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Social Anthropology and Aids

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For Alberto Cardin, master in heterodoxy.
In memoriam.

In 1981, in the United States, the epidemiological bulletin of the *Centre of Disease Control* in Atlanta announced that in New York and California there had been a dramatic increase in non-habitual illnesses linked to subjects with defective or depressed immune systems (normally children being breast fed, old people and patients receiving immunosuppressive treatments for pneumocystosis or Kaposi's sarcoma). The latest news was that the infected subjects – 5 cases in Los Angeles and 26 between New York and San Francisco – were young men who had nothing in common except their sexual preferences: they were all homosexuals. They had all previously been healthy but their analyses showed a decrease in their immune systems. At the beginning of 1982 there were more than 200 cases throughout the country; all the infected subjects showed an important drop in lymphs and especially T4 lymphocytes (Arrizabalaga, 1995). Aids introduced itself to the world.

By the year 2000 the Aids pandemic had shortened 19 million lives and produced 13 million orphans. Thirty-four million more people live with HIV which causes Aids; practically all of them will die. Although the disease was first identified in the USA it is now concentrated in the third world: 25 million people in Africa are infected and 6 million in Asia. In parts of Southern Africa more than 20% of all adults are infected [(1)]. For the almost two decades during which we have lived with Aids, numerous things have changed: the Eastern Block has been dismantled, conservative ideologies have increased and consolidated, neo-liberalism has been established and the free market strongly defended, the economy has become

global, the new technologies have undergone spectacular development, and there have been important discoveries in the fields of genetics and biomedical technology. But Aids continues to escalate bringing death and massive destruction, serving as a real and metaphorical reference to the hidden face of this "supposed" planetary development. The breakdowns in the system, with its increasingly important flaws, become clear from the socio-epidemiological data about Aids. Poverty, dependency, death and illness increasingly highlight the inequalities between rich and poor countries. The most excluded and vulnerable groups are hit hardest by the illness. Aids, like many other illnesses, reveals the economic, political and social processes of inequality and power, with blinding clarity.

It is hardly surprising, then, that since the inception of the epidemic, Aids has been continuously and thoroughly studied. It has been analysed by numerous social scientists from three different standpoints: its socio-historical construction as a morbid entity, the demarcation of the processes of vulnerability of the affected subjects and the processes of individual and collective identity. Likewise, it should be pointed out that the characteristics of Aids, like no other illness, have meant that the Social Sciences in general and Anthropology in particular have had to come to terms with the need for some of their researchers to get involved in the processes of health intervention, above all prevention and education.

All this has undoubtedly considerably enriched the debates, many of which have a long history in social anthropology, about the future of our discipline in the 21st century. In the paragraphs below I shall try to outline some of the main issues and problems that the analysis of Aids has helped to develop in Social Anthropology, and more specifically in Medical Anthropology (2).

Anthropology and Aids: the story of an encounter

From the mid 1980s, and particularly from the end of the decade to the present day, the number of anthropological projects researching into Aids has grown and exponentially increased the discipline's knowledge about health and sickness more than any other morbid phenomenon in recent history (3). Anthropology soon became an active part of the academic and political agendas on public health in the rich countries and subsequently in the poor ones. There are several reasons for this development.

First and foremost among these reasons are the specific characteristics of the sickness. It is a contagious infection; it is transmitted by sexual contact

and through blood, which meant that it was initially associated with the behaviours and lifestyles of "risk groups" characterised by particular sexual conducts or drug addiction; it is incurable; and it has a high death rate. Added to the fact that at present there is no vaccination, the health sectors and those in charge of public health policies have felt obliged to request the collaboration of social anthropologists since everything seems to suggest that, in the absence of other remedies more in concordance with the hegemonic biomedical model, the only chance of halting the epidemic is through preventative and educational policies. These, it is thought, should be based on knowledge of sexual practices and, in particular, the "*risk practices*" of individuals in the groups that have been epidemiologically defined as the most vulnerable, "*risk groups*" and "*high-risk groups*". Aids develops as a disease if a person is infected with HIV (Human Immunodeficiency Virus), which is transmitted sexually or through the blood, and from the very beginning the infection has been defined as deriving from sociocultural behaviours. Anthropology, then, seems to be a good ally in policies of prevention and education despite the fact that, as we shall see later, some anthropological research projects questioned the concepts of "risk groups" and "risk practices" as being ideological.

Secondly, in my opinion the demand for the collaboration of anthropological studies is growing because the Aids pandemic, according to medically established epidemiological profiles, seems to affect populational subgroups that are characterised as being "carriers of cultures". The scientific and popular images that form the social constitution of the Aids phenomenon –normalising, normativising and legitimising– portray homosexuals, drug addicts, Afro-Americans, prostitutes, poor women and Africans, to name but a few examples, as belonging to marginal groups, groups that are different and which have "exotic" behaviours. These behaviours are supposedly consolidated because they share sexually specific cultures – for example, Grundfest (1995) denounced the construction of "an African sexuality"– or they have lifestyles that for society as a whole, of which the medical-health groups are a part, are the cause of, and the explanation for, the parameters of epidemiological transmission. In this respect, the "oblivion" to which those infected by blood transfusions have been condemned is significant (see Glucksmann, 1995, for the situation in France and Scheper-Hughes, 1994, for the situation in Brazil). In short, the phenomenon of Aids is constructed on what Crawford (1994) has rightly called "fantasy groups", whose main characteristic is otherness. Aids *is* in "the others" and at the same time, since it threatens hegemonic normality, "the others" are Aids. These others, however, represent the limits of marginality and

subalternity. Their otherness, therefore, is stigmatised, which the disease then overstigmatises because it uses as an element of morbid naturalisation what has socially and historically been described as loathsome. As some anthropological research has pointed out (Lindenbaum, 1992; Crawford, 1994; Gatter, 1995 and Grimberg 1997) the ideological and political articulation of Aids as a looming menace inscribed –fortunately? – in the bodies of "others", has bestowed considerable protagonism on anthropological investigations ever since the beginning of the pandemic because, of all the Social Sciences, Social Anthropology has historically been responsible for studying "other cultures".

Thirdly, the numerous, and in many cases excellent, anthropological investigations into Aids reflect the theoretical and methodological power and maturity that Anthropology has acquired in the analysis of processes of health and sickness (4). A particularly buoyant period in the long history of Medical Anthropology was the 1980s, when investigators began to make incursions into hitherto uncharted territory: biomedicine as an ethnomedicine of the Western societies, illnesses and health problems that were not exclusively "folk", the need to analyse health, illness and care processes in the framework of political and economic historical contexts that provide them with explanatory coherence. This discipline, therefore, is in a perfect position to make a thorough, critical study of the Aids phenomenon and this is precisely what some of its leading specialists are doing: among others Frankenberg, Singer, Parker, Lock, Grundfest, Bolton, Lindenbaum and Scheper-Hughes. Most of these researchers have proven experience in the study and analysis of the problems health, illness and care and they consider research into Aids as a challenge. In their choice of themes and epistemological proposals, as we shall see below, they reflect the debates that take place within medical Anthropology as a whole

Fourthly, the connection between academic knowledge and its practical application plays an important role in the increase in anthropological investigations. Medical Anthropology's long tradition of developing projects from Applied Anthropology should not be forgotten. In the case of Aids, once again, some anthropologists are required to carry out interventions aimed at prevention and education. On most occasions the challenge is accepted, but previous experiences (5) mean that the specific ethnographic work leads to new proposals that are more critical with the processes and the forms of the intervention. This gives rise to a highly interesting anthropological production about models of social intervention.

And last but not least, it should be pointed out that in this story of the encounter between Social Anthropology and Aids, the extensive, but of course never sufficient, private and public funding for anthropological research into Aids plays a fundamental role, as is usually the case. In fact many projects on particular groups or morbid processes, which would otherwise never receive funding, have more chance if they are presented and redesigned to apply to the Aids environment.

As Arrizabalaga quite rightly points out (1995), 42% of the world's population is potentially at risk of malaria, mainly in the poor countries and funding is minimum in comparison with other less important morbid processes. This is a counter example which makes it possible to state that Aids, as well as being "the plague of the 20th century", "the most significant epidemic" and "the illness of post-modernism", has characteristics and complexities that highlight sociocultural and sociohistorical forms of being sick in all its multiple meanings (6), and represents a breakdown in the discourses of hegemonic biomedicine.

Anthropology of Aids

From the analysis of the anthropological production on Aids, we can deduce that the problems approached can be divided into four main groups:

- **The construction of medicoscientific concepts.** This group includes those studies that make a critical analysis of the languages and practices of medicine, epidemiology and anthropology itself to show that the ways in which scientific concepts and care practices are constituted are subject to social and historical processes of reaffirmation and/or concealment of political and social relations.
- **Social inequality in processes of health, illness and care.** This group consists of all those investigations that, from the perspective of Critical Medical Anthropology, analyse how the processes of social inequality connected to Aids are constituted. These projects analyse Aids as a morbid entity, the particular characteristics of which make it possible to study the unequal relations of class, gender and ethnic group as well as the structural processes of domination that are assessed as they intersect with the microsocial level in which they are interwoven.
- **Aids as a major illness.** Theories derived from interpretative Anthropology and symbolic interactionism give rise to a wide range of investigations which emphasise the need to analyse the meaningful and symbolic contents that take shape around the Aids phenomenon. Anthropologists focus on deciphering the symbolic elements that exist alongside Aids: blood, semen, the sick and healthy body, the individual and collective crisis of identity, the reconstitution of new forms of personal and collective identities, and the breakdown of frontiers and their re-establishment are just some of the main issues in these analyses. Many of the studies on the homosexual universe belong to this group.

– **Commitment to Intervention.** Some researchers call for anthropology to have a critical, ethical and political commitment to the subjects being studied. Faced with the suffering and death that the Aids pandemic means for so many people these researchers have suggested experiments of intervention both in prevention and health education. The applied work of some feminist anthropologists with poor women in both first-world countries and poor countries, proposals for intervention in collaboration with affected groups and work carried out directly with non-governmental organisations recuperate the problem of the possibility of an anthropology committed to social change. This work opens up old debates at the heart of first-world anthropology –debates that had never finished for the anthropologists from poor countries who study and analyse their own reality. This is particularly so in the case of Latin-American anthropology.

1. The construction of medicoscientific concepts

Aids, and the crisis that it has produced in the Western world on a number of levels, has generated a considerable number of studies in Social Anthropology, the History of Science and Sociology. They focus with great detail and precision on the connections between the constructions of concepts and medicoscientific practices and the social, economic and political structures and processes. They underline the lack of neutrality of the scientific concepts, and the ethical and political implications that are derived. Many investigations (Wallman, 1988; Treichler, 1992; Glick, 1994; Fee & Krieger, 1993; Frankenberg, 1993; Arrizabalaga, 1995; Singer M., 1994 among others) have pointed out the need to focus critically on the concepts and constructions that have come from the discourses of medicine, particularly from epidemiology, but also from the social sciences themselves.

As an infectious disease that affects the developed world, Aids opened up a crisis at the heart of biomedicine at a time when the dominant discourse was that infectious diseases had been almost definitively eradicated. Arrizabalaga evokes this crisis very well when he points out: *«The unexpected and spectacular outbreak of Aids took place within the atmosphere of exultant health optimism that twenty years ago radiated from the international community. It came as a complete shock… It should be stressed that that it is the first pandemic to strike the First World, that is to say the population of the United States and Europe since the influenza of 1917-18»* (1995: 8). As Arrizabalaga states, Aids erupted at a time when the WHO had announced that smallpox had been eradicated throughout the world (1977), the declaration of Alma Ata had been circulated *"Health for all by the year 2000"* (1978) and the first pathogenic human retrovirus had been identified and isolated, which opened the doors to investigations into cancer, slow viral infections and the so-called autoimmune diseases.

Although on the one hand medicoscientific knowledge was sufficient to identify Aids as a specific pathology as Grmeck pointed out – *«such a pathological state could not even have been conceived as a specific disease without certain conceptual and technological instruments which had only very recently started to be used in the health and life sciences»* (Arrizabalaga, 1995) – the reality of the ferocity of the infection meant that a historically constructed, sociomedical discourse soon took shape. This discourse contained a considerable charge of appraisals, representations and ideologies, to which the social forms of constructing reality were added either explicitly or implicitly. In this respect, the history of the medicoscientific paradigms about Aids is highly revealing.

During the two decades of Aids, three paradigms have been constructed about the pathology. They involve, as Fee & Kreiger (1993: 1477) have pointed out, various points of view about etiology, pathology, prevention and treatment. Likewise, they have different conceptions of the search for responsibilities –"*the blame*"– with reference to the relation between individual and society.

Aids as the gay plague is the first of these paradigms. Epidemiology is the discipline responsible for pointing out the disease's preference for young male homosexuals, linking its transmission to supposed group 'lifestyles' such as *"promiscuous"* behaviour, inhaling *popper* – amile nitrite – as a sexual stimulant and anal sex. At the moment, the disease is defined as a syndrome and the "first *risk group"* is constructed. The epidemiologists' fascination with constructing this risk group and the others that make up the "plague of the 4 Hs" – homosexuals, Haitians, haemophiliacs and heroin addicts – led them to ignore the fact that, as early as December 1981, the director of the Division of Allergies and Immunology of Albert Einstein's Medical College, Dr. Rubinsein, warned that his work with Afro-American children from the Bronx suggested that they were suffering from the same disease as homosexual males (Singer, 1994: 941).

The concept of a risk group with specific practices that link all the its individual elements to a particular "lifestyle" is the first paradigm. It claims to be empirically neutral and entails highly stigmatising and unifying social forms of group configuration. Prevention is organised in terms of modifications to lifestyles, which are regarded as being a set of behavioural features and forms that are mistaken and negotiable. The responsibility for modification lies mainly with the individuals themselves. The idea is that although lifestyle is social in shape, the subjects in which a particular life-

style is "embodied" have the individual capacity to change it: the victims are presented as having brought the disease on themselves (7).

Although Critical Medical Anthropology undertakes the important task of questioning the concept of risk group (Glick *et alii*, 194; Singer, 1994; Leap; Parker, 1994 i Brumelius & Herdt, Kate & Mason, Abramson, 1992 in Herdt & Lindenbaum among others), the fact is that Social Anthropology itself has also helped to "reify" the concepts of lifestyle and risk group by providing them with a coherence that is determined by the supposed unity of individuals who belong to a "subculture"; that is to say, the world of "drugs", gays African sexuality, etc. It is this unity on which the epidemiological profiles of the transmission and location of Aids are based.

In 1983 HIV – the Aids virus – was identified and from this point on the disease was no longer considered to be syndrome but an infectious disease produced by a virus, which is found in body fluids. The image of the dangers of casual transmission, the old popular idea of "bad blood" (Fee & Krieger, 1993), became part of the scientific and popular discourse. The virus was identified as an insidious "little bug" –undoubtedly helped by some of the publicity campaigns (for example, the Spanish campaign "*si-da, no-da*"– and was no longer limited to the risk groups. It was a threat to one and all but its transmission was conceptualised in the so-called "*risk practices*". The concept of risk conducts linked transmission of the virus directly to individualised, desocialised and ahistoric behaviour, which led to a campaign of prevention that encouraged the use of condoms and disposable syringes. The creation of "risk groups" had been fiercely contested by activists, mainly homosexuals, because they were policies of exclusion and collective marginalisation. However, the construction of the concept of "risk practices", apparently more universalist, ended up by disarticulating the individual not merely in its dependence on the social, but even in its own right as an overall entity. Considered in this way, the individual is the bearer of "good" and "bad" practices and the prevention and/or education must only aim to eradicate the latter, previously defined by medicine's discourse on "risk". This construct is, suspiciously, highly similar to the hegemonic biomedical discourse which is based on the concept of a compartmentalised biological body. This concept excludes the aspects that historically constitute health and illness because it considers them to be mainly social "facts", interwoven in the social forms of inequality in the production of morbid states. The doors have been opened for the consolidation of the second paradigm.

The reconceptualisation of Aids as a chronic infectious disease highlights a medical model based on pathology and treatment. In this second approach,

the main budgetary efforts focused on biomedical research to improve the pharmacological treatments and to decipher the internal mechanisms of the virus so that a vaccination could be developed. The preventive framework considered that it was fundamental to carry out massive campaigns, the aim of which was to produce behavioural changes in the general population. These campaigns were based on the individualist concept of biomedicine and on the political and economic concepts of liberalism, which consider social subjects as individual entities characterised by their "freedom" and "capacity for choice". This standpoint, still a hegemonic one, considers *«the populations and subgroups of these populations – including the 'risk groups' – as being made up of the sum of its individuals, which exist without culture or history»* (Fee & Kreiger, 1993: 1483).

The third alternative and critical paradigm, which has various denominations – «a collective chronic infectious disease and persistent pandemic» (Fee & Krieger, 1994) or "syndemic" (Singer, 1994) – defines the disease as *essentially social*. This basically means that Aids can be articulated and explained by analysing the historical and social construction of the processes of health, illness and care. In short, the complexity of the location, transmission and prevention of Aids, like many other diseases, cannot be understood without bearing in mind the political and economic processes which constitute the inequalities of health in their relation to the inequalities per social class, ethnic group and gender. We shall discuss below the problem that this perspective raises and which the Anthropology of Aids has to face.

2. Inequalities in the processes of health, sickness and care

Since the beginning of the 1990s numerous ethnographic studies carried out on collectives by anthropologists have stressed the need to use concepts from Critical Medical Anthropology in the study of Aids [(8)]. As Singer rightly pointed out (1994: 937), Aids emerges as an opportunistic disease in that its location and forms of transmission reinforce social divisions and structural inequalities that take shape in terms of social class, ethnicity and gender. In the case of the United States, studies by Singer (1994), Waterston (1997), and Bolton (1995), among others, focus on the analysis and conceptualisation of the new "*centres of poverty*" of the "*marginalized urban zones*" and on the increase in the distance between the levels of health and sickness between the different social classes that the neoliberal paradigm is providing. These inequalities are made even more complex by ethnic and gender variables. After working for 10 years in the marginal districts of Hartford. Singer confirmed the growth in infant mortality rates and in

the levels of infant malnutrition among the Afro-Americans and Hispanics – habitual neighbours in these areas – as well as the continuous rise, in "these hidden cities", of cases of contagious infections – gonorrhoea, syphilis, chancre, etc. In the case of Aids, national statistics show that in New York City drug addicts that use syringes – a possible means of infection if they are shared – were 38% Afro-Americans, 38% Latins, and 23% whites. In NYC the general population is 52% whites, 24% Afro-Americans and 20% Latins. The national data about the number of people infected with Aids confirm the social inequalities: of the total number of people diagnosed with Aids in the United States, 30% are Afro-Americans and 17% are Latins. «Whereas these two ethnic groups represent 28% of the population of the USA, they have 47% of the Aids cases. Significantly, the average time of survival for the individual cases diagnosed with Aids varies according to the ethnic group. In Connecticut, for example, the average survival is 11.2 months for whites in contrast to 7.7 for Afro-Americans and 10.2 for Latins. These figures reflect the differences in general health of these collectives and the unequal access to health services of the different populations» (Singer: 1994: 936).

It should be pointed out that the figures above cannot be understood exclusively in terms of ethnic subcultures. They must be seen in relation to the social conditions of discrimination, power, unemployment, the precarious nature of employment and frustrated expectations that are an integral part of the ethnic minorities only if these minorities are interrelated with the structuring processes of the social classes. This clearly shows that there is a tendency to "*ethnicize*" these groups and convert them into "exotic isolated tribes" in the heart of the city when the analysis should focus on the processes of inequality and social discrimination in the relations between social classes. If the interrelations between poverty and ethnicity are not studied, policies of care and prevention will merely obscure and mask social divisions; as life and work conditions improve, structural changes will be prevented from making real changes to the "real processes of risk".

Wallace expressed himself in the same fashion (1990) when he studied the problems of social disorganisation of the working classes in the poor districts of New York in relation to the sociosanitary and economic policies of the municipal services. Waterston (1997) also adopted a similar tone when he worked in a residence in Manhattan (Woodhouse) for tramps, the mentally handicapped and minority women who had unusually high rates of Aids.

Moreover, much critical anthropological research about Aids is being carried out in the context of poor countries and/or by critical feminist anthro-

pology. The studies by Farmer on Haiti, Schoep and Grundfest on Zaire, Baldo & Cabal on Sub-Saharian Africa, Parker and Paiva on Brazil and Lim Tan on the Philippines, for instance, show how important it is to see Aids and its distribution in the poor countries as the result of political and economic factors, among which should be included those problems derived from colonialism and post-colonialism. As Baldo & Cabral point out for Sub-Saharian Africa, the exponential increase in Aids can only be understood by LIW (low intensity wars) analysis. The low intensity wars that have been lashing the continent in recent decades are responsible for the important economic changes which have forced large groups of population to leave the conflict zones and head for urban areas. This has generated poor settlements and marginal circles – with new phenomena such as prostitution or street children – which provide an excellent environment for the development of infectious diseases, including, of course, Aids (Baldo & Cabral, 1990: 40). The correlation between economic policies and health inequalities is also highlighted, in this case from the feminist perspective, in the excellent studies by Grundfest (1992, 1995) on poor women in Zaire. In her twenty years of work in Zaire, she has analysed the construction of a – mainly feminine – Central African sexuality, based on information received from missionaries which, in agreement with the cultural and social discourses of many African males and spiritual leaders, reinvent an "African woman". This figure is portrayed as being sacrificed by tradition, having no freedom and being highly submissive; the fact that there are important realities and feminine practices in Africa that resist male domination is concealed [(9)]. She explains that, for many African women, AIDS stands for "Insufficient Salary For Years" or "Difficult to Earn an Individual Salary" [(10)] and makes it clear that many African women are obliged to work in the sex market and/or have various sexual partners because of the socioeconomic conditions of poverty and lack of protection for women. She also shows that the clients – mainly Westerners who are prepared to pay between $ 50 and $ 150 a night– make their sexual demands because of the supposed "voluptuous sexual practices" of African women. In fact, it is precisely this demand that is creating these practices (1995: 37), which are a source of possible infection for women.

Investigations such as the ones mentioned above, which stress the important connections between the economic and political forms that articulate the inequalities and the impact of Aids, try not to separate this disease from other general processes of health and sickness. Aids, therefore, is analysed as an infectious disease that, like others, can be used to analyse unequal social processes. This approach differs, to some extent, from oth-

er anthropological studies in which Aids is dealt with as a sociosymbolic construct whose meanings have to be unravelled.

3. Aids as a major illness

This perspective includes most of the ethnographic investigations about "homosexuality" and sexual identities. They work from theoretical, symbolic and interpretative approaches in an attempt to understand the "sense worlds" that Aids gives rise to. Although this perspective does not hesitate to point out that the Aids epidemic is inscribed in an important social crisis, its main concern is to show the need to understand and interpret it as a "major epidemic (Treichler, 1988; Wallman, 1988; Crawford, 1994; Gatter, 1995 among others). Aids as "a metaphor" of the general crisis of the end of the century creates its meaningful universe around the collective and individual crises of identity. As Gatter (1995: 1525) states, interpretative studies underline the importance of examining how subjects within cultural constructs build and rebuild their sexual identities and the associated practices in specific universes of meaning. These perspectives, which consider human culture to be essentially meaningful, defend that sexual identity in its sociohistoric construction has become a central element in the Western constitution of the "self" and of "the others" and that HIV, with its initial focus on homosexual collectives and/or sexual practices, has helped to reflect on the main cultural mechanisms that define sexual frontiers and how they can be crossed. Similarly, these studies and their painstaking ethnographic analyses of "gay" populations (Bolton 1992, 1995) defend the need to further complicate the collective concept in favour of the idea of diversity; in this way they could do away with stereotypes that use homophobic prejudices to reify the existence of a united "subculture" which gives sense to supposed gay practices. It is not surprising that the categories begin to take shape and people begin to speak of "men who have sex with men" from a heterosexual identity or of sexual partners who inject drugs. These categories are again relativised to convert the very concept of "risk" into an element of discussion as a constructor of realities and reinforcer of the processes of "empowerment" and "embodiment".

What is more, this situation and the fact that some authors connect it to the approaches of symbolic interactionism saves the study – in the best tradition of Goffman – from the processes of stigmatisation and the reconstitution of identities that takes place in the people that have to live with HIV. Cawford (1994:1348) pushes the analysis further by proposing that it is

impossible to understand sociosymbolic constructions if we do not interconnect them with four important aspects:

1) *The central nature of the concept of health in the shaping of modern Western identity*. The meaning of being healthy surpasses biological limits to become a significant referent of "being a responsible and respectable person", and this meaning of morality is related to images about class, race and sexuality.
2) Since the middle of the 1970s, attaining health has become highly valued and is crucial if we are to understand how contemporary personal identity is constituted.
3) The healthy "self" is built on sick "others", and constructs "imagined" othernesses, on which Aids confers the particular power of distance.
4) The practices of stigmatisation and the perceptions on which they are based make it possible to study the meanings of health in the construction of the "self" and of others as practices and perceptions based on domination. Not in vain does the social construction of the concept of health respond to the needs and imperatives of the urban middle class. Therefore, the concept of health and its corollary, sickness, are configured as powerful meaningful elements for "distinguishing" social classes.

As we can see, the approaches that attempt to decipher the symbolic universes and the sociocultural constructions of the Aids phenomenon do not abandon the critical spirit characteristic of Medical Anthropology in recent years. I believe that this is partly due to the fact that on most occasions, faced with the terrible suffering that Aids inflicts on people, many researchers who work on one or other of the problems described above have become committed to the intervention.

4. Commitment to intervention

If particular investigations and studies agree on one thing in prevention and health education in an Aids environment, this is their denouncement of the inefficiency and social irresponsibility of public health policies, which are based on the hegemonic conceptualisation of biomedicine. Because biomedicine highlights the need for behavioural changes that biomedicine itself defines as being of risk, the social forms of the behaviours are individualised and social subjects are conceived as individuals with a capacity to choose their habits, supposedly "freely", and negotiate their social practices with themselves and with others [(11)]. Waterston (1997), Grundfest (1995) and Bolton (1992, 1995) show the importance that the connection between the *macro* and *micro* levels acquires in intervention. The former levels are the ones that in the public sphere must promote structural changes for developing equality and eliminating the processes that increase social inequalities. The latter, on the other hand, promote particular and immediate strategies of care and protection for the most underprivileged groups. They include the proposals for research-action by Grunsfest with

poor women in Zaire. By creating small discussion groups, the women "speak" about their problems with Aids, about the possibilities and impossibilities of negotiating with their partners and about sexual practices. They recover some of the possible strategies of resistance that have traditionally allowed them to resituate themselves within the forms of gender discrimination and, likewise, take advantage of the new images that Aids and its dangers have constructed in the males with whom they have sexual relations. For their part, Waterston and Singer's model (CCP, community-centred praxis), which is also based on the idea of research-action, emphasises the importance of knowing the needs of the community at all levels, including infrastructure, and organising and consolidating through various social actors awareness policies that will help to solve community problems, particularly those that affect health, sickness and care. All these models are reminiscent of the transforming experiences that the Experimental Centre for Health Education in Perugia (Italy) has been carrying out for years, with the considerable involvement of social anthropologists.

I would like to finish by pointing out that the problems of Aids that Social Anthropology has mainly investigated are a good example of the centrality that Medical Anthropology has acquired in the anthropological discourse. On analysing the problems of suffering of the social subjects, Medical Anthropology is driven to commit itself to a socially relevant discipline that is critically committed to the subjects it studies. Without a doubt, in this respect it coincides with the best historical tradition of the Social Sciences.

Notes

(1) Sachs J.D. "The Director of the International Centre for Development, University of Harvard", in *El País*, *Negocios*, July, 2nd, 2000, p. 3.

(2) There is a long bibliography at the end of the text that contains the main contributions to the issues that I am going to deal with. Of course the bibliography is in no way exhaustive, given the extent of anthropological production on Aids. It focuses on work done in the Anglo-Saxon world and provides a brief sample of material produced by Spanish researchers. I would also like to point out that in recent years in our country several doctoral theses have been completed or are in the process of being completed, that analyse the problems associated with Aids from different perspectives. For example, the Ph.D. dissertation by José Fernández-Rufete focuses on a care centre for people with Aids, Fernando Villamil studies homosexuality and Aids and Purificación Heras writes about temporality in people infected with HIV.

(3) In 1992, Price questioned this growth and development. He pointed out that to a certain extent anthropologists would be nothing more than mere participants in a new research industry. In this case, the industry of research into Aids (quoted in Waterston, 1997).

(4) Comelles, J. M. and Martínez, A. (1993) have made a very complete study of the principal landmarks and paradigms in the development of medical anthropology from its beginnings to the present day.

(5) The debates and criticisms at the end of the 1960s about the collusion of Social Anthropology with colonialism undoubtedly had an effect. So, in some of these practical applications we can trace the responses back to the criticisms and questions that these debates raised. For example, how could "exotic peoples" be studied without taking into account that they were submitted to the colonial system's structural conditions of domination and dependence, particularly when the anthropologist belonged to this colonial system, which was the case on most occasions? To what extent do anthropological investigations contribute with their ethnocentrism and androcentrism to reproduce and consolidate existing inequalities? For an assessment of the present situation, see Gledhill, J. 2000. *El poder y sus disfraces*. Barcelona, Bellaterra, particularly chapters 4 and 9, which are splendid. Without discounting the idea that the "passion" for intervention may be the result of a somewhat "uneasy conscience" with respect to the subjects investigated and to whom we owe so much – which may explain the harshness of some of the criticisms of the anthropological "distance"– , see Scheper-Hughes, 1997. *La muerte sin llanto: violencia y vida cotidiana en Brasil*. Barcelona: Ariel.

(6) M. Singer, 1994, put forward the term 'syndemic' to conceptualise Aids – as opposed to epidemic or pandemic. It highlights the set of inter-relations and complex links that Aids creates between health and social problems, with reference mainly to poor urban populations. He also points out, from a theoretical perspective of Critical Medical Anthropology, that Aids should be reconsidered in the light of three important social dimensions: it's social construction, social transmission and social position (1994: 941).

(7) For the epidemiology of Aids and a general discussion about how Social Anthropology and Epidemiology handle the concept of lifestyle, Frankenberg (1993) and Menéndez (1998) point out the shortcomings of the latter discipline to work with a concept that owes its originality and richness to the Social Sciences. As a theoretical instrument for organising processes and structures, micro and macro levels, and individual and social levels, it is dehistoricised and disarticulated by the use that Epidemiology makes of it.

(8) Marxist writers, Gramsci and Wolf, among others – can be seen to have an active influence on some of these authors, although nowadays it is not very "politically correct" to say openly that one is a Marxist. For this reason I believe that the term "Critical Anthropology" is a convenient label under which to include a whole range of investigations that are central to Medical Anthropology but which still have a marginal role in Social Anthropology in general.

(9) The concept of resistance refers to an interesting debate in Social Anthropology in which popular cultures lose their folk and isolated nature, and become part of the domain of the concepts of hegemony and subalternity. This concept thus articulates the historical relationships between the cultural forms of the various social classes. Gramsci, Wolf, Fanon, De Martino, Seppilli and Menéndez, among others, are researching into this conceptual framework.

(10) Translator's note: This is a play on words using the Spanish initials for Aids, *SIDA,* which they say stands for *Salario Insuficiente Durante Años* or *Salario Individual Dificilmente Adquirido*.

(11) In a future article, which I am currently preparing, I reflect on different models of prevention and health education. I distinguish between those that can generate social change and those that reproduce inequalities in health. Some of the content appears in Otegui (2000) "Health Education and Anthropology. A case of misunderstanding: hypertension". *Jano*, June-July.

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