PERCEPTIONS OF AIDS AND AIDS EDUCATION IN RURAL BENIN: A CASE STUDY IN THE COLLINES DEPARTMENT

by

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ABSTRACT

This thesis presents the findings of a small-scale, qualitative study of attitudes toward AIDS and AIDS education campaigns in the village of Sota in central Benin. Through a language ideology framework, this study reviews the overlap and disparity between AIDS discourse and other systems of meaning in Sota, particularly rumors and religious beliefs. The portrait that emerges from this analysis of the social construction of AIDS by multiple discourses suggests that the impact of AIDS education may be limited only in part because the intended recipients fail to understand the information being provided. More importantly, the context and underlying assumptions of educational presentations about HIV/AIDS are not formulated in ways that are compatible with, or directly meaningful to, lived experience.

RESEARCH OVERVIEW AND PERSONAL BACKGROUND

This master's thesis comprises the analysis and discussion of two months of participant observation, interview and focus group data in a small village near Savalou in the Département des Collines in the summer of 2005. This data is analyzed in conjunction with interview data from health workers involved in AIDS campaigns in the same area. It explores the mechanisms by which information about AIDS provided by health workers is understood by rural communities and inserted into a larger distribution of knowledge about disease and sexuality.

The structure of this thesis reflects the methods by which data was interpreted, considering in turn each of the dominant themes that emerged from the research as cultural elements significant to local understandings of AIDS. After describing my personal motivations for conducting this research and the methodology employed, I provide a brief ethnographic sketch of Sota, the village where the bulk of the data was collected, by way of introduction to these themes. Data presentation focuses on the relative importance to villagers of traditional and Western medicine, the relationship between the discursive forms employed by health workers and their target populations, and the process and criteria villagers apply in establishing the credibility of a given piece of information, AIDS-related or otherwise. Gender relations, communicative norms, and perceptions of the relationship between individual and society are also considered in the context of potential influence on AIDS campaigns. In so doing, this section suggests areas where AIDS information is not being effectively taken up by local populations; the

concluding section highlights the most critical of these with recommendations for future campaign evaluations.

Personal Background

I came to this topic through my prior experience in Benin, where I served as a Peace Corps volunteer for two years in a village near Savalou. My primary activity involved implementing AIDS education trainings for rural and illiterate populations in collaboration with local health centers and performers. This work revealed that the majority of villagers demonstrated very little knowledge or awareness about the nature of the disease, and real interest in getting better information. In contrast, the urban populations had better education levels, especially youth attending school, but did not necessarily act in accordance with the information they had received regarding HIV. As a volunteer, I collaborated with Beninese colleagues in the Savalou region to bring more effective techniques of AIDS education to the small villages around Savalou. These techniques included organizing a training of village singers to educate them about HIV/AIDS, and then having festivals and radio performances of the songs they composed to spread messages of HIV/AIDS awareness and prevention. As a Peace Corps volunteer, I also organized a training of local fetish leaders, directed by a Maxi speaker active in AIDS education.

I left Benin convinced of a pressing need for qualitative studies that focus on local perceptions of the HIV epidemic to inform policy and practice in HIV/AIDS prevention and treatment programs. A general canvas of the extensive literature on AIDS in sub-Saharan Africa corroborates this impression, revealing that little has been written about how societies themselves perceive HIV/AIDS and the campaigns they hear and see to

prevent it, despite the recognition everywhere of the need for community participation in dealing with the problem (Bolton and Wilk 2004). As might be expected, most of the literature concerns areas that have already reached very high levels of seropositivity, and an external perspective dominates. Most publications on AIDS in sub-Saharan Africa entail an evaluation of a given intervention, and that evaluation is made by necessarily indirect indicators of sexual behavior, namely: changes in the rate of seropositivity, in the sale of condoms, or in improved scores on post-tests relative to pre-tests, a measure of knowledge but not of behavior. Of 150 articles on sub-Saharan AIDS campaigns published in twelve months (February 2006 to February 2007), I found only seven (<4%) that included qualitative analysis of local perceptions of the campaigns under evaluation, and all but three of these did so in the context of condom social marketing. Qualitative research on HIV/AIDS has been limited almost exclusively to the development stages of intervention trials, behavior change, and prevention intervention (O'Reilly 1995). I have found no qualitative studies of perceptions of AIDS in Benin that are not tied to social marketing campaigns. Without these kinds of qualitative studies, villagers may be subjected to interventions that do not address their perceived needs, and therefore do not receive their cooperation (Bolton and Wilk 2004).

I do not mean to suggest, however, that ideas within the theoretical framework of my research about the underlying assumptions of development models and the social reality of AIDS arise without antecedents. Treichler (1999) has written a great deal in a non-African context about the false neutrality of information provision about AIDS, arguing instead that the provision and reception of information are always dynamic negotiations in which power plays a significant role. Her analysis, among others

(Stillwaggon 2003, Schiller 1992, Setel 2001), treats AIDS as not merely a medical assignation, but as a social construct, or more precisely a set of social practices. Similarly, in her analysis of AIDS patient care in France and the United States, Feldman (1995) maintained that AIDS was actually a different disease in the two countries because of differing models of patienthood. This research has been most strongly informed by Pigg's research (2001), which explores the processes through which Nepalese form ideas about the existence and importance of AIDS from awareness campaigns.

Many authors, most notably Paul Farmer, have described the practices through which AIDS discourse places undue focus on the correction of cultural practice and sexuality. Farmer's research in rural Haiti (1994) also proposes the idea espoused here that even diametrically opposed belief systems concerning AIDS are not necessarily limited to either/or distinctions. Lupton (2000) outlines the matrix of sociocultural and historical meaning within which biomedical discourse is embedded, identifying some of the same underlying assumptions to be explored in this research. Scheopf (1991) questions the validity of the dichotomy established in development work between indigenous or folk models and the biomedical and modern systems, suggesting as I do that popular evaluations of truth value may operate similarly for both. Muula and Mfutso-Bengo (2004) raise questions about assumptions of autonomy and identity analogous to those raised in this study.

METHODOLOGY

The study was conducted partially in Cotonou (the administrative capital of Benin) and in the department capital of Savalou, but primarily in Sota[1], where the bulk of the research data was collected. The region seemed to be particularly well-suited to an analysis of rural perceptions of AIDS. Epidemiological studies in the late 1990s indicated a particularly high incidence of seropositivity for HIV in Benin's *Département des Collines*, resulting in increased attention from national and international health organizations (Bollinger et al 1999). Although educational campaigns focused primarily on urban areas, rural communities also received information about AIDS at this time from radio campaigns, outreach programs, and networks of peer educators. At the same time, expatriate Beninese living in southern Côte d'Ivoire, some of whom had been infected by the virus, began returning in increasing numbers to the area under increasing xenophobic pressure, a process which reached its peak during the Ivoirienne civil war. Rural understandings of the disease have thus been obliged to adapt an abstract construction of the universal experience of AIDS to a local and physical reality.

This village was selected for several reasons: firstly, it was identified, with the help of the CPS and Savalou Hospital, as a village that was typical of the region with regard to its economic activities, its social dynamics and relationship to urban centers, and its exposure to AIDS education messages. Secondly, although my former knowledge of village life was directly applicable to the research site, it was an area that I had never

[1] The name of the village and of all participants have been replaced by pseudonyms in this document.

visited as a volunteer. I wished to avoid any association with my prior work in the region, as I found it ethically problematic to be potentially associated with my previous activities in health education. Thirdly, initial visits to the village indicated that it was well suited to the questions I wanted to explore: Sota had had several AIDS campaigns pass through with very little attendance or response, had failed to provide trainers to various associations seeking to establish a peer educator system for the village, and was characterized by health workers as an unenlightened, stubborn, and difficult population. It was also part of the region to the east of Savalou which had recently experienced an upsurge in seropositivity rates as a result of the political unrest and xenophobia which had been occurring in Côte d'Ivoire for the last few years, forcing many Beninese to return and occasionally bringing the virus with them. However, confirmed cases of HIV in Sota had not yet been documented (at least not publicly), leaving the village at the very cusp between constructed and physical reality which so interested me as a volunteer.

A final reason for selecting the village was its size. In our initial community meetings, it was decided that participants would be selected from the entire adult population, and the village was small enough that I was able to speak to every adult in the village to discuss my research interests and explain my presence in the village before beginning the study. At the time of the study, the adult population[2] of Sota consisted of 147 individuals: 84 women and 63 men. Of the 84 women, 34 were living as wives in monogamous households, 27 were in polygamous households, and 15 were married to

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[2] I placed the onset of adulthood at 25 years of age, in part at the request of the National Program to Combat AIDS (PNLS) to conform to their data, and in part because I felt that both school-age youth and their age-mates not in class had been targeted sufficiently by other programs in the area. As mentioned earlier, boys in school were also obliged to live outside of the village during the school session, rendering them inaccessible for interviews.

men with regular residence outside the village, generally in urban centers in the south of Benin. Of the remaining 8 women, 6 were widows, and 2 were unmarried. Of the 63 men, 34 were married to a single wife, 13 were in polygamous marriages, and 16 men, all under 40, were unmarried. As even this rudimentary data indicates, Sota is typical of the region in that women tend to be married at an earlier age (and may suffer stigmatization if they do not) and typically marry older men. Men in their age group are therefore more likely to wait to marry, especially if they lack financial resources to attract a woman of good family.

Participants in the research were selected from all adult members of the community of Sota who expressed interest in participating in the study; this was, in effect, the entire adult population of the village[3]. All participants were of the Maxi ethnic group and speak Maxigbe as their first language. Among the recruited population, participants for focus groups and individuals interviews were randomly selected and stratified by gender to ensure equal representation of men and women.

Research participants were asked to join one of three two-hour focus group discussions. These focus groups were facilitated by trained professionals from local health organizations, who helped me to devise and vet the questions. Each focus group consisted of eight participants: one consisted solely of men, one of women, and one of four men and four women. The original design separated the groups by gender in keeping with previous work in country by PNLS and CEFORP; the mixed group was intended to provide comparison between responses in single-gender and mixed groups.

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[3] Although, as indicated, the mobility of the population and instability of households, particularly for extended households simultaneously in Sota and Savalou, makes the assessment of permanent residency difficult to establish definitively.

The focus group questions were intended to provide a general sense of villagers' knowledge of AIDS, the sources of that knowledge, participants' evaluation of the validity of those sources, and an understanding of the larger cultural context in which AIDS issues are considered[4]. Subsequent to their participation in these group discussions, each research participant was then interviewed individually for one hour, either in his or her home or in a mutually agreed-upon alternate location[5]. Questions in these individual interviews followed from and overlapped with the issues raised in the focus group discussions, exploring statements made by each participant during the focus group that were of particular interest to the researcher.

This methodology turned out to be highly productive, for two unanticipated reasons. Interviewing those individuals who have already participated in focus groups provided an additional level of data, in that direct comparisons could be made between claims of behavior and belief in the two contexts. Group discussions in villages often function as a means of establishing consensus, and serve to codify collective attitudes and values. Context-dependent disparities can therefore provide insight into the social constructions of and around HIV in the community. A further layer of information was provided by the work of the interpreters; although at the time the research was conducted, I was competent to conduct the interviews in Maxigbe, I preferred instead to ask

[4] Again, several of the questions were suggested by PNLS and PSI to provide comparable data to their own surveys of the area. Following the suggestion of several PSI protocols, I also included a section of hypothetical situations as springboards for group discussion. These situations were then reviewed and modified with the assistance of the focus group facilitators, and proved to be a very effective tool in eliciting productive discussion.

[5] One woman was excluded from the individual interview once it became clear that both she and Clotilde (the only French-speaking woman in the village, and thus indispensable as my interpreter) were uncomfortable with conducting the interview together. Clotilde's younger sister had recently been killed by the chief's family through sorcery, and the situation between the families remained volatile. The participant, the chief's youngest wife, was also extremely pregnant, a time for particular caution in avoiding possible curses.

questions in French and have my assistant(s) translate them into Maxi, since it is considered culturally appropriate to use a third party spokesperson in interview situations in Benin. I quickly realized that this method allowed me to closely observe the ways in which Western concepts from biomedical discourses of AIDS were (or were not) translated from French into local languages.

A second component of the research involved a series of hour-long interviews with ten health workers who provide local AIDS education trainings to the area around Savalou. These interviews were conducted across the full spectrum of AIDS educators: seven peer educators, ranging from illiterate and non-francophone cultivators working in small villages to high school graduates directing the AIDS activities of their commune; the director of the Savalou Hospital's AIDS program; the principal trainer of local educators for one of the most active NGOs in the region; and the director of the Department's Center for Health Promotion. These semi-structured interviews were intended to provide a sense of the method and philosophy of AIDS education, as a means to compare the underlying assumptions of their perception of that interchange with those of their target audience. Informal interviews with members of the major agencies in Cotonou, both governmental and international, served to supplement the information provided by these semi-structured interviews.

Although the research design outlined here is structured in such a way as to be partially compatible with the research of other organizations, the data collected from these methods is not intended to be representative of any population larger than the village. I hope to demonstrate that this research approach can provide insights not discernible through the overwhelmingly quantitative assessments normally conducted to

assess AIDS knowledge and the effectiveness of interventions, but the degree to which the particular factors identified here apply to other groups is not clear and cannot be assumed without further research.

In providing quotations from the interviews, particular care was taken to present statements representative of the general view; I have tried to include only those views expressed explicitly in at least three of the individual interviews, and corroborated by general impression through participant observation during the two months that I lived in the village. This is not to suggest that all Beninese speak with the same voice, or parrot prescribed social scripts as divorced from the influence of their personal experience; while preserving participants' anonymity, I have attempted throughout to provide a sense of the particular context of each quotation. It should further be remembered that attitudes toward AIDS are strongly determined by the presentation of self in the moment of interaction, and therefore perspectives are often inconsistent for individuals between their individual interviews and their statements in the focus groups, and even within a single interview.

ETHNOGRAPHIC BACKGROUND OF THE RESEARCH SITE

The department of the *Collines* (French for hills) is well-named, since most of the region is crossed by a range of small mountains which extend from Atakpame in Togo, across the entire breadth of Benin, and right on into Nigeria. Like something out of Patinir or Southern Song painting, the great rocks spring up abruptly from the savannah, which is parceled out into small, family-owned farms. Nearly all of the villagers of Sota cultivate large and starchy yams, which when pounded serve as the main staple of the diet, as well as corn, manioc, rice in low-lying areas, okra, tomatoes, peppers and several local greens. These crops serve at the least to meet the needs of household consumption, and women generally sell surplus produce in the regional markets. The dominant cash crop of the region has long been cotton, although increasing dissatisfaction with yields and the costly inputs and soil degradation required have led several farmers to plant cashews and other alternative cash crops on their parcels. The large cotton gin which lies at the junction of the rutted dirt path to Sota and the paved highway to Savalou was bankrupted a year earlier by massive internal corruption, leaving many of Sota's men suddenly unemployed. The rains had been disappointing for three years running, and villagers frequently commented on the hardships they were facing as they tried to economize until this year's harvest. Although the region is overwhelmingly agricultural, and men and women emphasize their separate but complementary roles in the fields with considerable pride, these lean years have led many young men to either move abroad (often to Côte d'Ivoire) or to the urban centers closer to the coast, while others work in Savalou, often as motorcycle-taxi drivers returning only occasionally to the village. Most

household economies in Sota depend at least in part upon remittances from either husbands or sons working in cities.

When the sky would abruptly clear every afternoon after the daily rains falling during the study period, the distinctive silhouette of the two peaks of Savalou would stand out on the horizon. Savalou dominates the cultural and political landscape of the region as well. Every four days, most of the village sets out early in the morning to sell and buy at the stalls of Savalou's market, traveling either on foot or in hugely overburdened trucks which lurch their way through the monsoon mud. Nearly all of the villagers of the area trace their origins to Savalou and have extended family there, the king of Savalou holds influence over the local fetishists, and the few children who continue on to high school move to Savalou to continue their studies. Savalou is the cultural capital of the *maxi mo so* (literally, "the Maxi in view of the mountain"), the ethnic group which conquered the area from its original inhabitants centuries ago, and who claim the region as the authentic heart of *vodun* country.

Although all of Sota's inhabitants identify themselves as Maxi, the population is nevertheless fairly heterogeneous in their access to information, distribution of social networks extending outside of their village and ethnicity, and social and commercial interactions with neighboring groups. Although there are a large number, particularly young women, who have never traveled farther than Savalou, many have spent parts of their childhood in Togo or Cote d'Ivoire, and continue to visit and communicate with large extended family networks there. In the summer grazing season, Fulani form camps with their cattle on the periphery of the village, providing a valued source of information about the larger world along with the beef, milk and cheese they sell to the village.

As with most of the coast of West Africa, the history of trade and colonialism has established a north-south gradient in Benin's development: access to health services, education levels, population density, and the influence of the central government all decrease as one moves from the coast toward the Sahel. The area around Savalou, although in the southern part of the country, deviates slightly from this pattern: it was populated by groups sold into slavery during the height of the Fon slave trade, and a certain sense of resistance and autonomy continues to permeate the local consciousness. In the decade after independence, Benin established a political pattern of intense regionalism, ethnic chauvinism and pork-barrel patronage that continues today; since the Maxi are the only major group to have been left out of this system, even during Benin's rapid succession of *coups d'état*, their sense of disenfranchisement and political cynicism has deepened. As they swerve to avoid the massive potholes on the road branching off of the main national highway toward Savalou, drivers are quick to point out that the Collines area was the last in the country to be paved.

Within a region already inclined to be unresponsive to foreign intervention, Sota had been identified by Savalou hospital staff and other health workers as particularly hard-headed in their non-compliance with various health programs. In one NGO's recent effort to develop a system of peer educators in every village, Sota had indicated interest in organizing a local office. However, on the date set by the NGO for their return visit, the village had poor turnout and were unprepared, and so the village was passed over for another one nearby. The peer educators trained in that village encounter strong resistance from Sota when they arrive periodically to speak about HIV/AIDS and enlist people to get tested, since many in the village believe they were cheated of money allocated for the

development of the local office. Their conviction that the NGO had gone against its word is extended to a general distrust of their practices, and villagers say that they refuse to be tested because they have little faith in the NGO's assurance that their status will not be revealed to others.

Interactions with NGOs and other health workers are coordinated through the *délégué*, the political leader of the village. At most times of the day and night, the dark foyer of his large concrete home holds a half-dozen men sitting together and talking over *sodabi*, a powerful alcoholic beverage distilled locally from palm trees. Between bouts of storytelling and teasing, the members of this very male gerontocracy receive a constant stream of visitors, seeking justice for wrongs committed within the community or mediation of family disputes. The *délégué* is informed before any significant undertaking in the village takes place, making the dark foyer an important source of community information and gossip. Similarly, the king's family, at the other end of the village, must be consulted about any event relating to Sota's religious life and fetishes, although his political power is largely symbolic.

The mountain caves of this area once sheltered the Maxi from Dahomean slave raiders, and their wilderness is still seen as full of mysterious and powerful places. Shortly after my arrival, the mountains of Savalou gained further religious significance, as Gbedayi, one of the charismatic upstarts within the Celestial Church of Christ, proclaimed that they were the true Mount Sinai, and pilgrims flocked to Savalou from throughout the country. Many of the villagers of Sota are members of the Church, which was founded in Benin and combines elements of traditional practice into Christian ceremony. The event is representative of the religious composition of Beninese rural life;

the area around Savalou, having had little proselytizing influence from the Muslim north or Catholic south (although both Islam and Catholicism are present in the village), has only recently gained a significant Christian population, and hardly to the exclusion of the *vodun* practices which continue to dominate daily life. Church members and fetishists alike went on the pilgrimage, eager to acknowledge and incorporate another spiritual entity into their pantheon. In Sota, as in most of the villages of the area, the Church tacitly accepts local beliefs although its doctrines oppose the worship of deities besides Christ[6].

Sota's new schoolhouse is empty most of the time, although the soccer fields next to it are very popular. The earliest years are full of children in their khaki uniforms, but each year sees a steep drop in enrollment as more and more children are pulled out to work in the fields and care for younger siblings, and this decline is far more precipitous for girls than boys. At the time of the study, only one of the twelve students at the equivalent of middle school was female, and all of the students who had been sent on to board at the high school in Savalou were boys. Literacy rates are very low for both genders, but negligible for women; my interpreter for French and Maxi was the only woman who spoke or read French beyond a basic level.

As mandated by the state, the schoolhouse also has four outhouses at the periphery of its grounds, although I never saw them used. These are the only latrines in the village, an unusual absence for a village of this size, but testament to the relative lack of social services provided. Health services are generally rudimentary, with a small

[6] Doctrine aside, the only real prohibition observed in Christian practice was the drinking of cock's blood or goat's blood in traditional ceremonies.

dispensary and three villagers trained as health workers: a *sécouriste* who has received trainings on specific health issues (including AIDS, malaria, and Guinea worm); a *matronne* who manages the dispensary and occasionally serves as midwife; and a village assistant as part of the community network of Savalou's Center for Health Promotion (CPS). The latter organizes periodic baby weighings for infants, in which mothers of young children listen to health information as a precondition for receiving USAID food packages. Very few families use mosquito nets, although every child placed in the weighing harness wore at least one *bo*, a protective amulet against disease and curses.

The threat of curses and sorcery is an important aspect of daily life in Sota, especially given the economic difficulties Sota was experiencing during the research period. Uncertainty and economic vulnerability correspond directly with religious activity; as the villagers faced increases in theft, fewer opportunities for employment, and a series of poor harvests, fetishism was particularly visible in Sota. As in most of the rural areas around Savalou, signs of the major regional fetishes are part of the backdrop of daily life: all compounds are protected by the mound and phallus of Legba, and several of the larger concessions have small shrines to Nesuxwe or the ancestors. The larger fetishes, such as Sakpata (smallpox) and Xebioso (lightning) are linked to the convents in Savalou and Logozohe, but the most important and specifically local fetish is Atingali, who seeks out and neutralizes sorcerers' weapons. Atingali was occasionally appealed to as an indirect mediator to these larger figures, but was primarily active in removing objects (*gris-gris*) placed in villagers' homes and fields to destroy their health or productivity. Innocent, my host during my research, was regularly in demand to deal with diseases which bore the typical signs of cursing, and near-continual reference was made

in daily conversation to mistrust, the dangers of jealousy, and the potential treachery of one's closest friends, even (and especially) kin. Several participants commented that it was easier to discuss their behavior with me because I was outside of their social network; this guardedness in one's most intimate relationships is an essential context to the discussion of AIDS and sexual behavior which makes up much of this study.

DATA PRESENTATION AND ANALYSIS

Prior Exposure to AIDS Information

Most participants claimed at first that no one had ever come to speak to them about AIDS, although when prompted many recalled certain trainings. Among those recalled were visits from a high-ranking nurse from Savalou, an educational session by a white woman, and a puppet show from a local NGO. In fact, health workers identified several campaigns that had canvassed the entire region, but had passed over Sota after failing to find any local commitment or interest. One organization had come several times but villagers had repeatedly failed to assemble on the appointed day; a participant had attended a training of trainers in nearby Logozohe but had found no response when she attempted to share what she had learned with the others and had given up. When participants did recall trainings, they remembered either the photographs of the disease or the ubiquitous condom and dildo demonstrations. Participants also cited the influence of radio programs as a major source of information for several health issues, AIDS included.

In contrast, the focus group facilitators and the health workers from the area that I interviewed were easily able to cite repeated efforts to involve Sota in AIDS campaigns, peer education networks, and trainings at the hospital and CPS. In fact, all evidence suggests that this area is fairly saturated with organizations working on AIDS education, and the degree and detail of the knowledge that villagers exhibited belie their claims of ignorance. The reason for this disparity is not entirely clear; it seems likely that some villagers may have originally believed I would be providing health services or funds to

the village despite my statements to the contrary, a hypothesis suggested by my focus group facilitators. But because villagers did readily recall campaigns when their memories were prompted, it seems more plausible that these campaigns left little lasting impression beyond the visual aides they used to illustrate the operation of the disease- and if this is the case, it seems unlikely that these campaigns have had a strong or durable effect on villagers' behavior. Through an investigation of the nexus of cultural relationships through which villagers place AIDS information into their local context, this section attempts to understand the factors which may limit the influence of AIDS campaigns on practice, even where campaigns succeed in conveying information about the disease.

KNOWLEDGE OF THE DISEASE AND ITS SYMPTOMS

Knowledge of the biology of the disease and its symptoms varied widely; some participants spoke eloquently about the virus and the immune system, while others described the disease in terms of heat retention or worms. Two of the women had lived in Côte d'Ivoire and had seen AIDS victims there; in their description, the head and upper limbs of the victim swell as the lower limbs wither, the hair turns gray and wispy, and the body wastes rapidly and experiences general fatigue. One of these women described a man whose penis had become filled with holes, so that his pants were always wet and he lived his final years in constant agony and humiliation. AIDS leaves abscesses on the body which, when punctured, stimulate the body's self-consumption. Many mention constant diarrhea, emphasizing that AIDS victims are unable to gain nourishment from their food because they are immediately obliged to eliminate it, and therefore hunger

specifically for meat (a luxury item, since most meals in Sota that contain any protein at all are prepared with fish). AIDS is a disease of inversions, so horrifying that they often inspired laughter in the focus groups: the body feels hot when it is cold out, and cold in the hottest months.

Despite the relative absence of formal AIDS education programs cited by both villagers and local health institutions, participants nevertheless had a very good sense overall of the nature of the disease and its means of transmission. Every participant but one was convinced of the existence of the disease, and most were able to identify the main forms of transmission as unprotected sexual intercourse, transmission by blood via shared razors at barbershops or in scarification ceremonies, clitoridectomy, blood transfusion, and mother-to-child-transmission through blood or breastmilk. Although several participants also stated that AIDS was transmitted by mosquitoes or flies, the majority did not believe this and these statements were corrected by other participants when made in the focus groups. Most participants also stated that the best way to protect oneself from the disease was through use of condoms, fidelity to one's partner, and blood tests, particularly when entering into a new relationship. These facts were promptly recited, with surprisingly consistent details between individuals: many specified that men can live for only five years with AIDS, but women can live for seven. Of the 24 participants, five had even heard of antiretroviral therapy. An evaluator of knowledges, aptitudes and practices, checking off the criteria for adequate retention, would certainly be pleased with Sota's performance.

BELIEF, CO-MORBIDITY AND CURSING

Although hardly any villagers denied the existence of AIDS, the few elderly men who did stated that it was simply an invented title for pre-existing illnesses treatable by traditional means. Many participants, however, pointed out that the symptoms of AIDS infection have co-morbidity with cursing (*gris-gris*) and with totem violation, which also produce strangely wasting bodies. The thinning phenomenon they describe so vividly is one that they say has existed long before AIDS. In the end, the only sure way to distinguish AIDS from the actions of *vodun* and sorcery is through blood testing for seropositivity, which marks the disease as definitively linked to Western rather than local systems. Given a scenario in which a villager exhibits AIDS-like symptoms, most participants did not consider AIDS as the first or most likely cause. Legbeounwa, an older woman respected in the community, explained the logic of determining causation to me slowly, as if speaking to a child:

"If the person who falls ill is a fetishist, she probably failed to respect the totems of the fetish and that's what killed her. It's the fetish that sucked up her blood until her death".

It was important to participants to express the parallel nature of the two systems, and the devious capacity of sorcery to mimic precisely the symptoms of illnesses commonly associated with hospital treatment. In case of illness, villagers generally prefer to seek treatment by traditional means unless symptoms are clearly related to hospital-illness or medication is cheap and locally available, since local solutions are generally much less expensive and more convenient. If the condition continues, the patient is brought to the hospital in Savalou. Continued failure to respond to Western treatment indicates proof that the illness involves *vodun* or sorcery, and is therefore the

exclusive domain of traditional healers. As will be readily apparent, this practical system assures the continued dominance of traditional health, since its inability never constitutes a demonstration of its inadequacy in relation to hospital techniques, but hospital failures always constitute evidence of sorcery and illness systems outside their domain- even though patients are often not brought to hospital until their condition has significantly worsened[7]. Ferdinand, the principal and main instructor of a small high school in Savalou, considers his responsibilities as educator to extend into the inculcation of civic and moral values in his charges. He has thus worked as a *de facto* health educator for many years, and I often sought his insightful advice on everything from social protocols in a polygamous household to grand expositions on the future of *negritude.* Once he warmed to a subject, he held forth with the same didactic eloquence and sincerity he expressed daily in his classroom. Here he testifies to the failures of hospitals to treat diseases seemingly identical to those they are known to be effective in curing:

"If one speaks of AIDS today, there is an African AIDS. What does this mean? The African has provoked a harm, and one takes the exterior signs of that harm, one takes AIDS, and the illness takes the exact same form as those exterior signs without being AIDS. If you take anemia: the African can create that. There's a way of entering into the body and sucking out the blood. You can get a transfusion, and five minutes later, the blood is finished again. The doctors call it 'anemia', but five minutes after the transfusion the blood is already used up. It's real, it's like that that things happen. I've seen several cases, with friends, they get a transfusion and the blood is used up two minutes after. That is to say, in this entire African reality that endures without the heart, even if one says that he dies of AIDS, the African says otherwise… and it's in relation to that, exactly, that on *radio trottoir* one says that traditional healers have found the cure. The traditional healers have found the cure, one doesn't believe it, but no! the African is capable of many things."

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[7]Although this was the dominant pattern expressed in both interviews and my observations, I do not want to overstate the antagonism between hospital and traditional techniques. There are many illnesses that are immediately recognized as requiring hospital attention or Western medication; Innocent, when tending a sick patient, was as likely to rush into his bedroom for paracetamol or chloroquine as he was to grab an amulet or gourd from the courtyard. Furthermore, some conditions are recognized as requiring a combination of traditional and Western medicine; independently, neither can be effective.

The "African" must live in two realities at the same time, with surface phenomena that are indistinguishable from one another yet require very different solutions. Although villagers do not generally believe that AIDS can be treated by traditional means, the fact of their double existence means that someone exhibiting the symptoms of AIDS may seek out traditional rather than hospital treatment. Many illnesses are understood to have effective treatments through both traditional and biomedical means, but the realms of sole authority of one form of medicine over another are nevertheless issues of heated debate, as households with limited means struggle to balance health risk with economic risk. Moreover, the fact of a given illness not only threatens the individual household, but presents an epistemological crisis to the society at large. In many cases, identification of the nature of the source as human or spiritual (brought on by sorcery or *vodun*) or natural (and tied to the medical system) appears as important as, if not *more* important than, treating the particular instance of the disease.

In this context, I would like to briefly recount the events of an exorcism conducted by Atingali around the midpoint of the research period, since it loomed large in the public imagination (and my own) and was referred to often during the subsequent individual interviews. Atingali, as mentioned earlier, hunts out the tools and weapons of sorcerers; he is composed of four villagers, two men and two women, who become collectively possessed by different attributes of the fetish[8]. When Nonhouegnon, a prominent member of the community and successful motorcycle-taxi driver in Savalou

[8] In *vodun*, possession is not a metaphorical or partial state: the physical body is understood to be a husk that various forces can inhabit. Those transformed into Atingali are thus fully transformed, with completely different personalities and even languages; Simone, the demure mother of two young twins whom I had interviewed in her yam fields the week before bore no resemblance to the raucous, chain-smoking Atingali bossing us around before the exorcism.

with large and productive fields, began to suspect that his mother's illness was unnatural, he asked Atingali to investigate his fields for signs of sorcery. After preparing the instruments for detection and examining two suspicious locations fruitlessly, Atingali settled on a spot in a manioc field and began protecting himself with oils, cigarettes, and (most importantly) *sodabi*, the local palm wine. Nonhouegnon examined the fetish king's body thoroughly before he began digging in the field, further protected from the malevolent force he was about to uncover by the other members of the fetish, who beat the ground while chanting or blowing whistles. Abruptly, the king was thrown from the hole, falling lifelessly on his back. He had stopped breathing, and his right hand was clutched tightly around an unearthed object. Gradually, the group around the hole managed to resurrect the dead king, and the *gris-gris* in his hand was passed around for us to examine: a strange object, with a small lock, cauris and what appeared to be human teeth, all bound together with string.

The ritual ended there: Atingali had successfully neutralized the toxic effects of the *gris-gris*, and predictably, Nonhouegnon's mother recovered very soon afterwards. A clear parallel exists between this process and the treatment of illness more generally: whereas a medical logic might see this exorcism as treating the symptoms but not the cause, since the actual perpetrator remained unknown, the performance was intended only to provide irrefutable proof that sorcery was the cause. Discussion of this phenomenon has a long pedigree in anthropology; in his famous essay on "The Sorcerer and his Magic", Lévi-Strauss explains that the function of identifying witches is not to condemn them, but to restore coherence to social life (1963:174), and Evans-Pritchard

draws similar conclusions in explaining the continued presence of known sorcerers among the Azande (1937).

Fascinatingly, the same cross-cultural argument regarding the importance of symptoms rather than causes occupies a prominent role in discussions of AIDS between health workers and villagers, albeit in reverse. Health workers identified the question of AIDS' origins as a primary concern among the villagers they speak with, and one that they are trained to deflect as irrelevant, or at least unproductive[9]. Just as Atingali focuses on neutralizing the present threat rather than removing the enemy who inflicted it, health workers expect villagers to act to protect themselves from the present crisis without concern for the factors that brought it to them, and therefore the likelihood of further epidemics.

The parallel here is not exact, however: the Western frustration with a system that stops at neutralizing the curse rather than eradicating the sorcerer rests on a general assumption that sorcery is eradicable, that the specific agents that seek to do us harm could be permanently eliminated, and that this would be a desirable state of affairs. As they readily pointed out, villagers do not live in a world where such levels of control feel possible; they are beholden to the uncertainties of an agricultural subsistence, the vagaries of the rainy season, the remote influences on price fluctuations for their products, a general instability in infrastructure and institutions, and so on. It is enough in this system to establish explanation, control over meaning, rather than real culpability-

[9] A standard response to this question has become canonical within most trainings of peer educators: "If your house were on fire, would you stand in the flames and ask who started it, or would you run outside?"

yet the refusal of health workers to address the origins of AIDS denies even this power over signification.

BEHAVIOR, EVIDENCE AND FAITH

Villagers often made claims about their beliefs and behavior that were later refuted, either by evidence from health workers working in the area, their partners and neighbors, or by their own subsequent admission. Reported numbers of condom sales through social marketing suggest that very few villagers are using them, yet many claimed to do so regularly. In scenarios where villagers were asked to identify the best course of action when entering into a new intimate relationship, or in the general protection of the village, nearly everyone spoke of the importance of seropositivity testing and asserted that they were regularly tested or would be tested before beginning a sexual relationship, yet information from the hospital and local NGOs suggests that a negligible number of people in the area have ever been tested for AIDS. This disparity between statement and action was equally prevalent in assertions of belief in AIDS itself, or in the reliability of AIDS testing. When pointed out to the participants, these discrepancies were not seen as attempts to be disingenuous, but were generally explained as “an African way of talking” which distinguishes between belief in the abstract and belief in practice. M. Kpakpo has probably worked longer than anyone else in the area on AIDS education, although his work has gone largely unrecognized and uncompensated. In our interviews in his office at the hospital in Savalou, his frustration with the medical system into which he was inserted was not always well delineated from a certain exasperation with the villagers he worked to educate and protect. He explained

to me with some resignation that human nature transfers the personal threat of infection onto everyone but one's self:

"AIDS exists, but for other people. For one's self, impossible. One believes in the existence of AIDS, but one believes at the same time that it won't happen to you. It can't arrive without respecting the ways in which AIDS can be transmitted. That's what makes it that one believes in AIDS, but one believes that it's a problem only for other people, because the rural man, he's not ready to use those *koffi gbakun* [condoms], he's not ready to stop looking for other women, but at the same time he maintains that AIDS exists. If he's not afraid of those little acts, that means that in fact he believes in AIDS but this belief refers to others and not to himself."

How can evidence impact individual behavior, rather than establishing theoretical guidelines for the society at large? To address this question, we must first examine the mechanisms by which villagers consider the reliability of signs of proof. As has been mentioned, distrust of AIDS testing was linked to a particular distrust of the organization offering local testing, but this seemed to me to be relatively groundless in itself. Rather, it indexed a more general mistrust of a system whose sign of proof was cloaked in a process opaque to villagers, even though many stated that the blood test was the absolute indication that an illness was AIDS and not one of its imitators. When I spoke with Athanase, one of the more prominent members of Sota's Catholic community, I was surprised by how often he referred to AIDS through the idioms of *vodun*. Although he understood more French than most participants, he was also more self-conscious about his lack of education and the limits it imposed upon his future opportunities. Nevertheless, our conversations were energetic and frequently interspersed with his jokes and asides. Here he suggests not only that the literate take advantage of the illiterate, but that their performance of the verdict of seropositivity fails essential criteria when compared to other systems of belief.

-"We believe…well, you have to understand that when people say they believe in the test, it's a way of talking. "You have to get tested", that's just a way of speaking, because the lab technician can always declare that you have AIDS just to make you suffer. Because we're illiterate, after all."
MB: "I think maybe there's something special in the fact of being able to read and write. It has a power."
-"It has a power, but just a power in the writing itself. The reality of what's written, they don't even think of that. Because when you act in that way, in fact… Atingali, there, when he emerges with the *gris-gris*, everyone believes. Even if you don't believe in the *gris-gris*, you believe in its power. He emerged from nothingness to present you with something. And if you were to see me emerge with something from nothing, that means that I have a power. From that moment on, you believe in what I'm doing."

Athanase is here identifying a focus on form rather than content in evaluating proof; just as Atingali's power and efficacy rest not in identifying the agent of cursing, but in the coherence of the ritual which neutralizes him, what signifies in the interaction between technician and patient is the fact of writing rather than the actual verdict of positive or negative response. But as he goes on to explain, once one accepts the underlying logic of each system of explanation, the ritual of transforming blood into verdict lacks the empirical strength of Atingali's demonstration:

"But the analysis, it's not what does it- and the guy who's writing, you don't know why he's writing + or -. And one brings you the paper, it's someone else who's going to tell you that he wrote + or – here, to tell you the meaning of that + there, and in reality you don't see it. In reality, you don't see it. You don't see like you saw for Atingali. One says one did the analysis for AIDS, but it's not something you can see. And in all that, there is a lesser degree of *truth* [emphasis mine]- that a person could bring together to say what is false."

Seropositivity status is conceived of as an absolute verdict (participants never discussed the possibility of false positives or false negatives), whereas in theory Atingali's claims would be falsified either by his failure to ever discover concealed *gris-gris* or the consistent failure of victims to improve after he has neutralized the source of

their afflictions[10]. In short, although health workers attribute villagers' failure to believe in AIDS or to comply with their advice to stubbornness or a lack of proper scientific reasoning, villagers like Athanase perceive the messages they receive about AIDS as less compelling than the evidence they find in other areas of belief. The logic of traditional healing, as has been ably demonstrated by a long line of anthropologists since Evans-Pritchard, has a great deal in common with the logic of scientific thought, and in Sota transitions are easily made between the two. Participants explicitly link the medical and traditional sciences as parallel processes, operating under fundamentally identical lines of empirical reasoning. Legbeounwa provides one example among many, pointing to the leaves and roots collected in her husband's bottle of *sodabi* to assuage his rheumatism as she explains:

"Traditional healing, that is our laboratory- you know, the healer, he goes to the fields to find the efficacious plants, and that's his research and analysis. He's just like a doctor in the hospital[11]."

Seen in this light, discussions of the applicability of traditional medicine in treating AIDS index an internal debate: on the one hand, villagers would like to declare

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[10] In practice, however, both of these events would be explained in ways that did not diminish the power of Atingali, established independently through his powers of detection and resurrection; a truly powerful sorcerer could escape detection or transcend the negating power of the fetish. In fact, stories abound throughout the region of occasional cases in which the bodies that Atingali inhabits during his dangerous work of handling *gris-gris* are permanently rather than temporarily killed by forces that exceed his powers of resurrection. (These stories, needless to say, are an essential part of the drama and suspense of Atingali's rituals).

[11] These rather superficial analogies between medical and traditional tools so readily expressed in the popular conception of the two do not do justice to the actual rigor of traditional healers. In reality, the traditional healers I met maintained impressive methodological parallels to their scientific counterparts, and I was continually surprised by the intellectual discipline and rigorous systematicity the traditional healer with whom I lived applied to his vocation. Like many healers, Innocent had become an apprentice to a famous healer after surviving a serious illness in his adolescence. We spent many of our evenings writing together; I in my field notes journal, and he in detailed notebooks describing the exact process of each treatment and its degree of success. Innocent even belonged to a community of healers who assembled regularly to exchange ideas and discuss which procedures and plants were most effective. This is all the more remarkable when one considers that healers are often cursers as well, a profession so secretive that it can't even be named.

AIDS as fundamentally foreign, and many therefore assert that only a European solution can be found for a problem of European origin. When Mazounfon, a ribald old man whose affection for storytelling (and for *sodabi*) often led to uproarious interruptions to our mixed-gender focus group, pointed out the necessity of European assistance, he was shouted down by the others for speaking out of turn and potentially offending their white guest. Nevertheless, his sentiments were echoed often enough in the individual interviews:

"People that do research on AIDS, they should do all they can to find a medicine that can kill the illness. So we, Africans, we have some things for us, but it's not enough. With the apparatus of Europeans I'm sure that they can detect the virus."

On the other hand, many Beninese are understandably uncomfortable with characterizing themselves as so completely dependent on foreign ingenuity. In claiming the validity of local systems relative to those from without, they are also asserting that the continued presence of AIDS stems from limitations in the funding and broader acknowledgement of these systems, rather than from an incapacity to resolve issues without the imposition of foreign values. Innocent responded to Mazounfon by asserting both the power of African ingenuity and his own profession as a healer:

"You can't say that Africans can't cure AIDS, and Europeans can cure AIDS. Everyone's trying to find the solution- we don't know who is going to find it. Leaves and teas that we make here, they're the same plants that Europeans use to make their medicines."

In an individual interview, Louise, a shy young mother from whom Clotilde and I had to coax every response, timidly volunteered her faith in traditional medicine, pointing to limited resources rather than intrinsic asymmetry in efficacy between the two systems to explain the lack of an indigenous solution:

"If the way that money has been invested into Western medicine were to be repeated with traditional medicine, we would already have a cure for AIDS. Imagine that AIDS is like worms that irritate, then traditional medicine is capable of destroying these worms, if that's what AIDS is made of."

Given that villagers draw such explicit comparison between traditional and medical systems, health workers' confidence in the superior appeal of their explanatory system seems ill-founded. As the comparison between Atingali and the blood tests illustrates, an empirical evaluation would find very little compelling evidence in the medical presentation of AIDS in comparison with the demands for proof of cursing or the validity of traditional cures. Pigg has pointed out in this regard that AIDS is "a concept involving an imprecise set of possible afflictions coming after an indeterminate period in which invisible organisms do something to microscopic particles in a part of your body (the immune system) that you don't even know you have" (2001). In a part of the world where direct interactions with Europeans are still more or less limited to those two pillars of the colonial *mission civilisatrice*, health interventions and proselytizing missions, it is perhaps unsurprising that so many participants would go so far as to draw comparisons between the demands for belief in AIDS and belief in Jesus Christ. Athanase, again, cogently linked the idiom of his Catholic faith to his understanding of AIDS' anomalies:

MB: Why is AIDS called the king of diseases?

"AIDS is the king because it does not respond to any treatment. We must take care and protect ourselves well today, because when AIDS comes for us on Judgment Day we who were not prudent and did not listen, we will fall into the trap."

Upon reflection, the demand for acceptance of AIDS information reveals itself to be not simply a demand based on insufficient evidence, but a demand for belief *because* of an absence of evidence not unlike the *creo quia absurdum* of religious faith. Beninese

have experienced AIDS campaigns in a nearly identical context to the introduction of this form of religious belief; a foreigner, perhaps a European, arrives in the village with a dire warning: although it's undetectable, a grave threat to the well-being of each individual exists, and each person will be condemned to a tortured existence if they fail to take the appropriate precautions. Those that wait for visible signs that this information is true will be too late to respond once the threat reveals itself. In Sota, this resolute refusal to provide evidence has been partially repaired (over the protests of missionaries) by the Celestial Church, among others, who make possession by the Holy Spirit a central part of their services, thereby restoring the system of visual evidence established in *vodun* and other ritual practice. Discussions of AIDS, however, allow for no such middle ground.

TRUST AND POVERTY

At least twice a week throughout the duration of the research period, a distinctive sound would join the chorus of early morning noises as the village awoke: the mournful accusations of a theft victim, announcing the losses of the night- a chicken from their field house, sacks of corn collected for market day sales- and threatening powerful curses if no compensation were provided. In the *délégué*'s front room, where he and other elder village men would pass the day with a bottle of palm wine, villagers would stop by to announce other thefts, or to demand his action against likely perpetrators. By all accounts this increase in theft was a recent anomaly, related to a run of disappointing harvests and the unemployment resulting from the closing of a nearby cotton-ginning plant. As the principal political figure of the village, the *délégué* was to some extent accountable for the rash of thefts, because he was responsible for inter-village relationships and thefts

were automatically and publicly assumed to be the work of those outside the village. In private, however, theft victims would confide that their first suspects were always their own family members.

An understanding of the dynamics of trust and poverty provides essential background to the ways in which AIDS is understood in village life. As has been mentioned earlier, the continued salience of cursing and sorcery, of systems that explain rather than adjudicate, rests upon the perpetual instability and absence of control which villagers experience in their daily lives. Life within these systems presumes mistrust of everyone but oneself as axiomatic- mistrust of foreigners, but particularly mistrust of family members, and especially of spouses within the family.[12]

Many anthropologists have written of the dangers of exaggerating the role of agency, and therefore moral culpability, in the actions of poor people (Farmer et al. 1996, *inter alia*). In much the same way, the concept of mistrust as described by villagers does not necessitate a sense of moral condemnation; rather, trust and mistrust function to point out the inseparability of sexuality, morality and economics in decision-making. While husbands lament the supposed depravity and opportunism of their wives, they still generally recognize that their actions are necessary when the husband fails in his role of providing for them. Similarly, although villagers may deplore the suspected corruption and disingenuousness of health workers and self-proclaimed PVVIH (people living with AIDS), there is always an accompanying (and occasionally even sympathetic) sense that

[12] It goes without saying that the actual degree to which family members and spouses are distrusted varies widely. In my time with Beninese families I have seldom seen norms of intrafamilial distrust manifested in emotional reservation or distance between members, even between those who have explicitly stated to me their distrust of one another. What is significant here is that these kinds of distrust are taken as socially normative, as evidenced by an entire family of Beninese stories and proverbs.

these people have simply succumbed to self-interest as a dominant attribute of human nature. Nevertheless, the extent to which messages about AIDS are considered as valid information, worthy of consideration and capable of eliciting behavior change, is strongly tempered by reflexive mistrust of the messenger and his motives. Ferdinand, the high school principal, explained the reasons for this skepticism with his usual flair and insight:

"But since the first days of the educational campaign, the African is unreceptive. But what are the phenomena that accompany these campaigns and which have turned his attention, which have converted his attention into distrust? They can't be interested any longer in what these educators are saying. There were projects that were initiated, NGOs that passed through here, and what did people notice? These are projects which carry with them a certain amount of funding. And even in the villages, there were small communities that started to form and say "we want to fight against AIDS. We want to start educating people"- and they were given great sums of money that were never used. And after living that reality, people in Savalou saw how things were; so now, when someone comes to talk about AIDS, it's as if, there you go, he's come to take some money and he's passing through just to entertain us."

AIDS, GENDER AND LUCK

All participants identified the supposed gendered disparity in survival times after infection with menstruation, since women were able to periodically relieve themselves of some of their infected blood. Like discussions of menstruation more generally, this characterization also ties in with a sense of women as mysterious and complex. Both men and women devoted considerable time in discussing which gender was primarily responsible for the transmission of the disease; men consistently described themselves as incapable of sexual restraint[13]. After repeated conflicts with the demands of his agricultural schedule, Anatole, a young farmer struggling with a disappointing harvest,

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[13] This is, on the face of it, contradictory and deserving of further research: much of Thompson's discussion of the Yoruba "aesthetic of the cool" resonates strongly with Beninese arts; in fact, several dances in Sota exemplify this sort of impassive nonchalance in gender relations. It is therefore surprising that men should emphasize their weakness and lack of control in sexual behavior when their self-mastery is emphasized elsewhere.

and I finally spoke late one night, both of us exhausted. I think his fatigue led him to produce somewhat stereotyped responses, but they were certainly echoed by the majority of his male peers:

"The word AIDS isn't written on women, so if we see a beautiful woman we fall in. Men can't be expected to be serious; they can't say that they'll avoid women."

Surprisingly, women generally agreed with this sentiment:

"We women should think well, because men never think at all!"

This statement, made by the wizened Winkoutchale in an early focus group to murmurs of general assent, seemed to me at first to be a sort of feminist declaration. Winkoutchale was, afer all, of an age where she could speak her mind with confidence on any subject, and often did. However, as emerged in subsequent interviews, "thinking" also connotes a pejorative sense of scheming inscrutability. Men are incapable of restraining their animal impulses, but are thereby intelligible and guileless- and women are thus to blame for enticing them when they know the inevitable consequences. In several conversations, man's weak resolve was even cited as the justification for polygamy: if one of his wives is ill, pregnant, has a young child, or is menstruating, a man will be able to relieve his overpowering urges without having to place the family at risk of infection. The stigma of sexual misconduct is much stronger for women, and women do not have the opportunity to discuss AIDS amongst each other as men do[14]. In

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[14] This is undoubtedly true- participants of both genders stated that women had few forums for discussion of sexuality, or self-protection from AIDS. I would like to emphasize, however, that older women, particularly post-menopausal women, have very different access to discussions of sexuality than younger women. In my first official village meeting, the male dominance and seriousness of the subject were interrupted by laughter after one old woman, pointing to her elderly friend, shouted, "If she has AIDS, then the whole village has it!" Old women have a very contingent access to discussions of sexuality; they can be very frank, even ribald and flirtatious, and speak openly about sexual relationships going on in the village, but only because they are understood to be themselves removed from that sphere of behavior.

conversation with each other, men and women came to a fatalistic truce. Jan, in her mid-fifties at the time of the interviews, had returned only a few years earlier from Ivory Coast, where she had been living since her adolescence. Both in her individual interview and in the focus group (as evidenced here), she spoke matter-of-factly and without bitterness or judgment about the mechanisms of extramarital sex:

Jan: "When a man has some problems in the household, the woman goes out and tries to find a man that can help her a little and the man takes advantage of her. If this man has the illness, she can bring it back to the house, and so on."
Innocent: "Effectively, we should love our women, and treat them so they can stay faithful to us in the future."

Although the social stigma and repercussions of infidelity are potentially severe for women (and are all but nonexistent for men[15]), the above quote is typical of the frank, almost off-handed recognition of the structural factors underlying women's behavior. Sympathy towards women's difficult position is further evidenced by the distinction between prostitutes (a highly stigmatized group) and *agaleto*, who may also have sex for money but through far less formalized contracts of exchange[16]. In practice, there exists a broad spectrum of sexual relationships and strategies women may use to gain access to economic resources (Barnett and Blakie 1992), and while none of these are openly discussed or sanctioned, they are considered as distinct from prostitution, which is generally abhorred.

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[15] As might be expected in a polygamous society, at least with unmarried mistresses. Extramarital affairs are so common that mistresses are given a hierarchy of euphemistic titles, most commonly "*deuxième bureaux*" (the "second office"). It should be noted, however, that these affairs, while sanctioned, are to be carried out with suitable discretion, and that failure to do so may well provoke the wrath of present wives- this is in fact a major theme of popular songs. Discussions of homosexuality are instructive in this regard: the topic is met with genuine bafflement by most Beninese, and yet homosexual relationships certainly take place; like other affairs, their failure to enter into language prevents them from acquiring any social reality.
[16] Although far less common, a few participants pointed out that *agaleto* are sometimes men who agree to sleep with women after material gifts are presented to them. Participants claimed that this kind of relationship is prevalent in other regions of Benin and among other ethnic groups.

In discussions of mistrust, women occupy an ambiguous position: on the one hand, their cunning ability to force weak-willed men to act on their sexual impulses makes them primarily accountable for sexual infidelities, for "falling in the trap" of sexuality. The female power of seduction is understood as being often a proximate rather than underlying cause- sometimes because of structural and economic factors, but also in a more sinister sense: women appear as mere conduits for communication between men, as pawns for their machinations against each other, and in these discussions the distinction between sexual and occult behavior may become blurred:

MB: Can you say more about the idea of "mistrust" [coo xwidee]?[17]
Paul: Mistrust is always in relationship to partners: mistrust concerns women, mistrust concerns men, because all that's depravity… when AIDS is there, the women that walk around too much… one knows that those women are synonymous with death. When that woman approaches you, you're going to die. So the woman that passes, the African mistrusts her. If I don't like you, I can kill you *through* the woman. The woman who is known to come to my house, to come to your house, when she leaves my home I can place something on her, and when she enacts it, the next time that you… I can kill you through her.

As was so often the case, what I originally assumed in this discussion to be a metaphorical reference turned out to be a literal one. Paul lives on the outskirts of the village and seemed to be marginally surviving at the time of the interviews, particularly since his wife had an infected leg and can't contribute to the fieldwork during the critical period. He never seemed to get over the initial fascination many villagers felt upon having a European in their midst, and took great pleasure in explaining the nuances of Maxi vocabulary to me. Paul is referring in this example to a real object, a rope tied around the woman that can cause illness in a targeted victim. The situation here is

[17] This discussion was meant to be part of a linguistic discussion of Maxi categories of mistrust: although "coo xwidee" and "di xesi" are both given as "*méfiance*" in translation into French, the first connotes self-protection and the second, fear. One protects oneself from loose women and the health messages of AIDS workers, but one fears the possibility of infection.

exactly analogous to the famous collapsing granary of the Azande: everyone knows that women of a certain type are deadly, that eventually sleeping with them will lead to infection. But although the biological causes are acknowledged, this is not in itself sufficient explanation for the moment of actual disease transmission; although health worker and villager may agree as to the process and mechanism of infection, the villager still requires the "second spear" of sorcery to account for any particular instance. Since health messages resolutely focus on the "how" of AIDS transmission and ignore the "why" entirely, this system of explanation continues quite independent of the degree of *sensibilisation* to which villagers are exposed.

THE UNIQUENESS OF AIDS

Participants were quick to emphasize the particular nature of the disease; even those who mentioned the availability of medications to slow the effects of AIDS invariably added that this was an inevitably fatal disease. It was this fact that set the disease apart from all others, making it qualitatively different from all other maladies. The sense of absolute and inescapable mortality associated with the disease was the source of considerable anxiety, and even fatalism. Clotilde seemed to be reciting a well-worn sentiment when she spoke during the women's focus group:

Jacqueline (Facilitator): "So there are so many diseases, why do you think AIDS is the most significant?"
Clotilde: "Because it has no cure- other diseases have a cure, but AIDS has no cure. That's what's going to end the world."

Health workers and villagers alike identified the deadliness of AIDS as one of its most essential characteristics. Health workers stressed AIDS' unique incurability as part of a democratizing discourse: like death, AIDS does not discriminate, and AIDS is of

universal concern because death is a universal experience. However, by inadvertently demarcating AIDS in the process as distinct from the medical logics of more familiar diseases, health workers may be rendering it unintelligible to villagers. As Abel, a laconic farmhand who drives the villagers who can afford to help pay for gas into Savalou on market days, succinctly explained,

"People don't believe AIDS exists because all other diseases have cures."

The act of marking AIDS as incurable also marks it as non-Beninese. AIDS was seen as an emphatically foreign disease, brought in by strangers and possessed of a different logic than local diseases. In their emphasis upon hospital care rather than traditional treatments, health workers have marked AIDS as a disease *de l'extérieur*, with foreign solutions. Since both discussions about AIDS and the known cases in the region appear to originate from without, the response of villagers is hardly surprising. Legbeounwa seemed to be addressing Jan and Clotilde, both of whom have lived for most of their lives in Ivory Coast, when she commented during the women's focus group:

"Those who are born here and never traveled, they've certainly never been the ones to introduce AIDS into the village. That's why we say it's strangers. I've never heard of anyone from the village bringing AIDS into the village, but from everything I've heard it's people from elsewhere that are bringing it in."

Anatole voiced a similar opinion when we spoke one-on-one, although he was more willing to acknowledge that villagers incorrectly resisted the possibility that AIDS could begin inside Benin's borders.

"Beninese are dying of it, but we don't yet believe that someone here can get AIDS. It has to come from elsewhere, from Côte d'Ivoire, or from countries where it's said that AIDS exists. But if the illness begins here, we don't really believe that it could be AIDS."

Group discussions became especially passionate on the subject of foreigners, whether from Côte d'Ivoire, Nigeria or even Cotonou, as a group to be distrusted as a possible vector of transmission. More surprisingly, everyone with whom I spoke in Sota, including the participants, believed that AIDS began with Europeans[18] and was foisted upon Africans. Most villagers, when I asked them to elaborate, told me the story of a white man who arrived in one of the urban centers mentioned above and convinced prostitutes to sleep with his dog in order to make a pornographic film. It was in the moment of this unnatural union between woman and animal that the disease was spawned. This story was so prevalent that people actually had Nigerian posters in their homes, depicting the events of the bestial origin in the typical cartoon-like sensationalism of the genre.

The uniqueness and foreignness of AIDS also explain, at least in part, why the disease has not become a *vodun* in Sota[19]. With no links to the past or to prior traditions, AIDS appears unintelligible within the *vodun* system of understanding the mysterious and productively harnessing its capacity for harm. Ferdinand explains with particular clarity the general sentiment expressed in the interviews:

"To talk about AIDS, the problem- when you talk about Sakpata, for example… well, it's going to take time for the African before he'll end up accepting the reality of the illness of AIDS… Sakpata is not imported… the fetish came from Africa, and the African knows what that means. When one speaks about lightning [Xevioso, another fetish]- the African knows what that means- and every time that it threatens to appear he's already

[18] References to "Europe" and "Africa" in this text should not be confused with the actual land masses; the terms refer to *yovotome* "the land of white people" and *mewitome* "the land of black people", and are locations within an elaborate cultural geography as far removed from the physical as are "Orient" and "Occident".

[19] Nor, indeed, has it done so in any part of Benin of which participants or health workers were aware. The system of *vodun*, as that which incorporates all that is sacred, mysterious and dangerous (Guedou 1985), has included several diseases in its pantheon, most significantly Sakpata, the god of smallpox and the most important divinity in the area around Savalou. Participants therefore expressed no surprise at the question of why AIDS was not also a *vodun*, and considered the question seriously before responding.

afraid. We know how to fear it, because those kinds of things come from our own home. But AIDS didn't come from Africa."

For the most part, health workers acknowledge villagers' difficulty in believing in a disease that refuses to conform to previous models. AIDS educators are caught between two models of presenting the disease; on the one hand, the idea of AIDS as a *vodun* would be entirely compatible with their conception of the work of cultural translation. Cultural practice (the belief in vodun) is understood as a way of encoding the underlying medical information in an accessible format. But educators are unwilling to sacrifice the essential concept of AIDS as impassive and impartial in order to render it intelligible within this religious framework, and are therefore obligated to seek other ways to present the disease in a meaningful way. (*Vodun*, after all, are hardly impartial, or else there would be no reason to make attempts to supplicate or appease them.) One alternative presentation of AIDS is to conceptually link AIDS to sexually transmitted diseases (STDs), which are familiar to rural communities and do not bear the mark of foreignness associated with AIDS. Laurent makes periodic forays into Sota as a health educator, although resentment over the choice of his village and not Sota for a project training AIDS educators has led to a chilly reception by some residents, particularly Innocent. He is a gentle, strikingly intelligent man, and seriously passionate about his work. He describes how AIDS can be made relevant to villagers by association:

"It's much easier to talk about AIDS since we integrated our campaigns with STD education. STDs, they're something that has been around for a long time. That means that we're talking about them, it lets them remember and refer back to the different STDs they've experienced, and they relive that hurt and say 'Ah! It's like that, effectively!'. Because it's something everyone knows and remembers, it lets us talk about AIDS."

AIDS and STDs, of course, are only indirectly related: AIDS educators underscore the increased risk of AIDS transmission and infection where STDs are present, and justify the simultaneous presentation of STDs and AIDS by emphasizing their overlap in behavior change recommendations to prevent infection. In doing so, however, they consciously allow the categories to become semantically blurred, in an attempt to link AIDS to a signifying system that is directly salient and accessible.[20] By connecting the abstract and subtle concept of an immune syndrome to graphic and physical images of STDs, the disease becomes knowable to the larger population. Charged with the difficult task of giving meaning to AIDS, health workers justify any loss of accuracy resulting from conflating AIDS and STDs by pointing to the urgency of convincing villagers to act on the information provided: in their view, the ends justify the means.

AIDS EDUCATION AND LANGUAGE IDEOLOGY

The proposition that health workers might be willing to blur the accuracy of the information they provide to target populations in the interest of establishing a simple and intelligible message is hardly unprecedented in Africa[21], but it is startling nonetheless. What is it about the way that health workers view AIDS, and their mission, that makes

[20] Before conducting this research, I had attended and even organized AIDS *sensibilisations* that educated about AIDS through an emphasis on STDs, relying on horrific images of gonorrhea and syphilis to convey the dangers of AIDS. Villagers who attended did not clearly understand that the kinds of genital lesions so graphically displayed in the sessions were not themselves part of AIDS. Ethical qualms about these kinds of presentations aside, I strongly suspect that such campaigns, focused as they are on fear and disgust, have little long-term effect on behavior change.

[21] For example, a Human Rights Watch report on Uganda's AIDS program (with the telling title "The Less They Know, the Better") outlined a systematic effort to use messages of abstinence and fidelity to undermine other prevention strategies through deliberate misinformation or omission (Cohen and Tate 2005).

this alternative preferable to a reformulation of the disease as anything but purely impersonal? A comprehensive understanding of the areas of miscommunication between health workers and villagers requires an examination of the ideological assumptions both sides bring to the interchange. In the preceding discussion, I have outlined some initial evidence that the presentation of AIDS information by health workers in rural contexts is not always understood in the ways intended:

- Discussions about AIDS are best understood to reflect the actions of an idealized community member, and their purpose of discussion is primarily one of achieving consensus and building cohesion within the group. Statements made by individual members in group discussions are not necessarily understood by anyone as reflections of actual behavior.
- The truth-value of medical information enjoys no particular privilege among sources of information about AIDS, and its truth-value is assessed in much the same way as rumor and gossip. Rumor and gossip function in part to address issues of power, race and agency that the biomedical discourse does not.
- Individuals, when faced with competing explanatory systems to describe AIDS and appropriate sexual behavior to avoid infection, may select freely from both medical resources and alternative resources. Beliefs are not necessarily absolute and exclusive, but may be held simultaneously and expressed depending on context

These kinds of considerations regarding the nature and context of communication may be productively treated in terms of language ideology (Gal 1998). Broadly speaking, the term *language ideology* refers to a shared body of commonsense ideas about the nature of language in the world, including cultural assumptions about the nature and purpose of communication (Woolard 1992). Rather than describe values associated with the use of a particular language, its treatment in this thesis deals only tangentially with the relationship between French and local languages. Rather, the idea of ideology refers here to the general sense of implicit assumptions about reality, language and the act

of communication which fundamentally determine how villagers and health workers interpret AIDS information.

Byron Good has demonstrated that the biomedical discourse is itself part of an ideological system, one which considers the underlying structure of language as sets of labels (1994). These labels render information intelligible to a particular speech community, so that information about AIDS exists as medical fact in a sort of pre-linguistic and objective state, and must be translated through the assignation of the appropriate labels to be received by a target population. Indeed, health workers considered one of their principal tasks in AIDS education to be one of cultural translation, the unproblematic transfer of neutral information into local idiom. M. Tchabi, who coordinated the AIDS education activities in the region for an American NGO, was clearly very proud of the elegant organizational structure of his employer, and believed with great optimism in the eventual, seemingly inevitable success of the program. He seemed very at ease explaining to me the linguistic adaptations that made such work so effective, as if he had done so many times for potential funders:

"There are simple terms we teach to peer educators to help them understand and pass the message on to others…. we say that AIDS is a serious disease without a cure, that it can kill a child as well as an adult, a rich man as well as a poor one. Simple terms. But there are also *technical* terms used by the local communities to designate condoms. For example, where I'm from in Savé, we use the term *gobi ajala*, so for us this is a *password*… that provides access to the community… we have a list of *equivalents*, these useful words, to prepare peer educators to discuss AIDS in local language."

Organizations such as M. Tchabi's, which operate principally in providing capacity-building training for networks of peer educators in local NGOs, take great pains to find these precise "passwords" which will make their French information meaningful in local languages:

"Every specific term designed for casual conversation [*sous-terme de la causerie*] is subcategorized: this one for STDs, this one for AIDS- and has been carefully prepared for the peer educators to memorize. There's a special organization that has created the pedagogic guide that we use, and it contains all of the elements necessary to communicate the equivalents in the local languages, all the necessary tools to pass the message from French to uneducated people."

Because language places information within a cultural framework, health workers expressed frustration with illiterate and non-francophone villagers who are in their view inappropriately socialized to reason properly about AIDS. In Benin, where local languages are denigrated by the educational system, literacy and *francophonie* are generally synonymous. Once information has been translated for villagers, their continued refusal to observe the behaviors dictated by health workers, or other forms of resistance such as rumor, are understood as either stubbornness or unclear reasoning. This is not to suggest that villagers are perceived as irrational beings; they are merely seen as untrained thinkers. This characterization is not necessarily unsympathetic to the structural constraints on village life: sound reasoning is to some extent recognized as the privilege of those not living hand to mouth. Nevertheless, failure to act upon translated information represents a qualitative difference between the mentality of the uneducated and the literate. M. Kpakpo, of the Savalou hospital, was himself from a small and relatively remote village, and understood well the Brechtian limitations on the capacity of the poor to act in their long-term best interest. Although not without sympathy, he explicitly linked their plight to their lack of education and the limitations it placed on their thought:

"If people don't believe, well, those who are stubborn will always find uncertainties concerning [the existence of AIDS]. And really, why don't these people understand? Well, remember, these people are illiterates. They're not too cultivated. They haven't been to school, they don't even know the alphabet of their national language. So there

are a good number of things which make it so that they don't think about the existence of AIDS, and even if one tells them they don't believe it, because… well, when they speak of poverty, you have to understand they're saying, 'I need money, I have to feed my family, and maybe I've divorced my wife or husband and all the children are in my care and I have to care for them. So maybe in that time there's someone there with money making advances toward me that doesn't believe in condom use. Who's going to believe in AIDS then?'"

More typically, however, the barrier between transmission and reception of AIDS facts is understood as cultural. This conclusion follows naturally from the ideological framework; culture stands as the specific and local mediator between two universals, the rational human mind and the pure truth of medical fact, unburdened by ideology. Once the barrier of culture is eliminated, primarily through identifying the proper format for communication, individuals will necessarily come to recognize the intrinsic superiority of medical knowledge over their cultural beliefs. Rumors about AIDS that compete with biomedical information can therefore be dismissed as ultimately and inevitably slated for rejection once the rational mind perceives their inferiority. M. Tchabi's optimism is founded upon the eventual triumph of reason:

MB: What makes your presentation more credible in the villagers' view than rumors [about AIDS in condoms]?
-"It's because the information they receive through rumor isn't well organized, it's information they put together from here and there, pell-mell. In contrast, our information is clear and well-presented. First we train the peer educators, teaching them how to find the appropriate terms in local language, and we're ready to respond just like that and lay it out for them, how to answer if there's this problem, this problem, this problem… so that all those implicated in their village sessions see that they are serious and right and the others are just noise. And they believe us because we use all of the tools available: flipcharts and slideshows and brochures, and they're free to compare what they've received before with what they're receiving from us and it's clear that we are right."

The tools referred to here- the flipcharts, slideshows and brochures- demonstrate a recognition on the part of health agencies of the importance of the visual in impelling belief. The disproportionate focus on non-sexual vectors of transmission which results

from this method of communication is in part an effect of semiotics: sex is difficult to represent and difficult to discuss, whereas the objects associated with other means of infection are clearly enumerable and lend themselves to the construction of clear narratives. In discussing AIDS, which emphatically resists association with previous models of disease, educators seek to associate it with subjects within the public discourse, and sex is definitely private. Nugboyonhoun is a peer educator in a large village outside of Savalou, and is an extremely charismatic and enthusiastic young man. He has assimilated the medical information from his training with remarkable sophistication, a credit to the skill and patience of M. Kpakpo. He explained his own sense of the disparity between the medical model and local sensibilities:

"There's a certain way to tell them things that makes them believe quickly. But it's not the same way that one uses when talking to them about AIDS. First of all, they're presented with things that run counter to their culture. For Africans, sex is not something that you can talk about openly. It's a way of flouting their moral system. Talking about the penis, and even representing the penis like they do, even in front of children, it's taboo."

The near-ubiquity of this view surprised me, because many Beninese do speak about sex and sexuality quite freely. Participants suggested that this distinction also has to do with context: joking about sex is understood as a kind of performance, whereas discussions of sex in the context of AIDS cannot be so interpreted[22]. In the years that I served as a volunteer, however, particular emphasis was placed upon frank discussions of sex. At that time, much of AIDS education emphasized the use of condoms, and demonstrations of proper use with a wooden penis (*koffi*) were the centerpiece of our

[22] Indirect evidence of reserve in discussing sexual relations may be found in the tremendous number of euphemisms and ellipses used throughout the interviews to describe sexual intercourse. Among the most common were: di sa (to walk around), ba nyonu/ ba sunu (to look for women/men), wa gon or wa nukun (to approach), ten kpon (try something), and gbon (to pass by); in the few instances in which villagers did speak directly about sex, they switched into French.

rather ritualized presentations. Despite their obvious discomfort, we were trained to insist that women demonstrate condom use as well, as part of our rhetoric of empowerment and insistence upon equality between the sexes in reproductive decisions. Although this kind of practice now seems misguided, it can also be understood in terms of Good's presentation of medical ideology; once information transmission is phrased as a task of cultural translation, "culture" naturally stands as that which intercedes between the transmission of purportedly neutral material (in this case, however, attached to the enlightened view of gender equality) and its successful reception by a (homogenized, linguistic) community. In the era of the condom, the urgency of controlling AIDS served to legitimize violations of cultural norms such as taboos about sex talk; in the modern age of abstinence- and fidelity-focused campaigns, the same logic establishes an inordinate focus on those practices that appear most exotic: ritual scarification, circumcision and excision. In the context of a global disease, the argument runs, respecting cultural belief becomes less important than the propagation of medical knowledge.

POWER, IDEOLOGY AND DIALOGISM

This dichotomy between the supposedly canonical and prelinguistic state of medical information, free of context, and the active, "pell-mell" engagement with multiple discourses that constitutes the dynamics of rumor calls to mind Mikhail Bakhtin's concept of dialogism (1986). In Bakhtin's philosophy of language, words are inextricably bound to the context of their utterance, and are inescapably polyphonic in their reference to previous and future utterances. Rumor, as an ephemeral and constantly reconstituting collective construction, stands as the heteroglossic form *par excellence*.

Meaning is always related to the moment of narration, engaging the fixed meanings asserted by medical and other discourses through a process of decentralizing which opens them up to the very conversations they disavow: the ideological, the particular, and the personal.

Bakhtin contrasts centrifugal genres such as rumor with unitary language: "A unitary language is not something given but is always in essence posited- and at every moment of its linguistic life it is opposed to the realities of heteroglossia" (1986: 270). Indeed, Good has demonstrated that perhaps the most essential aspect of medical ideology is its self-representation as naturalized, pure, empiric and devoid of ideology (1994). In disavowing the ideological component of its own discourse, biomedicine is unable to acknowledge the critiques presented by rumor. Like the discursive framework that constructs it, AIDS is resolutely defined as an impersonal and democratic system. M. Tchabi explains the systematic process of simplifying the disease into universal language:

"It's much more difficult to train peer educators who don't speak French. So we provide them with a simplified explanation that allows them to make understood to all concerned what the disease is. A simple definition of AIDS: A serious illness that can kill a child as well as an old man, that can kill a rich man as easily as a poor one, a white one as easily as a black one, and which has no cure. No matter their level, everyone can understand that, and it's easy to translate into local language."

Although health workers tend to dismiss rumors as the work of either superstitious minds or hecklers, *radio trottoir* is in fact an effort to engage AIDS dialogically in spite of the centripetal efforts exerted by the medical discourse. Luise White has written most eloquently about the function of rumor in African society: "Their very falseness is what gives them meaning: they are a way of talking that encourages a

reassessment of everyday experience to address the workings of power and knowledge and how regimes use them." (2000:43). AIDS rumors address precisely the gap which biomedicine refuses to broach: in insisting on AIDS' characterization as a democratic and impartial disease, health workers simultaneously mark the disease as incomprehensibly foreign and contradict the clear evidence before poor Africans: AIDS does discriminate, selecting the poorest and blackest people as its victims.

An ideological system which denies its own existence as such is contested by a fragmented and incoherent discourse: as Smith has pointed out in her work with *pieds-noirs* settlers (2004), this framework calls to mind Gramsci's formulations of hegemony and subaltern thought as well. Ultimately, Smith rejects Gramsci's formulation for its implication that a true counter-hegemonic narrative must be coherent; AIDS rumors provide a similar challenge to this claim. Rumor's force in engaging and working through the issues of power erased by medical discourse *depends* upon its ambiguity, versatility and multivalence. Basile works for a local organization without a fixed salary, although he is reimbursed for transportation costs. There is a disconnect between the organization's administration and its field operatives, who incur expenses that are not always of the sort that provide receipts and are thus obliged to lose money while they work, even as the agency inevitably blames them for fund mismanagement when it finds itself in financial hardship. His frustration no doubt contributes to his pessimism before the daunting task of competing with rumor systems for the opinion of villagers:

"In fact it's like those people who ran to the well to put out a fire: as they go along, they fan the flames that they run past on the way to put it out. Because these messages destroy seriously the messages that one installs in the head, and there's no way to stop them by reasoning with people. You have to consider how much has been expended to install these ideas in their heads, but *radio trottoir* doesn't need a single franc to destroy it."

INTERNAL CONTRADICTIONS IN DISCUSSIONS OF AIDS

Positing the opposition between medical and alternative information in a Bakhtinian framework also avoids considering individuals as mere representatives of a certain discursive position, with access to a single script. In reality, the negotiation between centripetal and centrifugal forces occurs as much within individuals as between them; the idea that people adhere to a single position is itself an ideological conceit of the medical discourse. The presence of multiple ways of understanding or explaining the same subject can remain relatively unconnected, emerging as speakers shift their stance in different conversational settings (Goffman 1959).

Summarizing Sota's beliefs about AIDS in the above discussion is thus a complicated affair, not only because beliefs within the community are heterogeneous, but because individuals draw from different sets of information when talking about AIDS, depending on conversational context. Despite the considerable level of knowledge about AIDS and its transmission reviewed in the above discussion, an entire system of competing beliefs exists in parallel to the information received in AIDS trainings and from official media. In fact, rumors abound concerning AIDS and its origins, often in seemingly direct contradiction to the facts stated above (by the same participants) about transmission and prevention. A popular story with several variants told of a traditional healer (generally a Ghanaian) who had found a cure for AIDS only to be killed: most often by his own family, although in some versions the European pharmaceutical companies take him to their land to "look into his brain" before killing him. Another set of rumors betrayed a deep mistrust of the institutions of health and medicine: some

claimed that doctors provided lethal medications to those who were found seropositive rather than tell them their status, others that doctors or whites had placed 1% (this meaningless detail never varied) of the virus in the lubricant on the inside of condoms in order to infect blacks. In focus groups, these horrific stories were often told immediately after the participant had produced the standard narrative concerning AIDS: one woman swore that she would never use condoms because they deprive both parties of physical sensation and can get into your intestines, less than a minute after claiming to use them regularly. In another typical exchange, Innocent discredits and prescribes the use of condoms in the same breath:

"When I got to Savalou, I saw that the women there will sleep with just about anyone, so I started to believe in the existence of AIDS. I asked some nurses who worked at the hospital what precautions they themselves took before sleeping with women, but they said this kind of trade in condoms is just to make money, otherwise they would use them."
"Then from what you've experienced, do you believe that AIDS exists?"
"Yes, it's real. So, if I'm going to fool around a little, I'll use a condom unless I know that the girl is serious and doesn't just go with anyone".

This phenomenon was not limited to rural communities, but was prevalent among their health workers as well. As my focus group coordinators explained the fantastic rumors of the village during our transcription sessions, they would often let the narration expand in their own voice, asserting their own belief in the stories. Even those health workers who most vociferously condemned the primitive thought processes of their target populations would recount tales of skilled curses designed to perfectly mimic the symptoms of AIDS infection. Most instructive was my observation of Denagnon, Sota's elderly *sécouriste*, explaining the transmission and etiology of AIDS with the help of an old training manual; after laboriously working through the French for the first few pages,

he focused on the pictures of transmission. Although he did speak briefly about the couple in bed (modestly represented under the covers, although no one in the village used bed covers themselves), most of Denagnon's discussion centered on the images of scarification, razors, and circumcision. He then turned to a picture of sketched black figures with spears inside a circle, and explained:

"We represent antibodies as soldiers, for example, who have to defend their country. And we take the virus as mercenaries that want to attack the country. Generally, in the beginning there are a lot of microbes that seek to destroy the body, that penetrate the body, but with the help of the soldiers the body can survive. But the virus, he arrives, and he doesn't seek to combat the soldiers directly, he seeks friendship with the soldiers, he seduces the soldiers. When he infiltrates their ranks he learns how they go about fighting mercenaries, and he ingratiates himself among them and learns how to live among them in the same place. And he learns their weak points, he learns when they let their guard down and when they no longer think he might harm them, and that's when he strikes and they can do nothing."

At first, the depiction of antibodies as warriors seems like a perfect example of the process of translation in the medical model: Emily Martin has pointed out that the metaphors of body as nation-state, immune system as soldiers, and infection as invaders, form the dominant imagery of American science (1990), although in the "Africanized" repackaging of American boilerplate, they've somehow become spear-wielding bushmen. But as he elaborated in subsequent conversations, the description given by the *sécouriste* is surprisingly polyvocalic, evoking two well-known phases of Beninese history as well, in ways plainly evident to his audience. Firstly, in his conquest of the southern kingdoms, one of the Dahomean kings sent his sister to marry the ruler of a large city. She revealed the troop movements to her brother and the city was easily defeated. More recently, in the late 1970s, during years remembered vividly by all villagers who endured them as the most difficult post-independence, then-Marxist dictator Kérékou lived in constant fear of

being deposed by white mercenaries, who in fact nearly succeeded in 1977. In other words, the metaphor of the body politic has been expanded in this narrative to refer to the same tropes identified earlier: the treacherous and opportunistic woman as vector of disease, and the characterization of the disease as European and foreign. The process of developing a memorable and meaningful narrative inevitably returns to those themes that are most salient to the listeners, so that in practice the lines between rumor and medical information are not so clearly delineated.

BELIEVING IN RUMOR, BELIEVING IN AIDS

Rumors contradict each other, are understood through their dialogic interrelation as a cultural system for expressing collective consciousness, and yet really exist in the minds of individuals (Bakhtin 1981:292). A direct comparison of the structure of rumor to that of medical discourse points out the shortcomings of the latter: as a unidirectional system of communication, focused on the immutability and validity of its sources, and thus codified as a system that resists (active, localized, individual) engagement on the part of both its producers and its consumers. Many treatments of collective consciousness have considered individual expressions as the site of meaning contestation between these two positions, the fixed official position and the protean collective unconscious. In this analysis, I do not discount the possibility that AIDS rumor serves as a counterhegemonic strategy, but find this perspective constraining nonetheless. Rumor can be understood as resistance, but not fully understood as resistance. Rather, rumor is best conceptualized as cultural practice, and as such, as the imbrication of the individual and the social. In the following discussion of rumors, I hope to demonstrate that local

epistemologies confer meaning upon even those rumors that are prevalent throughout Africa, and are commonly interpreted as discourses of resistance.

White has noted that rumors of vampirism in East Africa gain authority and credibility through their connection to local history (2000:8). As narratives develop and propagate, they retain those elements of social life that resonate most with hearers. In the act of their telling, the truth of rumors is established through the repetition and reinforcement of these resonating elements. Specificity of detail (the shape of a swollen head, the percentage of virus inserted into a condom) matters in rendering the narrative particular and accessible, and with each permutation the terms of the rumor gain greater malleability, more ways to talk about a greater range of things. This often results in rumor systems which are highly localized in their spread, suggesting that rumor also serves to give voice to local identity, and therefore as a force for local cohesion. There were villages only a few kilometers from Sota that claimed never to have heard of the dog-pornography origin story, and instead had their own explanations for AIDS' origin, uniform within the community but not encountered elsewhere.

Villagers establish the credibility of rumors in the same resolutely systematic way that they evaluate biomedical information about AIDS. The number of references to a given event or fact, the diversity of sources, and eyewitness accounts all serve to establish belief in both cases. Above all, visual evidence is understood as proof that rumors are true, even when this evidence takes the form of hand-painted posters[23]. Just as the photographs of AIDS victims were the salient detail recalled in an AIDS training three

[23] The documenting power of the visual image in Beninese social life is not limited to AIDS information. As with its Western forbears, the laundry soap of choice in Savalou, "Omo", demonstrates its efficacy with pictures on the package of a shirt before and after washing. The fact that these are hand-drawn pictures rather than photographs in no way diminishes the power of this visual testimony.

years past, and the condom becomes fetishized because its material presence allows for an iconic simplification of the complexities of sexual intercourse (Treichler 1997), the visual image provided the essential form to compel belief in the AIDS-genesis-by-bestiality rumor so prevalent in Sota. Again and again, participants would show me their cheap, garishly painted Nigerian posters illustrating the events of the story as irrefutable proof of its validity. As with the earlier comparison of religious proof (the *gris-gris* in the palm of Atingali) and medical proof (the less compelling test for seropositivity), belief always necessitates a material sign. Laurent, talking about his own experience educating villagers in Sota about AIDS, explained the necessity of visual images:

" In the village? Oh, since people aren't very well educated, they just say that it doesn't exist. If they can't see something with their own eyes, then it doesn't exist. It's just as if we who are educated, we come back home and try to demystify things for them, because the African that has never known paper, he has to see it with his own eyes before he can believe in it and recognize that in fact a certain thing happens in a certain way, either due to the explanation that you give him, or because of the images that you show him, they know that in fact what you're telling him is real. Otherwise he'll never believe you. So you have to show him images, tangible things, to show him that a certain thing exists."

NAMING AIDS

Physical demonstration is one form of proof, but it would seem that the discourse about AIDS itself might constitute another. When participants explain why they believe in AIDS, more often than not they cite as primary evidence the fact that people are still talking about it, making booklets about it, sending white people halfway around the world to do research on it… in short, *the social production of information can constitute proof in itself of that information*. AIDS is literally spoken into existence; Winkoutchale explained the rationale for her own belief as if it were glaringly obvious:

"If it's not a reality, they couldn't announce it on the radio and on the television. That's why I affirm that it exists. If it were a lie, they wouldn't have broadcast it on the television and radio."

Nugboyonhoun and Sylvain attended the same training by M. Kpakpo two years ago, and complement each other well as an educating team; Sylvain is semi-literate and very competent in French, so he can assure that Nugboyonhoun, the more dynamic speaker of the two, never strays too far from the talking points in the brochures M. Kpakpo has left with them. When I spoke with Nugboyonhoun and Sylvain in their village, I was particularly interested in how they were able to engage people in a discussion of a disease that had made no visible incursions into the region. Sylvain repeated the same logic as Winkoutchale: his peers believe him because he and the apparatus of social production around him continue to speak the disease into reality.

MB: What is it really that makes people believe in this virus, which up until today no one has seen here?
Sylvain: At first we had real problems with that, because people didn't really understand what AIDS was, and more that that, it's often said that a certain person "has" the virus, they're really dying of thinning [*amaigrissement*], that before we spoke about AIDS, there were many of our relatives who died of thinning, that it's just to discourage the population that we talk about AIDS, that before the existence of so-called AIDS, that our relatives were dying of thinning disease, so you can't say it's AIDS, it's just the same thing continuing. But they're starting to realize that if it didn't exist, we wouldn't keep talking about it.

Statements that information is credible because it is a topic of discussion should be taken at face value, and certainly not as evidence of blind, naïve faith in the media of transmission (White 2000:31). Although the above quotes could be interpreted merely as evidence supporting the prevailing view among health workers that repetition of health information impels belief, villagers often suggest that there is something more fundamental to these statements; that the very act of naming and discussing AIDS brings

it into being. In a country where a decade of discussion and health campaigns has preceded visible signs of HIV infection for most of the population, it is perhaps small wonder that the propagation of the disease and the propagation of the discourse concerning it are not always clearly separated in rural perception. Thus Nugboyonhoun supplemented his friend's words with this elaboration:

Nugboyonhoun: No one can say where AIDS comes from, because it's a disease whose name emerged in the world and we had never heard it before. The year that all of these questions appeared on the brochure was the same year that AIDS appeared in Benin.

Treichler has referred to the "epidemic of signification" that constructs AIDS in its American context by conflating the actual disease with the systems of meaning that surround it (1997); in Benin, the fact that AIDS exists as a social reality has real implications for its potency as a physical disease. Nugboyonhoun continued:

Nougboyonhoun: AIDS is a disease that thins a man. And the thinning of a person, you can't do theatre to pretend that you're thin, so you can't fake that on videos: the disease exists. There's another disease we call *azé* that if you have it, you scratch your body all the time, and to calm the illness you can buy powder and put it on the wounds and it calms the itching. After research and inquiry, we've learned that this disease is called "syphilis", and we've found the medicine for that disease. And now, that disease is no longer called *azé* as it was before. Now that we've found a proper name for it, it's eliminated from the world. Once we've found the remedy, a disease can't kill as it wishes. So in finding names for illnesses, the illness we're talking about now, AIDS, can't act in the same way that it did in the time of our parents, "this product is named so-and-so, it has these and these attributes", and so it can't kill as it did before, in the time of our ancestors.

A major subset of African rumors addresses the fused signification of message and disease, although it is seldom considered in this light. Rumors that health workers are themselves key vectors of infection, or that condom manufacturers place HIV in condoms, are generally interpreted (both by Beninese health workers and in AIDS literature more generally) as acts of resistance to hegemonic medical discourse, as mulish

inversions of the prescribed scripts. As Ferdinand explained to me one night near the end of my research, when I described stories about how intentionally punctured condoms are sold to Africans,

Ferdinand: "So it's like that, when the African starts talking this way, it becomes difficult to receive the message, because you can see that he already holds inside an idea of vengeance: it's the White that brought us this. And now the same White has come here to tell us: you can't do this, you mustn't do that…"

I do not dispute that part of what creates and sustains these rumors is a sense of betrayal, of powerlessness and resentment. But if we are to understand rumor as a larger system of cultural expression, it seems equally clear that many of these rumors are ways for communities to think about the parallels between the twin discursive and viral epidemics spreading throughout sub-Saharan Africa.

The idea that the act of naming might in itself impact the power of a disease is not as strange as it might first seem[24]. Throughout Benin, fetishes demonstrate their power through sleight-of-hand performances like Atingali's resurrection. In one village near Sota, for example, the raffia rings that comprise Zangbeto's body are assembled before the entire community, so that all can see that no human hides inside; nevertheless, the fetish dances away moments after being constructed. One might conclude that this places the actual performers in a conflicted situation, since they must knowingly register the artifice of the fetish they construct. Nevertheless, no subjective conflict arises: deities are explicitly acknowledged as constructions, and yet the effect on belief is one of reinforcement rather than skepticism (Barber 1981). Although the moment of original

[24] At every level of Beninese daily life, naming is understood to have real power over objects and people. Adults are referred to by their profession or as the parents of their children, and many people have secret names known only to their closest family members. Objects of religious value change their name during the night to avoid detection by spirits, and particularly vulnerable members of the community (pregnant women and very young children) also adopt linguistic disguises.

belief may have been contrived, once the community believes in the deity, its power is genuine: the moment of social belief establishes the existence of the fetish independent of the moment of its origin. In Benin, this concept is encapsulated in a proverb that gets at the very essence of belief: "It's the fetish and the people who believe in the fetish that make the fetish effective". The power of the fetish continues to serve the community to the extent that it continues to hold collective meaning.

Can we interpret belief in AIDS in the same way? A belief in AIDS founded upon the fact of its discussion is not quite a circular statement: once AIDS enters into discourse, it becomes an epistemological category which villagers can use to describe their world, thereby gaining a social reality that cannot easily be differentiated from its epidemiological existence[25]. But recognizing the social salience of AIDS is not the same thing as accepting the prescriptions of the medical community. Investigating the critical relationship between what people believe about AIDS and what they do becomes increasingly problematic, as language proves an inadequate instrument to access individual behavior. In the following discussion, I consider further the relationship between collective and individual identity in the context of AIDS beliefs.

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[25] This pattern is hardly unique to Benin; our own psychopathologizing tendencies have real impacts upon the prevalence of diseases, and the difference between their social and medical existence is similarly indeterminate. But the point I want to emphasize in this brief discussion is that the fact of similar processes elsewhere does not in itself constitute grounds to reject the suggestion of culturally-specific criteria for belief and social existence outlined above. In the same way, the nearly universal prevalence of rumors about AIDS-treated condoms does not necessitate a rejection of my interpretation of Beninese rumors as symbolic expressions of the conflation of disease and discourse. Narratives may travel, but the point of interest is always what they might articulate in a particular place and moment of enunciation.

Collective Identity and Individual Behavior

Since the research design allowed me to hear the same participants speak in groups and individually, I was able to compare the two directly. Unsurprisingly, much of the focus group time was spent in corroborating and building on co-constructed narratives about AIDS, whereas individual interviews tended to highlight personal experience in a more focused way. Contradictions such as the one mentioned earlier, in which a participant inadvertently exposes the fraud of condoms in a personal narrative and then claims to always use condoms in a general sense of habit, can therefore be interpreted to point up the disparity between belief and actual behavior. There are certainly plenty of examples of this in the data: everyone claimed to get tested regularly in the group, for example, but none of the participants actually had. The point that I want to emphasize here is that this is *not* an attempt to deceive the other members of the group through the presentation of a false self.[26] As participants explicitly stated in the interviews, the purpose of group discussion was the achievement of consensus, a means of codifying attitudes *without respect to actual behavior*.

A more striking example of this phenomenon should suffice to illustrate this point. The following two quotes are from Jan, a bright and extroverted woman in her fifties, during her participation in the mixed-gender focus group:

"When I heard about this disease on the radio, I was afraid, and now when I want to have sex outside of my marriage I only do so with a condom. I do believe that AIDS exists. This disease is really serious, and that's why everyone shouts about it, and we should really take caution (literally: mistrust each other). I'm afraid now to approach a man."
"For me, if it's not with a condom, I'm not going to go out with guys that commit the act. If we use condoms, we can go out."

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[26] Nor to deceive me, I think; although I certainly allow that possibility.

In our individual interview, Jan was genuinely confused when I asked her about this apparent confession. It seemed obvious to her (and to everyone else but me) that this statement was for the benefit of the group, to model proper behavior should one happen to be cheating on one's spouse. In her words,

"I'm really not concerned about AIDS. I have always been faithful, and since my husband is now too old to be chasing after other women, I don't see how I could be infected."

Had Jan stated in the individual interview that she had extramarital sex, but denied it in the focus group, one could be tempted to interpret the disparity in her responses as an attempt to avoid censure or stigma. As it is, these kinds of data suggest that all statements about individual behavior need to be considered very critically. If the goal of communication is the expression of collective mores rather than the assertion of individual opinion, it's not clear to what extent behavior is ever reliably accessible through survey instruments. Further research is needed to understand the real significance of this kind of interview data, but it would seem that assumptions concerning communication in the public sphere are not perfectly shared between health workers and villagers.

Perhaps too much has already been written on the difference between self-oriented and collectively-oriented societies, and I don't wish to overstate or simplify this dichotomy here. I would note, however, that much of Beninese social life privileges collective experience over individual experience. It has been argued (by Aguessy 1993, among others) that one of the dominant functions of Beninese religious structure is in fact the recasting of individual experience in collective terms. The fetish, as we have seen, is by definition a collective construct, and serves to exteriorize the personal and

psychological into forms that can be socially mediated. Expressions of strong individual emotion are extremely rare,[27] and daily life is generally organized so as to minimize isolation and privacy. In a society where few things are as abhorrent as solitude, it follows that when participants spoke of their fear of AIDS, it was always in terms of a fear of social exclusion. As Cyrile, the former director of Savalou's center for health and social promotion explained, as long as social exclusion is more feared than physical death, it is in no one's interest to be tested for HIV:

"At their level, maybe they're afraid that they have AIDS. But that's not what they tell us, it's just judging from their responses that we can tell that they're afraid that they might have AIDS. They ask a lot of questions about if they get tested and someone comes and tells them they have AIDS, what happens next- what's the support that they can expect. We say that if they have AIDS we'll try to take care of them ehre, so that they don't have to suffer too much and the virus doesn't arrive at levels that will kill them very early. And they say to us, if you want to separate me from the population and treat me, help me to get over the illness, that's no good, I might as well be dead- he feels already that he'll be cut off (*écarté*) from his family, he feels already that it will be told that he has AIDS, so how can he behave in the population? If he's to be cut off, he'll be cut off from his family."

An entire set of rumors are devoted to the horrific behavior of those who have been infected, who have already experienced the social extermination more dreadful than physical death. In an early women's focus group, Viviane and Doevi, two lively young women in their late twenties, recounted a story that was eminently part of *radio trottoir*, despite Doevi's statement to the contrary:

Doevi: There's a woman whose child has the virus, and she brings the daughter to the hospital for a test, and the results show that the child is positive for HIV. And the woman starts crying and berating her daughter, saying "I advise you each time, I try to protect you each time, and yet you sleep around and now you're infected with the virus". And

[27] In my time as a Peace Corps volunteer, I heard on several occasions of a ceremony near Savalou in which the entire village convened to cry rather than express its individual sorrows privately. These stories may well have been apocryphal, but the very idea that such a ceremony might make cultural sense seems significant in itself.

the daughter says “No, don’t get upset. I’ll spread the disease around as much as I can before I die.”
Viviane: What? She really dared to say that?
Doevi: This is not just a story- it’s the truth. The girl was thin- it was already noticeable that she had the disease. And she said that she would spread the disease around before she died- it’s not a good thing.

On the one hand, this type of narrative is a variant of that tremendously popular theme in Beninese gossip earlier discussed: stories resignedly deploring the general untrustworthiness and cruelty (*méchanceté*) of other people. In this case, these rumors also serve to recast AIDS victims as aggressors. Not only that, they also address another pervasive corollary of the primacy of the group over its members, one generally found in explanations for sorcery. Sorcery is often understood as a means of imposing collective domination over individual impulses, and can in practice provide very real disincentives toward individual accomplishment. It is characterized as the recourse of jealous people who, unable to compete fairly through normal interactions, are driven to level the playing field (*cherche à niveller*). This reasoning, that it is preferable in the interest of social cohesion to destroy those who rise above their station, is often used to explain how sorcery has prevented Benin from properly evolving. But even as it was generally condemned, this kind of logic also clearly made sense to many of the study’s participants, many of whom felt such deep resentment that Sota had been passed over for another village for an AIDS project that they hoped for its speedy collapse.

Sorcery provides an excellent vehicle for the enforcement of social unity because it is anonymous… or more importantly, because identifying its agents is not relevant to its social significance (recall that Atingali does not seek the names of sorcerers, but only defuses their handiwork). The structure of rumor provides an analogous expression of

the collective opinion, unassailably authorless, and can thus be understood as a disavowal mechanism (the zeitgeist said it!) that relieves any particular individual of the responsibility for his utterances. I give the incomparably eloquent Ferdinand the last word; here he compares the voice of rumor to the French subject pronoun "*on*":

> Well, to what can I compare *radio trottoir*; what's said in *radio trottoir* are words which have a terrible force. When they serve as conduits for the truth, this truth enters forcibly into all the heads in the same way, and when they carry destructive words, it's in the same way, and it goes far. And the words said on *radio trottoir* speak a truth that has no author, it's the "*on*" that carries it, so that the "*on*" can be assimilated to a radio. So when you ask a villager, "But who said that?", he'll say that he heard it on the radio. "But what radio?" -In any case, he was told that it was said on the radio.

CONCLUSION

One year after conducting this research, I returned briefly to Benin and met with the health organizations I had interviewed and observed the year before to talk about my findings. Our conversations were at the same time validating and extremely disheartening; although the kinds of issues I was raising were met with universal interest among individuals, health organizations as institutions were powerless to acknowledge them. The tremendous influence of foreign funding on AIDS education, dominated overwhelmingly by the United States, leaves health organizations with little room to deviate from their current programs. Whether the statistics meaningfully refer to behavioral change or not, USAID and other foreign agencies demand quantitative evidence of the efficacy of the campaigns they back, and the kind of nuanced and deep ethnographic perspective I would recommend as a counter-balance to these methods of evaluation is of little practical appeal to small NGOs competing for funding. In particular, since the introduction of PEPFAR in 2003, the largest international health initiative ever established to combat a single disease, AIDS campaigns throughout sub-Saharan Africa have become both increasingly homogenized and ever more beholden to the moral and methodological dictates of American policy (Burkhalter 2004).

With this acknowledgment of the significant structural constraints imposed upon African organizations from without, I wish nevertheless to conclude this thesis with some recommendations for the evaluation of AIDS education programs. As stated earlier, I do not wish to have the findings of this research interpreted as representing some uniquely Beninese mindset, and so I have limited myself here to a few brief recommendations

relating to the kind, rather than the specifics, of disparities evidenced between villagers and the health organizations that operate in their area.

1. Health workers sabotage their own efforts in resolutely refusing to acknowledge the place and function of *radio trottoir* messages concerning AIDS and the behaviors that contribute to its spread. Rumor is not the product of irrational or improperly socialized minds, nor is it a peripheral effect that can be simply discounted as heckling. Rather, rumor provides a valuable insight into the ways in which other discourses about AIDS fail to resolve anxieties about the disease, and if properly interpreted can be an important tool in designing relevant AIDS campaigns.

People engage rumors as a way of questioning and evaluating their experience, and not necessarily as a way of discovering truth (Geissler 2005:179). It is therefore unclear to what degree rumor affects actual behavior. Nevertheless, while the discussion in this thesis of the ideological framework that leads health workers to discount or misconstrue rumor is a significant concern, I do not wish to suggest that health workers should embrace rumors that contradict their information. Rumor, among many other things, can be understood as a form of resistance, and its messages therefore often take forms diametrically opposed to the hegemonic statements made by the political and medical establishments. Health workers do indeed have an ethical obligation to correct someone who maintains that AIDS can be cured by sleeping with a virgin, or that condoms contain HIV. What I am calling for here is recognition of the underlying anxieties that rumor expresses and the constellation of issues linked discursively to

HIV/AIDS. Understood in this way, rumor systems can serve as valuable tools for understanding and addressing local concerns.

2. In this regard, the language ideology of medical information has led AIDS educators to focus their efforts on modifying the form of their messages (the process of cultural translation), but their content remains inviolate. In refusing to allow the modification of their messages to make an understanding of AIDS compatible with local understandings of illness and evidence, health educators encourage the propagation of rumor to fill the epistemological void they create. Worse, they reinforce perceptions of AIDS as definitively foreign, and thereby limit local capacity to engage with the disease conceptually and develop real strategies to control its spread. One could easily imagine ways of addressing some of the concerns raised by rumor: by discussing some of the hypotheses regarding AIDS' origins; or acknowledging that although AIDS "does not discriminate" in a general sense of transmission, the patterns of its spread do disproportionately target economically vulnerable people. This is not to say that there are not sound reasons justifying the current presentation of AIDS to rural communities; even given its apparent shortcomings, the emphasis on AIDS' impartiality may well be necessary to avoid issues of stigmatization and victim-blaming that are clearly at issue in these communities. But if campaigns are to be effective, they need to actually make these kinds of cost-benefit analyses and be open to the idea of modification, rather than presuming that their current framing discussions of HIV/AIDS are somehow sacrosanct and unmarked by cultural influence.

3. AIDS education generally considers the context of presentation of information as irrelevant to its effective reception. Health campaigns are usually conducted in a formulaic way that does not vary from one targeted illness to the next. In situations where the particularity of a region or target population *is* considered, it is generally in the establishment of what Farmer et al. have called "immodest claims of causality" (1996): an exaggeration of the likely influence of cultural or psychological factors on susceptibility toward infection. In Benin, this has taken the form of a tendency to over-emphasize those practices such as scarification and fetish activities which are perceived as culturally "extreme". Care must therefore be taken in AIDS education to resist the impulse toward cultural correction, and to consider cultural particulars not as excisable segments to be treated with "password" idioms, but in a more holistic fashion as components inextricably enmeshed in larger systems of signification.

4. The mode of analysis employed in this thesis has relied in large part upon comparisons between systems of belief, attempting to understand the ways in which AIDS is conceptualized and discussed through explorations of religious and other models. If the resulting discussion has traveled rather far afield, it is in the hope that the breadth of information this study has uncovered will serve to convince organizations working in the area of the utility of including an ethnographic component in their evaluations. This study was conducted in two months, at almost no cost, and could be duplicated with much greater depth and less effort by a native speaker. As I have demonstrated through several lines of evidence, there is good reason to believe that the present methods of evaluation, such as KAP surveys and condom sales, do not in themselves provide a

complete picture of the factors that may influence behavior. Interview data from this study suggest that a villager's belief in the existence of AIDS does not necessarily increase her likelihood of seeking medical rather than traditional treatment for its symptoms, nor do her assertions of knowledge and practice have any necessary relation to her actual behavior. Although they provide easy comparability between regions and populations, reliance on present measures alone as indications of the effectiveness of a given intervention can thus be dangerously misleading.

The focus group work which has been conducted in Benin to date has been carried out in the context of social marketing campaigns for PSI's condom sales, and these have been founded on the exchange theory model of consumer resources exchanged for perceived benefits and are thus limited in ethnographic detail; in fact, in constructing Beninese as consumers they do the ideological work of erasing rather than attending to local context (Pfeiffer 2004:81). The methodology used in my research, comparing focus group data to individual responses, provides a partial check against the tendency documented here of reporting hypothetical actions reflecting social ideals as actual behavior, which normal quantitative instruments would not detect.

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