts of the epidemic. However, the researchers note that a degree of covert and self imposed stigma still prevails because society shrouds the disease in mystical descriptions to avoid direct reference to it especially in the presence of PLWA. The subtle stigma is also referenced by Kalibala et al. (1997) who argue that the very formation of organizations for PLWA in Uganda was a direct response to community perpetuated stigma that kept many patients out of the spotlight for fear of covert discrimination.

Based on the observation made by the participants, it can be deduced that the cultural paradigm set by the community with regard to the discourse on deaths caused by HIV/AIDS is consistent with the basic premise of the symbolic interactionism theory which suggests that individuals continuously construct and use language to interact and establish shared meanings, interpret and understand social reality in the world around them (Morris, 1934).

Describing one of the most enduring paradoxes of the 23-year old HIV/AIDS campaign in Uganda, participants referenced the controversy that continues to characterize the promotion of the condom in the triad of the abstinence, be faithful, and condom (A, B, and C) strategy that has been the hallmark of the Ugandan success story against the epidemic. All participants voiced the dilemma they faced as a result of contradictory messages from health educators, religious leaders, politicians, opinion leaders in their respective communities, and the media.

Participant number [4] in focus group number [6] held in Rakai district and attended by only women observed:

Health educators advise us to encourage our husbands to use condoms for family planning and to avoid getting infected with HIV from unfaithful men. However, church leaders and some opinion leaders in the community tell us that the condoms distributed in Rakai are old and dangerous because they spend a long time on the way before they arrive in Uganda. They say that when men use them, they break and poison the women to death. Now who should we believe?

Participant number [2] in focus group number [3] held in Kampala district noted:

Sex educators are very confusing. They say the condoms do not provide 100 percent protection from HIV infection and that we should first exercise self discipline before using condoms. But if you are not the type who cannot abstain, how can you be sure that the condom will save your life? For some of us, it is either a condom or coffin.

Participant number [3] in focus group number [1] held in Kampala group added:

President Museveni is even worse. Today he supports the condoms, tomorrow he is only for abstinence or faithfulness, for him, no “kuloza” (or “tasting”). Only the other day, he was telling catholic Bishops to withdraw their opposition to condoms because AIDS is finishing their flock. So, what does he want us to believe?

The observations by the participants underline a very critical and delicate cultural issue that has dogged HIV/AIDS campaign in Uganda. While the Uganda government launched the A, B, and C as a comprehensive strategy promoting all the three methods of protection, opposition to the condom from the powerful and influential catholic and the evangelical churches forced the government to provide only lip service to condom use.

The confusion and untruths about condoms seriously undermined and impeded public health efforts to promote condom use whose adverts were banned on the government Radio Uganda and Uganda television Berkley, Okware & Namara, (1989). The only positive aspect to this running paradox is that international and local non governmental organizations flooded the country with condoms using donor funds and launched a comprehensive and vigorous promotion campaign using alternative media throughout the country to save millions of susceptible people.

Lyons (1997) observes that President Yoweri Museveni's inconsistencies on the use of condoms in AIDS control and prevention almost derailed the entire campaign because it created widespread confusion on his position both locally and internationally. The researcher notes that president Museveni's shifting positions between the African tradition and modern western methods of HIV/AIDS control and prevention only served to politicize the campaign rather than enhance its effectiveness. Lyons (1997) states:

In December 1990 Museveni lashed out at African traditions and customary habits like polygamy which encouraged the spread of AIDS and advocated a revision of laws that encourage immorality. Six months later on June 1991, he told an International Conference on AIDS in Florence that young people must be taught the virtues of abstinence, self-control and postponement of pleasure... But to the consternation of the audience awaiting an endorsement of condom usage, he said that in the past, Africans had evolved cultural taboos and sanctions against premarital sex adding that he had actually reverted to those cultural practices because they stressed fidelity and condemned premarital sex. Two months later, while addressing members of the National Resistance Council he accused foreign cultures of helping in the spread of AIDS and called for an end to the practice of 'boyfriend / girlfriend' adding that he had even banished the business of dating among those close to him (p. 141).

While addressing another international conference on AIDS in Bangkok, Thailand last year, president Museveni de-emphasized the role of the condom in the campaign against HIV/AIDS and underplayed its contribution in the reduction of the incidences of infections in Uganda saying "human life should not be tied to a mere piece of rubber" (Uganda Observer, 2004, p. 1). The paper reported that Museveni told the conference that the "global community should not be condomized and should think outside the condom box because sex is an elaborate act that differs from culture to culture and may not be fully consummated by some communities with the use of the condom" (Uganda Observer, 2004, p. 1).

The perennial inconsistencies by President Museveni on the A, B, and C strategy have now become a source of political capital in the global political debate on HIV/AIDS prevention between the social conservatives and Christian organizations on one hand and the social liberals

on the other. Both globally and in Uganda, President Museveni has been roundly condemned for underplaying the effectiveness of the condom in the HIV/AIDS campaign yet available research indicates that none of the three strategies; abstinence, be faithful, and condom use has solely been responsible for the progress in Uganda's campaign (Green, 2004; Singh et al., 2004).

Indeed, Singh et al. (2004) note that Uganda's breakthrough in the HIV/AIDS campaign is attributed to the combined use of abstinence, monogamy or faithfulness as and condoms contrary to what the social conservatives in the Bush administration and elements in the Ugandan government sometimes want the world to believe. The authors warn that adapting such a position and using it as a model in the HIV/AIDS campaign elsewhere will be counter productive because it may result in "prevention and abstinence fatigue and a reversal to irresponsible sexual behaviors" (p. 130).

More recently, Stephen Lewis, the UNAIDS representative in Africa accused the Bush administration of forcing the government of Uganda to discard the condom (C), create artificial shortages in the country and emphasize the A and B of the original strategy, an accusation both governments have vigorously denied (The New Vision, 2005).

Describing another paradox that emerged during the 23years of HIV/AIDS epidemic in Uganda, participants reported that because the disease was stigmatized, many people used it as a weapon to discredit their rivals, supervisors, business competitors, and political opponents. According to the participants, if one was labeled as "suffering from AIDS," society would outcast the individual and denies him or her love, loyalty, business or support from community members. However, the participants noted that sometimes, the strategy backfires and the weaponization of the disease would be rejected by community members.

Participant number [3] in a focus group number 6[] held in Rakai and only attended by women stated:

The only way I had to protect my marriage and myself from AIDS was to label my husband's lovers in the village as AIDS sufferers. That scared him from going out with other women. Both women and men used the AIDS scare to protect their relationships from rivals. Even traders used to call their competitors AIDS victims to take away their customers.

Participant number [5] in a focus group number [3] group held in Kampala added:

If your boss annoyed you, the only way you had to avenge was to start a rumor among fellow workers that he had AIDS. Sometimes they would believe and start gossiping about it to scandalize him. President Yoweri Museveni did the same when he said that Kiiza-Besigye, his political rival in the 2001 presidential elections had AIDS in order to deny him votes. However, some people were not happy with the president and supported Besigye saying: "Katulonde mulwadde munaffe" (meaning "Let us elect our fellow patient").

The use of HIV/AIDS as a weapon against political opponents is confirmed by Michaels (2001) who reports that President Museveni derided his former physician turned political rival Besigye that: "... Museveni proceeds to get a few things off his chest. Besigye is suffering from AIDS, he says, a remark he has delivered a number of times on the stump" (p. 6).

The remarks by the participants illuminate the double standards that characterized the HIV/AIDS epidemic in Uganda and the deep-seated social stigma associated with AIDS that no amount of education could eliminate. That President Museveni, an internationally recognized champion of HIV/AIDS campaign and an erstwhile defender of the rights of AIDS patients would undermine his outstanding record and use AIDS as a weapon against his political opponent, underlines the extent of the AIDS paradox in Uganda. Salmon (2001) contends that when Museveni referred to his political rival Kiiza Besigye as having AIDS, it was not just an insult that he was not fit to be president, but the implication was that Besigye should be isolated and be doomed to destitution.

Ironically, President Museveni's political opponents both at home and in the Diaspora have now jumped on the bandwagon to weaponize HIV/AIDS to destroy his outstanding international reputation in the HIV/AIDS campaign following the recent "suspension of the 201 million dollar grants to Uganda by the Geneva-based Global Fund on AIDS, Tuberculosis and Malaria after learning of serious mismanagement" (The Monitor, 2005, p. 1).

The suspension of the grants from the global fund on AIDS has been interpreted as victory for the opposition who together with AIDDS activists had previously accused Museveni's government of mismanaging the fund and planning to divert the money towards his presidential re-election campaign due next year. The same groups had alleged that the Museveni government is holding AIDS patients to ransom by staking the distribution of the Anti-retro viral in exchange for votes in the coming presidential and parliamentary elections (The Monitor, 2005).

On the same day, the paper also published a letter by the groups lobbying the White House and the US Senate not to recognize President Museveni with an award for his efforts in the campaign against HIV/AIDS in Uganda. Interestingly, the same political groups lobbying the White House and the Senate not to host and recognize President Museveni have been at the forefront of accusing the Bush administration of conspiring with the Uganda government to promote only abstinence and faithfulness at the expense of condom use.

Responding to questions that demanded their experiences on the commercialization of HIV/AIDS tragedy during the last 23 years, the narratives exemplified the economic divide between the elite respondents from Kampala and the rural participants from Rakai district. Most of the respondents from Kampala were unanimous in their comments about the numerous economic and social opportunities the advent of the HIV/AIDS epidemic brought to them and

their educated contemporaries across the country. Conversely, participants from rural Rakai district complained that most of the funds meant to alleviate the impact of the epidemic in their areas are spent on maintaining a luxurious lifestyle for the elite in Kampala who have either secured employment with the hundreds of HIV/AIDS projects in the city or set up their own organizations to provide HIV/AIDS-related services.

Participant number [6] in focus group number [3] attended by men only in Kampala stated:

“Ebya siliimu bye bifuna” (meaning “Anything to do with HIV/AIDS is lucrative and valuable”). If you invest in a media, you can be sure of money from AIDS-related adverts, if you get a job with an AIDS organization, you will drive a four wheel drive, a good salary and travel. You can also set up a Non governmental Organization and make money.

On the contrary, participant number [5] in a focus group number [5] held in Rakai district sounded very bitter as he echoed the sentiments of his peers:

While people die in villages without AIDS drugs and other social facilities people working for HIV projects in Kampala spend a lot of money on seminars in Sheraton and other big hotels, they live in beautiful houses, drive big cars, take their children to the best schools, and have the best health facilities in the country. Both the “Bazungu” (meaning “White people”) and educated Ugandans are the same. They do not care about villagers like us.

The accounts by the respondents in both Kampala and Rakai districts indicate that some local and foreign individuals conspired to benefit from the HIV/AIDS tragedy at the expense of the most deserving AIDS patients in the rural areas. Lyons (1998) observes that by 1993 it was a widely-held view that AIDS was no longer a disease, but a huge multinational business in which international and local agencies as well as quack medicine men were cashing in on AIDS in Uganda (p. 194).

The observation is in concurrence with the contention by Friedman (2000) who metaphorically describes local agents of the globalization process as “the local herd which has to

plug into the international system and operationalize the global conventions in their local conditions” (p. 114). Thus, the emergence of a local group of beneficiaries from the global HIV/AIDS campaign does not come as a surprise. Foreign donors and international HIV/AIDS organizations needed local agents to adapt their lifestyles and implement their programs.

Thus, given the suspicious widespread mismanagement of HIV/AIDS funds, it came as no surprise that the United Nations Global Fund's on AIDS based in Geneva recently suspended its grants to Uganda allegedly because, “. . . many people are dying out there. . . .Yet we give the money to be utilized and not to be misused” The Monitor newspaper (2005, p. 1) quoted Bradford Herbert, the UNAIDS Global Fund official who directed the suspension.

Besides the widespread positive behavioral changes adapted by respondents as a result of the HIV/AIDS campaign, they also enumerated a number of negative effects that the campaign has imposed on them and the greater Ugandan society. While the positive changes enhanced the restoration of traditional moral virtues, the boomerang effect has been the creation and consolidation of a decadent moral lifestyle that is threatening to reverse the modest gains made during the campaign.

Participant number [2] in focus group number [6] exclusively attended by women in Rakai district observed:

The AIDS scare has preserved some of our young girls to delay sex and get married when they are still virgins. Ten years ago, it was unheard of. Both men and women of my age are more sexually responsible than in the past.

Participant number [6] in focus group number [1] held in Kampala echoed the similar observations: “Many girls and boys are getting married when they are virgins at 25 years. Previously, old women like me were divorcing to marry new lovers. That is now rare.”

The observations by the respondents reflect a degree of moral sanity that has been instilled in the sexually active groups in Uganda as a result of the HIV/AIDS campaign. Uganda's national coordinator of the HIV Counseling and Testing DR Zainab Akol claims that "Uganda could soon have an HIV/Aids-free generation aged between 15 to 25 years as the infected older people die off and more young people abstain from premarital Sex," (Monitor, 2005, p.1). The expert states that those who were sexually active during the advent of the epidemic and survived are more cautious than in the past.

However, participants noted that the HIV/AIDS campaign has resulted in a degeneration of some of the cultural values in their respective communities and the greater Ugandan society. They claim that new socially unacceptable sex lifestyles have emerged in society because of the laxity with which sex and sexuality are discussed. The participants observe that there is a lot of sex talk and sex images in society that lack sensitivity that young people can easily get influenced by new cultural norms hitherto unknown in the country.

Participant number [3] in focus group number [2] held in Rakai stated:

This sex education has spoiled us and our children are at risk growing up with too much sex in their lives. Very young boys and girls in the villages know about the condom. Some of my peers will not hesitate to go with any woman as long as they have a condom. We only used to hear about those things in towns and "Ebulaaya" (meaning "Europe") but they are now here with us.

A woman participant number [5] in the same focus group number [2] held in Rakai district noted: "Some women even keep condoms in their handbags just in case their lovers show up without one. Imagine such boldness by some of our peers."

The accounts indicate a gradual erosion of the traditional sex norms that prevailed before the onset of the HIV/AIDS epidemic in Rakai district in 1982. Similarly, the observations imply that the opening up of the entire country to both local and foreign organization involved in

HIV/AIDS control and prevention activities opened a Pandora's Box that exposed the population to a multiplicity of new cultural norms that have become difficult to contain. Twaddle and Hansen (1998); Lyons (1998) observe that the changing state of Uganda as a result of the HIV/AIDS epidemic will leave many communities overwhelmed by the far reaching social, economic, and political effects, some of which will be irreversible and hard to comprehend.

Participants in Kampala focus groups described the onslaught of the epidemic on urban lifestyles in the typical elitist perspective. Their accounts represented the changes in city sex lifestyles as portrayed in the media and the social hot spots in town.

Participant number [4] in focus group number [2] held in Kampala observed:

The sex courage that has emerged as a result of sex talk, education, and pornography in the media is simply troubling. Who ever thought that we would have "Ekimansulo" (meaning "Strip tease") in Kampala? It is now here and very lucrative business with a huge clientele. Both the girls involved and the thousands of men who attend are morally perverted. I attended once and gave up but some of my best friends are religious fans. A woman participant number [5] in focus group number [2] held in Kampala stated: There are more sex workers in Kampala today than five years ago. The numbers increase daily. They know they can use condoms to protect themselves from infections. Those already sick abuse the ARVs saying: "As long as the medicine is there, I can still make some money and survive on the drugs." "Kati nabalyi bebisiaga bematira balya butaala" (meaning: "Now even Gays and Lesbians are confident enough to come out in the open"). They freely and openly do their business in the city night clubs with "Bazungus" (meaning "Whites"). What a shame and miscarriage of the so called sex education!

The observations highlight a cultural backlash that followed the HIV/AIDS education and prevention campaign that liberalized the discourse on sex and sexuality in all communities across the country. In addition, stories that PLWAs have become complacent and boldly engage in commercial sex because of the availability of ARVs, is a clear case that the campaign has been oversimplified and undermined by the availability of the drugs. Responses that the number of sex workers increase daily in Kampala may not necessarily be as a result of the HIV/AIDS campaign

but point to an increasingly open society that has developed liberal views towards different sex lifestyles.

Furthermore, indications that there is an increase in sexual activities in the communities as a result of the campaign may be a signal that exposure to various strategies of protection from sexually transmitted diseases and HIV has rendered abstinence irrelevant. This could also imply that abstinence fatigue has started to take root in society.

That trend could also explain the increasing number of condoms being used in the country annually jumping from under 3 million in 1986 to 160 million this year (The New Vision, 2005). But the increase in sexual activity may spell danger to the campaign efforts because the prevalence rate of HIV/AIDS in the country has risen from a stable 6.1% since 1995 to 7% in 2004 (UAC, 2005). The increase, though small, was enough to raise the fears of the Ugandan Vice president Prof. Gilbert Bukenya to call upon Uganda's development partners "to fund the rapid development of an HIV vaccine to stop the bad situation from getting worse because the AIDS threat still endures" (The Monitor, 2005, p. 1).

To the participants, such cultural lifestyles like strip tease in nightclubs were not only unheard of in the past but also despicable just as homosexuality and lesbianism that were now openly practiced in the changed cultural landscape. This change in the mainstream culture of the participants represents ample evidence that acculturation at a population had taken place (Graves, 1967; Smith, 1969). Thus, the visibility of the gay culture, pornography, and strip tease represent some of the new cultural norms that have been integrated in the respondents' urban culture.

Friedman (2000), Randeria (2003), and Ritzer (2003) posit that although the negative reconfiguration of the cultural, economic, and political structures of a community amounts to

unhealthy glocalism, integration of the new norms that contribute the changed environment demonstrates how some cultural systems are too weak to resist stronger foreign influences.

Thus far, the data discussed in this theme demonstrates how communities continuously engaged in the process of creating and appropriating shared meanings and interpretations to understand the new environment ushered in by the HIV/AIDS epidemic. In addition to the data already highlighted in previous themes, the dynamic process elucidated in theme fully answer the first research question which sought to understand how the respondents adapted local meanings and definitions to communicate about HIV/AIDS.

Similarly, data elaborated in this theme that focused on the continuous process of localization of the global HIV/AIDS control and prevention campaign in the cultural environments of the participants provides a comprehensive answer to the second research question which was interested in ascertaining how the global HIV/AIDS communication campaign was transformed in the local environment to be understood by a section of the Ugandan population now aged between 40 to 50 years then living in Rakai district by 1982.

Finally, jointly with data explained elsewhere in this study, this theme offers the incremental and conclusive data that answers the third research question which sought to understand how Ugandans now aged between 40 to 50 years then living in Rakai district 23 years ago integrated the changes brought about by the HIV/AIDS epidemic in their mainstream culture to cope with the disease.

CHAPTER 5

SUMMARY AND CONCLUSIONS

This chapter presents the summary and conclusions drawn from the study. The chapter includes four sections. The first section: Summary, will present an overview of the study followed by a section outlining the conclusions from the research. The third section of the chapter; limitations will describe the scope of the study and the attendant constraints. The chapter concludes with a section addressing the implications of the study and directions for future research. The four sections will be discussed next.

Summary

Grounded in the social constructivist perspective, this study examined the role of communication in the globalization and acculturation of HIV/AIDS epidemic by a section of the Ugandan population now aged between 40 to 50 years. The age group was by 1982 living in Rakai district during the onset of the epidemic in Uganda.

The sample was selected based on sero surveys in the country, which consistently showed that all sexually active individuals were at risk of HIV infection because it was invariably transmitted through heterosexual intercourse. Sexual activity in Uganda is estimated to start at 15 years of age on average, which sometimes is as low as 13 years for girls. The participants selected for the present study are in the age group 40 – 50 and were between 17- 27 years of age by 1982.

Having recorded successes in the HIV/AIDS control and prevention campaign within a period of less than ten years, examination of the role of communication in Uganda's campaign became very compelling. Ten focus groups comprising a total of 64 participants were held in

both Kampala and Rakai districts. For this sample set, it was chosen because members of the age group have lived through the evolution of the epidemic since 1982 to the present day.

It was envisaged that their experiences would provide a deeper, broader and unique insight into the entire history of the epidemic in Uganda. Some of the participants were recruited from Kampala while others were recruited from Rakai district, the epicenter of the epidemic. The Kampala participants were also born and raised in Rakai district and only moved to the city after 1986 for various reasons. Their inclusion was to include an urban perspective into the study. Secondly, most elite in Uganda seek employment and live in Kampala because it offers better economic opportunities than rural areas like Rakai district. Indeed, the Kampala sample was the most educated of the two sample sets and greatly enriched the study.

Two concepts namely, glocalization and acculturation were applied in this study to explain how the campaign on the global HIV/AIDS pandemic was communicatively localized and understood by the section of the Ugandan population. The localization of the global pandemic has set in motion a process of acculturating the new norms and practices ushered in by the HIV/AIDS epidemic.

Similarly, two communication theories; the symbolic interactionism and diffusion of innovations theories were extended in the study. The symbolic interaction theory was utilized to understand how this group and the respective communities locally defined, interpreted, named and communicated about HIV/AIDS. The diffusion of innovations theory was used to explain how the new global concepts about HIV/AIDS were disseminated and diffused into the communities to a point of adaptation and change.

Three research questions were raised in the study seeking to understand how the global HIV/AIDS pandemic was communicatively named and how the section of the Ugandan population adapted the new social norms resulting from their encounter with the epidemic.

Findings from the study were consistent with the four concepts applied to explain the social or cultural change that the section of the Ugandan population have and continue to experience. Findings indicate that the global epidemic was socially reconstructed and reconceptualized using the shared cultural experiences of the communities in Rakai district. Several local names, metaphors, and concepts emerged to describe the strange disease that systematically decimated hundreds of people in villages, urban centers and towns.

Results from the study indicate that initial response to the advent of the epidemic was lackluster before a generalized pattern of deaths emerged triggering off a frenzied spell of speculation as to the origin and cause of the debilitating disease. Before 1986, confusion and chaos reigned as the afflicted communities of Rakai district tried to make sense of the debilitating disease.

At the time, the generally accepted explanation for the tragedy was witchcraft believed to have been engineered by the neighboring Baziba ethnic group across the border in Tanzania. However, with a massive HIV/AIDS control and prevention campaign, early adapters recognized that “Siliimu” as AIDS had been communally named, was largely transmitted through sexual intercourse with an infected person, an getting in contact with contaminated blood. The explanations could not have been convincing if the invincible Baziba were not also dying.

Findings from the study indicate that by the time the changes in sexual behavior started taking shape, desperation, fatalism, stigmatization of the patients, and suicidal tendencies had replaced all forms of sanity. Participants who survived this hemorrhage report of massive and

cumulative deaths that eventually ceased even to shock children. The omnipresence of death backed by a credible and consistent campaign to change high risky sexual behavior eventually paid off as epidemiological studies started to record a continuous decline in the infection rates. Thus far, the results show that the glocalization of the global campaign had taken place as new ideas about HIV/AIDS diffused into the communities through a multiplicity of organizations through a variety of communication networks.

The result of the campaign showed increased changes in high risk sexual behaviors. Results show that Individuals and communities abandoned cultural practices that were viewed as obstacles to the preservation of life. The results also indicated that compliance with the new social norms to survive the infection with HIV became the defining moment between life and death. Participants in this study from across all the ten focus groups reported that avoidance of infection by complying with one or all of the three strategies; abstinence, be faithful, and condom use (A, B, & C) became the aspired norm for all sexually active individuals

The findings also indicate that after the decline of infection rates and deaths became widespread, individuals and communities gradually transformed existing institutions to become permanent centers of HIV/AIDS education and materials while at the same time, the new norms became more and more entrenched and gained more visibility in the mainstream culture.

Clearly, the results indicate that all the four concepts applied in the study were effectively replicated and the data analysis answered all the three research questions investigated in this study. However, despite the effective glocalization and acculturation of HIV/AIDS in the mainstream culture of a section of Ugandans, the global concepts introduced in the local communities ignited some latent behaviors that communities detested as repugnant. Some of the immoral practices that emerged as a result of the pervasive sex education in all existing media,

were singled out as pornography, strip tease, increase in commercial sex, and public display of what the conservative Ugandan society referred to abnormal sexual relationships between individuals of the same sex; homosexuals and lesbians.

Finally, the results from this exploratory study provide some potential for future research into the Uganda's HIV/AIDS control and prevention campaign. The study has demonstrated that through communication, behavioral change became possible and a change in culture evident. This exploratory study also sets the ground for additional communication research to understand how other social communities in Uganda negotiated their contact with the epidemic.

Conclusions

Across all the ten focus groups, findings indicate that Ugandans now aged between 40 to 50 years then living in Rakai district at the advent of the HIV/AIDS have been experiencing fundamental cultural changes in the last 23 years. The changes, some of which are very drastic, are unique and specific in some ways to this particular age group.

At between 17 to 27 years, when the epidemic emerged in Rakai, the participants in this study were part of the most productive and reproductive section of the population. Yet, as the study shows, HIV in Uganda and Africa in general is invariably transmitted through heterosexual intercourse, an activity that highlights the life of the 17 to 27 year old African women and men. For those reasons, this unique and high risk group of the Ugandan population became the focal point of the HIV/AIDS campaign.

The study suggests that survivors of the HIV/AIDS epidemic in this age group have experienced a traumatic and turbulent 23 years of their adult life during which they witnessed their parents, siblings, peers, relatives and community members perish at the hands of a devastating disease that dumbfounded the entire nation and continues to wreck havoc across the

globe. Unfortunately, the findings indicate that before any of the interventions were made to sensitize the population about the real dangers of the HIV/AIDS epidemic, many members of this age group had either died, were infected or skeptical about the motives of the campaign. Due to the intervention gap during the advent of the epidemic, it long for many in this age group to get persuaded by the campaign messages thereby continuing with the risky but culturally bound sexual behaviors that resulted in ultimate death.

Many died young without children and those with offspring left them either infected or without care because the rest of the family members had also died and the traditional extended family and the community support systems stretched to the limit. The result was an emergence of an army of orphans either loitering in villages or heading homesteads at very tender ages. Thus, the results suggest that the HIV/AIDS epidemic destabilized the cultural structure of the community. The epidemic also disrupted the entire life cycle of some of the immediate and extended family system, the backbone and source of life for this community.

That the epidemic killed the most productive and reproductive members of the population, entire families were wiped out leaving no hope for regeneration and no trace of their existence as members of a family tree, clan, community or tribe. In most families, only helpless grand parents survived while chances that the orphans of the deceased were not infected remained extremely bleak. As the results show, the HIV/AIDS epidemic has seriously deprived this age group the socialization process through which their fore fathers and their respective communities were oriented and thrived.

For this age group, the only hope lies in their own hands because they are the ultimate decision makers between the limited choices of life and death. They have either to protect

themselves against HIV infection or perish. As the findings indicate, cases of HIV/AIDS prevalence in the country have now been reported among the 45-50 year age bracket.

What is even more worrisome is that signs of an ebbing HIV/AIDS epidemic in Uganda are slowly fading and being replaced in their wake, by a menacing reminder that the danger from the AIDS scourge still lingers. It is only hoped that since age is not on their side and with more responsibilities staring them in the face, the motivation to live and defeat HIV/AIDS will continue to prevail.

Despite the grim picture that hangs over the universe, all is not lost. The results show that survivors in this age group have expeditiously adapted the changes imposed on them as a result of the global HIV/AIDS pandemic. The study shows that survivors in this age group have behaviorally and psychologically adapted the new social skills that have enabled them function competently in the HIV/AIDS-infested environment. That they have the knowledge about how HIV is transmitted, avoided, and positively managed if infected is the strongest weapon that entails the demise of the epidemic among this age group.

Indeed, the massive and consistent HIV/AIDS control and prevention campaign resulted into universal awareness among this age group which in turn resulted in a major cultural change in the daily lives of the participants. Findings indicate that some of the archaic cultural attitudes and practices have been antiquated and replaced by new social norms to enable them competently negotiate the changed health environment. To that end, findings suggest that the participants have indeed experienced and adapted changes in their sexual behavior that have enabled them live to the present day.

Thus, the study shows that with a well-designed and implemented education and communication campaign, change in sexual behaviors of individuals is possible despite the

numerous and deep-rooted cultural obstacles that have to be overcome. Evidence from the results show that survivors of this age group in the Ugandan population now aged between 40 to 50 years living in Rakai and Kampala district have ultimately grasped, adapted, and integrated the strategies of abstinence, be faithful, and condom use (A, B, & C).

However, the use of a rural and an urban sample exposed very glaring disparities. The disparities between the two are disproportionately staggering. While the Kampala sample emerges from the study as the most privileged, educated, and economically superior, the sample from Rakai is depicted as the impoverished, rural, and least privileged sample in the study. Efforts should be made by the government to extend equal social services to the majority rural people where most of the country's wealth is generated from agriculture

For those already infected, the free access to Anti Retro Viral therapy is a new source of hope. They can now live qualitative and productive lives only if they do not abuse the drugs and if the corruption in the government administration of the Global Fund for AIDS and Tuberculosis is practically and completely stopped.

Therefore, this exploratory study has created an understanding of how the global HIV/AIDS campaign was communicatively localized among a section of the Ugandan population that was sexually active during the onset of the epidemic. Findings in the study are a fairly robust foundation for future communication research.

Limitations

Data for this study were collected in Uganda from Kampala and Rakai districts in Central Uganda from 64 participants belonging to the same ethnic group called Baganda. Ten focus group discussions were conducted to examine the role of communication in the globalization and acculturation of the HIV/AIDS pandemic among a section of the Ugandan population then aged

between 17 and 27 years then living in Rakai district by 1982 when the first cases of the epidemic were reported.

Grounded in the social constructivist tradition, experiences of participants were collected and analyzed to understand how the communities they lived in locally and communicatively reconstructed, understood, named, and coped with the HIV/AIDS pandemic and how they are integrating the new norms that have been introduced in their mainstream culture. By examining the communication behaviors of the participants, the study was able to understand how the section of the Ugandan population is coping with the new cultural norms adapted to survive the HIV/AIDS epidemic.

However, given the magnitude of the multi-dimensional challenge posed by the global HIV/AIDS pandemic to humankind, the present study only focused on the impact of the epidemic on a small section of the Ugandan population from a communication perspective. Thus, this study does not capture the breadth and depth of the entire glocalization and acculturation of HIV/AIDS process in Uganda. Secondly, due to the small sample size of only 64 participants, findings in this study should neither be generalized to the entire ethnic Baganda group nor Ugandan population of nearly 27 million people. At the same time, case study methodology is limited to an examination of specific social phenomena and its findings should not be wholly adapted as representative of all perspectives on the same phenomena.

In addition, the time frame within which the data were collected was too short to grasp the entire glocalization and acculturation process of this age group in Buganda region. A longitudinal study with multiple methods of data collection and analysis is recommended to capture the total picture of how this particular age group is communicatively negotiating the two processes of glocalization and acculturation.

Another limitation of the study was the difficulty experienced in finding individuals in this age group in Rakai district because many of them have either migrated to other parts of the country, died, or too traumatized to participate in HIV/AIDS-related studies without commensurate compensation. This prompted the researcher to use two sample sets drawn from Rakai and Kampala districts. .

Because of resource constraints, the author was unable to personally travel from the United States to Uganda to conduct the focus group discussions and physically select and interact with the participants. However, the facilitation of the focus group discussions and transcription of the data were undertaken by experienced Broadcasters and Newscasters who were trained and remunerated by the researcher for the specific purpose.

The researcher carried out all the data analysis and compilation of the study.

Implications

This study has potential practical implications for designers of health communication intervention campaigns, training, and policy makers. Specifically, for health interventionists, this study raises the issue of culture as a critical factor in campaign conceptualization, design and implementation. Besides, it is critical for global health campaign designers, implementers, and donors to be sensitive to the cultural idiosyncrasies of a campaign site. Findings from this study indicate that every community responds differently to any new phenomena or affliction. Discarding notions of recommending global blue prints for health communication campaign programs should be of utmost priority.

For example, findings in this study demonstrate how deep-rooted cultural norms, values, customs, attitudes, and practices are difficult to overcome in a campaign aimed at changing communal and individual behavior. For HIV/AIDS, the choice between life and death narrows

the options and becomes increasingly difficult for an individual to choose death over life. Therefore, choices may not be as limited in other health campaigns.

Health campaigners need to be cognizant of that fact and desist from replication of campaign programs. Findings in this study indicate that the HIV/AIDS campaign was successfully glocalized and is gradually being acculturated because it was customized to suit the local conditions and disseminated through the existing formal and informal communication networks. Policy makers, campaign designers, implementers, and other interventionists may adapt the Ugandan model but only use it in other health campaign sites after modification. With such caution, successful failures can be avoided in health campaigns.

Similarly, designers of health campaigns should take the cue from the findings of this study to always involve the local population in the conceptualization, design, and implementation of health communication campaigns. The key to maximizing positive results is to culturally bind and situate the campaign. However, the emphasis on cultural factors should not overshadow strict supervision and coordination of the campaign. Local implementers may become over presumptuous and mismanage the process especially if the use of funds is involved. Strict financial accountability should be enforced to avoid the Ugandan situation as indicated in the study.

In theoretical terms, this study has implications for social or behavioral change research to understand how communities use their shared experiences to reconstruct new realities and adapt social norms to cope with any phenomena. Although the global HIV/AIDS pandemic is too complex a crisis to cover and comprehend in one single study, the grounding of this exploratory research into a social constructivist perspective has provided insight into how communication can accelerate social change.

The most salient implication from this study to communication research is the revelation of important links between the processes of glocalization, acculturation, the diffusion of innovations and the symbolic interactionism theories with regard to their emphasis on social change. The four concepts accentuate adaptation and adjustment to new ideas, norms or values that are socially generated for communities to competently function in changed social environments.

Although the glocalization process refers to the adaptation of new and customized norms, services, products, values as assimilation of what is compatible and rejection of what is inapplicable, the final outcome is acquisition of new traits and discarding the least useful. On the other hand, the integration outcome of the acculturation process emphasizes adaptation of new cultural values and norms to effectively cope with a changed landscape.

For the diffusion of innovations theory, it suggests that when a new idea, concept, product, innovation is introduced in a society through a multiplicity of communication networks, it is either adapted or rejected depending on its relevance, simplicity, applicability, perceived benefits, and compatibility with existing social conditions, The theory suggests that if the idea is adapted, then a social change is underway.

Similarly, the symbolic interaction theory contends that communities continuously construct and establish meanings, interpretations, and definitions of social phenomena from shared experiences through communication activity. The theory suggests that members of a community have to adjust or adapt to the new, shared symbols in order to adequately communicate with the rest of the group.

Thus, findings from this study indicate that all the four concepts namely glocalization, acculturation, diffusion of innovation and symbolic interactionism are linked by shared

common outcomes. By examining the processes of glocalization and acculturation of a global health phenomenon in a local environment and simultaneously applying the diffusion of innovation and the symbolic interaction theories the intersection points between the four concepts in social change is illuminated. Thus, findings in this study provide a robust rationale for further social scientific research in cultural and social change through communication.

In conclusion, findings in this exploratory study have provided evidence that communication enhances social change. At the same time, the study demonstrates that communication is plays a central role in the processes of glocalization and acculturation. In addition, the study shows that reality about HIV/AIDS is socially constructed from the shared experiences of the afflicted communities. Finally, findings from the study are consistent with the Bio-cultural models which suggest that diseases should be conceptualized from a medical and cultural perspective but not viewed from a unidirectional standpoint.

APPENDIX A
IRB APPROVAL

UNIVERSITY OF NORTH TEXAS INFORMATION NOTICE

Title of Study: The Glocalization and Acculturation of HIV/AIDS: The Role of Communication in the Control and Prevention of the Epidemic in Uganda

Principal Investigator: Samuel Muwanguzi

The purpose of this research study is, to examine how Ugandans used communication to simplify HIV/AIDS-related information that was used fm their local way of life.

You are being asked to participate in a focus group that will take approximately 60 to 90 minutes. There are no foreseeable risks involved with this study. Participation is voluntary and you may stop at any time.

The focus group discussion will be audio-recorded. Tapes will be transcribed into the English language for subsequent analysis by the researcher. The tapes will be destroyed after all data are collected.

If you have questions regarding this study, please contact Mr. Samuel Muwanguzi at (940) 565 2588 or the faculty sponsor, Dr. Pratibha Shukla at the UNT Department of Communication Studies, (940) 565-2588.

This research project has been reviewed and approved by the University of North Texas Institutional Review Board ORB). Contact the UNT IRB at (940) 565-3940 or sbourns@unt.edu if there are any questions regarding your rights as a research subject.

APPROVED BY THE UNT IRB

FROM 6/8/05 TO 6/7/06
B

APPENDIX B

IRB APPROVAL TRANSLATED INTO LUGANDA

UNIVERSITY OF NORTH TEXAS

EKIRANGILIRO

OMUTWE GWEKYOKUYIGA

OMUGASO GWAMAWULIRE MUKAWEFUBE W'OKUZIYIZA N'OKUTANGIRA

SILIMU MU UGANDA

OMUNONYEREZA OMUKULU: SAMUEL MUWANGUZI

Ekirubirirwa ekikulu ekiri mu kunonyereza kuno kwe kuzuula engiri amawulire gyegamulungula ebikwata ku siliimu okumanyika mu bulamu bwabanna Uganda.

Osabibwa okwelaba mu kukubanga ebirowoozo okusengekeddwa obulungi nga kutwala ebbanga lya ssaawa 1 okutuuka ku emu nekitundu (60' – 90') okukubaganya ebirowoozo kuno okunaakwatibwa ku ntambi kwa kyeyegalire wokoyera ng'oleka tewali kukakibwa.

Entambi zino ezinabeera mulungereza olw'okwokennenyezebwa okulala okwo munonyereza zijja kusanyizibwawo oluvannyuma lw'okukungaanya amawulire agetagisa.

Oli waddembe okwabilila okunonyereza kuno wona wowulirira nti okukooye era tojja kukakibwa kwenyigira mu muboozi eno. Tewali kabi kona kasubirwa kutukako ebbanga lyona lynomala nga wenyigidde mu Musomo guno nebwegunaba guwedde.

Oba olina ensonga yona gyoyagala okwekanya ku musomo guno, kutuuse ewa Mw. Samuel Muwanguzi ku ssimu 940 565 2588 oba ewa Dr. Pratibha Shukla, Omusomesa ku University ye North Texas e Denton mu kitongole kye ebyempuliziganya ku ssimu, (940) 565-2588.:

Ekitongole kya INSTITUTIONAL REVIEW BOARD (IRB) ekya University ya North Texas kimaze okwekebeja okusaba kwokunoyereza kuno, era bwekito nekikiriza nti kugende mumaaso.

Bwebaawo omuntu yena eyetaaga okunyonyolwa ensonga yona ekwata ku lukusa oluweddwa okunonyereza kuno, tukirilira UNT IRB ku ssimu (940) 565-3940 oba sbourns@unt.edu .

APPENDIX C
CONSENT FORM

June 8th, 2005

Dear Participants,

Re: *Consent Form*

My name is Samuel Muwanguzi, a graduate student of Communication Studies at the University of North Texas in Denton. I am requesting you to participate in a focus group discussion on the advent, spread, decline, and current state of HIV/AIDS (Siliimu) in Rakai or Kampala districts since 1982 to the present day.

The purpose of this research study is strictly academic and will examine how a section of the sexually active Ugandans used communication to simplify HIV/AIDS-related information that was used in their local way of life. You are being asked to participate in a focus group discussion that will take approximately 60 to 90 minutes. There are no foreseeable risks involved with this study. Participation is voluntary, no identification is required, and you may stop at any time. The focus group discussion will be audio-recorded. Tapes will be transcribed into the English language for subsequent analysis by the researcher. The tapes will be destroyed after all data are collected.

If you have questions regarding this study, please contact Mr. Samuel Muwanguzi at the University of North Texas, Denton in the Department of communication studies on phone number: 940 565 2588.

This research project has been reviewed and approved by the University of North Texas Institutional Review Board (IRB). Contact the UNT IRB at (940) 565-3940 or sbourns@unt.edu if there are any questions regarding your rights as a participant.

Thanking you.

Sincerely,

Moderator

Participants' Signature

On behalf of

Samuel Muwanguzi

Principal Researcher

APPENDIX D

CONSENT FORM TRANSLATED INTO LUGANDA

June 8th, 2005

Eri Abateesa,

Re: *Endagaano*

Amanya gange nze Samuel Muwanguzi, omuyizi mu University ya North Texas e Denton.

Mbasaba okwetaba mu mbooji elubilirwa okuzuula no kwetegereza engiri amawulire gyegamulungula ebikwata ku siliimu okumanyika mu bulamu bwabanna Uganda abali wakati wemyaka 17 ne 27 mu mwaka gwa 1982 siliimu weyazulibwa mu Rakai district. Era kati Ban Uganda abo bali wakati we myaka 40 na 50 and babeera Rakai oba Kampala district. .

Osabibwa okwelaba mu kukubanga ebirowoozo okusengekeddwa obulungi nga kutwala ebbanga lya ssaawa 1 okutuuka ku emu nekitundu okukubaganya ebirowoozo kuno okunaakwatibwa ku ntambi kwa kyeyegalire wokoyera ng'oleka tewali kukakibwa.

Entambi zino ezinabeera mulungereza olw'okwokennenyebwa okulala okwo munonyereza zijja kusanyizibwawo oluvannyuma lw'okukunganya amawulire agetagisa.

Oli waddembe okwabalila okunonyereza kuno wona wowulirira nti okukooye era tojja kukakibwa kwenyigira mu muboozi eno. Tewali kabi kona kasubirwa kutukako ebbanga lyona lynomala nga wenyigidde mu Musomo guno nebwegunaba guwedde. Era tekyetagisa kutuwa manya go okwenyigira mu mumbooji zino ku siliimu. Ekilubilirwa ekikulu kyoka ekiri mu kunonyereza kuno kya kusoma. Teri nsonga ndala yona.

Oba olina ensonga yona gyoyagala okwekanya ku musomo guno, kutuuse ewa Mw. Samuel Muwanguzi mu University ya North Texas e Denton mu kitongole ekya Communication studies ku ssimu: 940 565 2588.

Ekitongole kya INSTITUTIONAL REVIEW BOARD (IRB) ekya University ya North Texas kimaze okwekebeja okusaba kwokunonyereza kuno, era bwekito nekikiriza nti kugende mumaaso.

Bwebaawo omuntu yena eyetaaga okunyonyolwa ensonga yona ekwata ku lukusa oluweddwa okunonyereza kuno, tukirilira UNT IRB ku ssimu (940) 565-3940 oba sbourns@unt.edu .

Mwebale nyo

Omukubiriza

Omukono Gomuteesa

Kulwa Samuel Muwanguzi .

Omunonyereza Omukulu

APPENDIX E
FOCUS GROUP PROTOCOL

Introduction

Dear Participants,

I want to thank you for sacrificing your precious time to come for this group discussion. My name is: _____. As you may know, I am a staff of Radio Uganda/Uganda Television and conducting this focus group discussion on behalf of our former colleague; Samuel Muwanguzi, a Graduate student of Communication Studies at the University of North Texas, Denton, Texas, USA.

Today, I want to discuss with you your knowledge and some experiences about the HIV/AIDS epidemic in Uganda. I especially want you to share your knowledge about how your age group, the government, medical practitioners, and your community responded to the epidemic since the disease was first identified to the present day. More importantly, I would like you to share with us your thoughts on how members of your age group, the political leadership, opinion and religious leaders, medical practitioners, patients, traditional healers (witch doctors) and the ordinary people talked about the disease, how they treated the patients and their attitudes towards them. Secondly, we also need to discuss how the entire country coped with the disease and finally how they adjusted their lives and came to terms with the epidemic as a new reality in their midst. This discussion will be divided into four topics: Genesis of the disease, Upsurge/increase in HIV/AIDS cases and deaths, decline in infection rates, and mainstreaming of the disease in all community activities.

This discussion will last between 60 to 90 minutes. No one will know your specific answers to any of the questions we ask today. Also, your participation in this project is completely voluntary, you do not have to answer any questions you do not want to answer, and you can leave at any time if you decide you do not want to participate.

This discussion is an opportunity for each of you to share your thoughts and opinions. We do not want you to share anything that will make you uncomfortable. You do not have to share personal stories or experiences if you do not want to. If you decide to discuss your own experiences, do so in a way that makes you feel as comfortable as possible. Secondly, I am here to make sure we fully discuss each topic and ensure that everyone gets an opportunity to speak, so please talk to one another and don't worry about talking specifically to me.

RULES OF PROCEDURE:

1. There is no right or wrong answers.
2. You don't have to agree with what anyone else says.
3. Give anyone a chance to speak.
4. What we talk about in this room must stay in this room.

ICE BREAKER

I would like to begin by going around introducing ourselves by first name only, and having everyone say a few words about what they do for a living and in their free time.

MODERATOR:

As much as possible, try to remember your impressions the very first time you heard about HIV/AIDS and the first time you saw an AIDS patient. Your initial reaction, the community and government response to the disease and patients. Our main focus should be on how all the issues relating to the HIV/AIDS epidemic were discussed at all levels in the country e.g. in interpersonal relationships, through the media, churches, drama, song, politics, in the community, in the workplaces, at schools etc. Equally important is how members of your age group and yourself as an individual managed to survive since the disease was first identified to the present day.

SECTION ONE

Before we start our discussions, kindly take a few minutes to complete this brief questionnaire which asks for some demographic information. Don't write your name on this paper.

1. Age:
2. Sex:
3. Highest level of education:
4. Occupation/Profession:
5. Ethnicity :
6. Religious affiliation:
7. Where were you living by 1982?
8. Were you sexually active by 1982?
9. When was the first time you heard about HIV/AIDS?
10. When did you first see a person that was suspected to be living with HIV/AIDS?

SECTION TWO

BEGINNING OF THE DISCUSSION

GENESIS (1982-1986)

1. How old were you when you first heard about HIV/AIDS? Were you already sexually active then? Where were you living at the time?
2. When you hear the word AIDS do any particular stories come to mind from either your own experiences or from experiences of your age-mates or other Ugandans?
3. How did you understand HIV/AIDS as it was defined and explained by your community, medical practitioners, the media, and government?

4. Can you please discuss any HIV/AIDS conversations and experiences you have had from any Ugandans who had first-hand contact with the disease? If not, what do you consider to have been the most important features of HIV/AIDS epidemic in your own knowledge and experience at both the community and the national level?

UPSURGE IN HIV/AIDS INFECTIONS AND DEATHS

(This is the period when HIV/AIDS infections and deaths were at their highest in the country)

1. How did individuals, your community, the mass media, and government locally and nationally communicate their response and how did they cope with the increasing AIDS related cases and deaths?
2. What changes in the communication behavior about AIDS did you notice among your peers, at the community level, and did these changes become part of the new vocabulary?
3. How did you as an individual respond to the anti-HIV/AIDS messages during this period?
4. Did you experience any form of temptations to indulge in any risky sexual behavior that were contrary to the anti-HIV/AIDS campaign messages? How did you handle such temptations?
5. What is the major factor that contributed to your survival and how was it communicated to you?
6. What do you think were the major obstacles in the campaign against HIV/AIDS?
7. Why and how do you think the obstacles against the HIV/AIDS campaign were overcome?

DECLINE IN HIV/AIDS INFECTIONS AND DEATHS

(From 1995 government and international organizations reported decline HIV/AIDS infections in the country. Let's talk about that time period.)

1. Have you recognized any decline in the rate of HIV/AIDS infection and deaths in your age group in your community and the country?
2. How is the decline changing the way your age group communicates about AIDS?
3. Have you noticed any changes in behavior among your peers as a result of the HIV/AIDS epidemic?
4. Have you witnessed or participated in any local or national discussions on how AIDS has been recognized as an existing reality in the day to day life of your peers and the rest of the people in your community?
5. As a result of HIV/AIDS, have you observed any changes in customs, attitudes, norms, beliefs, and values in your community and among other Ugandans?
6. What is your general opinion about HIV/AIDS in your community and in the country today?
7. Is there anything new about HIV/AIDS that you do not know and need to be educated about to protect yourself from the disease?

MAINSTREAMING

(Let us talk about AIDS in today's culture)

1. How has AIDS changed the social, economic, cultural, and political lives of people in your age group and among other Ugandans?
2. Is there any evidence to show that HIV/AIDS is gradually contributing to a new and emerging culture on health among your age groups and among other Ugandans in general?
3. How is the existence of AIDS in your community and national life contributing to the entrenchment of new communication styles and behaviors about AIDS among your contemporaries in your community and the country at large?

4. Do you think health is a priority among your peers, other citizens, and to the current government?
5. Do you think people living with HIV/AIDS are more stigmatized in your community and at their place of work or have a contribution to make to the development of the country?
6. Do you think HIV/AIDS is still a taboo subject to talk about in any community or people freely discuss the subject with patients and others in the community?
7. When people die of HIV/AIDS, are their deaths freely and publicly attributed to HIV/AIDS or they are covered up in some indirect descriptions? Why?
8. Is there anything of communication importance about HIV/AIDS that we have not discussed?

Thank you for sacrificing your time to contribute to this study.

APPENDIX F

FOCUS GROUP PROTOCOL TRANSLATED INTO LUGAND

ENTEGEKA YE'EMBOOZI

ENYANJULA

Abateesa mwena mbaniriza.

Buli yenna gwe tuli naye wano mwebaziza okwerekereza byonna najja yetabe mukukubaganya ebirowoozo kunsonga enkulu bweti.

Nteseteese oba ntegeese okukubaganyiza awamu ebiriwoozo kuno ntegeere Baganda banno naddala bwemwenkyanya emyaka bwebategeera n'okunnyonyoka ebifaku siliimu eyaggukira e Rakai mu mwaka gwa 1982 naguno gujwa. Olumbe luno siliimu njagadde nnyo tulukubaganyeko ebirowoozo ku ngeri gye lusasanidde Uganda yonna; nga naye ekisinga kwe kutegeera oba okusala amagezi ag'okululwanyisa wamu kitole; gavumenti, abasawo ab'ekizungu n'ekinnansi, abantu babulijjo, abakozi naddala aba gavument ssaako abavubuka nebannaddini. N'ensonga endala gwogere ku ngeri gavumenti gye yasobola okulwanyisa nawokera oyon'abantu benyini basobola batya okweddamu nga bategedde nti siliimu lumbe olwabayingirira. Ensonga eno tujja kugigabanyamu emitendera ena tugyogereko kinnemu: Enkwata, okukanya omuli nokuga oba okutta, okukkakkana oba okukendeera n'okumulangirira mu lwatu.

Amateeka getunagoberera

1. Kyonna kyetwogerako kisigala wano.
2. Tosanye kugoberera oba kukkiriza byamunno byayogede.
3. Buli omu ajja kuweebwa omukisa okuwa endowooza ye.
4. Byonna byetunayogera byakukoma wano.

Omukubiriza

Mu bwangu bwekitalo jukira gyewabeeranga omale owulire ku siliimu. Wawulira otya ddala kubikwata ku siliimu olubereberye nengeri gye wasooka okutunula ku mulwadde w'olumbe olwo?

Mwe ng'abantu ne gavumenti yonna magezi ki ge mwawa eri abalwadde n'obujjanjabi?

Essira tulisse ku ngeri ekizibu kya siliimu gyekyayasanguzibwa n'okusalirwa amagezi muggwanga lyonna gamba mubantu nebannaabwe, okweyambisa emikutu gyamawulire, amasinzizi (Kelezia/Kanisa) katemba, ennyimba, eby'obufuzi, mubantu kumirimu kumasomero nawalala, naye ate ekikulu era ekyomugaso okumanya ggwe nebanno bwemwenkana emyaka mwekuumye mutya olumbe olwo, bukya lumanyika okutuusa leero?

EKITUNDU EKISOOKA

Nga tetunatandika mboozi yaffe, mbasaba musoke mujuzeemu ebibasabidwa wamanga Ensonga zino zikukwatako nnyo bwoty'o osabibwa okujjuzaamu ebisabiddwa wabula towandiika linnya lyo ku lupapula luno okujjako ebyetagisa byoka.

1. Emyaka
2. Ekikula
3. Obuyigirize obwokuntikko
4. Omulimu
5. Eggwanga
6. Eddini gyosoma

EKITUNDU EKYOKUBIRI

Enzija ya siliimu 1982 – 1986

1. Wali wenkana otya lwewasooka okuwulira ku siliimu? Wali otandise ebyomubuliri/akaboozi ak'ekikulu? Wali oberawa mukiseera ekyo?
2. Buli lw'owulira lku kigambo siliimu oina ekinty kyonna kyojjukira ggwe wennyini oba ku banno bwemwenkana ekikwesiswaza?
3. Wateegera otya olumbe olwo siliimu nga lwogerwako abasawo, emikutu gyamawulire, abantu ne gavumenti?
4. Oyinza okukubaganya ebirowoozo ku siliimu ng'osinziira kubyali bikulombojjeddwa banna Uganda abasooka okukwatibwa olumbe olwo? Oba tekisoboka olowooza abantu aba gavumenti bandisanye kukolera ki olumbulege olwo?

Okusajjuka kwa siliimu nabatta

(Kino kye kiseera siliimu weyattira abantu abangi enyo muggwanga).

1. Abantu ssekinoomu, ebibiina, emikutu gyamawulire, gavumenti ezebitundu neyawakati byesowolayo bitya okwanganga omulabe n'okutakiriza abantu baleme kuggwaawo?
2. Njawulo ki gyolaba munkwata ya siliimu evudde mu kwogerwangako ennyo emikutu gyamawulire era akaati ako akogerwa ku siliimu eyo gyobeera yafuuka ngombo?
3. Mu kiseera kino gwo ng'omuntu obubaka bwokwewala siliimu obutwala otya ng'ekyokuyiga?
4. Wali omemeddwaako okukola ekikolwa ekyobukaba ky'omanyi nti kikontana n'obubaka obwokulwanyisa siliimu? Ekiseera ekyo wakiyitamu otya?
5. Ddala mu kulaba kwo kki ekyakusumattusa siliimu, era ngeri ki gyewamuwona?
6. Olaba mizizikoki egyekiika mu kawefube w'okulwanyisa siliimu?

7. Ngeri ki gy'olowooza nti ye yeyambisisbwa okujebalama?

Okukendeera kwabakwatibwa n'okuttiibwa silimu

(Okuva mu 1995 gavumenti n'ebitongole eby'ensi yonna byalangirira nti siliimu akendedde, kati katwogere kubibadde mukiseera ekyo).

1. Gwe kululwo okakasizza nti siliimu ekendedde okukwata n'okutta abantu abekigero kyo, ewammwe n'emuggwanga lyona okutwalira awamu?
2. Abantu ab'ekigerokyo bawa kifaananyi ki nga siliimu akendedde okubakwata.
3. Siliimu okakasa nti asobozesezza nnyo abantu okweddako munneyisa naddala abato?
4. Wali obaddeko awantu wonna nemwoger aku siliimu nti ddala aluma abantu?
5. Bwewetegereza siliimu alina engeri gyakyusizza empisa zabantu ezenjawulo ng'obuwangwa, enzikiriza nebirala mweyandiyise okubakwata?
6. Wetwogerera gwo ngomu siliimu omulowoozako otya eyo gyobeera nemuggwanga lyonna?
7. Eriyo ensonga yonna ekwata ku siliimu gyotannayiga gyewandyetaaze okuyiririzibwa osobole okwetaasa?

Okwoleka lokwasanguza siliimu mulujjudde

(Katwogere kaati ku siliimu kyakoze).

1. Siliimu nga bwolaba akyusizza atya embeera za'abantu abekigerokyo ezabulijjo, obuwangwa, nebyobufuzi wano mu Uganda?
2. Siliimu alina engeri gyatangiddemu abantu bewammwe obutamala gegyagyamya neggwanga lyonna okutwalira awamu?
3. Siliimu ono ddala yandiba ensibuko y'obulamu obujja mu banna Uganda ab'ekigero kyo nabalala okutwalira awamu mu Uganda yattu?

4. Olowooza ebyobulamu nsonga eri ku mwanjo eri banna Uganda abato n'abakulu ne gavumenti yennyine eyawakati?
5. Olowooza n'okukakasa nti abalwadde siliimu benyinyalwa eyo ewammwe negyebakolera oba nabo bakola kinene mu kukulakulanya eggwanga?
6. Olowooza siliimu akyakwaasa ensongi okwogerako oba abantu bamwogerako kaati kababe abamulwadde bennyini?
7. Abantu nga bafudde siliimu kyogerwa kaati oba wabaawo okwekwasa ensonga oba endwadde endala yonna?
8. Eriyo engeri yonna ekwata ku siliimu gyetutakoonyeko?

Okoze omulimu gwattendo mu kunonyereza kuno. Webale nnyo webalire ddala.

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