For twenty years, the HIV epidemic has been defined largely by the dominant Western medical system of biomedicine.¹ Epidemiological studies have identified the virus and its transmission pathways and biomedical institutions, such as the Centers for Disease Control (CDC), have shaped mainstream intervention programs. Theoretically, biomedicine has the information and resources available to control the epidemic. However, the virus still infects millions of people annually, largely in non-Western societies. The continued smolder of the epidemic is tragic evidence that the current response is ineffective. Within this context, the continued spread of HIV therefore serves as an impetus to critically analyze the current medical approaches.

I use critical medical anthropology (CMA) to establish a framework on which biomedical interpretations of the epidemic are deconstructed and analyzed. This analysis is based on the CDC’s 2001 plan for HIV interventions and other biomedical literature on the epidemic. Critiquing the dominant discourse is vital to understanding the underlying ideologies and theories of the biomedical discourse on HIV. Through the CMA critique, I show how biomedicine is based largely on culturally-specific notions. These views shape the biomedical response, but they also make the exportation of biomedical discourse into other cultures problematic.

Before mounting such a critique, however, we must first explore how biomedicine understands the HIV epidemic. Starting with the viral pathway, biomedicine’s approach in dealing with the epidemic is a complicated process that involves science, politics, and public health. Yet the subsequent intervention programs are all based on the construction of the epidemic as a biological phenomenon. My research shows that this viewpoint, and its underlying ideology, is often culturally-specific to societies that are ingrained with Western values.²³

¹ A more complete definition of biomedicine is offered by Kleinman: biomedicine is the Western system of healing and interpretation of the body that reduces the disease to a phenomenon affecting the temporal organic body.
² Critical medical anthropology (CMA) theories approach medical systems as dynamic histo-social constructions that are incorporated into macro- and micro-level power relationships. CMA analyzes the calculus of economic and symbolic power in medical rituals, critiquing the systems upon which medical exchanges and meanings are built. Thus, CMA moves beyond a social understanding of healing systems to expose their fundamental (and socio-culturally specific) principles.
³ Social structures, such as healing systems, are created by societies in their efforts to explain surrounding phenomena, such as health and illness, and answer the existential questions that arise from them. These structures arise from a perspective unique to a society's historic, moral, cultural, and political experience, since it is within this context that individuals interpret the world around them. Biomedicine is a healing system originating from the Anglo-European experience, and as such, derives much of its epistemology from Anglo-European perspectives. These perspectives include colonization, imperialism, capitalism, Cartesian logic, and the dualities of mind and body, nature and society.
The CDC’s interventions programs are based largely on epidemiological models of HIV dynamics. However, many of the assumptions fundamental to epidemiology (and therefore intervention programs) are not universally shared across all cultures. Reviewing biomedical literature and the CDC’s interventions programs shows that three culturally-specific notions are fundamental to epidemiological approaches to the epidemic. A critique and cultural comparison of these assumptions shows how they form the basis of epidemiology, continuing the shape the discourse of even ‘culturally-sensitive’ interventions. In my research, I focus on risk, the individual, and health as three core components of modern epidemiology. They are often assumed to be immutable, uncontestable truths – empirical and objective, they are given authority and the ability to describe health and illness in Western society. These views, while harmonious within Western societies, often conflict with the healing systems of other cultures. The conflicts created by these assumptions often create spaces that are exploited by the epidemic.

In biomedicine, risk is perceived as a quantifiable, identifiable phenomenon that can be used to accurately assess the health risks of an individual. However, the quantification of risk in biomedicine and the CDC’s discourse on HIV as a biological phenomena are often in conflict with the cultural interpretations of risk. Risk management strategies are often strongly determined by socio-cultural organization, including moral, political, and knowledge hierarchies. In CMA, risk is often understood as a social construction that varies with an individual’s social status, agency, and available survival strategies. Biomedicine tends to view risk and its management as quantifiable, objective phenomena; CMA argues that risk can only be understood in a contextualizing perspective, where subjective assessments based on multiple factors shape one’s decisions.

Contextualizing risk assessments can explain the variability of risk perceptions and their effect on health decisions. As exemplified by the Rwandan culture, risk management strategies do not always incorporate quantifiable notions of risk, nor do they reflect scientific ‘truth’. In Rwanda, risk is often associated with disruptions to the flow of body fluids. This cultural belief is inherently at odds with HIV intervention programs that emphasize risk reduction through condom usage. Indeed, instead of providing protection from risk, condoms are often perceived as a greater threat than HIV. In the CDC’s risk heuristics, condoms are presented as value-free latex barriers. However, in a culture where the flow of body fluids is paramount, the barrier of the condom threatens the social and moral fabric. That the very properties that are valued in the West are perceived as a threat in Rwanda highlights the degree of cultural difference between the two risk perceptions. HIV risk perceptions occur within a complex set of conditions affected by social values, cultural morals, socioeconomic forces, power structures, and politics. As demonstrated by Rwandan concepts of risk, the CDC’s message of safer sex through condom use, intended as a culturally-sensitive alternative to abstinence programs, is itself fraught with cultural connotations and perceptions of risk.
Similarly, the use of the ‘individual’ in epidemiology is often problematic in non-Western societies. The simplification of social relations through the use of the individual implies that society is nothing more than a sum of its parts. While this may work well in modeling the epidemic, it does not correlate with many cultural perceptions of social relations. For example, the Rwandan concept of the person is based on a complex web of social relations that shape and are shaped by each other. This concept, termed the ‘fractal body’, affects risk perceptions because health choices are not made by a singular entity, like the ‘individual’. Rather, they are made on fractal topographies where choices and consequences have tremendous and far-reaching impact. These Rwandan concepts of social structure do not isolate the individual as a unit independent of his social relationships. Instead, the individual (and consequently, his risk strategies, behaviors, and choices) are framed within the larger social network within which he operates. In such a cultural setting, biomedicine’s message of individual identity does not contextualize the epidemic.

In biomedicine, health is located within the organic, temporal body and defined as the absence of organic disease within it. However, while the CDC’s perception of health may work well within the dominant Western culture, other cultures provide alternative perspectives. The Rwandan notion of health within the fractal body shows how other cultural interpretations of health do not derive from the same conceptions. Biomedical interventions that emphasize the notion of health as the product of biology on the individual body therefore do not work within Rwandan perspectives. However, instead of acknowledging these differences and adjusting to the cultural beliefs, biomedical interventions focus on changing non-Western perspectives to mirror their own.

Moreover, by locating health within the body, biomedicine essentially reduces the impact of social forces on health and disease. Instead, it targets interventions on the organic body. Although environmental factors are often discussed as causative agents for disease, biomedicine continues to frame the discourse on health and disease within the individual body. For example, in the clinic, the risk of HIV infection is related to the probability of exposure to HIV; the probability of such an exposure is determined by an individual’s choices. Consequently, health intervention efforts focus on reducing exposure to the causative agent – in HIV interventions, the focus is on controlling transmission through the three main transmission pathways. Health risks are those behaviors that place the organic body at risk for exposure to pathogens, and education programs are directed at increasing awareness of these risks. There is little attention paid to what Paul Farmer has called ‘structural violence’ – the broader social forces, such as economic conditions, housing availability, and social power structures, which have a strong relationship to health and the HIV epidemic.

Like biomedicine, non-Western healing systems reflect notions of health and illness that are contextualized within historical, socio-cultural, and political contexts. For example, the historical and socio-cultural elements that shape health are illustrated by health perceptions in African-American folklore. In many African-American communities, alternative theories of HIV
causation are plausible, especially those that echo the African-American experience in the United States. Therefore, theories of HIV as a government conspiracy to develop a new biological weapon or to destroy marginalized populations are culturally important. They derive from the historical pattern of exploitation of black bodies by the US government that have made many African-Americans wary of government interventions.6

Analyzing biomedical interpretations of risk, the individual, and health shows how HIV intervention programs assume these notions to be universal and acultural, when they actually echo Western ideologies. The culturally-specific elements often prevent biomedicine from truly contextualizing and thereby understanding the HIV epidemic. Deconstructing these notions reveals how they are used by social systems to perpetuate social ideologies; comparing their use to that in other cultures reveals how they are culturally-specific and highly contested among societies. Intervention programs that assume a universality of risk, the individual, and health fail to bridge the cultural divide between Western and non-Western societies. HIV transmission often occurs within this void. Other health models, including that of public health, can be incorporated into biomedicine to expand the paradigms through which health and disease are understood.

While the CDC has begun to recognize the cultural limitations of its mainstream programs and is developing culturally-sensitive intervention programs, it continues to operate from a Western framework. Within this context, non-Western HIV theories are useful. Their value rests not on their empirical validity, but rather on their cultural capital. They explain how others see disease within the context of their own cultural, political, moral, economic and social conditions. Interventions that operate from an understanding of these conditions will contextualize the epidemic into the conditions that shape our realities, thereby providing feasible and realistic measures to control the epidemic.

Historically, epidemics have been the forces of tremendous social change. As societies cope with the devastating impact of mass illness, social structures, systems of power, and knowledge are challenged and re-shaped. The societal disruptions caused by epidemics create the opportunity to develop new world paradigms. The tragedy of HIV, enacted on a global scale, is also an opportunity to challenge the dominant systems of healing and illness and create a new health paradigm. The failure of biomedicine to effectively reach non-Western populations speaks both of its cultural origins and the necessity for a new health framework.

References: