life

Should we all be anthropologists?

Understanding human beings is the first step to mount an effective response to HIV/AIDS, argues **Catríona Macardle**

Once upon a time doctors and medical students were primarily concerned with two things—bugs and drugs. But winds of change have blown through educational establishments, and now the emphasis is increasingly on putting the patient first as a person rather than a diseased being. However, compared with spending an extra hour learning cell signalling pathways that will yield high marks in an examination, attending lectures on culture is often unappealing. Lecture halls lie empty; the students who do attend are often catching up on their sleep—all except (perhaps) that one eager student at the front who keeps asking questions and inevitably ensures that the lecture runs over.

Many of you may shun "touchy feely" lectures and strive as doctors to prevent or cure diseases by using factual information learnt from books, lectures, and observing patients. The belief is strong in Western medicine that a disease exists in a global context and can be diagnosed and treated anywhere in the world with the right drugs or therapies. However, this is not what everyone believes. Others believe that illness exists in a cultural context and changes depending on your cultural beliefs. Say hello to the anthropologists.

What is anthropology?

As a result of people's colonial travels in the 19th century and the interest in the "savages" they met, with their strange clothes and rituals, anthropology has risen to become a discipline that attempts to understand what makes up an individual person. Anthropologists spend months, even years, with or within a society, learning the language, becoming part of the furniture, and observe, through a foreigner's eye, how culture affects life.

Anthropology has many branches, from the investigation of human evolution, to biological processes—how living at altitude affects your body—to the interest in religion, kinship, politics, and economics—"sociocultural anthropology." The branch which sits astride anthropology and medicine is known as "medical anthropology." It examines health in a cultural and environmental context,[1] to understand how human behaviour affects wellbeing and the treatment of illnesses.

Given the social nature of AIDS, how does anthropology aid our understanding of the HIV virus? It is known that HIV is transmitted through sexual contact, and that many countries lack money and drugs makes it difficult to prevent or treat. However, this does not explain why in the UK—where drugs, treatment, and preventive measures are free—HIV still exists outside the migrant refugee population.

Polio was eradicated with a vaccination programme, so why is a safe sex programme not working? Maybe it is because the reasons people have sex, transmit the virus, get tested or not, go to the clinic or not, are all set in a deeper, personal, cultural mesh. The need to procreate is a biological urge, but the way in which we go about this varies around the world; it is cultural—for example, there is monogamy, in contrast to having multiple wives, or accepted use of prostitutes. If we accept that culture has an impact on health and consider that the ability to "cure" the world of HIV virus lies in the understanding of the person and his or her beliefs, then maybe we can move forward in the fight against HIV/AIDS.

Someone to lean on

W PHILLIPS/UNAIDS

Hidden dimensions

Poverty is a major social contributor to the HIV burden in the developing world, but it is an issue that runs deeper than affording appropriate drugs or buying time with a doctor. For example, civil unrest and the resulting poverty in Africa have driven men to become migrant workers in an attempt to provide for their families. They live a lonely and transitory life; the hostels they reside in are a focus for local commercial sex workers who themselves are often rural migrants now living in urban poverty.[2] Twinned with a cultural construct of masculinity that perceives regular sex as essential for good health and key to being a "real" man,[3] this state of affairs promotes and validates the use of commercial sex workers even in times of poverty, when away from your own family and regular sexual partner, but it also increases the risk of HIV transmission.

Poverty does not stop there. The burden of HIV disease falls on the young and middle aged adults, usually the economically lucrative members of a family. Their carers are the younger children who themselves are then unable to attend employment or education, perpetuating the cycle of poverty and HIV. Poverty exacerbates the consequences of HIV infection. If one's immune system is initially depressed by years of inadequate diet, poor water sanitation, and repeated diarrhoeal diseases, opportunistic infections that ravage a person with HIV are easier to contract and harder to fight off, creating a faster path to death.

Poverty and its consequences are not just reserved to people in Africa. In the United States, three quarters of children with HIV are from ethnic minorities, usually lower social classes unable to afford health care, good food, or adequate housing. Poverty has such a grip that even if a male child is HIV negative, in some parts of Harlem the chances of a child surviving past 40 years of age is lower than that in Bangladesh.[4]

STEFFEN HONZERA/STILL PICTURES

A healing ceremony with trance dance in Perspeka village, Namibia

Women and children

Women are at higher risk of HIV than men. They are a focus for rape in times of conflict, but in many cultures they are second class citizens even in times of stability, and their health needs are ignored. In India some "female conditions" are not considered health issues, neither by health professionals nor by the women themselves. Many doctors are men, so women refuse any examination. Also, many Indian women lack the freedom to leave the house, all culminating in putting space—culturally and physically—between them and a health centre.[5] Thus many Indian women will not be considered for HIV testing, let alone treated for it.

In Ghana, women's poverty and lack of education or employment opportunities necessitate some to take "boyfriends" to provide for them. They are not in a position to demand condom use,[6] while other women worldwide do not have access to condoms.[7] Many cultures see contraception as family limitation devices and nothing else, certainly not HIV protection. Permanent sterilisation of women and long acting methods of contraception (the coil, for example) are considered better than others in India, and the matter of condoms and HIV are quietly forgotten.[5] Some women are reluctant to use condoms because they, like their partners, value large families. Others reject the use of condoms because of their association with prostitutes.[6]

In the United Kingdom some new cases of HIV outside the homosexual and refugee populations (among whom the risk is high) come from unsafe sexual practices abroad.[8] If this is the case then we should tackle the sex industry overseas. However, one anthropologist studied a child prostitution ring in Thailand, expecting to find the children abused, HIV pressed on them by predators, desperate to be rescued. Instead she found the children expressed no hatred for their "friends"; they denied abuse: "He is so good to me, he gives me and my family money whenever I need it, how can he be bad?" At Christmas, the children wrote cards for their clients, writing on them "I love you" and "thank you."[9] As practising Buddhists, the children believed that the good they were doing providing for their family negated their prostitution. So how do you protect a group of people who do not want to be protected?

Cultural acceptance

Acceptance is understandably a major cornerstone of HIV prevention and treatment; personally accepting your risk factors, governments accepting it as a health issue in need of addressing. However, what happens if your cultural understanding of health and disease prevents you from ever accepting that HIV/AIDS is a problem?

Many studies show adolescents in Africa are aware of condoms and their relation to AIDS[10] but have trouble accepting their own mortality, and despite their knowledge of sexually transmitted infections, youths often do not consider AIDS as personal threats and seldom use condoms.[7]

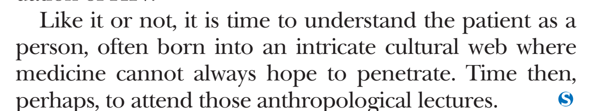
Denial is common, banishing the cultural existence of HIV. If you die of a common disease rather than of AIDS it is often culturally more acceptable, so there is a common practice—for example, Malawi for "chronic anaemia" or "pneumonia" to be a common cause of death with no mention of AIDS in obituaries.[11] Remember the early days of HIV/AIDS in the West?

In many African societies, ill health is considered as a manifestation of misfortune, a physical price paid for a wrongdoing. Therefore the cause of ill health is sought for in the person's actions rather than a biological reason for the sickness. Taking medicine for a supernatural curse would be ineffective.[12] These supernatural forces are often akin to fate or destiny, so why or how could you possibly prevent a disease if it is either a curse, or your destiny?

Open questions

Biomedical science explains how the HIV virus lives in the body and how we can treat it, but it is anthropology that shows how poverty, social instability, gender relations, and cultural notions of sex and ill health all compound to make this a problem that a pill or condom cannot fix. This is just the tip of the iceberg, but as doctors we need to realise that medicine relies on specialist knowledge and sophisticated technology, and the export of this Western package to areas of the world where disease and illness is not understood in the same way, will result in Western medicine becoming unaccepted and ensuring the perpetuation of HIV.

Like it or not, it is time to understand the patient as a person, often born into an intricate cultural web where medicine cannot always hope to penetrate. Time then, perhaps, to attend those anthropological lectures.



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