Armed with 15 years of HIV-related mental health experience in New York’s inner city and six boxes of books and documents, I arrived in sub-Saharan Africa in January 2003 committed to assisting the University of Namibia respond to the HIV epidemic. I also arrived with feelings of great urgency: “People are dying here,” I thought, “Let’s get moving.” Seven months into that Fulbright Scholar Program-funded year, I had not made the slightest dent at the university. Nor could I convince the U.S. Agency for International Development to fund a testing and counseling center for university students.

Preparing for Namibia, a polyglot country with about 13 ethnic groups, I knew that I would find significant differences in cultures. I knew that counseling and mental health care, when it was available, was construed differently than it was in the United States. But the depth of the differences and my inability to crack the cultural and political codes made me feel what I had not in a long time: ineffectual. With my failures piling up at midyear, I almost gave in to the panic. Fortunately, I had the sense to step back before I gave in to giving up.

I realized that I needed to take time: time to accept my ignorance, time to let go of the need to achieve, and time to simply observe. Understanding came slowly but powerfully. It led me to a greater appreciation of Namibian cultures and toward the recognition that I might have something useful to contribute after all.

These stages of being a cultural stranger—trying hard and failing, feeling incompetent, acknowledging cultural ignorance, quelling the hyperactivity, and opening up to the culture—may or may not be typical of the professional who attempts to contribute in another country. But it was my path.

A Battered World

It is hard to imagine aspects of life in which people from the United States and people from Africa are greater strangers to each other than in the psychosocial realm of HIV disease and the deeply personal realm of mental health. In addition, the relationships between White providers, whether from Africa or other continents, and Black African clients are often freighted with painful histories, including colonial rule and, in Namibia and South Africa, apartheid. Namibia’s political leaders are deeply suspicious of aid now offered by Northern countries that had failed to back their liberation struggles. Yet, representatives of several Northern nations and aid organizations privately expressed to me concerns that the Namibian government is corrupt and inept.

While these politics play out, the people of Namibia suffer enormously. Namibia has one of the highest rates of HIV infection in the world, ranging regionally from 9 percent to 43 percent for women seeking prenatal care (the population sampled by the country’s biannual seroprevalence survey). There is no information about infection rates in men in this overwhelmingly heterosexual epidemic. Independent of South Africa’s apartheid regime since only 1990, Namibia has a bare-bones public health care system and almost no public mental health care, and there is little HIV care available.

The University of Namibia, founded in 1993, mirrors its society. Although the faculty senate passed an exemplary HIV policy in 2001 the policy remained mostly unimplemented during my visit.

Namibia’s Christianity permeates everyday life. It is no surprise, then, that counseling, which is largely advice-giving in Namibia, often expresses Christian sentiments and morality. Several times, I heard Black or mixed-race African counselors tell...
American popular culture values clarity, certainty, and rationality, and remains clear and certain that these goals are attainable. When venturing into other cultures, however, all that I believe or have always known is suddenly neither clear nor certain nor true.

As the epidemic has spread, it has swerved one way and then the other, affecting one "type" of people and then another type and then the first type in a different way. To ride this twisting dragon, providers working with HIV have been best served by the capacity to cross cultures. This capacity enables them to perceive "truth" in the relative terms in which it appears, not in science, but in nature, the nature of human relations and beliefs.

I, as a perceiver, rely too much on past experience, on assumptions and stereotypes, in my interactions not only with strangers and acquaintances, but also with those closest to me. This is true even when these people share a gender, a sexual orientation, an ethnicity, an age, all the attributes that we line up to describe culture. I strive for simple explanations of their moods, their motives, their desires, our interactions—and I strive for certainty. I cannot move through life without making assumptions, but I can be alive to my assumptions, and that awareness seems to be the essence of working cross-culturally—whether it is across the house, across town, or halfway round the world.

Mark Winarski, a psychologist who routinely crosses cultures in his work in the Bronx, bravely narrates that journey from cultural certainty to cultural confusion to cultural responsiveness in his article about his year in Namibia, sharing both misunderstandings and successes. Likewise psychiatrist Paul Linde describes the gulf of cultural difference he discovered during his year in Zimbabwe, where the difference between modern psychiatry and traditional beliefs may be more about the divergent questions people ask than the answers they finally agree upon.

Lisa Loeb's review of the uniquely successful disease control efforts of Uganda suggests that assumptions can undermine efficacy not only when providing services, but also when evaluating the results of that service. While many have assumed that the appeal to be faithful to married partners was responsible for dramatic drops in seroprevalence, it appears that the situation was much more complex and multifaceted, and that fidelity may be the one message for which there is no significant evidence suggesting a role in Uganda's HIV success story.

These African experiences are particularly important now as the world rushes, overdue but still underfunded, to help this continent confront an AIDS epidemic that we can only begin to imagine. They may also be more relevant than they seem as we in the United States continue to face divides among our own subcultures in places like New York, San Francisco, rural Georgia, and Newark, New Jersey.

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Editorial: The Truth about Truth
Robert Marks, Editor
The Namibian Cultural Context

Having failed to make any progress at the university or to persuade USAID to establish a counseling and testing service for students, I gradually realized that my agenda was not the same as that of my hosts. It was only July and I was to be in Namibia until Christmas. I now took time to reflect and observe, to try to understand the complexity of Namibian cultures. Among the aspects that engaged me were community, spirituality, sexuality, and fatalism.

Community. For most Africans, their ethnic community offers their primary means of survival and sustenance. A norm of most ethnic communities in Namibia was silence regarding HIV. Disclosure of HIV infection, inadvertent or deliberate, can mean being stigmatized—marked and cast out of the community—and losing sources of love, protection, and sustenance. It can also result in beatings or murder without community dissent.

It occurred to me that a culturally sensitive counselor in Namibia would consider not only a Namibian client’s immediate family, but also his or her community system. The counselor might help an African client keep secret rather than disclose HIV infection, even teaching that client how to hide medications. African counselors must also consider community-level interventions, for example, involving community leaders in projects that support the role of men and boys in fighting violence against women.

Spirituality. The expressions of African life that I witnessed were abundantly spiritual. Namibians and other Africans I met were in awe of the design of the nature they experienced so intimately. Little night lighting, no screens on windows, and few fences mean that Namibians are not separate from the outdoors and other creatures. In nature, many Africans apprehend something greater, an awesome underlying force that many call God or Allah. Most Namibians express their spirituality through Christian churches, whose responses to HIV have included silence, punitive messages, calls for abstinence, and pragmatic action.

I realized that secular Western counseling practice seems arid to Africans, since it ignores their emotional responses to nature and God. Afrocentric counseling and mental health practice, as it is evolving, is more spiritual and less “rational” than Western practice. A skillful therapist would acknowledge my first client’s “curse.” The therapist might go on to suggest that this client both take his antipsychotic drugs and consult a traditional healer who would seek to counter the original curse.

Sexuality. For Northern health care workers concerned about preventing HIV, sexual practice and mores in Africa remain mysteries. One Namibian politician, in the foreword of one of the few books on culturally based sexual norms, wrote, “Sex, sexuality, and sexual preferences are some of the most feared taboos in Namibia.”

In Namibia, there was little public discourse about sexuality, other than attacks on homosexual behavior. The single book I could find on sexual practice—focusing on two Namibian ethnic groups—helped me understand the painful ignorance of Northern HIV prevention experts. The author reported that these two groups have no word equivalent to the English term “abstinence,” and that prevention messages focusing on intercourse and abstinence have not been tested in such a polygamous environment.

I also failed to anticipate the strong feelings White Africans voice about Black sexual practices. First, I encountered the White social worker’s allegations of Black psychossexual disorders. Then, a White psychologist called me unethical (immoral, really) for suggesting that condoms with a mild anesthetic to retard premature ejaculation might induce Namibian men to use protection. She objected to the idea, she said, because it focused on sexual performance rather than on sexuality within monogamous relationships. President Thabo Mbeki of South Africa has observed that White Africans regard Black Africans as “rampant sexual beasts, unable to control our urges.”

Fatalism. One afternoon I found a crowd of students by the university swimming pool, watching as a Swiss volunteer futilely tried to resuscitate a young man found at the pool’s bottom. The pool had no life-guard, alarm button, telephone, or other lifesaving devices. Campus security officers could not help.

Afterwards, I asked several people why this situation exists. One man explained, “That’s the way people think. If you go to the countryside and get bitten by a mamba (a poisonous snake), well, that’s just bad luck. If you get bitten by a mosquito with malaria, that’s just bad luck too. The boy who drowned had bad luck.” Upon reflection, this story suggested to me the reason

for the country’s failure to respond to HIV: the perception that people with HIV simply have bad luck. Perhaps there was little point trying to prevent or respond to bad luck.

My Small Contribution

Forced only to observe and to learn more about these other cultural realities, I discovered that I might be able to make a small contribution after all. I suspected that some Northern counseling practices might, in fact, fit well into Namibian cultures.

In my final months the country, I wrote a counseling primer for the Africans, who typically have no more than a high school education, being recruited by HIV organizations to be counselors for people affected by HIV.7 I offered it humbly.

Perhaps it was because of decades of pain, compounded by new losses, that Namibia had so many people of great empathy. I saw Catholic AIDS Action volunteers, with little more resources than their clients, walk kilometers to make home visits. It seemed natural that counselors seek to understand themselves to be “participant-observers.” The mindful counselor observes and considers every-thing, paying attention to such aspects as the physical context of the visit (for example, in a clinic, a refugee camp, or a home), the culturally defined ways in which both provider and client behave, and the feelings that arise during counseling.

Because death is a daily occurrence for many communities in Africa, I suggested that J. William Worden’s grief counseling principles may assist the healing.9 Finally, my book suggests that 12-step programs are consistent with the spirituality and communality of many Africans, and that the transtheoretical model10 and motivational interviewing,11 might assist counselors to work with the ubiquitous and generally unaddressed substance use.

Conclusion

My problem with the Serenity Prayer of Alcoholics Anonymous has been this: How do I know for sure that I cannot change something? My experience in Namibia taught me about the singular role of wisdom in knowing. But knowing—the rational—and feeling—the not-rational—are two different and sometimes opposing experiences. It is difficult to be patient or to give up the fight when so many people are suffering, in Namibia or in the Bronx. Faced with delays, I thought to myself, “This waste of time would be tolerable if there weren’t an epidemic.” Americans say, “Let’s get going,” while Namibians say, “Take time to get to know us,” not rushed by an epidemic that is just another in a long queue of life-threatening conditions. When the expensive programs provided or dictated by Northern workers show little improvement in African infection or mortality rates, perhaps it is because those providers arrived, as I did, impatient.

Clearinghouse: HIV in Africa

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See also references cited in articles in this issue.
The terms sub-Saharan Africa and AIDS have almost become synonymous and for good reason: HIV is the leading cause of death, and in certain countries in the region, more than 20 percent of the adult population is HIV-positive. One country, however, stands apart. Unlike its neighbors, Uganda’s response to the epidemic was swift, dramatically reducing estimated HIV prevalence among adults from 18 percent in 1992 to around 5 percent in 2004. As a result, international policymakers hold out Uganda’s response as an example of “best practices,” and encourage other nations to adopt this approach.

Specifically, many attribute Uganda’s success to its “ABC” campaign, the combination of Abstinence, Be faithful, or use Condoms. But the evidence is equivocal; in particular, the role of monogamy (“be faithful”) in the decrease in HIV prevalence is not clear. This article briefly reviews the literature on the Ugandan experience, and explores what we know and what we do not regarding the success of the Ugandan approach.

**Story of a Small African Nation**

Uganda is a tropical nation, about the size of Oregon, located between Sudan and Kenya. Ninety percent of the population of 27 million live in rural areas, surviving generally as subsistence farmers, and more than 40 percent live “in absolute poverty.” About 50 percent are children, and one-third of children ages 6 to 9 have never been to school. About half of the population has no appreciable access to health care facilities.

The Masaka Study determined that circa 1990, 52 percent of the population had never tested for HIV, and one-third of men and women ages 6 to 9 have never been to school. About half of the population has no appreciable access to health care facilities. To get medical attention, the average person must walk one full day to reach a health center, and most of these centers are staffed by lay personnel with no formal medical training. Life expectancy is currently 43 years, and has dropped significantly as a direct result of the AIDS epidemic.

Approximately 84 percent of all HIV transmission in Uganda is attributable to heterosexual transmission. The rest is attributable to parent-to-child transmission.

**The Cuban Connection**

When the current Ugandan President Yoweri Museveni overthrew the notorious dictator Idi Amin in 1986, he sent the army he inherited to Cuba for training. Fidel Castro had these men tested for HIV, discovering that 18 of the 50 generals were infected. Castro called Museveni and said, “You have a problem.” Shortly thereafter, Museveni spoke to the whole nation about HIV in Uganda, and this willingness to confront the issue, directly and publicly, marked the beginning of Uganda’s large-scale, multisectoral, and candid HIV education campaign.

In the early 1990s, HIV prevalence in Uganda was almost 20 percent, versus about 5 percent in most other African nations. This situation has basically reversed itself, with prevalence in many other African countries rising to between 20 percent and 30 percent as Uganda’s has fallen to about 5 percent.

These data demonstrating Uganda’s unique success are compelling, but they do not tell the full story. To track the epidemic, Uganda, like most countries, has used sentinel surveillance, collecting data on HIV prevalence among pregnant women attending an urban antenatal clinic. Failure to track true incidence or, at least, monitor other groups, such as young men and sick people who are not sexually active, has resulted in an incomplete picture of the current epidemic.

Generalizing from antenatal clinic data will bias the estimate in favor of the healthy and the fertile; a true population-based estimate of HIV prevalence may be much higher. Indeed, data from sexually transmitted disease clinic attendees showed HIV prevalence of 52 percent in 1989, declining to 23 percent in 1999, and recently estimated at 20 percent.

Conversely, data from voluntary counseling and testing sites indicate that HIV prevalence rose among women older than 39 years of age, a population not typically attending antenatal clinics. Moreover, antenatal clinic data fail to capture important trends of improvement in other populations or localities, such as a trend among certain districts which had never reached more than 10 percent prevalence but still managed to decrease prevalence to below 5 percent.

**HIV Prevention Interventions in Uganda**

Uganda has been the setting of three seminal intervention studies, whose results have made key contributions toward the design of potentially effective interventions. The HIVNET 012 trial demonstrated that a single dose of nevirapine, given to mother and baby, reduced the risk of mother-to-child transmission by about 50 percent. This simple and inexpensive intervention has been implemented throughout the world and has saved countless lives.

The Masaka Study determined that certain behavioral interventions—including an education intervention using theater, video, and counseling—alone were insufficient to reduce HIV incidence. The Rakai Project References
determined that antibiotic treatment of all of a village’s residents to treat and prevent sexually transmitted infections had no effect on HIV incidence. However, researchers suggest that the most likely explanation for the lack of effect in both studies is the relatively advanced stage of the epidemic in Uganda.

The Rakai Project showed that male circumcision might reduce risk of HIV infection, and demonstrated the importance of addressing domestic violence and substance abuse: 90 percent of the women viewed “wife beating as justifiable in some circumstances,” and frequent use of alcohol before sex by the male partner increased the risk of domestic violence almost five-fold. Each of these ancillary discoveries is currently being expanded into full-scale trials of formal interventions.

But it is the “ABC” campaign that has garnered the most public attention. “A” represents “abstinence,” the act of delaying the onset of sexual activity until marriage. “B” represents “Be faithful,” the behavior of limiting sex to one partner, thereby interrupting sexual networks and preventing infections from spreading into or beyond couple-pairs. “C” represents “Condoms,” the practice of consistently using condoms if a person does not achieve either abstinence or fidelity.

There is evidence for increases in both “A” and “C” since the institution of the campaign in Uganda. There is even evidence that HIV-related mortality alone may have accounted for the decline in HIV prevalence, meaning that the number of existing cases decreased because sick people were dying, not because new cases were prevented. But there are not compelling data showing an impact on the epidemic of “B,” the adoption of monogamy by previously non-monogamous people.

For example, the average age at sexual debut, a proxy measure of abstinence, which increased among young men from about 17 years old in 1995 to about 19 years old in 2000 did not change among young women. Overall, regular use of condoms remains rare; in 2001, only 7 percent of women and 15 percent of men reported that condoms were used at their last instance of sex, although the rate was higher with non-cohabitating partners (38 percent and 59 percent, respectively).

Despite this evidence, and the desire to link decreases in HIV transmission to ABC, it would be epidemiologically dishonest to directly ascribe the changes that did occur to any one policy or program. Further, Uganda has instituted other programs beyond ABC: Uganda “pioneered approaches toward reducing stigma, . . . involving HIV-positive people in public education, . . . involving religious organizations, enlisting traditional healers, and much more.”

What Worked in Uganda?

In fact, the “Ugandan Success Story” began before ABC with the visible commitment at the highest levels of government to addressing the HIV epidemic from its earliest stages. UNAIDS has identified the key components of this success in the agency’s “Best Practices” series. These practices can be summarized as: national commitment, inclusive responsibility, and large-scale response.

Once Fidel Castro told President Museveni about the presence of HIV in the Ugandan military, Museveni took action immediately. He proclaimed that “fighting AIDS is a patriotic duty.” He ensured that responsibility for the epidemic was shared throughout multiple government ministries, and taken up by political, community, and religious leaders. Museveni backed up this commitment with a national AIDS budget. With this, Uganda implemented prevention programs on a large scale, for example, the government instituted condom social marketing services and HIV voluntary counseling and testing throughout the country.

Despite this success, it is important to mention three factors that have limited the success of Uganda’s response to the epidemic in terms of prevention, care, and the consequences of HIV-related death. First, access to HIV antiviral treatment has been severely limited (although dramatic price reductions, among other factors, are changing this). Second, Uganda has failed to curtail “property grabbing,” the act of taking home, cattle, and material goods from a widow and her children by the male head of household’s family after his death. Third, Uganda has no national policy regarding the care and support of the more than two million orphans left behind by AIDS.

Conclusion

Whatever the precise cause, it is clear that Uganda’s success is a tribute to a combination of decisive leadership and broad and sustained grassroots activity. Still, behavioral scientists will struggle for some time to tease apart the effective components contained within the strategy. But even as the epidemiological dust settles, it is clear that lives have been saved, families have been held intact, and Uganda’s efforts are worthy of praise indeed.
Visualize a misplaced Bedlam: a dusty courtyard in Africa, its perimeter marked by a chain-link fence topped with barbed wire; over-medicated and under-medicated patients milling about in institutional garb. In the male ward, furnished with metal beds and threadbare mattresses, 20 men wandered about in various states of undress, some heading for the shower.

That was my workplace in Zimbabwe—the Harare Psychiatric Unit—where I worked as a psychiatrist for one year. The story of one client offers a view into the challenges that European and U.S. mental health clinicians face when providing care to people in Africa.

Psychosis or Bewitchment

I saw Tichaona M., a young man exhibiting manic symptoms, during my first month on the unit. Although Tichaona’s case appeared exotic to me at the time, I soon discovered that his presentation of psychosis was downright garden-variety in Zimbabwe, where patients and their relatives matter-of-factly attribute psychotic symptoms to ancestor bewitchment.

Tichaona had been treated for three days with high doses of chlorpromazine, the 1950s-era antipsychotic drug, the sledgehammer of psychopharmacology. Because it is dirt-cheap, it is Zimbabwe’s first-line agent for psychosis or bewitchment, either customized vexing engineered by a displeased ancestor spirit or diffused hexing imposed by a malevolent witch or sorcerer.

Psychiatric treatment from the n’anga included herbal concoctions, steam baths, scarification, and throwing bones to divine the source of a bewitchment. If the n’anga discovered a specific bewitchment, then he gave the family instructions to mend community rifts that may have been caused by the misdeeds or broken taboos of someone in the afflicted person’s family.

Peter told me that the n’anga scurred the top of Tichaona’s head and brewed a special tea for him to drink, but Tichaona’s symptoms worsened. The n’anga told Peter that he could do no more and told the family to bring Tichaona to a hospital, to a psychiatrist first when they view the cause of an illness to arise out of the “natural” world of the external environment, then they seek the opinion of a Western biomedical practitioner. Within Shona culture, disturbed behavior such as a psychotic break is generally thought to be a spiritual problem, the result of a bewitchment, either customized voring engineered by a displeased ancestor spirit or diffused hexing imposed by a malevolent witch or sorcerer.

Conceptualizing Illness

Approaching Tichaona’s case, I considered his family history, primarily the fact that his great-grandmother may have had schizophrenia and that his cousin may have had epilepsy. At the same time, I considered a medical cause, including cerebral malaria, neurosyphilis, tuberculous meningitis, HIV infection of the brain, and a nutritional deficiency of niacin called pellagra. I found no physical evidence of HIV disease, no indication of an infectious disease, and neither the telltale rash nor the diarrhea that would implicate pellagra.

I also ruled out a reactive psychosis. While marijuana—which Tichaona smoked

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—might have brought out the illness prematurely or exacerbated it, I doubted that smoking was the sole cause of Tichaona's psychosis because cannabis-induced psychoses are generally brief and respond quickly to treatment. A positive family history, Tichaona's eccentricity as both child and young adult, and the persistence and severity of Tichaona's psychotic symptoms all added up to what I suspected to be a first psychotic episode of what would probably become a chronic illness.

A Western-trained psychiatrist understands psychosis as an observed phenomenon with its basis in the malfunctioning of the brain's systems of chemical neurotransmitters and electrical pathways. But I knew that there was another way of conceptualizing the case, one that posed different questions. For example: Did Tichaona's great-grandmother have the power of prophecy, as Peter suggested? Was his cousin a conduit to the spirit world? Can psychosis actually be caused by a bewitchment?

Tichaona, with his sixth-grade education, readily understood the concept of faulty wiring in his brain as the cause of his troubles in the same way as he would understand that pneumococcal pneumonia is caused by a bacterium. But the beliefs and values of his African cultural heritage, the traditions passed down from generation to generation, made him care much more about the questions of "Why me?" and "Why now?" rather than "What?" or "How?"

In short, the magnificent powers of Western medicine could not provide Tichaona with answers to the questions that he considered most important. These answers could come only from the spiritual and existential realm that, for him, could be found only in the context of his traditional culture.

For Tichaona, the explanation that his illness stems from spiritual bewitchment becomes theoretically plausible. I, on the other hand, was left with the question, "How can I disprove this explanation?" Instead of attempting this task, I simply avoided interfering with Tichaona's understanding. Moreover, I told Tichaona that I understood his perspective: that his ancestor spirits had been speaking to him and afflicting him with anxiety, hallucinations, and paranoia. I believe that the fact that I did not think of him as a specimen or a madman was reassuring to Tichaona. Yet, this did not contradict my offer of solace and medication to alleviate his suffering. In the end, his spiritual model of affliction and my medical model of illness peacefully coexisted.

Even before I landed in Africa, I always thought that those of us practicing psychiatry were privileged to live in the border zone between the "natural" and "unnatural" worlds, by necessity, conversant with all three spheres of mind, body, and spirit. Yet, in stark contrast to the n'angas, I was indoctrinated to search for psychological and physical causes of psychosis and had no experience conceptualizing a spiritual cause for illness.

I ordered routine blood tests, including an HIV antibody test and a urine toxicology screen for cannabis. I stopped his chlorpromazine and started a more potent anti-psychotic medication called trifluoperazine to reduce his psychotic symptoms. Tichaona was much calmer, although he still suffered paranoia, intermittent hallucinations, and thought disorganization. Two weeks later, when he returned for a follow-up visit, it was clear that Tichaona had sustained his recovery. But since he still heard voices and experienced paranoia at times, I concluded that that his illness would likely be chronic.

**Conclusion**

During my year in Harare, other patients continued to teach me about the ways in which psychiatry could supplement, be supported, or be defeated by cultural beliefs. While this was enriching as an intellectual experience, it was even more rewarding as an emotional one. I provided expertise and knowledge that otherwise was scarcely available in Zimbabwe. In return, I received a daily lesson in the healing power of the clinician-patient relationship and how listening and understanding are the keys to healing.
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