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What's Wrong with this Picture? The Hegemonic Construction of Culture in AIDS Research in the United States

Rather than serving to combat the epidemic, the use of seemingly politically neutral epidemiological categories to portray AIDS risk groups as culturally distinct may have impeded AIDS education and prevention efforts. This article critiques the construction of intravenous drug users (IVDUs) as an AIDS risk group by contrasting the portrayal of an IVDU subculture with studies that report on the diversity of behavior of people who use intravenous drugs. The tendency of epidemiologically oriented AIDS researchers to equate intravenous drug use with minority populations and to construct a category of "Hispanic" as a population at risk for AIDS is shown to be problematic. The cultural construction of HIV is analyzed as part of the hegemonic processes of the United States that exclude those seen as culturally distant from the body politic. [AIDS, risk groups, intravenous drug users, hegemony]

It is well known that the spread of HIV infection is the result of human behaviors that vary cross-culturally. Consequently, public health researchers have become increasingly interested in the ethnographic documentation of cultural differences and the explication of patterns of "risky behavior" among culturally differentiated populations. The concept of culture has become one of the research tools of public health investigators interested in tracking the HIV epidemic and developing ways of preventing the spread of infection. Since an epidemic raises life and death questions, clarification of the conceptual categories that organize and direct AIDS research is crucial.

In this article I analyze the manner in which culture has been conceptualized in AIDS research in the United States and argue that the construction of culture that has been widely employed in this research serves to distance and subordinate. Much of the existing cultural analysis has concealed more than it clarifies about the epidemic. Its hold on the domain of public health research has been so firm that anthropologists, called in as experts on the topic of culture, have had a hard time making themselves heard when they have questioned this type of cultural analysis. I will use three vignettes of discussions of AIDS prevention drawn from

Medical Anthropology Quarterly 6(3):237–254.

my experiences as an AIDS researcher to illustrate themes I will develop in this article. In each, anthropologists encounter resistance when they offer other U.S. public health researchers a critique of the use of the concept of culture as an explanatory variable.

In the first scene, bioethicists at a prestigious research center have decided to address ethical conflicts between what they call "communitarian values" and "minority subcultures." In preparation for their work, one of the bioethicists meets for a cup of coffee with three anthropologists and questions them about the cultural values of ethnic groups that he sees as most affected by the AIDS epidemic. All three anthropologists respond by critiquing approaches to the AIDS epidemic that focus on the culture of those infected. The anthropologists try to interest the bioethicist in issues of gender and power. The discussion is cordial and intense but both sides leave feeling a bit unclear as to what, if anything, has been accomplished.

The setting of the second vignette is a more formal meeting. A group of social scientists from various disciplines sit around a polished wood conference table at the National Institute of Mental Health. An anthropologist is presenting a study of an African American household that he conducted as part of his work with intravenous drug users. The anthropologist describes the behavior of a young African American man who is HIV-positive. The young man lives with his grandmother and brings people back to her apartment to shoot up in the bathroom. His grandmother charges a fee for each needle user who comes to shoot up in the apartment.

The anthropologist carefully specifies the context of these actions. The young man cannot find a job. The grandmother has to support her grandson, herself, and her teenage granddaughter who has just had a baby. The teenage mother cannot apply for social service assistance since she can find no other housing and is not supposed to live in her grandmother's public housing. But the assembled social scientists do not address the housing shortage, unemployment, or racism in their subsequent discussions of the presentation. Instead what concerns them is what they call the "dysfunctional black family." And they call for more studies of the cultures of high-risk groups.

In the third scene, an anthropologist is speaking about Hispanic women and AIDS at a lecture sponsored by a prestigious research organization. The speaker carefully frames her comments about the "high-risk" behavior of the women by specifying that there is a fundamental problem in trying to prevent the spread of HIV by educating women about condoms. In society as a whole, she says forcefully, women lack economic power and control over their sexuality. The members of the audience, however, do not respond to this part of the talk. Their questions focus on the cultural values of the Hispanic women, especially their views about prostitution, childbirth, sexuality, and drug use.

In all three vignettes, health researchers and anthropologists hold different and contrasting causative models of the manner in which behavior that puts individuals at risk for HIV infection is shaped by broader forces. At the heart of the difference in perspective are different conceptualizations of how culture is to be understood and interpreted. For the health researcher, drug users and minority populations are at high risk for HIV because they belong to subcultures that deviate in practices and life-style from the behavior and values of the general pop-

ulation. By incorporating racial and ethnic categories within their conception of cultures at risk, the health researchers were implicitly suggesting that the risky behavior of intravenous drug use was a product of African American or Hispanic culture.

In contrast, the anthropologists in the vignettes "contextualized" culture by positing that the behavior that puts people at high risk for HIV infection must be understood in relationship to the structure of power and wealth within the larger society. The cause of the risky behavior was embedded in the intersection of culture (including household composition, gender roles, and the positive valuation of children), economic conditions, and power relationships. For these anthropologists, racial and ethnic categorization of risky behavior was misleading and could lead to erroneous health policies.

While different and competing interpretations of culture underlie the contention between anthropologists and health researchers described in the vignettes, it was the health researchers who spoke with the authoritative voice. After critiquing the manner in which U.S. AIDS researchers have constructed intravenous drug users into a distinctive culture, I will return to the question of the legitimacy and authority that has been accorded this cultural construction of AIDS risk groups. The process by which U.S. biomedicine has constructed a risk group of intravenous drug users and identified this group with the categories of "black" and "Hispanic" will be shown to be part of larger hegemonic processes by which the dominant forces in U.S. society maintain and reconstruct social order.

The Paradigm of the Contagious Cultural Other[1]

Locating the source of lethal epidemic disease in populations perceived as culturally different is a practice that predates modern health research (Brandt 1985; Slack 1988). An age-old paradigm of the contagious cultural other both delegates the origin of the disease to the cultural other, who is seen as different and immoral, and holds that the disease is highly contagious so that the "other" must be separated from the body politic.

While these ideas can be found broadly within the society, they become formulated, codified, sanctified, and incorporated into the systematized "knowledge" of the era by those concerned with maintaining social order and discipline. Hence, in their efforts to impose centralized authority within the "body of Christ," church authorities in the 12th and 13th centuries stigmatized Jews, homosexuals, and heretics (Solomon 1986). During the plague years of the 14th century, amidst the chaos that resulted from the broken social order brought by the disease, it was widely held that Jews, culturally differentiated in feudal Europe, were responsible for the pestilence, and massacres of Jews were widespread (Slack 1988).

Centuries later in the U.S. cholera epidemic of 1832, the disease was associated with "intemperance and vice" (Rosenberg 1962), and people identified as foreigners were said to exhibit these behaviors. Officials refused to allow immigrants across the border from Canada for fear they came with the disease (Rosenberg 1962). During World War I, syphilis was seen as transmitted by casual contact and also attributed to outsiders and deviants. This dual theory of transmission was the justification for placing prostitutes in detention camps.

In the AIDS epidemic, we again see a dreaded epidemic disease attributed to the "dangerous other," specifically defined as culturally different and deviant (Clatts and Mutchler 1989; Treichler 1987). The logic of attributing lethal diseases to those who are culturally different continues, becoming embedded in the epidemiological category of the risk group. Disease became linked with culture through the manner in which epidemiology has constructed and popularized a concept of "high risk."

The Epidemiological Construction of the Cultural Other

Epidemiologists begin to delineate the factors that put groups of people at high risk for a disease by identifying populations thought to be distinctive along parameters that may increase their degree of risk. They then search for relationships between factors that characterize each population and the presence or absence of disease within that population. Textbooks in epidemiology carefully specify that a statistical correlation between population characteristics and the presence of a disease does not prove causal relationships (Susser 1973). However, the manner in which epidemiologists draw the boundaries to create the population groups is less discussed. As Deborah Stone has pointed out,

> risk factors and designations of high-risk groups do not grow immediately and automatically out of epidemiological research. They are created in a social context that involves judgment, persuasion, bargaining and political maneuvering. This larger social context also shapes decisions about what is considered a risk factor, [and] how broadly categories are drawn. [1990:91–92]

At the beginning of the AIDS epidemic, epidemiologists thought that the disease was transmitted through the sexual activities of homosexual men, and so they grouped homosexual men into an exposure category. One can argue that the early linkage of HIV disease to gay men was a product of the particular manner in which the disease was first reported and tracked by the Centers for Disease Control (CDC) (Oppenheimer 1988; Shilts 1987). The labeling process persisted, however, and was incorporated into a hierarchy of risk factors by the CDC long after HIV was identified as a virus that was transmitted from one host to another by body fluid-to-blood or blood-to-blood contact. The CDC continued to inform the public that:

> a wide variety of persons are at risk for AIDS including: homosexual or bisexual men, intravenous drug users, transfusion or tissue transplant recipients, heterosexual partners of infected persons (including persons born in "Pattern-II" countries—Caribbean and central African countries where heterosexual transmission predominates), children born to infected mothers and persons with mucous membrane and percutaneous exposure to blood and body fluids of infected persons (e.g., health-care workers). [1989:7]

In other words, the CDC divided the population in the United States into two sectors. One sector, the general population, was at risk through a specific act or relationship that exposed them to the virus. Heterosexuals, for example, were at risk if their partner was known to have the virus. Health-care workers were said to be at risk if they experienced direct exposure to the blood and fluids of infected persons.

A second sector of the population had risk embedded in the identity that distinguished them from the general population (Treichler 1987). Men classified as homosexuals or bisexuals and all intravenous drug users were said to be at high risk no matter what they did or who they did it with. Persons from nonindustrialized countries such as Haiti, where cases of HIV had been reported in the first years of the pandemic, were also seen to have embedded AIDS. Hence, the heterosexual sexual partner of any person born in countries of the Caribbean or central Africa (designated Pattern II countries)[2] also were said to be at risk (CDC 1989:7) merely by virtue of their relationship to someone from these countries.[3]

This population was differentiated and separated from the general population by their shared high-risk behavior. The supposed distinguishing characteristic of shared risky behavior was treated, in standard epidemiological logic, as a dichotomous variable which was signaled by the term "risk group." A person's identity was seen to stem from his or her membership in a risk group so that the person was either part of the differentiated population or a part of the general population. Researchers were then called in to study not the behaviors of transmission wherever they occur, but the separate bounded populations of the risk groups that were seen as distinct both in their behavior and identity. What distinguished these bounded groups from the general population came to be seen as their culture. The study of HIV transmission became the study of the culture of "risk groups." When the risk group was seen as particularly separate, distant, and "hard to reach," ethnographers were called into the battle.

The Construction of the High-Risk Culture of the Intravenous Drug User

Although both intravenous drug users and gay men have been seen as having distinctive cultures, most of the ethnographic work has been done with intravenous drug users, who have been thought to be particularly hard to reach by survey methods. The initial researchers tended to see intravenous drug users as sharing a distinctive subculture marked by a common way of life and shared set of values. "Needle sharing" was identified as a key value in this subculture. Conviser and Rutledge, for example, told us that "Needle sharing is a central part of the subculture of drug users—a symbol of social bonding among people who otherwise have little occasion to trust one another" (1988:45). The members of this subculture were said to have a particular life-style centered around "an authentic risk culture" (Bibeau 1989:12). In keeping with this perspective, the National Institute of Drug Abuse (NIDA) has employed ethnographers as part of research teams at sites throughout the United States. Their ethnography has focused on street populations.

Employment for ethnographers certainly has been welcome, but the concept of subculture that motivated this research funding has been problematic on a number of counts. The description of the subculture provided by researchers working in one geographic location has often proved not to be generalizable. For example, Conviser and Rutledge's (1988) description of the values of intravenous drug users may have been accurate for the particular individuals studied but is not representative of the population as a whole. The tendency, however, has been to generalize descriptions of the behavior of drug users in the most impoverished neighborhoods of a handful of inner cities to all members of the "risk group."

The generalizations ignore variations among intravenous drug users according to class, gender, and geographic location.

This image of a risk group of intravenous drug users who share a common culture has become part of the public perception of AIDS, despite the fact that some of the anthropologists who did the street ethnographies took pains not to generalize beyond the limits of their data. Bryan Page and his colleagues (1990), for example, have specified that their description of hustling, stealing, and dating among African American drug users in an impoverished neighborhood in Miami does not even apply to the life-styles of intravenous drug users in Miami who are of a different class or ethnic background. It certainly would not be applicable to all intravenous drug users in the United States. Even in the Miami neighborhood Page studied, some of the drug users went to work every day.

Part of the problem lies in the manner in which epidemiological analysis transforms populations into contrasting variables characterized by cultural differences. Such a method of analysis contains no conceptual space in which to include data on the conditions that form the context of culturally varied behavior.

In a survey conducted in New Jersey and based on a random sample of persons with AIDS, individuals who had been labeled by state AIDS surveillance procedures as intravenous drug users were found to have diverse life-styles (Crystal et al. 1990; Glick Schiller, Crystal, and Lewellen 1993). In contrast to the image of intravenous drug users as street hustlers, the 65 intravenous drug users in the sample had substantial work histories and diverse job skills. Rather than living on the streets, respondents lived in a variety of social locations that included stable working-class and middle-class suburban neighborhoods. While 22% had been homeless at some time since their diagnosis of AIDS, at the time of the interview, only 5% remained homeless. Several individuals who were previously homeless were housed by their families at the time of the interview.

A careful reading of ethnographic descriptions of intravenous drug users living in the street reveals a population that actually cycles between drug use on the streets and living in working-class neighborhoods as part of the "general population" (Mason 1989). Moreover, there is evidence that intravenous drug users may "age out" of drug use so that even the street "culture" of the drug-using population may be more an age-grade phenomenon than a discrete subculture (Mendel, Aldrich, and Biernacki 1989). In the words of the National Research Council, "the IV drug using population is heterogeneous with respect to drug use, life style, and risk-associated behavior" (1989:189). This variation makes questionable the effort to see intravenous drug users as a culturally distinct population.

Policy Implications

The diversity of culture found among intravenous drug users is not just a matter of anthropological interest. It has direct bearing on issues of AIDS education and prevention. The behavior of needle sharing, described as a common pattern among intravenous drug users, is a case in point. The term "needle sharing" has been applied to a range of behaviors, from the use of the same needle by spouses to the renting of needles in shooting galleries. Page reports that in Miami,

> most of the injection settings observed by the field team have enough used syringes in stock to allow simultaneous shooting by fairly large numbers of people.

> We have therefore observed needle sharing behavior only rarely. Needle pooling, however, has been observed frequently, because the needles returned to the coffee can or pouch are distributed later to other users. [1990:67]

Based on these observations, Page warns against what he calls "generic approaches to preventing HIV contagion" because "intercommunity variations in self-injection practices are potentially infinite, and each variant may be accompanied by different kinds of risk of HIV infection" (1990:69). Intravenous drug users in Miami who receive and heed AIDS education messages about not sharing needles still are exposed to multiple sources of transmission of HIV.

The conception of intravenous drug users as culturally differentiated from the general population also has implications for the planning of support services for persons with AIDS. Intravenous drug users are commonly described as having "sexual partners," rather than lovers or spouses. While it is useful in talking about transmission to look at all sexual relations, irrespective of whether they are legally sanctioned by marriage, the practice of reducing spouses and long-term mates of intravenous drug users to sexual partners is culturally distancing. It is part of an image of drug users as strange, unsavory creatures who live on the streets, estranged from or rejected by family members.

Because drug users are envisioned as people without families, there has been little research into family caregiving for HIV-infected intravenous drug users. In the research literature about drug addiction, however, there are glimpses revealing that family ties remain significant for intravenous drug users. For example, there are reports of significant family support among Mexican and Puerto Rican immigrants with histories of drug use (Singer et al. 1990:90). A random sample of people with AIDS in New Jersey revealed extensive family ties among intravenous drug users (Glick Schiller, Crystal, and Karus 1989, 1990; Glick Schiller, Crystal, and Lewellen 1993). Almost all 65 respondents with a history of intravenous drug use had ongoing relationships with family members and received physical or emotional support from them. Most lived with family members. Female family members predominated among those providing concrete support to both men and women, with mothers, sisters, and wives proving to be the mainstays of family support. The significance of family members, however, has gone almost unnoticed by both AIDS researchers and health planners.

Racial and Ethnic Categories and the Construction of Risk Groups

Most ethnographies of HIV-infected intravenous drug users have been conducted in inner-city neighborhoods, and most surveys of homosexual men have been done in the gay communities of major cities. As a result of this dichotomized research strategy, HIV-infected intravenous drug users and gay men are commonly portrayed as racially distinct from one another (Brown and Primm 1988; Schilling et al. 1989). For example, Caplan, Greenberg, and Landsbergis tell us that "Gay men and IVDUs (and their sexual partners) constitute separate at-risk populations. Gay men are typically white. . . . IVDUs and their sexual partners are more often black or Hispanic" (1989:152). Bisexuality becomes a category of homosexuality, lumped with the white gay population.

In point of fact, the national picture and the picture in a number of states seems to be more complex. While most intravenous drug users were reported to

be "black and Hispanic," a major sector of the black and Hispanic populations with diagnosed AIDS reported homosexual activity. Based on 1989 CDC statistics, Singer and his colleagues report "homosexual transmission remains an important risk among Latino men, with 48% of AIDS cases among males attributed to homosexual/bisexual contact alone" (1990:75–76). In the 1989 figures, the percent of blacks who reported male homosexual or bisexual contact as a source of transmission of HIV (37%) was almost equal to the percent who reported transmission through intravenous drug use (38%). Another 7% reported both contact that was homosexual or bisexual and intravenous drug use.

It should be noted that when state and federal statistics about the incidence and prevalence of HIV across populations are presented, the procedures by which individuals are placed into racial and ethnic categories and into transmission categories are never described. The accuracy of the categorization procedures for these designations is taken for granted. In contrast, if individuals report no standard transmission mode, the data are often rigorously scrutinized by the CDC. However, my field observations of surveillance officers working for the Department of Health in New Jersey lead to me question the accuracy of the surveillance data that report race and ethnicity and mode of transmission.[4] Most often, case reporting for state and federal AIDS registries in New Jersey was done by surveillance officers hired by the New Jersey Department of Health to scrutinize hospital medical records. It was unclear whether the data on the medical records came from self-reports or from the assumptions and judgments of a medical practitioner about risky behavior and about racial and ethnic identity. Particularly questionable were decisions to categorize individuals as "Hispanic."

The entire category of "Hispanic" or "Latino," used in epidemiological reporting as if Hispanics were a clearly demarcated population with a common culture, is itself extremely problematic. As Singer and his colleagues have pointed out, "alternative definitions of the category (e.g., by language, country of origin of parents, Spanish surname) result in differing data and different conclusions" (1990:74). Moreover, the category "Hispanic" encompasses diverse nationalities, and within each nationality there are internal class divisions and different degrees of education, knowledge of English, and familiarity with U.S. culture. The nationalities are clustered in different regions of the United States, and each of these variations has significant consequences for epidemiological research. Exploring variation in national origin alone, researchers have found that the rate of infant mortality varies greatly within the category of "Hispanic" according to the country of birth of the mother (Ventura, cited in Zambrana 1991).

All the many sources of variation in populations designated "Hispanic" can affect the rate of seropositivity in a population as well as the knowledge about AIDS and the receptivity of that population to AIDS education. For example, researchers who have reviewed studies of socioeconomic factors that affect AIDS knowledge report that the degree of education and acculturation have a positive bearing on AIDS knowledge "regardless of ethnicity" (Singer et al. 1990:86).

The area of settlement of each nationality is of particular significance because different regions of the country differ in HIV seropositivity rates. Selik, a CDC researcher, has demonstrated that within the category "Hispanic" there is actually wide variation in seropositivity rates by country of birth.

> The present study shows that the risk in persons of Mexican ethnicity is similar overall to that in the reference group of Whites who are not Hispanic, but varies by region. . . .
>
> The high proportion of cases in heterosexual IVDAs found among Hispanics overall primarily reflects the high proportion in persons of Puerto Rican ethnicity (birth or ancestry). The strong association between persons of Puerto Rican ethnicity and heterosexual IVDAs with AIDS may well be related to the concentration of both in the Northeast region. . . . The Puerto Ricans' geographical location at the center of the AIDS epidemic in heterosexual IVDAs could have exposed them to a greater risk of IVDA AIDS. [Selik et al. 1989:837–838]

One could conclude from Selik's arguments that it would be sensible for epidemiologists to put aside the use of explanatory variables such as "Hispanic" or "Puerto Rican" culture and begin a serious discussion of geography as a risk factor. This direction was not, however, taken up by Selik or most other AIDS researchers. Despite clear documentation that the category "Hispanic" obscures the prevalence of AIDS in different sectors of the population of the United States, the term "Hispanic" has persisted throughout the AIDS epidemic and is found in CDC national surveillance reports.

What's Wrong with this Picture?

Two examples, one from the bottom of society and one from the top, illustrate the problematic outcome of a public health approach to HIV that has presented risk for AIDS as linked to culturally distinct populations rather than to specific behaviors that increase the possibility of infection.

Residents of a homeless shelter, interviewed by Susser and Gonzalez, had heard and were heeding public health messages about AIDS but the messages were not assisting in AIDS prevention (1992). Drug users took precautions to keep their needles clean, although they tended to see homosexuals as the ones at risk; gays admitted it was important to practice "safe sex," although they saw intravenous drug users at high risk rather than themselves. The major failure of the public health message, however, was among those who identified as neither gay nor habitual users of IV drugs. Many of these men engaged in homosexual relations with each other and with others outside the shelter for comfort, money, and shelter. In such situations these men sometimes used drugs, if not intravenously then by "skin popping." Since they did not self-identify as members of a risk group, they practiced high-risk behavior while seeing the other people in the shelter as at risk for becoming sick with "the virus."

When we move from a homeless shelter to a Presidential Commission we find similar reasoning. In 1989 the Presidential Commission on the Human Immunodeficiency Virus Epidemic recommended that "people who fall into any [high risk] categories should seek testing and counseling services from their physician or public health agency, regardless of presence or absence of symptoms" (quoted in Rhame and Maki 1989:1248). The logical result of such advice was that if you did *not* see yourself as gay, as an IV drug user, or as a sexual partner of an IV drug user, you did not think of yourself as being at risk for AIDS. By 1991, health practitioners in the United States were still slow to diagnose women with HIV even though worldwide, women showed the highest increase in incidence of HIV infection of any population group (AIDS Alert 1991).

In fact, by 1991, women, adolescents, and minorities—groups that had not originally been identified as populations at high risk—all showed dramatically increased incidence of HIV infection. Confronted with the changing face of AIDS, some researchers have called for adding these three new groupings to the standard risk groups. To rectify the classification system of risk for HIV by adding women, adolescents, and minorities as risk groups is so absurd that it is revealing. The result of this logic would be that white heterosexual men would be the only ones left in the general population.

Among the serious consequences of the construction of AIDS risk groups seen as culturally distinct from the rest of the population have been: (1) misunderstanding who is at risk and who is not; (2) poor targeting of health education efforts; (3) the resultant spread of disease because people do not understand who is really at risk; (4) the stigmatizing, distancing, and silencing of the population with AIDS; and (5) a concentration on HIV disease itself without placing it in the context of conditions that have a direct impact on AIDS education and HIV disease, diagnosis, and treatment. Among these conditions in the United States are unemployment and growing structurally caused poverty, the subsequent development of the informal economy of drugs, the lack of primary and preventive health care, and the oppression of women and people of color. The concept of risk group, as it has been used in AIDS research, has perpetuated these consequences through what it does not allow us to see as much as through the type of thinking it promotes (Treichler 1988).[5]

When the concept of risk group is discarded, numerous insights begin to emerge about HIV transmission in the United States. For example, heterosexual men who frequent prostitutes can be seen to be a possible important vector of the disease in the United States. Leonard (1990) has been able to show that in the United States, men who travel across the country on business and become the clients of prostitutes in different cities may spread the infection in much the same way that truck drivers in East Africa have been found to carry HIV across national borders. The risky behavior of the men puts both themselves and the women who are their subsequent sexual partners at risk.

It is important to note that almost half of the men in Leonard's study in Camden, New Jersey, were married. Women whose husbands do not use intravenous drugs are the targets of no HIV education or prevention efforts in the United States. Many of Leonard's findings about clients of prostitutes are similar to research findings in England, Canada, and Africa, indicating that neither national cultures nor divisions between Pattern I or II countries provide useful categories of analysis. Certain patterns of HIV transmission should be studied in terms of global behaviors.

Stall and his collegues provide data to show that 60% of his sample of heterosexual patrons of singles bars in San Francisco engaged in moderately high or high-risk sexual practices, despite being well informed about the behaviors that transmit HIV (Stall et al. 1990). Although falling into no conventional definition of risk group, they were clearly at risk in a city with as high a seroprevalence rate as San Francisco.

Other sexually transmitted diseases (STDs) are co-factors that increase the probability that sex with a person infected with HIV will result in the transmission of the virus. Documentation showing that STDs significantly increase the risk of

HIV infection has been available for several years (Holmes, Karon, and Kreiss 1990; Schoun et al. 1988). This finding, however, has been largely disregarded while extensive interest has been focused on building prevention efforts around culturally distinct risky behaviors.

Because they decrease inhibitions and make unprotected sex more likely, drug and alcohol use during sexual activities also increases the risk of HIV infection (Flavin and Frances 1987). Factors such as the presence of STDs or alcohol use during sex do not neatly delineate populations into bounded risk groups. Yet AIDS education oriented toward these co-factors of infection might provide useful new avenues toward preventing the spread of the pandemic.

Discussion

American anthropologists have long expounded on the explanatory value of the concept of culture. Culture, we tell ourselves, our students, and our colleagues in other fields, has proven to be an invaluable concept. It allows us to understand that the primary source of differences among different groups of humans is learned, socially patterned behavior. Culture, therefore, is a liberating concept. Ideas and patterns of living are not encoded in our genes and men and women are their own creators.

In point of fact, the concept of culture can be used to subordinate as well as liberate (Asad 1973). The past use of the concept of the "culture of poverty" and the recent flourishing of the construct of the "underclass" provide examples of how cultural constructs can serve to obscure relations of domination. Anthropologists have come to recognize that colonized peoples have been constructed as the cultural other, reinforcing political subordination with cultural domination (Rosaldo 1989). Hence the struggle of the colonized for liberation involves not only struggles to obtain political power but contests over the legitimization of alternative cultural constructions (Chatterjee 1986; Cooper and Stoler 1989).

The predominant conceptualizations of culture within American anthropology have left little space for the recognition of the continuing dialectic of cultural construction and contention, of co-optation and opposition, that takes place between politically dominant sectors and subordinated populations. This lack is most apparent in what Singer, Davidson, and Gerdes (1988) have referred to as "the culturalist perspective" theorized in Sahlins's *Culture and Practical Reason* (1976). In this approach, because it is an autonomous realm, culture can only be explained in its own terms and its own logic.[6] This is, of course, the same mindset that actuates the epidemiological approach to culture employed by the health researchers in the vignettes described in the beginning of this article. Although epidemiology is empirical and positivist and the culturalist perspective often appears interpretive or even intuitive, the two share a similar approach to culture. They both tend to view culture as the necessary and sufficient framework to delineate populations and to explain behavior differences among them.

The anthropologists in the vignettes reflected the perspective of a different school of thought, one that has specifically counterposed the culturalist perspective in medical anthropology to what I will call a contextualist approach. The contextualist approach is found in the writings about AIDS by anthropologists such as Bateson and Goldsby (1988), Worth (1989), and Page and his colleagues

(1990). Contextualists tend to see culture as responsive to changing political, economic, and social structures. They have not focused on the interrelationships between "culture and relations of power and domination" (Roseberry 1989:25). Contextualists have not directly addressed the manner in which cultural texts empower and "master fictions" (Geertz 1983:146) order social life. In their analysis of the relationship between culture and structure, microlevel and macrolevel analysis, contextualists have not approached cultural construction as a hegemonic process.

Developments in the field of cultural studies (Brenkman 1987; Nelson and Grossber 1988) that build on the work of Marx, Gramsci, and Foucault and an emerging understanding of hegemonic processes have given us new insights into the historical, structural, and "authoritative" location of symbolic construction (Comaroff and Comaroff 1991). There is an emerging understanding of the interpenetration of structure and agency (Comaroff and Comaroff 1991; Roseberry 1989) and of "contextual constraints, meaning systems, and individual experience" (Bibeau 1988:405). Central to this renewed theorizing about culture is the insistence that power "is not a phenomenon external to culture but integral to it" (Kapferer 1988:430).

The concept of hegemony gives us the language with which to investigate the manner in which dominant classes or sectors of society use culture to obtain consent from subordinated populations (Hall 1988; Williams 1977). This approach to culture specifies that "the ruling class dominates by force but directs through the contradictory but consensual common sense of culture" (Frankenberg 1988:328). Hegemonic processes are the means by which subordinated populations participate in cultural constructions that contribute to their continuing subordination (Hall 1988; Williams 1977). Hegemony is built on daily practice and commonsense categories by which we understand the world. Hegemonic processes frame the way in which we understand our experience and so shape the experience itself, including the experience of epidemic disease.

Central to this conception of hegemonic processes is the understanding that contention over meaning is constant and that all of us, including anthropologists, are both subjects and agents (Kapferer 1988). Anthropologists are able to provide new understandings of HIV disease that challenge the hegemonic constructions of risk that have influenced the way in which the disease has entered into the popular imagination.

Marshall and Bennett, introducing a theme issue of *MAQ* that contains some new ways of looking at the epidemic that is called AIDS, call on anthropologists to avoid the trap of restricting our research to:

> identified high-risk groups, because we are in fact all vulnerable to becoming AIDS victims. . . . [W]e may help refine the notion of "risk group" and the concept of risk itself. Although the "risk group" idea is useful, in reality all people are at relative risk as a result of particular behaviors—their own or others'. Anthropologists may find it more illuminating to focus on risky behaviors and not on categories of membership, such as homosexual versus heterosexual, male versus female, intravenous drug user versus non-intravenous drug user. [1990:4]

Putting aside a conceptualization of risk as embedded in culturally different high-risk populations makes possible a whole new perception of possible ways

that HIV might be spreading. Thus the habitual, by now thoroughly ingrained thinking about risk has to be challenged. Instead of accepting that the concept of risk group is "useful," we must ask "useful for whom to do what?"

We saw that in the Middle Ages, when epidemic disease threatened the daily habit and practice that maintained the social order, it was to the benefit of the dominant classes to promote and validate the construction of cultural others. By reacting collectively against the other, social order and ordering were reestablished. Constructions of the cultural other enforced and reinformed the continued structuring of society.

The current historical conjuncture is one in which the authority of the dominant order in the United States is being threatened from a number of sources. The global restructuring of capital has led to large-scale migration of Third World people into the United States. This new influx of people without a sense of loyalty to the United States has been met with a range of responses. The last two decades have witnessed the rebirth of blatant racism as well as vigorous efforts to incorporate immigrant laborers into the body politic.

The AIDS epidemic both contributes to the sense of disorder in the land and provides opportunities for dominant forces to define the terms within which the world is to be explained and experienced. It is an opportunity for biomedicine, a central order-making institution of the society (Kuipers 1989; Scheper-Hughes and Lock 1987), to reassert an authority that had been undermined during several decades in which alternative constructions of health and illness had contended for legitimacy.

This contention for legitimacy provides the context for understanding the manner in which risk has been defined for the AIDS epidemic in the United States. Linking AIDS to populations said to be culturally and racially differentiated from the social body of the United States contributes to nation-building processes. The persisting efforts of federal authorities to make a whole nationality—Haitians—into a risk group becomes explainable within this analysis. Haitians became the black visible outside against which the nation of the United States could be imagined and reconstructed. Epidemiology has been constructing a sense of the unity and identity of the nation, that is, a sense of citizenship, as those who belong to the strong and healthy general population of the nation are distinguished from the weak and vulnerable subjects of study—the "at risk."

In the AIDS epidemic, we see how what seems to be neutral scientific categories describing people at risk are in fact hegemonic constructions. For anthropology, the current efforts to study the AIDS epidemic form the locale of a struggle about how the concept of culture is to be used. Given the power behind the message and the manner in which the methodology and logic of science become part of the cultural construction of AIDS, it is not surprising that anthropologists who pose a critique of the cultural analysis are having trouble making themselves heard by their colleagues.

To challenge this construction of AIDS, it is not enough for us to talk to our colleagues about the structure of social relations within which people who are defined as belonging to culturally differentiated populations live their lives. We only resist our roles as actors and agents in the hegemonic processes, a historic role played by intellectuals, when we challenge the entire process by which population boundaries have been constructed for epidemiological analysis. Our ef-

forts to stop the transmission of HIV must include a critique of the hegemonic processes by which risk groups have been constructed.

NOTES

Acknowledgments. This research was supported by an NIMH Postdoctoral Fellowship in Mental Health provided by the Institute for Health, Health Care Policy and Aging Research. I am also indebted to a grant from the New Jersey Department of Health and to Stephen Crystal, the Principal Investigator on that grant, for an opportunity to conduct a needs assessment of persons with AIDS in New Jersey, and to the many persons with AIDS and health providers who shared their experiences with me. Earlier versions of this article were delivered at the annual meetings of the American Ethnological Association and the American Anthropological Association, and at the symposium on AIDS, Culture, and Class sponsored by the New School for Social Research and the Wenner-Gren Foundation. Many of the ideas in this article are the product of a collective effort by Denver Lewellen, Betty Levin, Pat Antoniello, and me. I would like to thank them for their keen insights and intellectual generosity. I would also like to thank Kate Crehan, Ann Millard, the editor of *MAQ*, and anonymous reviewers for their suggestions and encouragement.

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[1]This section of the article was jointly written with Denver Lewellen.

[2]The World Health Organization designated the United States and Europe, countries in which the major risk groups were thought to be homosexual men, intravenous drug users, persons with hemophilia, and individuals who received blood transfusions, as Pattern I countries. These were compared with Pattern II countries, which were characterized by a high incidence of HIV and a high frequency of heterosexual transmission (Centers for Disease Control 1988).

[3]See Schoepf (1991) for a discussion of culture and political economy within the AIDS epidemic in Africa.

[4]These field observations were part of a larger Needs Assessment of Persons with AIDS conducted for the New Jersey Department of Health (Crystal et al. 1990). In the course of the study, we also obtained data indicating that, despite the fact that the New Jersey AIDS surveillance efforts were among the most extensive in the country, there had been a sizeable underreporting of AIDS deaths (Crystal, Glick Schiller, and Sambamoorthi 1990).

[5]Most fundamentally, of course, one could say that the focus on cultural differences as the source of risk in the AIDS epidemic is part of a failure to address underlying structural problems of global capitalism of which the current global epidemic of AIDS is an indicator as well as a grim reaper.

[6]Singer, Davidson, and Gerdes (1988) have provided an extremely useful critique of the culturalist perspective in medical anthropology.

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