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CHAPTER 1
ANTHROPOLOGICAL PERSPECTIVES ON HIV/AIDS

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Chapter I
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Anthropology and AIDS

The most important attribute of anthropological research on HIV/AIDS studies is that it emphasises on the social and cultural aspects of behaviour rather than conceptualizing an approach that is individual centric. Anthropology in the study of HIV/AIDS is valuable because the nature of risk behaviour is often perceptible in marginal communities. Ethnographies permit a broader insight into communities than self-reporting surveys, and anthropology often leads to unexpected discoveries about the culture being studied (Singer 1992). Anthropologists are interested in how disease is perceived, related theories of sickness, methods of education about disease, and the effects of disease on the social and cultural environments of the people. The anthropological standpoint helps the medical researchers and health care workers to execute a socially and culturally responsive program of efficiently educating and medicating people.

Since the late-1980s, research on AIDS by anthropologists has grown rich and diverse, situating these studies within major theoretical and methodological approaches as also controversies within the discipline. These richly contextualized studies allow the voices of sufferers and people at risk to be heard, by incorporating narratives, texts of interviews, observations, and public speech. Most adopt a historically grounded “political economy-and-culture” strategy (Schoepf, 1988, 1998; Singer, 1998). By the late 1980s, anthropologists began to raise the importance of cultural systems in shaping sexual practices relevant to HIV transmission and prevention. The emphasis on cultural analysis took shape alongside a growing anthropological research focus on structural factors shaping vulnerability to HIV infection. As Farmer’s (1992) work, in particular, has demonstrated, the political economic factors that drive the HIV/AIDS epidemic in virtually all social settings are intertwined with gender and sexuality, which hierarchies, on socio-economic considerations make women, and low-income women in particular, especially vulnerable to HIV infection).
During the early 1990s, there was a growing focus on the interpretation of cultural meanings (as opposed to the calculus of behavioral frequencies) as central to a fuller understanding of both the sexual transmission of HIV in different social settings and the possibilities that might exist for responding to it through the design of more culturally appropriate prevention programs (Treichler, 1999). On the other hand, emerging at the same time but gaining greater attention over the mid-to late 1990s, there was increasing concern with the impact of a range of wider structural factors that could be seen as shaping vulnerability to HIV infection as well as conditioning the possibilities for sexual risk reduction in specific social contexts (Farmer, 1992; Farmer et al., 1996, Schoepf 1992a, b, c, Schoepf et al., 1988, Treichler, 1999). The focus of much important research on sexuality in relation to HIV and AIDS over the course of the past decade has thus moved from behavior, in and of itself, to the cultural settings within which behavior takes place—and to the cultural symbols, meanings, and rules that organize it (Bolton 1992; González Block & Liguori, 1992; Henriksson 1995; Henriksson & Mansson 1995; Herdt 1997a, b, c, Herdt & Boxer, 1991, 1992; Hogsborg & Aaby, 1992; Kendall, 1995; Lyttleton, 2000; Paiva, 1995, 2000; Setel, 1999).

The growth of social violence stemming from poverty, hopelessness, and illegal trafficking is a major contributor to HIV transmission. Several studies focus on recent decade-long situations of unchecked violence and “dirty wars,” in which civilians are targeted. They document the political and economic contexts of violence and the common use of rape as a weapon of war (Bond & Vincent 1991; Baldo & Cabral 1990; Cloutier, 1993; Leclerc-Madlala, 1997). For example, “... extension of AIDS in Uganda is an unintended consequence of the macro-order of international political and economic relations. Yet, it has an immediate effect on the everyday activities of specific regions and localities, affecting how individuals conduct their daily lives” (Bond & Vincent, 1991:119).

Gender rapidly emerged as a significant concern in the representations of AIDS and in vulnerability to infection (Schoepf 1988, 1993a, b, 1998; Kisekka 1990; Bassett & Mhloyi 1991; Jochelson et al., 1991; Goldstein, 1992; Obbo, 1993a, b, 1995; Bardem & Gobatto, 1995; de Zalduno & Bernard, 1995; Hassoun, 1997; Kane, 1998; Bujra,
2000). The varieties of women's experience and their struggles for agency in the face of AIDS are the focus of much research (DeBruyn, 1992; Ulin, 1992; Schoepf, 1993a; Ackeroyd, 1997; Seidel & Vidal, 1997).

A major social fault line is drawn between people of high moral repute and stigmatized “others” like working class men and women “on the move.” They include transport workers, miners, domestic workers, farm workers, waitresses, prostitutes, job seekers, and other poor migrants (Hunt, 1989; Jochelson, et. al., 1991, 1994; Nzokia, 1994; Herdt, 1997; Migrations et Santé 1998). Painter (1999), who has worked for nearly two decades with migrants and their families in the Sahel, notes that migrants are represented as bringing sickness—constructed as social pollution and ritual danger—from “out there” in the case of returnees from other African countries, or from “over there,” in Europe. As the epidemic went on, however, deaths from this “long and painful sickness” mounted. AIDS came to stand for “Acquired Income Deficiency Syndrome,” a disease brought on by poverty, unemployment, and the strategies that poor people commonly adopted for survival.

International discourses were translated into familiar local concepts and actions. Elite men continued to deny their risk and responsibility as they subjected youth and women to moralizing discourses cast as “tradition”, not accepting even for a moment that they may be instrumental in the spread of the virus (Schoepf, 1988; Obbo, 1993b, 1995; Seidel, 1993; Nzokia, 1994). Young men found political reasons for rejecting condom protection (Fay, 1999). HIV/AIDS consequently became more than a health concern. It found reasoning in political and religious discourse. It also transcended national boundaries to acquire international voices and struggle for power positioning.

Some scholars propagate an area studies approach. An area studies focus assists in discerning the extent to which anthropological research on HIV/AIDS has compared and contrasted infection and disease across cultures within the same area and in wider fields. In the Caribbean, Latin America, Asia, and the Pacific, discourses of morality and transgression also resound, although the particular groups and their designated attributes differ (Kammerer et. al., 1995; Hammar, 1996; Lyttleton, 1996; Benoit, 2000).
Thailand and China, distant ethnic minorities were the other; in Myanmar it was poor sex workers returning from Thailand. As fiscal crisis struck in Indonesia, government and religious leaders blamed both prostitutes and returning labor migrants who demanded jobs (Husson, 1999). In Malaysia, the way that the state managed burials of people who died from AIDS triggered social exclusion of survivors (Vignato, 1999). While on other continents, stigma and blame attached to men having sex with men, is so powerful that this mode of transmission finds little ethnographic exploration, even as a minor theme. India in particular is still engaged in a legal battle to remove criminal sanctions (section 377 of the Indian Penal code) against consensual homosexuality (Mehta & Singh, 2005).

Brummelhuis & Herdt (1995) embrace the creative tension of anthropology as it “lives” “between subjective experience and objective reality.” They find that AIDS has shattered many anthropologists’ particularistic conceptions of local societies in favor of contextual studies that examine their global interconnections as well as cultural disjunctions. The methodological stance is not new; they cite the late Eric Wolf (1980), who throughout his career urged that such interconnections be studied. Many cultural anthropologists and physicians who heretofore eschewed this critical perspective have adopted it as a result of their experiences in AIDS research.

The choice of epistemology was political rather than disciplinary. Critical traditions in epidemiology and public health for long have employed a more social focus; beginning with Virchow who in 1848 wrote that to preserve health, medicine must intervene in social and political affairs (Hunt, 1989). Some health planners, including epidemiologists and physicians, offered alternative views of AIDS, often writing in collaboration with social scientists about the social projection of AIDS in Africa. Struggles over meaning had become international and interdisciplinary. African and western researchers contested the narrow paradigm within which HIV/AIDS programmes were conceptualized. They fiercely debated its implications, but funding agencies and major players in the programme simply ignored them.

Mann noted two reasons for this state of affairs. One was medical dominance: “… a desire by public health workers to ‘own’ the problem … by keeping the discourse at a medical and public health level.…” The second was to avoid “… the inevitable
accusation that public health is ‘meddling’ in societal issues which ‘go far beyond’ its scope and competence and inevitably puts [researchers] ... potentially ‘at odds’ with governmental and other sources of power in the society” (Mann, 1996: 6). In many countries this struggle is still on and India is a case in point.

Some early studies of culture and AIDS in Africa, undertaken at the behest of biomedical researchers, were not able to meet the requirements of effective management of the HIV/AIDS prevention strategy. Novices to African studies produced rapid assessments and put together reports of hurriedly conducted surveys. Sweeping statements were made about a special “African sexuality,” based on traditional marriage patterns different from those of Europe and Asia. Culture was designated as the culprit of HIV spread. Blaming cultural differences for situations were clearly linked to precepts of ethnic inequality. In many ways it also mooted a kind of status quo based on the assumption that people in these ethnic societies are not capable of controlling their sexuality (Sobo, 1999). Frankenberg (1995) describes the travails of anthropologists struggling with the categories imposed by epidemiologists in interdisciplinary teams. Anthropologists were “... token members on research projects [directed] by scientists who regarded 'culture' as an obstacle” (Obbo, 1999: 69). For years anthropologists struggled in India to find a place in the teams that were engaged by NACO to fight against HIV/AIDS.

Anthropologists objected that emphasis on promiscuity and sex with prostitutes reinforced the African perception that westerners continued to stigmatize their sexuality as “excessive,” “diseased” and “dirty.” Depiction of prostitutes as “a reservoir of infection,” fueled local constructions of AIDS as “a disease of women,” or of the “lower orders,” from whom the “pure” required protection. This construction is found among some people in Africa, Asia, the Caribbean, and the United States (Brandt, 1988; Taylor, 1990; Lyttleton, 1996; Fay, 1999; Le Palec, 1999). Not unexpectedly, stigma aroused defensive reactions among African officials, intellectuals, and journalists, making it difficult to conduct culturally sensitive qualitative research on sexuality (Schoepf, 1991, 1995; Obbo, 1999). The perceptions were not different in India either. For years, success of Sonaganchi was claimed to represent acceptance of sex work as a profession and
voices for legitimizing it became louder by the day. However, opposition to it also came from within the community of Home based sexworkers, who felt that any such move will lead to further marginalization and is likely to take away the opportunity for them to pursue their profession in silence. Even today any systematic research with these communities is difficult for the same reasons that Schoepf and Obbo mentioned in the year 1991.

Epistemological support comes not only from anthropology’s humanist tradition, but from feminist studies in Africa and “subaltern studies.” Most research on AIDS avoids the excesses of postmodernist anthropology in which all is reduced to discourse (Herdt, 1992). Instead of viewing the world as endlessly fractured and shifting, or seeking non-conflictual interpretations, some have attempted to identify “productive conflicts” that can lead to social change (Gorz, cited in Singer, 1998). Singer provides an excellent statement of the theoretical underpinnings of the genre (Schoepf, 1988, 1998). Studies using the approach appear likely to make lasting contributions to anthropology. Much current research seeks to integrate both cultural and structural concerns in providing an alternative to more individualistic behavioral research paradigms.

1.2. Ethnographies of AIDS

A large number of anthropologists working on HIV/AIDS are interested in the study of meanings, symbols, healers, and sexuality, professional responsibility also demands attention to the embodiment of inequality represented by HIV and AIDS. Schoepf (1988, 1991, 1998), Farmer & Kim (1991), Herdt (1992), Farmer (1997, 1999), Obbo (1999), Schoepf & Symonds (2000), among others, are critical of researchers who omit analysis of political economic forces, thus leaving the impression that the pandemic is caused by unchanging cultural representations.

Much like physicians who suffer from therapeutic impotence in their inability to cure, anthropologists who believe they know how to effectively engage people in protecting themselves suffer from a kind of social and political impotence. Some suffer in silence; others write, use gallows humor, or scream; still others disengage,, but most continue to burn mid-night oil hoping to come somewhere close to an understanding that
can give some possible insights as to why ‘people consciously move towards self destruction’.

Humanist dimensions of anthropology also are implicated in the research process. Like the experiential community-based disease prevention methods, lived experiences of sufferers and their families shed light on the interfaces between structure and agency. They show how stigma and fear of death disturb identities, and how, through collective struggles, people can sometimes create new, valued identities for themselves (Farmer 1992; Berer & Ray, 1993; Vidal, 1996; Desclaux & Raynaut, 1997; Kerouedan & Eboko, 1999). Several of these studies chart the evolution of associations of people living with HIV and AIDS.

Many anthropologists are personally as well as professionally engaged, for AIDS have witnessed deaths of informants, colleagues, students, lovers, family members and friends. “Witnessing” of social suffering” (Farmer & Kleinman, 1989) is a potent subtext to many research rationales. Some view this as an activity that surpasses their professional role as anthropologists, but what francophone writers call the “accompaniment” of sufferers has clinical applications (Vidal, 1996). Witnessing may be part of the research process in a time of tragedy, for writing “… about absence and loss, makes present through revealing and re-inscribing the historical and human processes implicated in the making of that absence and loss” (Muteshi, 1998:73). Accompanying people who are in deep distress is not easy. Few anthropologists have written about their personal “burnout” (Vidal, 1996; Kane, 1998), or their anger at too much needless death and suffering. Writing also may bring healing to anthropologists (Silverman, 1999).

Anthropological literature on AIDS in the international arena from the 1990s shows researchers' increasing attention to linkages between local socio-cultural processes that create risk of infection and the life worlds of sufferers to the global political economy. The combined strength of theory and practice in the field of international research on AIDS is a significant contribution made by anthropology in the twenty-first century. It is this perspective that is the guiding principle for the research that will be presented in the following sections.
1.3. Approaches to the understanding of AIDS

Focus on Africa, where the heterosexual epidemic has attained catastrophic proportions, reveals some cultural particularities but many more regularities in the social production of disease. Global inequalities of class, gender, and ethnicity are revealed, as poverty, powerlessness, and stigma that propel the spread of HIV. Anthropologists' witness to suffering, their concern and engagement, are potent elements in the research process and are integral for advocacy in national and international arenas.

It is now well established that the cultural and social conditions propel spread of the virus; the same elements combine to make HIV-prevention education and behavior changes difficult. Disease becomes evident only long after infection takes place (on average, ten years) and then presents itself in many different forms of opportunistic infections. Denial and stigma go hand in hand. This makes acceptance and necessary intervention a mammoth challenge. All this combines to make the reality of AIDS difficult for lay-people, including political leaders, to grasp, especially in early stages of the epidemic. Complex cultural and psychological meanings also intervene in representations of AIDS. With transmission linked to body fluids—to semen and vaginal secretions, blood, and mothers’ milk—to sex, reproduction, and death, AIDS in many cultures is freighted with extraordinary symbolic and emotional power, including ideas about social and spiritual “pollution.” It is important that approaches to the understanding of the epidemic/pandemic recognize importance of these symbolic elements. For years, we are engaged in possibilities of behaviour change without comprehending the full import of restraining attributes. Moving in consonance with existing epidemiological approaches, it is imperative that the significance of cultural approaches is recognized to make the programme viable.

Spread of infectious agents is shaped by political economy, social relations, and culture. A disease of modernity and global population movement, AIDS has struck with particular severity in communities struggling under the burdens of poverty, inequality, economic crisis, and war. Many people who know about the danger of sexual
transmission, especially many girls and women, cannot avoid becoming infected because they cannot control the relations of power that put their lives at risk. The pandemic is much more than a series of personal and family tragedies. AIDS’ deaths have depleted the workforce, lowered life expectancies, raised dependency ratios, and are likely to shred the already torn social fabric of numerous countries.

Worldwide, the HIV virus strains spread in geometric progression. The Asian pandemic has begun to burgeon, with an estimated four million people already infected. Due to the large numbers of people potentially at risk, there is cause for deep concern. Unless the familiar patterns of fear, denial, stigma, and disempowering education campaigns, coupled with conditions of widespread poverty, inequality, and violence are ended, Africa's tragedy will be replicated elsewhere.

The epidemiologists’ focus on individual sexual behavior, their claim to exclusive value-neutral objectivity, and reliance on surveys as the sole method of “science” has diluted the kind of intervention necessary for meeting the challenge upfront (Fee & Krieger, 1993; Frankenberg, 1994; Hunt, 1996; Seidel & Vidal, 1997; Bastos, 1999).

Anthropologists have repeatedly pointed out that the focus on individual risk reduction was simply too narrow, for it was unable to deal concretely with the lived social realities. Mann has repeatedly drawn attention to the fact that … applying classical epidemiological methods to HIV/AIDS ensures, rather, pre-determines that ‘risk’ will be defined in terms of individual determinants and individual behavior…. (1996:3).

Anthropologists were invited to collaborate in surveys of knowledge, attitudes, and practices (KAP) sponsored by public health agencies from the mid-1980s in certain parts of the world. Qualitative methods were often confined to focus groups and rapid appraisals. Anthropological demographers, experienced in surveys of reproduction and migration, sought to devise methods, principally studies of sexual networking that would yield valid data to explain the spread of HIV and aid in its prevention (examples are found in the works of Dyson, 1991; Herdt, 1997; Health Transition Review, Migrations et. Santé.). These researches showed that measurable differences in sexual behavior are not correlated with differences in HIV incidence and prevalence. Surveys discovered that
around the world increased knowledge of AIDS did not translate into widespread protection, which course, anthropologists familiar with studies of past public health campaigns, had predicted. It gives no satisfaction to be proved correct in the face of overwhelming tragedy yet Anthropology and its epistemologies are intrinsic to the understanding of various angularities of the HIV/AIDS epidemic. They facilitate comprehension of why the virus attacks some cultures and populations more virulently then others. Given this understanding, I have ventured to undertake the study of HIV Positive Intravenous drug users in its bastion—the state of Manipur.

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