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On Being Comfortable With Being Uncomfortable: Centering an Africanist Vision in Our Gateway to Global Health

Collins O. Airhihenbuwa, PhD, MPH

African identity must be central to research on African health and development. This article focuses on three primary themes for advancing a different vision for understanding health issues in Africa. The first is the need to deconstruct conventional assumptions and theories that have been used to frame public health problems and solutions in Africa. The second is to insist that identity be central to how we frame issues of health and behavior in general and in Africa in particular. The third is the importance of the notion of "social cultural infrastructure" in defining African ways of knowing to guide public health research and intervention in Africa. Finally, the metaphor of the "African gate" is used to illuminate these themes while drawing on examples from an HIV- and AIDS-related stigma research in South Africa and its implications for addressing the critical global public-health issues of today.

Keywords: *African culture; global health; PEN-3 model*

No man should enter his house through another man's gate.

—Chinua Achebe

That there are challenging health issues and seemingly intractable problems in African countries that deserve immediate attention and a long-term solution is without debate. What has been, is, and remains at issue is on whose experience and in whose tradition of knowledge production should solutions to these issues and problems be anchored. That there are well meaning and committed African and non-African scholars who address African health issues is not at issue. What is at issue is the negative

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representation of Africa in the Western imagination and how scholars have been trained to think of and theorize about Africans and the health issues that affect them.

In this presidential address, I want to focus on three primary themes to advance an Africanist's vision for understanding health issues and systems in Africa. The first theme I want to advance is the need to deconstruct conventional assumptions and theories that have been used to define problems and frame solutions for public health in Africa. Second, I want to offer a frame and lens—anchored in African ways of knowing and using the metaphor of the "African gate"—in a manner that draws attention to the importance of identity in how we contextualize health problems and solutions in African and non-African cultural spaces. The third theme is the central role of identity in public health and health education, which I will illustrate by using some examples from a research project on HIV and AIDS-related stigma in South Africa on which I have been working in recent years. Thus, my primary thesis is that experience from Africa should serve as an important gateway for advancing health promotion at the global level. To begin, however, we must first examine the inherent assumptions encoded in conventional approaches and reconstitute a different approach to study African identity and health. To accomplish this, I have situated my point of discursive departure at an "African gate."

CONVENTIONAL ASSUMPTIONS ABOUT AFRICAN IDENTITY

In the book *Hopes and Impediments*, Chinua Achebe (1988) offered the epigraph I quote at the outset of this article as a way of calling attention to the need to challenge the construction of non-African solutions that are imposed on African identity with impunity. There is strong interest in addressing issues about identity in international and African scholarship (see *African Intellectuals* by Mkandawire, 2005). But such scholarship, although illuminating, does not address health matters. Such scholarship addresses political, racial, and ethnic matters; only by default, health is treated as though it were a technical matter devoid of political substance or cultural context. I would argue that global health issues are identity and social issues and thus should be analyzed using frameworks that can be derived from the social and behavioral sciences. I would also argue that public-health research in Africa need not be African oriented only but reconnected with the experiences of scholars from multiple fields of specialization in ways that render a single disciplinary focus inadequate and limited in community- based projects.

I am proposing not only an African solution to African problem, I am proposing locally grounded modes of addressing and framing problems, regardless of their geo-cultural locations. This means we must truly understand and value "the local" before we can possibly understand and engage meaningfully at the "the global." I focus on Africa as my theoretical anchor as a way of illuminating the meanings and call to action embedded in the African proverb: "Until the lions produce their own historian, the story of the hunt will glorify only the hunter" (see Achebe, 2000, p. 73). My line of argument thus draws inspiration from Africanists but has its international allies, such as the historian Basil Davidson (see his book *The African Genius*, 1969, and his 9-hour video documentary entitled *Africa*). My concern is that Western knowledge production has stripped itself of its local base in its crusade to universalize its knowledge production (Bhabha, 1994). This is why I argue that all knowledge is local. And to illustrate, I offer a frame that allows us to localize and "provincialize" Western discourse about public health by demonstrating that every theory is anchored in a local culture, regardless of its global reach.

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To localize Western discourse as cultural does not invalidate its relevance within its local or national contexts but rather contextualizes the meanings ascribed to its cultural assumptions. We cannot work with prefabricated solutions or seek to address other people's problems. In the same vein, African scholarship achieves global relevance when its methodology begins first with a local cultural context. This is what I believe offers other scholars the opportunity to see the extent to which African analyses and solutions resonate with their experiences (see Makoni & Meinhoif, 2004). For example, a common discursive space in which African experience has had a global appeal has been in the field of development.

The programmatic nexus where an interdisciplinary group of workers continues to address how to "help" Africa advance beyond its current political and health systems and conditions has been largely housed in the language of "development." Indeed, development has offered a rallying point for both researcher and practitioner of different disciplines to converge and agree to do unto Africa as has not been done unto others. This concern for the persistence and unrelenting Western programmatic interventions that are encoded in the development agenda is what led the Council for the Development of Social Science Research in Africa (CODESRIA) to vote in 1986 to abandon the use of the term *development* (Keita, 2004), even though scholars were recently urged by CODESRIA leadership to rethink the representation and appropriation of development in Africa rather than total rejecting it (Olukoshi & Nyamnjoh, 2005).

DECONSTRUCTING CONVENTIONAL ASSUMPTIONS AND THEORIES: A QUESTION OF CHOICE

To deconstruct is to lay bare the assumptions and meanings that underlie knowledge and the value encoded in the theories and models we apply in our research and practice. As a central theme in all my scholarly projects, my primary aim in this address is to question the question. Questioning the question means to examine the assumptions inscribed in the theories and models that have become the foundation for programs designed for Africans and people of African descent. This is what the philosopher V. Y. Mudimbe (1988) referred to as "epistemological vigilance." Epistemological vigilance refers to the need to critically examine the assumptions that inform the theoretical question. Theorizing is a process and product of professional allegiance. Scholars who are trained in professions and disciplines, such as psychology, that understand and frame societies as an aggregate of individuals typically produce scholarship and theorizing that are markedly different from theorizing from professions and disciplines, like anthropology, that understand and frame society as a constellation of groups. Although I have chosen psychology and anthropology as sites of discursive contestations, my primary interest here is in the deployment of their assumptions to public health and health education. By and large, the atomistic view of individuals has enjoyed a dominant frame in social and behavioral sciences such that, when applied in Africa, the cultures are either believed to be irrelevant or relevant but simplistic. Thus, unfortunately, theorizing about Africa centers on aggregates of individuals or cultures that are believed to be simple and unchanging and mostly unconnected to the present. The degree to which personal experiences in childhood and adulthood are reinforced by professional training often fortifies or weakens the strength of one's professional allegiance to notions of individuality or groupings.

Theories of group behavior tend to be related and rooted in anthropology; however, the application of these theories in Africa could be termed *anthropologism*, by which I

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mean theorizing that misrepresents African cultural norms and values as simple and unchanging. Theories of individual behavior, on the other hand, tend to be related and rooted in psychology. The acultural application of these theories in Africa often results in what could be termed *psychologism*, by which I mean theorizing, as may be employed in public health, which tends to focus only on individuals and their attitude or actions. Typically these individual-based theories undermine the cultural and political contexts that shape behaviors (Airhihenbuwa, 1995). A focus on individual intention, for example, often results in analysis of truth seeking in judgment or questioning of honesty in decisions, rather than an intellectually honest examination of the contexts of behavior and the relevance of choices that are made based on the politics of identity (Airhihenbuwa, 2006). In his book *Necessary Illusion*, Norm Chomsky (1989) warned against the overreliance on individual intentions in framing behavioral arguments. He declared that

> what is at issue is not the honesty of the opinions expressed or the integrity of those who seek the facts but rather the choice of topics and highlighting of issues…and the general framework imposed for the presentation of a certain view of the world. (pp. 11-12)

When individual intention is not the focus, attempts to shift to group values advanced in anthropological theories often result in representations of Africans as culturally simple and unchanging. Scholars like Zeleza (2003) and Mudimbe (1988) have critiqued the fascination that anthropologism (also engaged by many scholars in social and behavioral sciences) has with Africans by representing Africans as people whose agency is best expressed in the voices of non-African scholars. This is what has been described by Trinh Minh-ha (1991) as the anthropologization of meanings in what she refers to as "a conversation between us and us about them, whereby 'us' is the Western scholars and 'them' are the Africans who must remain silent" (quoted in Airhihenbuwa, 1995, p. xiii).

Anthropologization, a process that many scholars in public health and health education continue to practice, thus becomes an ideological discourse in which Africans are considered voiceless in the production of their own knowledge. Psychologization, on the other hand, defines African agency mostly on individualized terms at almost the exclusion of their cultural contexts. Thus, psychologism has ignored culture and promoted individuals, whereas anthropologism has embraced African culture as simple and unchanging, as understood mostly from the theorizing imposed by non-Africans. In the end, the theories that are produced from these non-Africans represent more of an imagination of Africans than their true agency as knowing subjects. It is for this reason that contestations over these theories remain, and a reconstructed strategy is needed, particularly in this era of eliminating health disparities, if we are to have a chance of addressing the needs of people in any real and meaningful way.

RECONSTRUCTING THEORIES BASED ON AFRICAN WAYS OF KNOWING

One of the defining characteristics of African scholarship in public health is that there is no firm distinction between theorization and intervention. We regard all theorization as political intervention and all intervention as theoretically motivated. This perspective aligns particularly well with theorizing engaged by African feminists like Oyewumi and Nzegwu. In as much as we need strategies for deconstruction, we need strategies for reconstituting and rearranging the relevant components.

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Figure 1. Taking a bath.
SOURCE: Photo by A. Olusegun Fayemi (fayemi.com). Used with permission of photographer.

A critical point I want to put forth in this regard is the need to be certain about the motivation for one's interest in studying and intervening in Africa. How we are introduced to a population and what we think about such a population and its collective and individual identities greatly influences our approach to studying such a population. Those whose images of Africa have been framed mostly through lenses that represent the region as one that is burdened with disease and despair typically choose to study disease and despair and little or nothing else. For many scholars studying or interested in studying Africa, Africa for them is worthy of attention only when the focus is on crisis, human misery, or death. According to Macamo (2005), "there is a saying according to which no one is listening until you make a mistake…Bad news in Africa, is good news, elsewhere. Good news, in Africa, is no news, elsewhere" (p. 5). Thus, is it surprising that those studying the experience of Africans or African Americans approach their research from the deficit and need models within which scholars have and continue to be trained, models that almost universally equate the identities of Africans with images of diseases, despair, and dependence? Rarely are Westerners exposed to images of African children as seen in Figures 1 and 2.

Thanks to the African cultural production and transformative work of Dr. A. Olusegun Fayemi (www.fayemi.com), we are welcomed to images of Africans (Figures 1 and 2) that are neither a romanticized nor diseased representation of children but simply images of children living the daily experience of being an African. In Figure 2, it is not the physical infrastructure but the social cultural infrastructure that propel this child to a new level where his possibilities are endless. It is within such personhood that family experience is centralized.

A related issue that renders even more problematic this issue of misrepresentation of African identity is the question of the researcher's identity whose experience invariably serves as the referent against which the research is framed. In this case, I centralize the identity of the researcher as a necessary point for his or her departure in interpreting the representation of Africans as disease-ridden and crisis-plagued rather than the humanity that populates the region. It is for this reason that I pose the question: Can you define who you are without referencing what you do? Most researchers are very comfortable

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Figure 2. Doing the high jump.
SOURCE: Photo by A. Olusegun Fayemi (fayemi.com). Used with permission of photographer.

in encapsulating their identity in their profession. It is as though they had no identity until they became a professor or a director of some organization. Some researchers go into communities to pose questions of the people who inhabit the community and expect answers based on who the community members are rather than what they do. Unfortunately, many of these researchers are incapable of defining who they are outside of their professional identity, even though this is exactly what they expect of their study participants. Indeed, I would argue that researchers hardly ask themselves whether they are separate from what they do. It seems to me that one ought to be able to define one's identity beyond one's professional capacity before engaging anyone in a community to do the same. It is for this reason that we must identify through whose gates we enter theorizing and intervening in Africa.

To advance a model or framework based on African ways of knowing is to locate human experience within African cultural logic. Such a location does not suggest an oppositional frame to Western cultural logic, but one that establishes a gate through which knowledge production, acquisition, and distribution in Africa is legitimated and affirmed. What scholars in the humanities have exposed for years is slowly gaining attention in social science and public health. That is the need to debunk Westernized theorizing about African health issues. In the tradition of Frantz Fanon (1958, 1968),

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Cheikh Anta Diop (1991), and W. E. B. Du Bois (1969), Africans in social science and public health are demanding that African gates be used as the only entrance to the production of knowledge for Africa.

In the United States, tens of millions of dollars have been expended on projects for researchers to eliminate racial and ethnic health disparities. Yet the question of disparity and how to understand it dates back well over 100 years. In *The Philadelphia Negro*, a study originally published in 1899 (reprinted in 1996), W. E. B. Du Bois concluded that "in considering the health statistics of the Negroes, we seek first to know their absolute condition rather than their relative status" (p. 148 of 1996 edition). In other words, it is not enough to simply compare Blacks to Whites but to understand the totality of the conditions that creates vulnerability that, in turn, leads to disproportionately high rates of disease and death among Blacks (see the August 2006 issue of *Health Education & Behavior*). Implied in this analysis is also the social-cultural infrastructure that nurtures a state of resilience among many African Americans such that they are able to cope and thrive in social and political contexts where the assault on their identity remains chronic and systemic.

PUBLIC HEALTH AND A FOCUS ON SOCIAL-CULTURAL INFRASTRUCTURES IN AFRICA

The most critical issue I want to address is that of the relationship of research to intervention in communities in general and African in particular. This is where a choice is made on privileging a particular "gate" through which one must enter the theorizing and representation of Africans. As noted in the opening epigraph, Achebe (1988) cautioned that no one should enter his or her house through someone else's gate. Similarly, no one should enter his or her profession through someone else's profession. The most relevant point in this case is to establish a rule that says no one should enter research on African health and identity through someone else's identity. Much of the theorizing about Africa has been done through theorizing that has been framed in non-African cultural, geopolitical, and historical spaces. Indeed, the language of universality that assumes that theoretical truths, deployed through the prism of psychologism and anthropologism, are universal truths. This has led to the design and implementation of interventions designed to offer solutions at the exclusion of identity in whose contexts problems and solutions are better understood.

The PEN-3 cultural model (see Figure 3) offers an opportunity to promote the notion of multiple truths by examining cultures and behavior and by beginning with and identifying the positives—allowing us to examine and acknowledge the existential, which represents values that makes a culture unique—before identifying the negative. In this way, intervention and theorizing is as much about promoting positive values as it is changing negative ones. As I have always insisted in the application of the PEN-3 model, the positive value and behaviors are the first components that must be discussed and engaged before negative values. A researcher or an interventionist who is not capable of identifying positive value should be considered incapable of having a meaningful impact in the community. Such a researcher or interventionist has no business being in the community. (For an illustration of PEN-3, see Figure 3, which has appeared elsewhere, including Airhihenbuwa, 1995, 1999; Airhihenbuwa & Webster, 2004. For a more recent and detailed description of its origin, modifications, and application, see Airhihenbuwa, 2006.)

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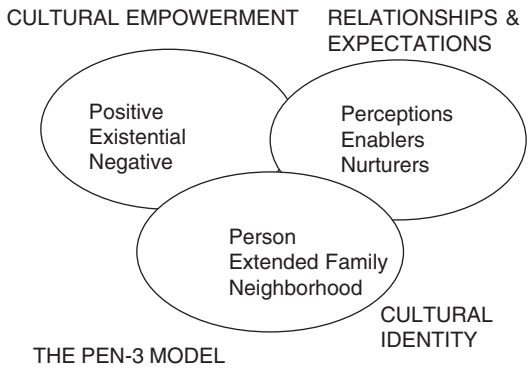

Figure 3. The PEN-3 model.

In my own, current research on HIV- and AIDS-related stigma in South Africa, the strategy has been to use the PEN-3 model to examine the contexts in which stigma occurs and why. We approach the study from the perspective of researching stigma without using the word *stigma* during our data collection. We use the word *stigma* only if it is initiated by a participant. Social and behavioral science research on the study of stigma tends to fall into the individual-based behavioral assessment of shame associated with a disease as influenced by the work of Erving Goffman (1963). Others have recommended an expansion of Goffman's work by focusing on the location of power as theorized by the French philosopher Michel Foucault (see Parker & Aggleton, 2003). I have argued that the issue of stigma could not be addressed completely in Africa without an examination of the question of identity (Airhihenbuwa, 2005). Indeed, the question of identity and how the issues of belonging have framed approaches to African research is central to the issues and questions I examine in *Healing Our Differences: The Crisis of Global Health and the Politics of Identity* (2006). To theorize stigma in Africa is to invite the seminal works of African scholars like Cheikh Anta Diop (1991), Frantz Fanon (1958, 1968), Chinua Achebe (1988, 2000), Paul Zeleza (2003), Thandika Mkandawire (2005), Oyeronke Oyewumi (1997, 2003), Nkiru Nzegwu (2003), Obioma Nnaemeka (2005), Ngugi Wa Thiong'O (1986), Ali Mazrui (1986), Sinfree Makoni (2003), and many others. All these scholars represent social science and humanity disciplines even though they focus on the same theme—situating the process of theorizing about Africa within cultural contexts. These scholars help to recontextualize theorizing about African cultural spaces from the conventional assumptions that narrowly focus on the person at the center of several layered forces around her or him as though throwing a dart at him or her at the center will create a dominos effect that will cause the circumventing forces to fall apart. To the contrary, I would argue that it is the forces around the person at the center that must be the focus of research and intervention if we are to understand the context within which the agency of the person at the center of our efforts should be liberated, as seen in Figure 4.

In rethinking the cultural meanings of stigma, we first had to acknowledge that stigma is a word that does not exist in any of the South African's African languages. We also wanted to examine whether or not the commonly cited measures of stigma hold similar meanings in South Africa. For example, the sharing of utensils for eating is commonly

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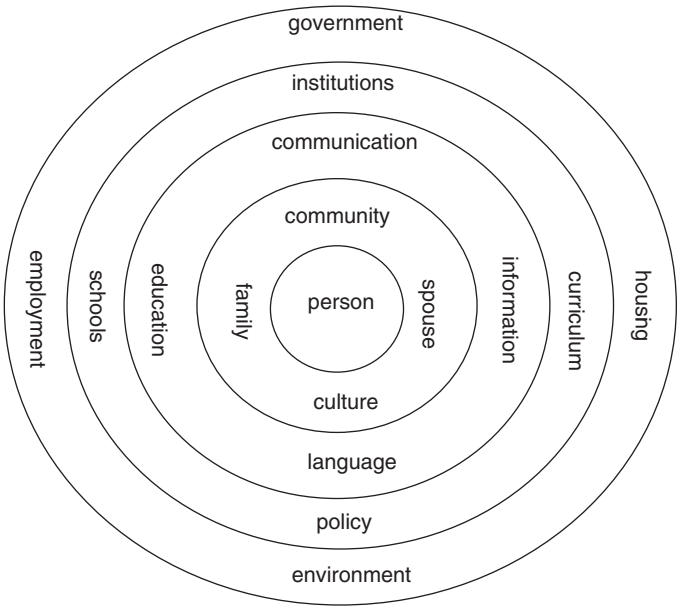

Figure 4. A concentric circle illustrates the need to focus on the context rather than focusing on the person at the center.

cited as a good measure for understanding stigma. However, in cultures where it is the contexts of eating that is more important than the implements for eating, we are finding that food has multiple meanings that include valorizing a measure of institutional trustworthiness of health institutions and family members. We have found that food does play an important role in how acceptance and rejection is perceived by South Africans. These perceptions go beyond measures of sharing utensils and cups, as found on previous study by Herek, Capitanio, and Widaman (2002). The roles of food seem to encapsulate issues of trustworthiness and a feeling of being accepted by an institution based on whether food is offered to patients while they await treatment. For example, in a focus group interview, one participant noted a particular clinic "is a good clinic,…they give you food to eat while you wait." Such a value on food is highly consistent with values placed on food as a measure of hospitality when hosted by a family in many African cultures.

A second issue that has emerged that we are exploring further is the intersection of positive cultural practice with laws and practices about privacy in HIV disclosure. A question that has emerged is what happens when an elder in the family calls a meeting of family members to discuss a major health problem facing a family member. Such a practice has always been considered positive and reflects an elder assuming his or her leadership and responsibility in the family. However, on the question of disclosing one's HIV status, such a responsibility is in direct conflict with the right of the person to privacy about their own HIV status. Thus, when disclosure occurs within a caring tradition, HIV disclosure may represents a potential for violating the law even though the value was positive. Our challenge is to be sure we protect and promote human rights but not by compromising positive cultural values, especially those that have endeared these cultures for generations.

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CONCLUSION

Using the observation by Karl Marx that religion is the opium of the people, I observed once that if indeed religion is the opium of the people, then perhaps theory is the opiate of many researchers, given that theory is the only "doctrine" on which the identity of many researchers is firmly placed. Addiction researchers have taught us that drug addicts believe that the problem and solution is contained in the same drug—hence the inability to separate the benefit, albeit momentarily, that they derive from the drug from the damage it does to their minds and body. I believe that the analogy of a theoretician behaving as a drug addict is evident in how problems are defined and solutions sought in the social and behavioral sciences. Researchers tend to define problems and solutions as sharing common gateways to all cultures leading to the conclusion that what works in the United States or Europe should work in Africa or, for that matter, anywhere. The critical roles of social cultural contexts that nurture such behaviors are typically ignored. I have argued in previous publications that how we frame a question is not how we necessarily should frame the solutions.

Overall, one could surmise that the primary question in engaging in meaningful research that affirms African agency in their own health and well-being is the ability to locate an African "gate." Locating such a gate should result in conclusions that answer three basic questions. The first is: Will research be anchored in culture? This question allows us to examine the ways in which African ways of knowing are central to solutions framed for Africans. The PEN-3 model provides guidance on how to answer this question. The second is: Will research results have policy implications? Quite often research conducted among Africans ends up in pages of reports and publications that have no direct link to policies in the countries in which the studies were conducted. SOPHE's leadership in advocacy for the health education profession demonstrates organizational commitment to use health education research to inform health policy. And the third and final question is: Will the research method produce results and meanings that will be African? This is perhaps the most critical question. The concept, methodology, and language of the research will determine the question of meanings and relevance for Africans. Thus, to enter an African health issue, we must learn about and use African theoretical gates.

Finally, researchers whose work does not focus on Africa may wonder about the relevance for them of the ideas and propositions set forth in this article. It is for this reason that I maintain that lessons from Africa offer a gateway to better understand every local context to promote global understanding. I challenge each of us working to improving the health conditions and systems of persons or groups to substitute the wording "Africa" to the area in which you find yourself working (i.e., southern U.S., inner city, Tex-Mex border) and the word "Africans" with your specific population (i.e., African Americans, Latinos, poor, elderly). What is required is to develop a theory of society that emphasizes our interconnectedness at the personal and group levels. I am confident that you too will agree that the African gate presented in this article offers a path to locating your own gate of entry.

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