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Title The Unsafe Sex of Exchanging Bodies Fluidly: Religion and Public Health Intersecting in the Context of HIV

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Background Dr. Blevins offered this lecture at *Maps and Mazes*. This conference represented one of the first large public conferences sponsored by Emory's Religion and Public Health Collaborative and was carried with significant participation from IHP and from colleagues at the African Religious Health Assets Programme. Dr. Blevins examined the role of religion and politics in relation to global HIV prevention programs, especially ABC (Abstinence, Be Faithful, Condoms) programs sponsored by the US government and carried out by faith-based organziations.

If you were paying attention to news stories in the midst of your Thanksgiving preparations last week, you may have been aware of two stories in national media in regard to HIV/AIDS. They were confusing because they were also contradictory. One news report implied that the HIV surveillance data published by the Centers for Disease Control and Prevention (CDC) had seriously underestimated the annual rate of new HIV infections in the United States; the other news story reported that the United Nations and the World Health Organization had seriously overestimated worldwide HIV prevalence last year. In order to understand the implications of these reports, we need to explore some of the background underlying their claims.

We'll begin that exploration with a media story reporting on a rise in new HIV infections in the United States in 2006. Media outlets focusing on gay communities in America released a news story on 16 November 2007 in which they claimed that the US Centers for Disease Control and Prevention (CDC) will announce in the coming weeks that the long-held statistic that approximately 40,000 Americans contract the HIV each year is wrong; according to these sources, the CDC is now estimating that number at approximately 60,000 (58,000-63,000), an increase of 50%.[1] There is no consensus regarding the causes underlying this sharp rise according to the report, though most experts agree that one component in the rise is improved HIV reporting from the fifty states now that HIV names reporting has been universally adopted.[2] Closer analysis of the data, however, does reveal troubling and ongoing trends: some local studies show sharply rising rates of infection in particular subgroups such as men under 30 who

have sex with other men while other subgroups have actually shown a drop in infection.[3] The news media interpreted the story to offer the following lesson: our HIV prevention efforts have reached an impasse in the United States and are failing us.

The second media story was released only three days after the first. It announced that the annual report on HIV/AIDS co-released by the United Nations and the World Health Organization would revise downward the current world-wide HIV prevalence rate from 39.5 million to 33.2 million.[4] In this new report, new infections in 2006 would be estimated at approximately 2.5 million, a reduction of 40%.[5] Though these particular data are too new to have been analyzed, the general consensus is that the overestimate was due to flawed statistical methods to ascertain the HIV prevalence rate in developing countries. In those countries, the HIV prevalence rate for women accessing antenatal care (ANC) in the healthcare setting was extrapolated according to mathematical formulas to the entire population.

The "meanings" attributed to this overestimation are just beginning to be heard. They are coming—and will likely come in greater numbers in coming weeks—from various social locations and contexts. In each case, these "meanings" are manufactured[6] to reinforce the values that underwrite those contexts. This manufacturing is not new. A literature review of the statistical analyses of HIV prevalence estimations reveals ongoing uncertainty as to the adequacy of either sampling or population survey methods. These analyses contradict each other: one study published in 2002 concluded that ANC sampling in Cambodia was statistically accurate except in rural settings, where the method overestimated general HIV prevalence[7] Another study published this year concludes that the method underestimated general HIV prevalence in Uganda in 2004 and overestimated HIV prevalence in Uganda in 2005.[8] Likewise, a study conducted in Zambia demonstrates that ANC sampling can both overestimate and underestimate, depending on other factors. This study demonstrates that ANC extrapolation underestimated HIV prevalence in both urban and rural settings; it overestimated HIV prevalence in the cohort of teenagers aged 15-19; and it underestimated HIV prevalence in adults (both men and women) ≥ 30 years of age. Published in 1998 (nearly ten years ago), this study offers this conclusion: "ANC-based data might draw a rather distorted picture of current dynamics of the HIV epidemic."[9]

Just last week in the popular media we had two stories that seem to convey oppositional messages. This is not a new phenomenon; efforts to interpret the various dimensions of the HIV epidemic have produced contradictory meanings and understandings for over twenty-six years now. This paper will argue that, on the whole, programs designed to respond to the multiple challenges that the HIV epidemic requires are limited in their effectiveness because they do not address the multiple social contexts and social realities of people who are at risk for the virus. Those social contexts are inherently contradictory, multiple, and ambiguous; this means that interpretation of the meaning behind the "facts" (e.g. data) will be contradictory, multiple, and ambiguous as well. We are uncomfortable with this ambiguity; we want and are demanded to develop evidence-based models with quantifiable efficacy. But there is a cost to that discomfort. The material cost of our inability to negotiate this ambiguity can be seen right here in Georgia as we examine HIV surveillance data and names reporting to the CDC.

When Bodies Count, Body Counts Matter: What Happened to 14,872 people?

Georgia began reporting the names of people who tested HIV-positive to the Center for Disease Control and Prevention (CDC) for epidemiological tracking in 2004. Prior to this time, Georgia had chosen only to report AIDS diagnoses to the federal government.[10] Since December

31, 2003 Georgia has identified 12,143 HIV-positive citizens.[11] Despite this large number, however, only 6,436 (53%) have been added to the official federal HIV surveillance data for Georgia. The reasons given for the absence of the 5,707 individuals who were diagnosed and reported but not counted were two: 1) the individuals had an initial positive test in another state and therefore "counted" in that state's count; and 2) clear demographic information (the ambiguous, contradictory, or missing information regarded risk exposure in almost all cases) required by the CDC to substantiate a case had not been provided by the state. [12] Both of these reasons are direct examples of the failure of public health institutions to traverse social locations. The first reason reveals that the CDC cannot account for people actually moving between two states (a clear example of inhabiting a different social location). The second reason reveals the ambiguity and anxiety in quantifying risk behaviors; those risk behaviors occur in social contexts, not in isolation.

In addition to these 5,707 individuals who are residing in Georgia but who do not appear in federal statistics for the state, there are an additional 9,165 individuals who tested HIV-positive in this time period that the state did not report to the CDC because the state's own surveillance reports were incomplete; of these individuals, 2181 had a CD4 count below 200 cells/µl (an AIDS diagnosis).[13]

The numbers at the heart of these data are staggering: 14,872 people in Georgia have been diagnosed with HIV but they are not represented in the federal HIV surveillance data for this state. The impact of this discrepancy is even more staggering: Georgia loses out an ever-tightening federal dollars for HIV services—this is the money that provides medical and support safety nets for HIV-positive individuals who have no recourse beyond the public health system for their care—because disbursement formularies for Ryan White funds are determined by HIV prevalence rates. In fiscal year 2007, metropolitan Atlanta saw a two million dollar reduction in Ryan White funding even as the agencies serving HIV-positive clients reported an increased case load.

Exchanging Bodies Fluidly: The Multiplicity of Social Location

People inhabit various social locations as they go about their daily lives, participating in a variety of larger social networks. Prevention programs, to use one example of large-scale responses to the epidemic, fail to address this multiplicity adequately. Catherine Campbell, a social psychologist who has studied HIV prevention programs in South Africa, argues that most research in HIV prevention has focused either on macro-level barriers (the effects of poverty, racism, sexism, homophobia, and other social ills on society understood in monolithic universals) or on micro-level interventions with individuals isolated from their larger social networks (e.g., health education efforts that emphasize individual behavioral changes to lessen the likelihood of transmitting or contracting the HIV virus). Campbell focuses her research on the intermediary social space between the macro and the micro: the various social networks of local communities.[14] In this paper, some of the powerful social networks that will be explored are Christian churches. [15] Churches are powerful social networks in regard to HIV because they are perceived to offer clear messages about risk behaviors, particularly sex and drug use.

In moving beyond the binary of either the isolated individual or the monolithic society to an analysis situated in the context of the social networks with which people affiliate, this paper also reconfigures the body. The body, from this context, is not a discrete, isolated biological organism; it is a social body. People do not travel among various social networks only in their minds. They bring their bodies with them. A Christian in church on Sunday enters into that

space in her body: she uses the body in her religious practice. Maybe she prays or sings; maybe she dances and claps; maybe she kneels; maybe she embraces those around her as she wishes for them the peace of Christ; maybe she feeds her body with the body of her Savior. But the person and the body who experience all of these social practices in the context of Sunday worship also inhabit other social sites. Where does she go in the other patterns of her life outside of Sunday? What does she do with her body in those places? And in what ways do those social settings communicate their values? What are the complex and myriad mechanisms—sometimes explicit and oftentimes implicit—which educate individuals in the expectations and the taboos that mark their bodies in social spaces?

How many people in Atlanta inhabit social bodies that perform the rituals of their religious community and that also perform the rituals encouraged by the networks of, say, the various bars and nightclubs in midtown (I'm not sure I would call this network a community, though I would argue that gay bars are important institutions in the social fabric of the gay community)? How many of those same people feel, in their very bodies, the prohibitions that each of those social sites communicates about the other sites? After all, many people don't talk about church when we're flirting with a potential date and we don't recount the blurry haze of Saturday night when we're in church on Sunday morning. And so, even as we traverse various social sites, those very sites attempt to barricade themselves from the influences of other social sites. This is the case not only in the binary of nightclub and church; it multiplies beyond any set of binaries across multi-faceted networks of work and church and recreation and friendships and nightlife and marketplace and school and neighborhood. We traverse multiple terrains; when we migrate across terrains that are discontinuous in their presuppositions or implicit values, the messages, meanings, values, and practices in one context do not easily migrate with us. Meanings remain local, parochial. HIV prevention program, for example, may permeate one of those locations, spreading a message about risk reduction in that context. But because we are all nomads across multiple social locations, the message in one context does not easily immigrate to another location. Bodies may travel fluidly, but knowledge and meanings may not.

The challenges of negotiating the intermediary space between the macro/social and the micro/individual become clearer in light of a specific example. Because this paper argues that Christian churches are important social sites for the creation and enunciation of the meanings our culture ascribes to HIV, it will utilize a widespread (nearly universal in US-funded programs) model of HIV prevention known as "ABC": ***A***bstinence, ***B***e Faithful, and ***C***ondoms as such an example. This analysis will reveal the complex intersections and tensions between public health and Christian religious communities. Following this analysis, the paper will point to examples of some religious and public health programs that find ways to negotiate the intermediary space of local communities; these programs will be offered not as solutions to the challenges of HIV in public health and religious communities but as examples that could help scholars either in religious studies or public health begin to formulate alternatives that could resist the either-or binary of the macro/culture or the micro/individual and that could help gain a degree of comfort with ambiguity and contradictions.

Administering and Building Coherence: The Other ABCs of HIV Prevention Programs

The ABC model of HIV prevention has been pervasively implemented in sites which receive United States federal government funding (largely PEPFAR and USAID) around the

world. The model is widely criticized in some arenas and vigorously defended in others. The purpose of this paper is not to take sides in that debate but to say that the debate itself in completely predictable. It is predictable precisely for the reasons articulated above: HIV traverses across a multitude of social contexts because people traverse them; culturally-imbedded messages of meaning, values, and choices do not. In the context of ABC as a model of prevention, a message penetrates different social contexts—but only a part of the message takes hold in each of those contexts. The other parts of that message are ignored or rejected or attacked.

This is so, in part, because the messages are not value neutral. They do more than merely offer choices and describe behaviors; rather they are perceived either to consolidate and support the norms of particular contexts or to challenge and attack those norms. To understand the impact of these prevention messages on perception, we need to examine each of the three messages of ABC.

In contexts where "Abstinence" reinforces the formal social norms—social contexts for adolescents such as schools or church youth groups—abstinence reiterates ideals of sexual delay as sexual purity while also providing a fool-proof prevention strategy. The message dovetails with the second of the prevention messages, "Be faithful," which is held up as a future ideal of monogamy in marriage. The message of abstinence is strongly and directly tied with religious organizations. A striking example of the connections among abstinence in HIV prevention, religious organizations, and government funding can be seen in the prevention programs developed in Uganda with funding from USAID and PEPFAR. Uganda adopted the "True Love Waits" program first developed by the Southern Baptist Convention and amended by the Roman Catholic Church as the model for HIV education in the country. In reporting on the role of Ugandan President Yoweri Museveni and his wife, Janet, in implementing abstinence education, press releases from the Southern Baptist Convention spoke not only of the success of abstinence as an approach to HIV prevention but also of the dangers of any other approach:

> Janet Museveni spoke June 17 to a crowded room at the Omni Shoreham Hotel in Washington, D.C., during The Medical Institute for Sexual Health's annual meeting. The institute presented Museveni with the "Hero Award" for the efforts she and her husband put forth to create awareness and for their success in promoting abstinence over "safe sex" methods. Museveni said one of the most effective strategies used in communicating that message was through True Love Waits….
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> "Religious organizations played a major role in prevention [of HIV/AIDS] and had a strong influence," Museveni said. "When we adopted the True Love Waits slogan, we found that the most important thing was focusing on our spiritual foundation and values." Uganda's willingness to embrace the abstinence-until-marriage program helped turn the AIDS crisis around. Museveni cited a 2000 report in which 95 of 100 Ugandans were either abstinent or only had one sexual partner. She added that 99.7 percent of the population in Uganda is aware of HIV/AIDS….
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> Museveni referred to safe sex initiatives, such as distributing condoms to the public, as both irresponsible and ineffective. "The truth is, there is no safe sex outside of faithfulness in marriage" -– a foundational message of True Love Waits. "One thing my husband used to say is that 'a thin piece of rubber is all that

> stands between us and the death of our country if condoms are allowed to become the main means of stemming the tide of AIDS.'"[16]

In many Christian organizations, Uganda is still held up as a model for the success of abstinence in HIV education[17] even though studies from public health and health sciences researches paints a much more complicated picture. One of the more provocative findings, a finding widely cited in the literature, concludes that the rising death rate in the general population due to HIV/AIDS was a predominant factor in the falling HIV infection rate. According to this study, HIV prevalence rates in Uganda had begun to fall by the early 2000s because those who were already infected with HIV were dying at a faster rate than the rate of people being newly infected.[18] Despite widespread evidence that abstinence alone was not the reason for the drop in HIV prevalence, this claim continues to be made by many, including the President of the United States, who spoke to the annual meeting of the Southern Baptist Convention via satellite in June 2007: "I thank the Southern Baptists who are working to promote a culture of life abroad by helping lead the fight against malaria and HIV/AIDS. Southern Baptists run hospitals and provide medical care to many suffering from malaria and HIV/AIDS across Africa. In Uganda, Southern Baptists sponsor an abstinence program called True Love Waits. And thanks to efforts like yours, Uganda has made progress against HIV/AIDS. And now you're building on the success by expanding this important program to six more countries in Africa."

In some of the social contexts which HIV traverses, abstinence is a welcome message and model for HIV prevention; in others it is not. These sharp divisions are, not surprisingly, found in the third response, "Condoms." The message "be faithful" functions in different ways, where the sharp divisions that had emerged in response to abstinence do not follow the same lines. We will explore the differences in the message "be faithful," but first we will look at the social contexts in which the message "condoms" plays out.

"Condoms", the third point in the pervasive prevention triangle, functions as the mirror, the antithesis, of "abstinence." "Abstinence" is a noun that invokes a certain kind of behavior—a behavior of refusal—and connects that behavior virtue to identity. We know what *kind* of persons abstain. "Condom" is a noun that invokes a certain kind behavior—a behavior of activity—and connects that behavior to identity. We know what *kind* of person uses condoms. The terms themselves are definitionally exclusive—one who abstains does not use a condom—but they are also exclusive in the values they inscribe on the person who behaves in the ways they underwrite. Each one reinforces mutually exclusive social identities which are perceived as threats to the other.

In many Christian settings, abstinence is encouraged to support certain values and norms. Condoms are encouraged in far fewer Christian settings. Two exceptions are sexuality curricula jointly produced by the Unitarian/Universalist Association of Congregations and the United Church of Christ entitled *Our Whole Lives* and *Sexuality and Our Faith*.[19] Those curricula discuss condom use with teenagers in ninth and tenth grade. Unlike the curriculum developed by Southern Baptists, *True Love Waits*, these curricula have not been implemented in general HIV prevention programs using United States federal funding. Christian communities are not social sites in which condoms adhere to identity; those social sites are, with very rare exceptions, outside of Christian communities. When Christians develop an argument of limited approval of condom use, those arguments generally advocate accommodation: "We Christians will agree that condoms should be used so that the spread of HIV might be slowed." In these arguments, the rhetoric does not imply that condoms are things that Christians themselves might use but are

things that Christians could permit to lessen the spread of HIV.[20] The problems with limiting Christian speech to this claim are at least two: 1) it assumes that Christians themselves do not use condoms to limit the spread of HIV and thereby does nothing to enforce the social identity of a condom-wearing Christian; and 2) it reinforces the social identities of people who use condoms as the kind of people who are specifically not Christian—people with social identities such as "player" or "sexual obsessive" or "promiscuous gay man" or "down-low brother." Of course, Christians regularly do use condoms to lessen the spread of HIV and the social identities just named—the player, sexual obsessive, promiscuous gay man, or down-low brother—are all worshipping in pews on Sunday mornings; these inconvenient facts are generally effaced in the language of Christian communities and condoms.

The second behavior in our ABC triumvirate, the behavior we are considering third, is 'Be faithful." The model, a rather complicated negotiation of desire and behavior, is almost always invoked in social contexts as monogamy, the formal ideal of modern heterosexual marriage, professed both by the state and by the church. In these contexts "Abstinence" is the past which we've left behind (with "thank God" being the common response to that past—very few people in America envision lifelong abstinence as their goal even if they regularly approve of that norm for others) and "Condoms" are the option for people "not like us" who can't control themselves. This ideal of fidelity is celebrated despite the practices of one or both of the couple moving into other social contexts (movements that are both widespread and strictly guarded as secrets) where sex outside the marriage occurs. "Be faithful" often collapses into monogamy. But there are some (albeit few) who argue that fidelity and monogamy are not congruous.[21] One might wonder how we would understand the practice of "being faithful" if these minority voices were heard.

Despite multiple studies which demonstrate that lowering the numbers of sexual partners (without necessarily adopting monogamous marriage) has been the most successful behavioral change in lessening disease progression, this concept of fidelity has not been taught. One of the few to push this point is Helen Epstein in her book *The Invisible Cure: Africa, the West, and the Fight Against AIDS.* In that book, Epstein writes:

> It turns out that partner reduction has played a key role wherever HIV rates have fallen—from the market towns of East Africa to the red-light districts of Asia to the gay enclaves of the United States…. In Zimbabwe and Kenya, the HIV rate began to decline in the late 1990s. Rates of condom use had been increasing throughout the decade, but it was not until rates of multiple partnerships began to decline that the HIV rate in these countries also fell. Meanwhile, in such countries as Botswana, South Africa, and Lesotho, where no partner reduction occurred in the 1990s and where condoms were emphasized as the main method of prevention, HIV rates rose.
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> [T]he Bush administration's "ABC"…policy was weak on partner reduction. Although the fifteen-billion-dollar President's Emergency Plan for AIDS Relief earmarked $1 billion for abstinence-and-faithfulness program, PEPFAR-funded programs on the ground in Africa overwhelmingly emphasized abstinence for unmarried youths; very few addressed adults or multiple partnerships directly. In 2004, Halperin and his colleagues put it this way in the *British Medical Journal*: "Partner reduction has been the neglected middle child of the ABC approach…
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> The [UNAIDS] agency's "Best Practice collection of briefing documents contains issues on condom programs, voluntary testing and counseling, STD

> treatment services, but… there was no Best Practice document about encouraging partner reduction or fidelity.[22]

In a doctoral seminar I taught last spring, a white, American gay man presented a critical analysis of one of the newer books on Christian Theology and HIV: *Reflecting Theologically on AIDS: A Global Challenge.* This student argued that the various theological and ethical arguments presented in the text did nothing to illuminate the reality of gay men in Atlanta who might be shaped in their identities and behaviors by other Christian theological claims than the ones this book espoused. Another doctoral student in the class, a student from Zimbabwe, agreed with the student presenter of the inapplicability of the theological positions articulated in the book to his own context. For this student, the text said nothing to the widespread and socially negotiated polygamous practices in his village. As I reflect back on this very surprising, enlightening conversation occurring between two people who came into the social location of this doctoral seminar from other, widely divergent social locations, I was struck by their common perspective, a perspective more akin to Helen Epstein than to any of the Christian systematic theologians they were reading.

These commonalities across divergent social locations raise significant questions as to our understanding of "being faithful." Those questions are numerous and complicated. Exploring them is difficult. It is precisely for these reasons that we should ask them. What kinds of Christian communities are the kinds of social locations from which these kinds of questions—questions that violate the rigid boundaries of exclusive social sites—might be asked? To conclude this paper, I will list and briefly describe a small, admittedly biased sample of such communities.

A Foot in (at least) Two Worlds: Christian Communities Straddling the Borders of Social Locations

> *Has Christian theology ever considered the desire for travel with backpacks and temporarily habitating with strangers that some people experience in their lives? It might well be that Christian theology has presumed redemption for such a long time that it has forgotten to look at what travels in its midst.*[23]

Imagining alternatives to the sharply drawn boundaries of social locations that protect their own space by refusing to entertain other viewpoints is difficult. One tactic could consist of finding religious institutions that are situated/situate themselves across the sharp divisions of various social contexts. Some examples include:

First Response/Metropolitan Interdenominational Church in Nashville, TN

Metropolitan Interdenominational Church in Nashville is an independent Black church that has created a social service agency called First Response as one of its social ministries. First Response works with men and women who are: homeless, actively using drugs, striving to maintain sobriety, at risk for HIV and hepatitis; and who are infected with hepatitis and HIV. Metropolitan/First Response receives federal funding through Ryan White (Part C/Title III) to provide comprehensive primary care for HIV-positive patients who have been dropped from other primary care programs because of unmanageable chaos in their behaviors. The staff at the

agency and the members of the congregation are immersed in a social location that no other religious community or public health institution in Nashville occupies. From that location, they offer comprehensive healthcare and substance abuse treatment services (from pre-treatment to aftercare and maintenance) to people who are living on the margins of the generally established social boundaries of American culture. The church develops this program out of which they see as a faithful response to the call for social justice. Because Metropolitan/First Response straddles those boundaries, the community can work with people who do not fit inside the either/or boundaries of other institutions.

English Avenue Baptist Church in Atlanta

I spent the afternoon of Christmas Day 2003 in the fellowship hall of English Avenue Baptist Church, an independent Black Baptist church in Atlanta. On that afternoon, I worked with the staff and volunteers of the Atlanta Harm Reduction Center (AHRC), the agency which runs Atlanta's only syringe exchange program, to serve active drug users in a holiday meal and then to sit down with them to eat together. It was a powerful experience. Fortunately, English Avenue has not limited its involvement in this kind of program to Christmas dinners. It supports the work of an AHRC, agency that works on the streets of the neighborhoods most devastated by drug abuse. That work includes syringe exchange; it also includes street outreach, basic medical care, HIV/hepatitis screening, substance abuse treatment contemplation groups, referral into substance abuse treatment programs, aftercare programs for people in recovery, and supportive environments for independent living in order to maintain sobriety. English Avenue supports these kinds of programs because it chooses to situate itself across social locations that are often marked by strict boundaries.

Balm in Gilead

When the primary response of Black churches to the HIV/AIDS epidemic here in the United States was silence, Pernessa Steele was speaking up. She has developed a national ecumenical Christian organization, Balm in Gilead, that calls churches (predominantly Black churches, though all churches would do well to listen) to live up to their own values. Balm in Gilead advocates for compassionate welcome for those infected with HIV/AIDS. But it also calls the church to offer HIV prevention programs while acknowledging the church's role in creating and maintaining the silence around HIV in churches.

Those are only three examples. There are countless others. Finding them and building networks among them—networks that might allow fluid bodies to find hospitable welcome in various social locations—is imperative. This is, I believe, the reason why the kind of work that ARHAP is undertaking and that Emory is beginning to implement is so important. Human beings are nomads. We do not stay in singular social locations. It's past time that we figured out how to develop responses to the HIV pandemic that take this reality into account.

NOTES

[1] Lou Chibbaro, Jr. "Gov't to Report Alarming Rise in HIV: Sources," *The Washington Blade* 16 November 2007; available from http://www.washblade.com/2007/11-16/news/national/11592.cfm; Internet; accessed 16 November 2007. As of the date of the publication of this story, the CDC has refused to confirm or deny these data.

[2] States were not required to report their HIV infection rates to the CDC prior to 1 January 2004. After that date, states that chose not to report their rates of HIV infection (as opposed to a limited reporting of AIDS diagnoses) were ineligible for federal funding for HIV prevention and services. All fifty states began HIV names reporting on that date; prior to that policy change, eighteen states had opted only to report only AIDS infections.
[3] Sewell Chan, "Rise Seen in HIV Infections Among Young Men," *The New York Times* 11 September 2007; available from http://cityroom.blogs.nytimes.com/2007/09/11/rise-seen-in-hiv-infections-among-young-men/; Internet; accessed 16 November 2007.
[4] The story was reported in various media outlets on the day before the report was released. See, for example, "AIDS Cases Drop, But Bad Data to Blame," *New York Times* 19 November 2007. Available from http://www.nytimes.com/apoline/AP-Global-AIDS.html; Internet; Accessed 20 November 2007.
[5] Craig Timberg, "New Report to Show UN Overestimated AIDS Epidemic," *Washington Post*, 20 November 2007, Sect. A, p. 01. Available from http://www.washingtonpost.com/wp-dyn/content/article/2007/11/19/AR2007111900978.html; Internet; Accessed 20 November 2007.
[6] In the use of the term "manufacture" I specifically am not implying that the interpretations given to these data are fabricated distortions or lies. I mean, rather, that interpretation is always a process that is open to multiple meanings. This includes interpretation of data.
[7] V. Saphonn, *et. al.* "How well do antenatal clinic (ANC) attendees represent the general population? A comparison of HIV prevalence from ANC sentinel surveillance sites with a population-based survey of women aged 15-49 in Cambodia," in *International Journal of Epidemiology* 31 (2): 449-455, April 2002.
[8] Massimo Fabiani, *et. al.* "Adjusting HIV Prevalence Data From a Program for the Prevention of Mother-to-Child Transmission for Surveillance Purposes in Uganda," in *Journal of Acquired Immune Deficiency Syndromes* 46 (3): 328.
[9] K. Fylkesnes, *et. al.* "Studying dynamics of the HIV epidemic: population-based data compared with sentinel surveillance in Zambia," in *AIDS* 12 (10): 1227-1234, 9 July 1998.
[10] Sixteen other states and the District of Columbia had made the same choice. The reasons for the decision not to track the numbers of HIV-positive citizens are complicated and numerous. They are intertwined with the governmental and cultural response to this epidemic over the last twenty-seven years. In Georgia, the argument against names reporting for HIV infection grew out of concerns that governmental authorities could not guarantee the security of the record-keeping and individuals' HIV status would be revealed publicly. This concern was not merely hypothetical; this scenario had occurred in Florida. The counterargument, that we needed to have a clearer picture of the HIV epidemic in Georgia and that individuals identified early in their course of disease progression could access healthcare before the immune system was so compromised that opportunistic infections necessitated hospitalization. This counterargument, while theoretically logical, has not played out in the manner expected in implantation, as the paper describes. The debate over whether to report the names of people diagnosed with HIV disease became moot after the federal government required it if states wanted to remain eligible for federal funding for HIV services. Georgia, like the other seventeen states, complied.
[11] Luke Shouse, "HIV/AIDS Reporting in Georgia: Chlallenges and Opportunities." Presentation at the Georgia Statewide Ryan White All Parts Meeting, Atlanta. 25 October 2007.
[12] The information about the discrepancy in the numbers and the reasons for the discrepancy was presented in a question and answer period following Dr. Shouse's presentation.
[13] Shouse. Some of the cases were not reported because a confirmatory Western Blot had not been completed. However, of the 6,984 cases which were HIV-positive and not AIDS diagnoses, over half (3,561) did have a Western Blot; in those instances, other demographic data were missing.
[14] Catherine Campbell, *Letting Them Die: Why HIV/AIDS Prevention Programmes Fail* (Bloomington, IN: Indiana University Press, 2003), 2-3.
[15] I recognize that the kind of sociological analysis of the function of religious institutions that this paper lays out is problematized by the choice to limit that analysis only to Christian institutions. With that critique in mind, I would only say that any attempt to explore various religious traditions in a paper of this length would end up covering over important distinctions among those traditions for the sake of brevity. I do think that an analysis of specifically Christian contexts, while limited, can be useful because of the predominance of Christianity in American religious life.
[16] Shawn Hendricks, "Ugandan first lady honored for support of abstinence education," Press Release of the Baptist Press Service, 23 June 2004; available from http://www.bpnews.net/bpnews.asp?Id=18556; Internet; accessed 21 November 2007.

[17] See, for example, Gudrun Schultz, "Abstinence Alone Protects Fully Against HIV, Ugandan First Lady Tells Youth;" available from http://www.lifesite.net/ldn/2006/dec/06120601.html; Internet; accessed 21 November 2007. The national organization Focus on the Family continues to invoke abstinence-only programs in Uganda as models of success. See, for example, "First Lady Promotes Abstinence in Africa;" available from http://www.citizenlink.org/CLBriefs/A000004945.cfm; Internet; accessed 21 November 2007 (this press release was published in 2006). The Southern Baptist Convention touts its True Love Waits campaign as the source for the reduction of HIV prevalence in Uganda, despite data that show that HIV prevalence is actually rising. See, Don Beehler, "True Love Waits summit held in Africa," Press Release of the Baptist Press Service, 24 September 2007; available from http://www.bpnews.net/bpnews.asp?id=26485; Internet; accessed 21 November 2007.
[18] Maria Wawer, *et. al.* "Decline in HIV Prevalence in Uganda: Not as Simple as ABC," *12th Conference on Retroviruses and Opportunistic Infections*, Boston, MA: 23 February 2005. Abstract available from http://www.retroconference.org/2005/cd/Abstracts/25775.htm; Internet; accessed 21 November 2007.
[19] The curricula are known jointly as *Our Whole Lives* and *Sexuality and Our Faith*. They were developed jointly by the two religious organizations and are published by the United Church Board for Homeland Ministries of the United Church of Christ. I realize that the Unitarian/Universality Association of Congregations encompasses traditions broader than Christianity and also includes those who profess no religious tradition.
[20] See, for example, James F. Keenan, "AIDS and a Casuistry of Accommodation," in *Reflecting Theologically on AIDS: A Global Challenge*, Robin Gill, ed. (New York: SCM Press, 2007), 186-202.
[21] In Christian theological and ethical writing, Chris Glaser develops this distinction. See Chris Glaser, *Come Home: Reclaiming Spirituality and Community as Gay Men and Lesbians* (New York: Harper Collins, 1990).
[22] Helen Epstein, *The Invisible Cure: Africa, the West, and the Fight Against AIDS* (New York: Farrar, Straus, and Giroux, 2007), 176-177.
[23] Marcella Althaus-Reid, *The Queer God* (New York: Routledge, 2003), 49.