The Shortcomings of Culturalism and the Relevance of the Social Dimension in the Approach to AIDS in Africa

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Some analyses have strongly emphasized the causal link between behaviour and representations regarded as culture-specific and the dynamics of the AIDS epidemic in Africa. These analyses can lead to culturalist interpretations of the epidemic – interpretations that pose two major problems with which I should like to deal here. Firstly, they lead to an excessive characterization – usually but not exclusively negative – of African societies in terms of their cultures; and, secondly, they tend to mask the real factors that explain the AIDS situation.

I shall begin by looking at the approach to the question of circumcision, which has assigned to culture a role that, while admittedly "protective", remains ambiguous. I shall then review a number of analyses of cultural practices put forward as being responsible for the spread of HIV. Thirdly, I shall try to show the value of refocusing the debate on the social dimensions of the epidemic, which presupposes paying special attention to individuals.

A tendentious over-emphasis on culture: the case of circumcision

Circumcision is a recurring topic of discussion in the specialized literature on AIDS, and is emblematic of an ambiguous process involving the "culturalization" of AIDS in Africa.

In the early 1990s, epidemiologists put forward differing interpretations of the role of circumcision in HIV infection. Some believed that the statistical link between circumcision and a lower rate of contamination was proven, while others thought that it had not been. In any case, no one knew for certain "whether circumcision has a direct effect on HIV transmission or an indirect one through, for example, its protective role in relation to ulcerative STDs" (Ferry, 1999). These uncertainties concerning the effect of circumcision on HIV transmission did not, however, prevent the development of culturalist analyses. Circumcision was defined as a cultural practice (this remains to be demonstrated), and one could therefore point to the cultures "at risk" (those that did not practice circumcision) and position them on a map of the circumcision "belt" (Caldwell & Caldwell, 1993). This led to the designation of "good" and "bad" cultures. What such categorizations overlooked were the conditions governing such practices, their uneven spatial distribution, and the existence of other factors that might explain why HIV is more prevalent in the non-circumcising populations.

More recently, epidemiological studies have advanced our understanding of the link between circumcision and the reduced risk of HIV infection. First of all, herpes is very clearly associated – more systematically than the absence of circumcision – with a strong prevalence of HIV. The protective function of circumcision is attested in some areas, and less so in others. Nonetheless, the epidemiological and clinical studies allow us to conclude that the effect of circumcision in the reduction of the risk of HIV transmission – to which all analyses tend to point – "are probably not due to the cultural and behavioural factors with which they are supposed to be associated" (Weiss & Lagarde, 2000). What this means is that a statistical association does not signify a causal relationship,

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since numerous other factors come into play, contrary to what was advanced in the early culturalist simplifications. Thus, in practice, what is critical from both an epidemiological and sociological standpoint, more so than a given religion or "culture", is the age at which the first sexual relation or marriage takes place and the presence of other STDs (especially herpes).

The identification of "circumcision cultures" thus formed part of a kind of "culturalization" of AIDS. While undoubtedly hasty and ill-founded, it was aimed in a way at enhancing the status of cultures that practiced circumcision. Yet this leaves an essential question unanswered: even if one accepts the conclusions of recent epidemiological studies that specify the role of circumcision in protection against HIV, what public health measure can reasonably be promoted on this basis? How are populations to be encouraged to practice circumcision from now on? One solution would be to highlight its medical value, without however decrying populations that rejected it; the rejection of circumcision should not be assimilated to cultural inertia. In any case, it is important that this objective should not be made the be-all and end-all of an information campaign on ways of controlling the spread of HIV infection.

The rhetoric of cultures as obstacles to prevention

Because of their restricted vision of reality, some culturalist interpretations of AIDS go so far as to designate cultures in negative terms: – with reference, for example, to the levirate, polygamy, recourse to hairdressers and "traditional" nail-cutters, and the use of condoms. The perpetuation of these practices or, in the case of sexual relations, the reluctance to adopt them has long been viewed as the archetypal expression of African cultures potentially at risk from and exposed to AIDS.

As regards the levirate, the question needs to be carefully weighed: firstly, the real issue is access to the HIV test and information on AIDS prevention; and, secondly, anthropologists have stressed the importance for a woman whose husband has died – from AIDS, for example – of remaining in the family circle, whereas breaking with the practice of the levirate would lead to the abdication of family responsibility towards infected women (with the very real risk of their infecting other partners) (Taverne, 1996). In the case of polygamy, no higher prevalence has been noted for polygamous couples compared with monogamous ones. What is essential is that each partner should know the other's HIV status and that sexual relations within and outside the couple should be protected, whether the couple is polygamous or monogamous. Where so-called "traditional" practices are concerned, no case of HIV infection has been formally attested consequent upon a visit to the hairdresser's or to a nail-cutter.

Lastly, with respect to the use of condoms, obstacles can also arise as the result of inappropriate information. The conclusion to be drawn from all these observations is that greater prudence should be exercised with regard to the culturalization of explanations for the spread of HIV infection in Africa.

The myth of isolated and immutable cultures

Prudence requires that we should pause to consider a number of universals in the field of HIV prevention. Although the link between information on AIDS, the way it is interpreted and its effects in terms of changing behaviour remains a complex question (involving psychological, economic and social factors at once universal and culturally delimited), there is broad agreement that without information on AIDS, however delivered, the behaviour required to avoid HIV infection cannot be adopted. It is a minimal position admittedly, but one universally held. When arguments predicated on "African cultural traits" are advanced, it is findings of this kind that, although virtually beyond

dispute, are either called into question or else overlooked by this culturalist reductionism.

It is moreover striking that the cultural dimension should obscure the social in this way. An image of "asocial" cultures is thus gradually built up in which urbanization, the search for work, the processes of individualization and many other phenomena are sidelined. Culture is thus isolated from other cultures, creating an illusion of cultural isolates. The illusion is that of a culture capable of defining itself in relation to and for itself, whereas a culture essentially defines itself in its relationship to other cultures. J.L. Amselle speaks in this regard of "interconnections", placing the emphasis on the analysis of relationships rather than on the elements brought together, so as to dispense with the image of cultures as "closed systems".

Finally, an obstacle that is deemed "cultural" is judged, in the minds of those who so define it, to be insurmountable. This is the case when the reluctance to use condoms is attributed to "cultural obstacles" (always leaving open the possibility of having children, not "wasting" one's sperm, not accepting reduced sexual pleasure …) The inference is that it is impossible *ipso facto* to overcome them. This amounts to a "fixation" of cultures which is purely arbitrary.

Taking the social dimension into account

Anthropology has endeavored to show that the conditions governing the spread of AIDS and its consequences are predominantly social. This shift of analysis from the cultural to the social is not to be construed as a denial of any explanatory value to the former: what is being contested is the reduction of a set of behaviours or representations to a uniquely cultural thesis. In the processes of urbanization and migration, the organization of schooling and the plantation economy (for example, in Côte d'Ivoire), population movements resulting from conflict and, more generally, the everyday relations between men and women, it is possible to identify a whole range of situations that contribute to the exposure of individuals to HIV. It is certainly reductionist to assert that such situations remain culturally determined; we are dealing here with social issues that cut across cultures. They do not exclusively concern either given linguistic communities, the followers of a particular religion or the inhabitants of a given region or town. These different factors contain within them explanations for the spread of the HIV infection. It is indisputable that they combine to intensify the risk of infection and that they are linked to cultural particularities; it is essential to underscore the paramount importance of social conditions as distinct from cultural considerations in the spread – or control – of the epidemic.

The individual as the key to the social dimension

Under the common denominator of "social conditions", we must group the patterns of family life of the infected person, the everyday situations of all concerned – whether it be a sick person, a woman in a relationship, a young man looking for work, a midwife in a health clinic – and also the functioning of a variety of structures (medical, public health, the "fight against AIDS", associations…) The diversity of forms of the "social" should always be approached through individual experience. In order to understand the way therapeutic treatment functions, one should therefore explore the motivations of the sick and the way they organize their lives, or describe the fear that midwives have of contracting AIDS in the course of their work. But the main thing is to view the situation from the point of view of others. Many lessons are to be drawn from the way HIV-positive individuals perceive the work of health personnel or AIDS-prevention campaigns. This is also true when HIV-positive people talk about the experiences of their sick friends and their attempts to secure treatment or to cope with the reactions of the people around them who know about their HIV status. Placing individuals at the center of our thinking implies analyzing their

choices and exploring their representations for what they can teach us not only about their own attitudes but also those of other people. The way the caregiver sees the patient should also be scrutinized to understand the way the patient sees the doctor or the nurse, as well as to have a better grasp of the issues governing the patient's choice of treatment as well as the caregiver's.

This focus on individuals – their relations to others, what they "reveal" of others and what others in turn "reveal" of them – takes us into the social arena as a place where collective strategies are expressed. In concrete terms, when the observer of a society notes the development of an association that assumes responsibility for health problems, the researcher's acquired knowledge of the way therapeutic treatment functions and the representations of risk among health personnel can be turned to account. Moreover, a researcher who is familiar with the political, statutory and economic strategies of the leaders of religious movements will be best placed to understand the complexity of the issues that arise on the appearance of a new form of worship or church. The conclusion we draw is not only that familiarity with the "field" is important and that it immediately permits a relevant and operational approach, thereby facilitating sociological or anthropological analysis, but that the "familiarity" that is really necessary and the anthropological "expertise" that is crucial are those that enable the connection to be made between the individual and social levels of a practice. That is to say, describing the process whereby a set of individual attitudes expresses a social tendency, namely a series of positions or reactions shared by groups whose interests and strategies may diverge (family groups, associations of the sick, professional bodies, members of a faith…)

Conclusion

The culturalist interpretations of AIDS have been part of a confining movement of stigmatization: confining because the impugning of individuals because of their practices ("punished" by HIV infection) finds a discreet echo in a culturalist approach in which, above and beyond the individual, it is a whole culture that is placed beyond the pale. It is a case, then, of stigmatization dictated on the one hand by behaviour and on the other by cultural referents. True, this process of stigmatization does not have the same cause in both instances, and is not aimed at the same people or expressed in the same way. Nonetheless, the image that emerges is in the final analysis, that of "cultural individuals", with presuppositions of inertia and immobilism, whereas individuals who try to come to terms with the threat of AIDS or to live with the disease are also, and possibly above all, "social individuals".

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