

The Contributions of Cultural Theory to the Study of AIDS and Education

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The social and biomedical dimensions of AIDS coalesce in the field of education as students and teachers struggle to make sense out of the multiple, and oftentimes conflicting, messages about the disease circulating inside and outside their classrooms. Johnny Sachs (this issue) provides a poignant example of this struggle in the case of South Africa, where President Thabo Mbeki has questioned the prevailing view that HIV causes AIDS and can be effectively treated with anti-retroviral drugs. Although he has recently moved away from this position, at least in public, the President's views present South Africans with mixed messages about the prevention and treatment of AIDS. Controversy about the etiology of the disease extends beyond Pretoria, with scientists, journalists, and politicians in many countries engaging in lively discussions over the process by which SIV (simian immunodeficiency virus), found in certain non-human primates, was transferred from chimpanzees to humans (Cohen, 2000). Even more acrimonious are current debates among health officials, AIDS activists, and pharmaceutical companies over drug pricing and patent contracts for triple therapy medications in the Third World (Rosenberg, 2001).

These debates among prominent politicians, researchers, and activists highlight an important sociocultural aspect of the epidemic: what one 'knows' about AIDS and how one acts based on that knowledge depends on socially-constructed messages about the disease that are meaningful for an individual. In other words, "Our social constructions of AIDS (in terms of global devastation, the threat to civil rights, the emblem of sex and death, the 'gay plague,' the postmodern condition, whatever) are based not on objective, scientifically determined 'reality' but on what we are told about this reality" (Treichler, 1999, p.15). We need to study schooling as part of the process by which young people link the biomedical 'reality' of AIDS from the official curriculum with the social 'reality' of their peers to form their own constructions of personal risk. Institutions of formal and non-formal education serve as critical sites in the epidemic because they are places where biomedical messages about the disease become reinterpreted and incorporated into the social world of adolescents.

In this article, I draw upon the valuable material presented in this volume of CICE to explore the relationship between the social and the biomedical--between representations of AIDS and the deadly disease itself--in order to develop more efficacious health education programs. I begin by tracing my journey of understanding about the disease and conclude with a discussion of how this journey has shaped my current approach to the study of AIDS in Africa¹. Throughout the article, I attempt to show that cultural theory can inform empirical research and advocacy about a problem that extends far beyond the biomedical arena.

As I began working on this piece, I was struck by the parallels between my life course and the course of the AIDS epidemic as it has unfolded in mainstream American media over the past two decades. In the early 1980s, as a college student at a conservative

Midwestern university, I considered myself immune from this new illness described in the newspaper because it was a 'gay disease' that could only be transmitted from one man to another. Then in the mid 1980s, when young Ryan White became infected through a blood transfusion and stories of female prostitutes were featured in the press, the term AIDS entered popular campus discourse. However, AIDS was still viewed by the heterosexual majority as something that affected 'them' rather than 'us.' Citing reporter David Black, Treichler (1999) argues that media accounts of AIDS during the 1980s presented it as the domain of "homos, heroin addicts, Haitians, and hookers," or the "4-H Club" (p. 53). Since 'heterosexuals' and 'Hoosiers' were not yet regular club members, we escaped biomedical scrutiny and failed to scrutinize our own practices because they did not fit into high-risk categories of "sexual identities and behaviors" (de Sousa and Cruz, this issue).

Though absent from media and medical reports at the time, "family women" and conjugal aspirants from Bloomington to Brazil were being infected by their bisexual male partners even though these men may not have defined themselves as bisexual (de Sousa and Cruz, this issue). It was in this context that AIDS finally hit home, when a former college sweetheart was found dead in his San Francisco apartment several years after graduation. The college's safe-sex brochures, predicated on a rigid dualism between heterosexual and homosexual, failed to introduce the possibility that sexual identity was fluid and multifaceted. This is not surprising because sex education programs at the college were "developed from the top" by nurses, doctors, and public health officials with little input from the young people whose lives were being affected by engaging in unsafe sex (Kelly, this issue). Thus, despite the best intentions of school officials to present the student body with up-to-date medical 'facts,' their lack of engagement with co-eds in program development led to dangerous omissions about sexual identity and high-risk behavior. The participatory methods described by Kelly in his article on Zambia would have provided critical information about youth culture and sexuality that was missing from the college's public health program.

As AIDS continued to take its toll on individuals in my social world, I slowly began to understand its effects on the collective body, especially in Africa. I started graduate school with a specialization in African studies just as AIDS on the continent was beginning to make headlines in the United States. Because traveling to Africa was considered rather exotic by my neighbors and family, they inundated me with stories from their local papers to prepare me for my first trip to East Africa in 1990. These tales of disease and despair on the continent stood in stark contrast to the studies of strength and resistance I had been reading about in my courses on African history, so I was anxious to discover the 'real' Africa for myself. Yet as in the case of AIDS, I saw what I was conditioned to see through coursework, the media, and my conversations with other American students on this study-abroad program. My letters home from Tanzania and Kenya were full of references to "households" and "kinship" rather than to families; to "rituals" rather than to spontaneous celebrations; and to "AIDS" as the most pressing health issue for Africans while failing to see the toll that diarrheal diseases and malaria were also taking on the lives of those I met.

Ten years later, I can reflect on this experience as the beginning of a journey whose goal has been to understand the interplay between the social and biomedical dimensions of

health in one African setting, namely, the Kilimanjaro Region of Tanzania. Along the way I have collected newspaper stories on AIDS in Africa, analyzed survey data on education and knowledge of the disease, and conducted ethnographic fieldwork that examines the worldview of Tanzanian adolescents in relation to their reproductive health. At this point in the journey, with bags filled with statistical and qualitative data, there remains a need for cultural theory to understand the biomedical consequences of the socially-constructed dimensions of the disease.

The articles in this volume of CICE demonstrate the contributions that social science research can make to the development of sound health education programs, and I would not advocate dispensing with this research to pursue cultural and linguistic theory exclusively. I suggest, however, that empirical studies of AIDS and education are one way among many of producing knowledge about the disease. Looking first at the statistical data, there is a positive correlation between women's level of education and her knowledge about HIV/AIDS (Vandemoortele & Delamonica, this issue). There is also ample evidence showing that Sub-Saharan Africa, especially southern Africa, will be hardest hit by the epidemic as it continues to spread through the population. According to Malambo (this issue), Zimbabwe and Botswana have prevalence rates approaching 25%, while Coombe (this issue) presents the disturbing figure that one out of ten South African children will lose their parents to the disease over the next fifteen years. Based on her analysis of AIDS and education in South Africa, Coombe argues for "a research agenda on HIV/AIDS and its impact on the education system, with priorities agreed, academic and other research partners mandated, resources allocated, and research outcomes linked to change."

Given the gravity of the situation in Sub-Saharan Africa, a call for cultural theory seems ludicrous when so many lives are hanging in the balance. Indeed, and indeed not. The data make it clear that there is an urgency to act upon research findings and to demand that more resources be allocated to the prevention and treatment of AIDS. But the debates over how to treat people infected with HIV and who should be treated ought to caution us against abandoning theory too quickly in the face of the epidemic². An analysis of American media coverage of AIDS in Africa makes this point clear.

As part of my research examining Tanzanian students' views on education and health, I have also been studying news stories on AIDS and population change in Africa written in the U.S. The file I began a few years ago titled "Africa--Media Reports" now has a number of clippings from American newspapers showing the map of Africa recast as the face of the Grim Reaper. The first time I saw this image, I assumed the editor of the local paper simply had bad taste, and I filed the story without a letter of protest. When similar images began to appear in the Boston Globe and the New York Times, however, I realized that this representation of the continent as death itself was far more pervasive than I imagined. Both national papers have printed ground-breaking stories on the AIDS epidemic in Africa, but they have also published articles such as those that appeared in the "AIDS and the African" series that ran for four days in October 1999 in the Boston Globe. The lengthy articles contain a tremendous amount of data about the epidemic and powerful stories from individuals coping with the disease. However, the text and the photographs that accompany the stories present uniform images of Africans that are widespread in American mass media. In this series, Africans are portrayed as either

passive in the face of the epidemic or as irrational for engaging in high-risk sexual behavior. For example, there is a photograph of an African woman sitting in almost complete darkness except for the light that shines on her face and the face of the AIDS orphan she is holding. In another photograph, a group of scruffy children huddle together outside their thatched house while a woman lies ill on a straw mat in the foreground. The passivity of the women and children in these photographs suggests to the American reader that Africans cannot take action themselves to combat the disease. When Africans are cast as actors, they are often granted negative agency as prostitutes. Though the articles in this series briefly mention female sex workers' economic struggles, it is the struggle to make them understand the importance of condom use that is highlighted by the reporters. The photographs do not show us African health educators teaching sex workers nor do they help the reader to understand the difficult choices women must often make to feed themselves and their families. Instead, the accompanying images are of female prostitutes soliciting male customers and then walking off into the South African bush to have sex. These articles undoubtedly achieved the goal of raising public awareness of the AIDS epidemic in Africa, but they also reduced a set of complex social, economic, political, and biomedical issues into a singular health problem facing "the African."

The material consequences of these socially-constructed representations are evident in a recent article on AIDS in the *New York Times Magazine*. The author, Tina Rosenberg, uses the successful example of Brazil to refute arguments against providing anti-retroviral therapy to AIDS patients in the Third World. She implicates pharmaceutical companies in perpetuating the belief that the triple-drug therapy is too complicated for people in developing countries to understand, though she acknowledges that taking the medications improperly could create drug-resistant strains of the disease. However, Rosenberg (2001) describes the education and training program in Brazil to show that the adherence rate to the medical regimen in this Third World country is about the same as in the United States. Thus, the author argues that "the worries of rich countries that the poor and uneducated will mess things up for the rest of us have proved unfounded" (p. 29).

These examples from mainstream American media highlight the ways that knowledge about AIDS and the Third World is produced and how it can influence policy-making. Statistical knowledge about the disease impinges upon the process of policy formation in a very direct way, but the indirect effect of cultural knowledge does not make it inconsequential. Tony Bennett (1992), among others in the field of cultural studies, has called for greater engagement between cultural theorists and policy makers. He suggests that there is "the need for forms of cultural theory and politics that will concern themselves with the production and placing of forms of knowledge--of functioning truths--that can concretely influence the agendas, calculations, and procedures" of influential institutions and organizations (p. 32).

Some of the authors who contributed to this volume of CICE are already employed by such institutions, and it is hoped that their research will bring about tangible results in the fields of health and education. Yet there remains a need to put cultural theory into policy making if we are to understand how representation and cultural knowledge shape the formation of the problem under study and the possible solutions with which

to solve it. Material intervention and cultural critique are necessary to understand the production of deadly education.

Notes

1. The metaphor of journey is popular among cultural theorists, and I risk contributing to its overuse by applying it here. However, I can think of no more appropriate metaphor for the tale that unfolds in the following pages than a "journey of understanding" as described by Rothenberg (2001).
2. This sentence refers to the title of Paula Treichler's book on AIDS entitled *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS* (1999).

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