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Healing Logics

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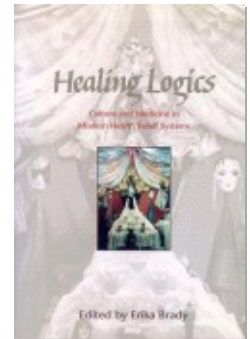
Published by Utah State University Press

Brady, Erika.

Healing Logics: Culture and Medicine in Modern Health Belief Systems.

Utah State University Press, 2001.

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COMPETING LOGICS AND THE
CONSTRUCTION OF RISK

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“**R**isk” is a word we hear a lot these days, whether it be in academic discussions of “risk assessment,” “risk analysis,” or “risk perception” or in discrete areas of life such as “environmental risks,” “financial risks,” or “public health risks.” AIDS literature uses the word “risk” perhaps more than any other term and, in fact, a significant moment in the epidemiological understanding of AIDS is marked by the change in reference from “risk groups” to “risk activities.” The notion of “risk groups” (such as Haitians, homosexuals, and intravenous drug users) rather than “risk activities” (such as sharing needles or sex without a condom) was seen in the mid-1980s to stigmatize specific groups while simultaneously allowing individuals to disassociate themselves from perceived vulnerability by disavowing memberships in identified risk groups. The logic of this change in usage is clear, shifting the focus from groups to specific behaviors. The shift in reference and in thinking would seem to be both a public health and a human rights victory. And indeed, it was.

Still, the stigmatizing nature of “risk” theory did not simply disappear. While “risk groups” were no longer in academic discourse, “risk activities” were, and the popular association of specific behaviors with specific groups remained. Sharing needles, for example (or even access to used needles), generally occurs in certain contexts; contexts require participants, and participants make up groups. Cindy Patton observes, for example:

Despite efforts among activists to shift the terminology from risk *groups* to risk *behaviors*, AIDS education information concerning risk *reduction*

was directed almost exclusively toward gay men, and soon (though much less consistently and effectively) toward injecting drug users. (1994, 14)

But other issues exist in relation to the fragile attempts at disassociation of risk activities from groups. As Mary Douglas notes in her book *Risk and Blame: Essays in Cultural Theory*, the word “risk” has been removed from its older connotation involving choice to a generalized notion of danger. Douglas notes:

“Risk” is the probability of an event combined with the magnitude of the losses and gains that it will entail. However, our political discourse debases the word. From a complex attempt to reduce uncertainty it has become a decorative flourish on the word “danger.” (1992, 40)

This association of danger with the sense of risk distanced the notion from issues of cultural understanding involved in weighing of gains and losses used in personal risk assessments. Risk activities (translated in Douglas’s terms as danger) tend to be seen in institutional terms as generalized, predetermined, and unquestionable. Richard Stoffle et al., in writing about environmental risks, discuss this institutional imposition of risk estimation. They note:

Often, the specialists who conduct these assessments believe their estimates reflect the “real risks” of a technology or project because the estimates derive from scientific calculations. These “real risks” typically are presented through formal processes, such as public meetings, in which information flows one way, from risk communicator to the public with little or no exchange of information between these two groups. (1991, 612)

The emphasis on “real risk activities” as predetermined areas of danger framed risk assessment in etic, externally defined values and concerns; leaving emic, locally defined concerns out of the picture. Risk assessments which are based on emic criteria focus on risk as it is perceived and evaluated by the lay public. The tendency to ignore perceived risk as a valid component in the assessment of risk is based on the notion that perceived risks are neither objective nor scientifically derived.

The failure here is in not recognizing that *all* notions of risk are culturally constructed based on socially and culturally shaped concepts and statistics. Such a view is not intended to be nihilistic (arguing that there is *no* risk reality) but rather, social constructionist (arguing that concepts such as risk have been constructed in such a way that they appear devoid of ideological content, and therefore are self-evident). Social constructionist theory “assumes that social categories have been constructed through historical and

social processes . . . in such a way that the ideological and institutional interests served by a particular construct are erased and the categories appear natural” (Patton 1994, 4).

Social constructionist theory lends itself easily to HIV research because the epidemic is worldwide while the bulk of research and policy comes from the West. The social constructionist questions the categories of epidemiology attempting to demonstrate their culture-bound, political, or moralistic basis or examining their general applicability. In striking contrast to public health risk associations and “prostitution,” for example, Patton demonstrates:

Evaluation of sex worker risk reduction projects suggest that women who sell sex are more likely to adopt prevention measures (especially condom use or avoidance of intercourse) than are women who simply have sex in the context of recreation, love, or other socially condoned sexual arrangements. But the strong separation between sex for hire and sex for “love” also results in a bifurcation of sex workers’ risk reduction strategies. Women who sell sex are more likely to engage in prevention behaviors while having sex in the context of “work” than in their domestic relationships. (1994, 53)

The social constructionist argument is that risk categories are only made meaningful in social context and that the categorization systems must be analyzed, not simply adopted.

THE MEDICAL (MIS)USE OF ETHNOGRAPHY

Taking this approach, I intend in the remainder of this paper to examine the uses of ethnography in the medical construction of African AIDS risk categories, represented in articles and letters found in a variety of medical research journals such as the *Lancet*, the *British Medical Journal*, *Science*, and the *New England Journal of Medicine*. Focusing on African “high risk activities” these articles use ethnographic information to foreground aspects of traditional culture, emphasizing the failure of Africans to adjust to the conditions of Western civilization. Heavily stereotyped and abstracted from social, historical, or cultural context, these studies condemn traditional culture through an emphasis on the risks intrinsic to such practices as blood brotherhood, ritual scarification, and traditional healing techniques. By highlighting the dialogue on African risk, this chapter will attempt to outline and illustrate the specific cultural misunderstandings found in medical researchers’ uses of ethnographic data, misunderstandings which allow research on risk to become a dialogue on neocolonialism.

Although the medical use of ethnographic materials would seem to suggest a sensitivity toward locally constructed perceptions of risk, this is not the case. Ethnographic data—the folklorist’s guide to vernacular perception—at the hands of medical researchers appears to become grist for the “real risk” mill. Rather than being constructed as information to be used in weighing gains and losses or being measured statistically in terms of actual incidence of infection, the data is piled into the unexamined “danger category” suggested by Douglas. The inclusion of ethnographic material in these danger areas, while problematic in that it is unweighed, unexamined, and not part of a dialogue with the lay public, might still be an improvement over total ignorance of cultural data, were it based on sound ethnography. The selection of ethnographic material, however, is a significant part of the problem.

Due in part to the demographic profile of the AIDS crisis, the greater awareness of medical consumerism, and the strengthening of voices in the medical humanities and social sciences, medical researchers are becoming increasingly aware of the need to take account of cultural issues in health care and public health education. While this newfound awareness is commendable, it points out problems intrinsic to unskilled collection and interpretation of ethnographic data. Having received no training in the discursive aspects of cultural representation, medical researchers generally are unable to weed out ethnographic accounts which are unsystematic, patchy, inaccurate, or incomplete, and do not recognize the problems inherent in materials which have been collected and interpreted in a context of condemnation. Unfortunately, using such data, they construct images of the diseased or “at risk” cultural “other,” and in turn, produce their own seemingly authoritative ethnographic texts.

AFRICAN AIDS¹

The literature on African risk for AIDS generated over the last fifteen years is enormous. Most of this literature focuses on what are seen as two very different epidemiological patterns. “Pattern One AIDS,” found in the United States and Europe, affects largely the male population at a male to female ratio of 8 to 1. “Pattern Two AIDS,” found on the African continent, has a reported sex ratio of 1 to 1 (Hunt 1996, 1345). The contrast between Pattern One and Pattern Two epidemiologies has caused considerable comment on African paths of transmission and risk factors. Further, while 10 percent of the world’s population lives in sub-Saharan Africa, it is estimated that about 55 percent of persons with the HIV virus live there, including over 80 percent of the world’s seropositive women (Goldin 1994, 1360). While estimates of prevalence of the

virus in Africa differ and while the worldwide AIDS statistics are constantly changing, it is clear that the magnitude of AIDS in Africa is significant.

Though the epidemiological statistics suggest heterosexual transmission in Africa, AIDS researchers and writers continually push for more exotic explanations of African AIDS.² Simon Watney notes:

African AIDS must . . . always be presented as *sui generis*, a completely different disease from AIDS in the First World. Indeed, most commentators have preferred almost any explanation of the 1:1 AIDS ratio of men to women in most African countries other than that of heterosexual transmission. (Watney 1990, 96)

Even when heterosexual transmission is granted as the major route of infection, the construction of risk takes a shape of “otherness.” In an article entitled “Reassuring News about AIDS: A Doctor Tells Why You May Not Be at Risk” published in *Cosmopolitan*, Robert E. Gould writes:

The data I gathered concerning heterosexual intercourse in Africa show marked differences from the way it is usually practiced in the United States . . . Many men in Africa take their women in a brutal way, so that some heterosexual activity regarded as normal by them would be closer to rape by our standards and therefore be likely to cause vaginal lacerations through which the AIDS virus could gain entry into the bloodstream. (1998, 147)

Although the Gould excerpt may appear easy to dismiss by virtue of its publication in a popular magazine, it is indicative of the wider medical picture. A search through computerized medical indexes for articles on AIDS in Africa betrays a widespread evolutionary paradigm. While AIDS researchers clearly recognize that African cultural beliefs and practices have to be accounted for in any discussion of the disease and its African ramifications, the belief and practices which are discussed are stereotyped heavily and are abstracted from any kind of real context. Medical researchers of African birth are continually writing in to the journals to head off overzealous Western researchers making uncontextualized pronouncements about African traditional life and culture. The following controversy, which took place in the letters and commentaries section of the *Lancet* in 1987, is representative of these debates. The first letter, entitled “AIDS and the Witch Doctor,” was printed as follows:

Sir,—The reassurance given by the Medical Acupuncture Society (May 30) about the risk of contracting AIDS is welcome. In Africa, however, the use of non-sterile instruments is widespread among witch doctors, who are often consulted initially by patients.

Many patients presenting to hospital with pain or swelling are seen with small lacerations over the affected area, indicating that the witch doctor has been at work. One patient recently seen with chest pain . . . had 150 of these markings.

Witch doctor induced gastrointestinal disorders are commonly seen in this hospital, but many psychiatric patients benefit from seeing the witch doctor. The methods of traditional healers are thought to be similar throughout Africa, and in view of the huge population consulting such healers I suggest their name be added to the possible risk factors for the transmission of HIV infection. (O'Farrell 1987, 166)

A response was published one month later, entitled "AIDS and the African Healer":

Sir—In rural Africa most people who feel ill first consult traditional healers, herbalists or as Dr. O'Farrell calls them witch doctors, who often apply concoctions of herbs, roots, and leaves to skin that has been scarified around the suspected lesion. O'Farrell fears that through use of non-sterile instruments these traditional healers might contribute to the spread of AIDS in Africa.

O'Farrell seems unfamiliar with the methods of traditional healers and the limited capability of HIV to survive outside the human organism. For scarifications only razor blades or similar cutting devices are used, never needles or other hollow instruments where blood might stay inactive for longer. It is very unusual for scarifications to be done on several people one after another, the only way that might permit transmission of HIV. In Tanzania a complete treatment by an herbalist takes 20–60 minutes and by the time the razor blade is used again the retrovirus should be destroyed. (Schmutzhard 1987, 459)

As the second letter points out, the problem with much of the disinformation about Africa and AIDS is a lack of proper contextualization. A piece of social data is simply matched with a risk category.

Issues of sexuality were the focus of many of these articles and controversies, portraying African sexual practices based on questionable ethnographic information or taking a practice recorded at one place and time and generalizing it to the whole of African culture. Again from the *Lancet*, a medical researcher warned:

In his book on the sexual life of people in the great Lakes area of Africa, Kashamura writes: "to stimulate a man or a woman and induce them to intense sexual activity, monkey blood for a man or she-monkey blood for a woman was directly inoculated in the pubic area and also in the thighs and the back. These magic practices would therefore constitute an

efficient experimental transmission model and could be responsible for the emergence of AIDS in man. (Noireau 1987, 1499)

While the author of this article is to be commended for considering actual ethnographic studies of African life and culture in his commentary, the study he has chosen is based on observations reported in 1927 with no more recent data. The data is not given its proper historical context, but rather presented as current practice.

Geographical generalizations provide the same difficulty. Africa is taken as one culture without variation over time and space. Little attention is paid to urban and rural differences, differences by district, or differences within populations. Debates over female circumcision have focused on exactly this issue. The journal *Science* published the following debate:

The high incidence of AIDS among men and women in Africa has led to the suggestion that a different mode of transmission may be at work there. Colin Norman echoes this view in his summary of the international Symposium on African AIDS. In fact the spread of the disease among heterosexuals in Africa and homosexuals in the West may point to a common factor in their sexual practices. Contact with blood during intercourse is thought to be largely responsible for the transmission of the virus among homosexuals in the United States. The same principle may apply to heterosexuals in central Africa, where female circumcision is still a widespread practice. In its most extreme form referred to as infibulation, the operation consists of the removal of some or all of the vulval tissue, after which the two sides of the wound are sewn together, leaving only a small opening for the passage of urine and menstrual blood. Subsequent vaginal intercourse is therefore difficult if not impossible and is chronically associated with tissue damage, tears and bleeding. Anal intercourse is a common recourse for heterosexual partners. . . . Understanding the pattern of AIDS in Africa will probably first require understanding the cross cultural differences in sexual practices. (Linke 1986, 203)

It would appear that the author of this letter, anthropologist Uli Linke, has generalized the geographical context of the practice of infibulation. One of his colleagues responded:

Uli Linke's letter about AIDS in Africa suggests that contact with blood during intercourse may be an indirect consequence of the African practice of female circumcision. It then describes an extreme and rare form of female circumcision—infibulation. Infibulation is found only in a part of Northeastern Africa outside the region where AIDS has been reported and is very different in its social and biological effects from the kind of female circumcision that is practiced more widely in Africa. A secondary

problem with the logic of hypothesizing that AIDS is transmitted by traditional custom is that in Africa it appears to be primarily an urban disease, as it is in the United States. Traditional customs, such as female circumcision have their origins in the rural sector. I think it would be most productive to look at data pertaining to life in African cities and to examine such phenomena as male labor migration, often described as being disruptive to marriage and family life. (Burton 1986, 1236)

In relation to the geographical generalization of African AIDS issues, Simon Watney argues:

. . . the notion of "African AIDS" already obscures the specific characteristics of the different AIDS epidemics in these countries, constructing them in the spurious unity of an "Africa" which is immediately denied any of the cultural, social, economic, and ethnic diversity which is taken for granted in Europe and North and South America." (Watney 1990, 94)

What is clear from the literature on Africa and AIDS is that much of the data which is used to describe cultural practices takes a part of the story and confuses it with the whole. AIDS researchers in Africa, knowing that they are dealing with a very different lifestyle, have gone looking through the ethnographic data for cases of "risky behavior." In this sense the literature searches out the deviant and uses it to understand the health needs of the entire culture. Reports are taken at face value, with little thought given to how the data was collected, by whom, and under what circumstances. The researchers do not recognize that ethnographic data, like scientific data, is not all methodologically sound. One must understand the methodological orientation before adopting it as a source of factual information. Much of the data used in these discussions were originally collected and interpreted in a context of condemnation, emphasizing the failure of Africans to adjust to the conditions of Western society. The data tend to be patchy and unsystematic in nature, and yet the health and lives of an entire country are being tied to its implications. The data exclude the less exotic, more mundane sexual behaviors and by so doing target the unusual for health education efforts and health development policy.

But another problem with the portrayal of African sexual culture in this literature has to do with the issue of how normalcy, deviance, and risk are defined. Prostitution, said to be widespread in African culture, is frequently defined in the medical literature as sexual exchange with a monetary component (Packard and Epstein 1991), but clearly the risks of such an exchange are based on the numbers of partners and on the practice of unsafe sex. A woman, paid by one man who is only sexually active with her, would according to such definitions still be classified as a prostitute. While such a case may

seem unlikely, it points to the more widespread limitations of risk involved with prostitutes who service a small regular clientele versus those who engage in such services with an unknown larger public. Clearly the risks are different, perhaps indicating one of the reasons why urban populations must be dealt with differently than rural populations. Cross-cultural researchers need to consider the issue of what counts as equivalent phenomena. The well-known association of African sexuality with polygamy is a good example. While polygamous relationships do increase the number of partners one has, the assumption, seen regularly in the medical literature, that polygamy constitutes promiscuity, is unjustifiable. While numbers of partners exceed those considered the norm in Western society, individuals are not necessarily active outside of those relationships, and such activities do not in themselves constitute a risk.

FOLK CULTURE AS RISK

I am not suggesting here that such risk behaviors do not occur or that they are not potential avenues for HIV infection, but I am suggesting that medical evidence concerning AIDS in Africa has been constructed to fit preexisting notions about African sexuality and disease, and to fit preexisting notions of the exoticism of traditional cultures. Western research on AIDS had already defined AIDS as a behavioral problem associated with “aberrant” lifestyles; perhaps this provided a predisposition to looking for deviance in an African setting. The result, however, is a discourse which privileges those patterns of social intercourse suggesting that Africans have multiple sexual partners or inject monkey blood, and excludes from discussion the broader patterns of sexuality found on a day-to-day basis.

This search for the exotic invariably leads medical researchers to folklore and particularly customary practice. In Africa, risk becomes associated with traditional healing, children’s games, and initiations such as those associated with blood brotherhood. Daniel B. Hrdy writes in *Review of Infectious Diseases*:

Factors thought to influence sexual transmission in Africa include
 1) promiscuity, with a high prevalence of sexually transmitted diseases;
 2) sexual practices that have been associated with increased risk of transmission of HIV (homosexuality and anal intercourse); and 3) cultural practices that are possibly connected with increased virus transmission (female circumcision and infibulation). Other nonsexual cultural practices that do not fit the age distribution pattern of AIDS but may expose individuals to HIV include 1) practices resulting in exposure to blood (medicinal bloodletting, rituals establishing blood brotherhood and possibly ritual

and medicinal enemas; 2) practices involving the use of shared instruments (injection of medicines, ritual scarification, group circumcision, genital tattooing and shaving of body hair; and 3) contact with nonhuman primates. (1987, 1109–10)

The discussion of African AIDS and risk is part of an authoritative and sophisticated medical discourse of control and exclusion, which uses folklore as an index to socialization and traditional culture as a flag of physical danger. The new wrapping paper on this old evolutionary argument, though, is outwardly biomedical and scientific and, as such, passes for nonideological and neutral.

Central to the perception of African health issues is the evolutionary image of the “primitive native” making a difficult adjustment to conditions of a “civilized” industrial world. The development discourse of which this is a part is much older than the battle with AIDS. In 1963 the director of Kenyan medical services stated:

The African in his rural setting is strictly bound by tribal patterns of behavior, beliefs and customs. He is an integral part of his community and his thinking tends to be communal. . . . With the transposition to the town he forsakes the communal life for an individualistic life, unsupported by tribal rules and regulations. While forsaking these supports, he is not yet ready to adopt the codes and rules which have brought social stability to western civilizations. Furthermore, he is abandoning ingrained centuries of agricultural and pastoral tradition and learning the technical skills of an industrial world quite strange to him. (Fendell 1963, 574)

What is perhaps most interesting about the concentration on exotic tribal customs of the natives is that while tribal life is seen as uncivilized and risky, it is simultaneously discussed as protective and constrained. The dilemma is fascinating. One researcher indicated:

As people leave rural villages and migrate to urban areas, the general level of promiscuity increases. This increase may be attributable in part to the relaxation of traditional village values. . . . (Hrdy 1987, 1112)

RISK REDUCTION

What I have presented here is meant neither to oppose the efforts of those researchers attempting to slow the rate of HIV infection in Africa, nor to attack the attempts made to allow for the consideration of cultural issues in AIDS education and policy making. Quite the reverse is true. It *is* meant, however, to argue that shoving health care workers in the direction of ethnographic material is not

enough. We must raise awareness of the need to understand the methodologies of cultural study and their radical impact on health issues. Understanding sexual and cultural issues cannot be a process of deviance seeking or risk seeking. It must be a process of investigating a range of cultural issues which bear on sexual behavior, a range which may include marriage, divorce, kinship, fertility beliefs, initiation rites, gender roles, child rearing, and so on. But it must also be a process of trying to understand not just the exotic, but also the mundane.

We must, as health researchers and as social scientists, place more value on the subtleties of ethnographic research. Is the data contextualized historically, geographically, or in terms of groups and subgroups? What are the political, social, and economic ideologies which motivated ethnographic collection? Is a part of a behavioral complex being taken for the whole? Is cultural difference being taken to constitute danger or commanding a focus which obscures more pervasive mundane threats? Are very different types of health behavior with different degrees of risk being assumed to constitute equivalent phenomena?

More to the point, we must involve the lay public in the identification of risk, if for no other reason than to have them articulate community *perceptions*. At worst, such information could provide public health needs analysis. At best, it could indicate a whole new set of unknown risks or put to rest those based on exoticism.

We should not lose track of the special skills which are required in the treatment of cultural information. Without those skills, epidemiology may become neocolonialist ideology and risk might become what we take when we steer physicians in the direction of ethnography. Dressed up as biomedicine and couched in a discourse of risk, even colonialist ethnography passes for neutral and nonideological.

NOTES

1. The phrase "African AIDS" is intended here to refer to the discursive construction of AIDS in Africa. Simon Watney (1990) cites Cindy Patton as initially coining the phrase in "Inventing African AIDS" (1988).
2. Simon Watney notes:

As a cultural and psychic construction, "African AIDS" exhibits at least five consistent aspects. First, it speaks of a peculiar and special affinity between a virus and a continent. Second, it reads the modes of transmission of HIV as signs of a generalized and homogenous African "primitiveness" whether sexual or medical. Third, it singles out the alleged

“misreporting” of African HIV and AIDS statistics as further evidence of “backwardness” and “unreliability.” Fourth, it equates black Africans and Western gay men as willful “perverts” who are equally threatening to “family values.” Fifth, it regards “Africa” as the source of the HIV infection in the sense of origin and of *cause*. (1990, 94)

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