AIDS & Anthropology Bulletin

The Newsletter of the AIDS and Anthropology Research Group

November 2005 Volume 17, Issue 3

Letter from the Chair – Doug Goldsmith

This letter marks both transition and continuity in the Officers and Editors of AARG. Moher Downing, Chair Elect, will become Chair at the Washington AAA meeting on December 2nd from 12:15 to 1:30 in the Ethan Alan room. Karen Kroeger will continue as our able Secretary/Treasurer. Anna Marie Nicolaysen is passing the Bulletin Editor torch to an enthusiastic group of Co-Editors – Catherine Mitchell Fuentes, Luci Latina Fernandes, Dugeidy Ortiz, and Lisa Rose-Rodriguez. We owe many thanks to Anna Marie for helping assemble the new co-editors, and in this, her last issue, conveying to them her wisdom in obtaining so many solid submissions, and her special expertise in layout and design. We also thank Anna Marie's gracious colleagues Janie Simmons, the former Editor, and also Michael Duke, Carolyn Fisher, Kim Koester, Susan Shaw, Erica Hastings, John Humphries, Rosemary Diaz and Rebecca Floor, who, in various ways helped out, or provided submissions to, the AARG Bulletin as part of the "Newsletter Collective" at the Hispanic Health Center, over the past four years. These are the years that Merrill Singer has served us ably as Chair Elect, Chair, and Past Chair, and we owe many thanks to him, as well. I hope that you are one of the many who received this Bulletin via email. If not please convey you current email address, and your desire to receive the Bulletin electronically to Membership officers Susan Pietzyk and Monica Stanton Kokobaz, or to our Dir.e-comm. Ray Bucko (all of whom I take this occasion to thank for their work on behalf of AARG)

In this last letter my thoughts turn to our important relationships as anthropologists in AIDS studies, as spokespersons on AIDS issues, and, often, as advocates for AIDS causes. I want to emphasize that we cannot accomplish the work that needs to be done, in documenting the struggles with this pandemic, epic and mundane, and in evaluating the responses and remedies--outreach and protest, medicine and prevention. I think our membership, and therefore this letter's readership, are primarily anthropologists involved in this work. Many are medical anthropologists – as indeed we are a subgroup of that 'Society'. I think will find the following quote to be apt., Oliver Sacks, in a footnote (on p. 216) of his "The Island of the Colorblind", muses that "An anthropologist sees cultures, one wants to say, as a physician sees patients. The penetration, the sharing, of different circumstances and cultures needs skills beyond those of the historian or the scientist; it needs artistic and poetic powers of a special kind." I do not believe Oliver Sacks is praising the routine way physicians see patients, and therefore equally not praising the way anthropologists see culture. Indeed, seeing the 'whole box' with its 'working parts' necessitates a level of abstraction that makes for a gruff bedside manner, or a preoccupied ceremonial-side stance. The special kind artistic, poetic powers needed to truly see what is most important, and perhaps to most perceptively recommend potential solutions, or most profoundly give potent solace, comes from our closest collaboration with our colleagues – people living with AIDS, peer educators, outreach workers, caregivers--with those embedded in the search for a cure, and telling the story.

In this Issue:

Letter from the Editors

In this our inaugural issue, we wish to extend a warm hello to all the members of the research group and readers of the bulletin. In this issue we have three articles. Barret P. Brenton's article, *HIV/AIDS, Food Insecurity, and Genetically Modified Emergency Relief Food in Zambia* highlights the controversy with GMO foods in developing countries and their impact on international aid and food programs. In *AIDS Accommodation Syndrome: Understanding the Trauma of Acceptance,* Miller, et al., discusses the coping mechanisms by which individuals newly diagnosed with HIV/AIDS may use to manage the disease. Our last article, *Branding Young People as "Vulnerable"* by Thabo Sephuma reiterates the importance of including young people in the formulation and implementation of HIV/AIDS related interventions, policies and programs. Additionally, we have included information on current events concerning HIV/AIDS issues and links to further information.

This issue is the first issue with the following new editors: Luci Latina Fernandes, Catherine Mitchell Fuentes, Lisa Rose-Rodriguez, and Dugeidy Ortiz. We would like to introduce ourselves. Luci Latina Fernandes received her Ph.D. from the University of Connecticut in 2004. She conducts research in Latin America in both Ecuador and Cuba. Her latest inquiries examine medicine and environment, human rights, and social justice in Havana. To contact her, please email Luci.Fernandes@Uconn.edu. Catherine Mitchell Fuentes is a medical anthropologist with her Ph.D. from the University of Connecticut. Her most recent research examined the relationship between women's life-time experiences of interpersonal violence and associated STI/HIV risk factors. She can be reached at cat-mitchell@earthlink.net or (860) 423-2299. Lisa Rose-Rodriguez is a certified HIV Counselor and Tester. Her MPH research focuses on the intersection of healthcare outcomes based on socio-economic disparities. She currently serves on the board of the University of CT radio station WHUS Storrs, as the Minority Affairs Director. E-mail: lroserod@rocketmail.com or minorityaffairsdirector@whus.org. Dugeidy Ortiz is a doctoral student in medical anthropology at the University of Connecticut. Her dissertation research looks at cultural constructions of sexuality among second generation Dominican women in NYC. Please feel free to contact her at dugeidy.ortiz@Uconn.edu.

Finally, due to increased costs of printing and mailing AARG newsletters, we would like to encourage members to receive electronic copies in lieu of hard-copies. You can do so by notifying the membership coordinator (Susan Pietrzyk) at spietrzl@binghamton.edu

In the News

On September 25th, in Portland, Oregon thousands of people participated in the 19th annual AIDSWalk 05 sponsored by NIKE. With AIDS reportedly on the rise in Oregon and Southwest Washington states, the public gathered to show their solidarity in the fight by taking part in the 5K fundraiser. The goal is to raise $300,000 to support HIV prevention, service, and advocacy programs. With nearly 8,600 men, women, and children living with HIV or AIDS, and some 3,068 Oregonians who have lost their lives to the disease, the citizens are dedicated to raising money that provides quality care for their family and community members. For further information, please visit www.cascadeaids.org, or call 223-9255 (WALK) to receive brochures and donation materials.

The U.S. Department of Defense has co-sponsored a four-day Military HIV/AIDS Prevention Workshop with the Russian Federation's Ministry of Defense in Moscow on September 12-15, 2005. The goal of the workshop is to foster an international partnership that will help to reduce the rate of infection by improving military HIV/AIDS prevention programs, using "scientifically based yet culturally appropriate prevention activities." The U.S. Department of Defense HIV/AIDS Prevention Program has been working for the past five years in 56 countries around the world to combat the spread of the HIV/AIDS pandemic. This workshop is significant because the infection rate in Eurasia has been reported as one of the fastest growing regions in the world. Participants included expert speakers from the United Nations, the Russian Ministry of Health, the U.S. Agency for International Development, the U.S. Centers for Disease Control and Prevention, as well as speakers from the U.S. and Russian militaries. For more information on how the U.S. Department of Defense is fighting the global HIV/AIDS epidemic, see the article "Combating AIDS" in the State Department's November 2004 eJournal Improving Lives: Military Humanitarian and Assistance Programs.

Link: http://usinfo.state.gov/eur/Archive/2005/Sep/09-454838.html?chanlid=eur

AARG Announcements

*Living with Aids. Illness, Death and Social Relationships in Africa. An

Ethnography*
Hansjoerg Dilger
Frankfurt / New York: Campus, 2005
368pp.
ISBN: 3593377160

More than two million people died of Aids in Africa in 2003. How do communities and individuals live with the consequences of the epidemic?

How do they integrate the massive experiences of suffering and death into their everyday life?

Drawing on longtime fieldwork in Tanzania Hansjoerg Dilger describes how social and cultural relationships are being re-negotiated in the context of rural-urban migration and the HIV/Aids epidemic. He shows that the ongoing confrontation with illness and death leads to severe ruptures in kinship relations, and frequently also to the stigmatization and exclusion of people with HIV/Aids. At the same time, however, individuals, families and communities undertake substantial efforts to arrive at a reordering of social and cultural relationships in the context of crisis: This permits them to counter some of the disintegrating effects that HIV/Aids has on the social fabric, and to re-establish control over the inseparable unity of life and death

AARG Announcements cont.

Human Sexuality Studies Interest Group Organizational Meeting

104 Annual Meeting of the American Anthropological Association.
Washington DC

Anthropology and Sexuality Studies Interest Group Organizational Meeting
AAA Meetings

Date: Friday Dec. 2
Time: 12:15-1:30
Location: Delaware A

If you research, teach or are engaged in the field of sexuality, sexual health, sexual education and rights, or their community applications vis-à-vis health disparities, you are cordially invited to attend the second organizational meeting of the Anthropology and Sexuality Studies Interest Group. We hope to build upon membership interest, work on organizational issues such as establishing a standing steering committee, setting objectives and goals, and discuss general directions for the interest group. In particular, the planning of a special workshop on sexuality research training in 2006 is underway. If you know of anthropologists involved in the field of human sexuality studies, research, and applied anthropology, please email the names and email addresses to:

- Gilbert Herdt (via Mona, at hmsxdept@sfsu.edu)
- or Anne Bolin at bolina@elon.edu.

Thank you for your interest.

Funding Opportunities

Title of program: The Collaborative HIV-Prevention Research in Minority Communities Program

Offered by: The UCSF Center for AIDS Prevention Studies
Sponsoring agency: National Institute of Child Health and Human Development (NICHD) and National Institute of Mental Health (NIMH)

Who should apply: Scientists/Researchers in tenure track positions and investigators in research institutes who have not yet obtained RO1 funding from the NIH or an equivalent agency.

Description of Project: The Collaborative HIV Prevention Research in Minority Communities Program is designed to assist Scientists/Researchers to improve their programs of research and obtain additional funding for their work.

Purpose of project: To increase the numbers of ethnic minority group members among principal investigators at NIH, CDC, and other equivalent agencies. Investigators from the UCSF Center for AIDS Prevention Studies collaborate with scientists to develop an ethnic minority-focused HIV prevention research project.

Program Overview: Participants will: (a) receive mentoring and $25,000 to conduct their preliminary research; (b) spend six weeks in San Francisco for three consecutive summers; (c) receive a monthly stipend for living expenses and roundtrip airfare to San Francisco each summer.

Application deadline: January 13, 2006

Contact: M. Margaret Dolcini, Ph.D.
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Website (info and application):
<http://www.caps.ucsf.edu/capsweb/projects/minorityindex.html>

HIV/AIDS, Food Insecurity, and Genetically Modified Emergency Relief Food in Zambia.

Barrett P. Brenton
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Presented at the Society for Applied Anthropology Annual Meetings. Santa Fe, NM. April, 2005

Summary:

Ongoing droughts and need for emergency food assistance in southern Africa are unlike similar crises that have emerged in the past. The impact of the HIV/AIDS pandemic has exacerbated the problem to catastrophic proportions, creating what some have referred to as a new variant of famine. In Zambia for example it is estimated that at least one in four to five adults are HIV positive. In addition Zambia's life expectancy has dropped from a high of 52 years of age in 1980 to an estimated 37 years in 2005. A missing generation of productive parents is emerging as they die from HIV/AIDS, leaving orphans, grandparents and vulnerable children burdened with the responsibility of food crop production. Their deaths along with others debilitated by the progression of various disease-states has led to declines in the area of land planted, crop yields, agricultural knowledge, and household labor. All told, over 30% of Zambian children are malnourished. In addition, worsening regional economies and political uncertainty have exacerbated an already deteriorating food security situation. This stark reality sets the backdrop for issues facing many of the peoples of Sub-Saharan Africa, and begins to reveal both the need and challenge of seeking common ground solutions through a commitment justice and sustainability.

Increasingly, HIV/AIDS food security issues have been complicated by the resistance of some countries to genetically modified organisms (GMOs) or genetically modified (GM) foods. A case in point is the refusal of GM maize as an emergency relief food for countries like Zambia, who do not want it to contaminate local food production and taint export markets that demand genetically modified free foods. They also have concerns related to food safety, the environment, and sustainability. These paramount trepidations are not taken lightly by many Zambians who struggled with the decision to resist GM maize and soy imports from the U.S. during a severe food shortage in 2002-2003. The consequence of their actions however must be placed in contradistinction to the U.S government's condemnation of countries limiting their acceptance of genetically modified relief food when people are near, or at least claimed to be near starvation. This view has evolved over time into the declaration that it is a moral imperative to use biotechnology to feed the world, a view actively promoted by pro-GM multinational corporations.

There are strong anti-GMO positions around the globe. However, many people in the developing world are ambivalent, cautious, or unknowledgeable about the issue. Unfortunately any GMO concerns are often dismissed as being unscientific, based on the limited knowledge (understanding) of decision makers, and/or under the influence of developed nations (the European Union in particular) or environmental activist groups (Friends of the Earth, Greenpeace, etc.) who have an anti-GMO agenda. The strong and often terse paternalistic tone used toward or against the developing world that resist GMOs rings of an unsettling neo-colonial enterprise for many in the formerly colonized nations of Africa and Asia.

The United States' "take it or leave it" stance and outright promotion of the biotechnology industry through GM food aid, which some could argue has now become repackaged as a moral imperative, was made especially

AIDS and Anthropology Research Group Business Meeting

Sponsored by:
Society for Medical Anthropology

Date scheduled: 12/2/2005

Time: 12:15:00 p.m. - 01:30:00 p.m.

Room: Ethan Allen Room

The paper prizes will be awarded.

clear when the U.S. Agency for International Development (USAID) would not budge on a compromise to send non-GM food aid or to mill it before shipping. If maize is milled before distribution it cannot be planted, as would be the case with whole kernel maize, and therefore could not have its altered genome spread into local crops. This milling solution had only limited success during the 2002-2003 crisis since USAID refused to send milled maize, stating that the process was too costly and would lead to too great of loss during transport. It was only used as a final resort for Zimbabwe, who accepted GM food aid after the cost and act of processing were provided by the South African milling industry. Zambia continued to reject any form of GM food aid.

Overall, the primary question of whether or not the problem of GM food aid could have been foreseen during the 2002-2003 crisis is still unanswered. However, it did force various aid agencies to make clear policy statements on its use and highlighted the need to integrate the role of HIV/AIDS on food security issues in an area of the world where as many and one in three adults are HIV positive. In short, most organizations have taken the position of following what ever mandates and policies the host governments have regarding GMOs in their country. They admit however that their relief efforts would be easier if GM food aid was not an issue. But this has to be put in to the context of a U.S. perspective on GMOs since it provides the majority of direct food aid worldwide and has taken its own "take it or leave it" stance on the issue.

Regardless of the combination of factors contributing to food insecurity it appears that resistance to GMO food aid has not significantly contributed to the HIV/AIDS problem. There is however a real need for continued integrated programs that address the nutritional demands of fighting HIV/AIDS along with sustainable food security options that articulate with and are sensitive to the disease progression. Regardless of their GM emergency food aid position, USAID funded programs operating in Zambia, such as SUCCESS (Scaling Up Community Care for Social Safety Nets) and RAPIDS (Reaching HIV/AIDS Affected People with Integrated Development and Support), are showing some success by including food supplementation for patients receiving Anti-Retro-Viral Treatment (ARV/ART) or who are screened as symptomatic HIV+, People Living with HIV/AIDS (PLWHA), and Orphans and Vulnerable Children (OVC). It should be noted that sources of non-GM food aid have been found for these programs. Other efforts must be expanded to the family and community level, as in the case of the integrated Bwafwano ("helping one another") Community Organisation currently operating outside of Zambia's capital, Lusaka.

Again, regardless of the combination of factors contributing to food insecurity (poverty, drought, HIV/AIDS, etc) it appears that Zambian resistance to GM food aid has not significantly contributed to those problems. Rather than condemn countries for limiting their acceptance of genetically modified relief food I argue that the crisis must be approached with an integrated perspective that deals simultaneously with HIV/AIDS, malnutrition, food insecurity, and concerns over GM food safety. To do so we must strive to confront and challenge the assumption that there is a moral imperative to use biotechnology in order to meet the world's food needs. "There is certainly a moral imperative to feed our hungry world, but there is no moral imperative to do so with biotechnology." Inequitable food distribution not inadequate food production is the problem; GMOs do not address this issue. The current crisis in Zambia must be met with respect for national decision making while seeking social justice by addressing the underlying structural reasons for poverty, hunger, and disease around the world.

AIDS Accommodation Syndrome: Understanding the Trauma of Acceptance

Thomas W. Miller, Ph.D.
Timothy Maggio, M.S., CRC
Lisa Rose-Rodriguez, D.P.H. Candidate
Chelsea A. York, M.A. Candidate

Center for Health & HIV Intervention and Prevention
University of Connecticut

Abstract
The psychological impact of HIV-induced disorders is believed to form a trauma-based pattern. Stressful life events affect the immune system and this has become the object of recent research (Miller & Miller, 1996). Persons with AIDS experience trauma in the discovery of this condition, and an AIDS Accommodation Syndrome involves a sequential processing of information on the part of the patient.

Introduction

Learning one is diagnosed with AIDS is a significant life stress event both to the patient and significant others and has been recognized as a significant factor in the care and treatment of this patient population. It has been more than a quarter of a century since the HIV virus was first identified. The psychological impacts of HIV-induced disorders are believed to form a trauma-based pattern (Miller, 2004). Miller & Belak (1993) first addressed how a person with a diagnosis of Acquired Immune Deficiency Syndrome processed this information according to trauma accommodation theory. Using diagnostic criteria for traumatic stress disorder, the authors applied this to the processing of understanding the person who is HIV positive (see Figure 1 below).

AIDS Accommodation Syndrome

Stressful life events affect the immune system and this has become the object of recent research (Miller & Miller, 1996). Changes in cell-mediated immune function have been realized in individuals undergoing stressful life experiences. The major psychological stressor for a person with AIDS is the knowledge and awareness that he/she has contracted a disease entity, which can be terminal and holds a strong potential for a rapidly declining course in life. Three major assumptions about the self and the world are disputed by trauma. These include the belief in personal invulnerability, the view of oneself in a positive light, and the belief in a meaningful and orderly world. The patient with HIV disease will meet the challenge of each of these assumptions in accommodating this disease entity into his/her psyche.

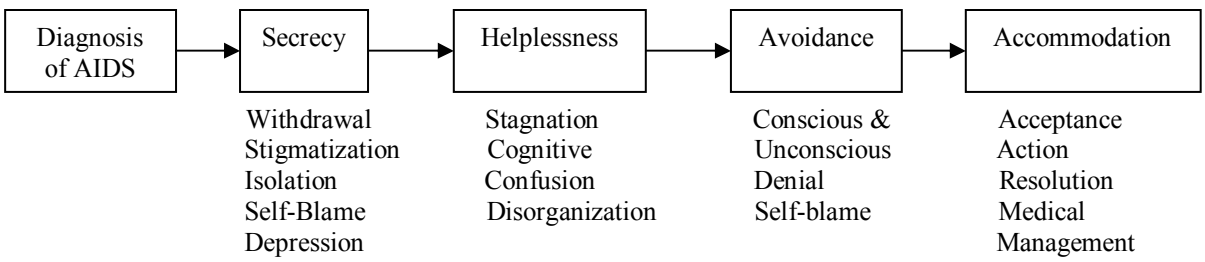
Secrecy

Secrecy involves stigmatization, isolation, and self-blame. Secrecy often occurs in HIV-positive patients. It is prompted by both the subjective sense that they are contaminated and the fear that others want to avoid contact. The secrecy is prompted by objective causes such as peers fearing infection, and feeling uncomfortable and psychologically threatened in the presence of an HIV-positive person. Patients who suspect they are HIV-positive may become preoccupied with their physical status. This hypersensitivity to changes or perceived changes in their physical condition suggests the patient has moved into an anxious and hyper-vigilant state. It allows patients to deal with the physical rather than psychological concerns, and they need reassurance that the medical staff is able to respond to their needs.

Helplessness

Helplessness involves the realization that infection with this virus frequently causes a debilitating condition that is terminal. It has been suggested that the basic cause of all the deficits observed in helpless people after

Figure 1: AIDS Accommodation Syndrome



uncontrollable events occur is the expectation of future non-contingency between responding and outcomes. The HIV-positive patient often experiences helplessness and becomes depressed. The etiology of the depression can be difficult to delineate. The possibility of suicidal attempts on the part of the patient may appear at this stage. The helplessness experience results in depressive features and may show itself clinically through a limited motivational response as well as the usual signs of clinical depression.

Avoidance

This is the stage of conscious or unconscious denial that provides relief to the patient for both the trauma and confusion experienced in the disease's detection. Denial involves psychological repression as a means of coping with the progression of the disease, with its periods of apparent health followed by ever more frequent and severe episodes of illness. This is, however, brought into consciousness by the reality of repeated illnesses. In some cases, the avoidance is so pervasive that minimal progress can be made in providing for the therapeutic need of the patient.

Accommodation

This is realized through acceptance and seeking of medical care, which often includes both the clinical benefits achieved in drug recipients, as well as the significant drug toxicity that becomes an accepted part of the treatment process. This may be considered as the final stage of dealing with a terminal illness. Evidence that this has occurred would include disengagement from family and friends, writing a will, and organizing legal and financial affairs. Medical complications may be of such a nature in the final stage that the patient may experience guilt and remorse. Guilt often distinguishes those with HIV infection from those with other terminal diseases.

Application of the AIDS Accommodation Syndrome

Researchers note that the predominate emotional reactions to receiving a diagnosis of HIV range from denial to depression, fear, guilt, shame, and or social isolation (Coleman 2003). When a person first hears he/she is "positive" their reactions can be any of these, or all. However, these are usually the most common reactions. Problems with sleep, focus, and attention span are also common. Heckman (2002) studied HIV infected patients for over two years and found that they demonstrated difficulty in coping with stress; which in turn impacted negatively on their quality of life. A further outcome of receiving an HIV diagnosis is feelings of hopelessness as investigated by Johnson (2003) at Columbia University. He was building upon a study by Abrahamson (1989), which looked at hopelessness as a factor in depression. What was found was that increases in hopelessness manifested in increases in depression. This makes sense because when a person feels hopeless and helpless they feel they are not in control of their life course.

Heckman (2002) researched the psychological symptoms in people aged 50 and above infected with HIV. He found that approximately 10% of all US AIDS patients are 50 years of age or older, and that their mental health needs are grossly overlooked. This could possibly be due to age discrimination. When he tested participants, 25% reported depression. If mental health needs are in fact grossly overlooked, then how many mental health needs of people 50 and older go unmet? What is the true frequency of depression existing in the population as a whole?

Discussion

Understanding the well-established framework of disease acceptance, researchers and academicians will remember denial. Patients who receive a terminal illness diagnosis upon hearing the doctor or other professional deliver the bad news, can be heard uttering, "No not me," "That test is wrong" "You are wrong." etc. These behaviors are rampant with in pop culture media productions of living with a terminal or chronic illness. One need not be a psychologist, clinical social worker, medical doctor or other health processional to be aware of these behaviors. Not unlike other terminal illnesses, the diagnosis of AIDS impacts the social support system to which the AIDS patient is aligned. It is this social support system that also experiences the trauma of awareness, recognition, and acceptance. All too similar to other terminal illnesses, AIDS appears to generate a unique series of stages, which allows accommodation, and acceptance of this disease entity. This AIDS Accommodation Syndrome provides a series of stages that may be helpful to health care providers working with patients with HIV and AIDS. To the extent that the process of accommodation of this disease involves clinical, ethical, and legal considerations, health care providers must be sensitive to the complexity of diagnosis and service provision for the patient with AIDS.

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Acknowledgements

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Please feel free to submit any papers, news, announcements or funding opportunities to the Bulletin at AARGsub@gmail.com.

Thanks!

Branding Young People as "Vulnerable"

Thabo Sephuma

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Across the globe, we young people are referred to as being "the future". That may be, but we are also the present, and the present shows that 50% of the 15,000 new infections each day globally are among persons aged 15 to 24 years, 75% of whom are girls. HIV is spreading faster and young people are at the centre of the epidemic. This leads policy makers and program implementers to define young people as a "vulnerable group".

Branding young people as "vulnerable"

Young people are not one single group. We do not appreciate being put into a single box. Strategies that are developed to address youth as a homogenous group are inefficient because they do not take into account differences in gender, culture, norms, values and sexuality. What unites youth are common interests, goals, lifestyles and unique perceptions.

Defining people as "vulnerable" may foster an attitude that this population is too complicated to serve and may perpetuate the situation and circumstances that people find themselves in. People often label groups as vulnerable to cover up their inertia in providing the right services. "They are a vulnerable group, so it is difficult to reach them".

Implementing prevention interventions

Merely targeting one so-called vulnerable group does not take into account the correlation between different groups. Young people may not see themselves as vulnerable. South African National survey shows that 60% of young people who were tested HIV positive had not considered themselves as being vulnerable or having been at risk. This makes it practically irrelevant to address people based on our perception of their vulnerability. Personally, I consider vulnerability to be the inability to make free and healthy choices. But as we try to understand and
reduce vulnerability, we have to make sure that we do

(Continued on page 11)

Branding Young People as "Vulnerable"

(Continued from page 10)
this based on individuals dreams and desires and that we celebrate diversity.

Branding young people as "vulnerable"

As young people, we have been labelled--we have been defined as a vulnerable group. We are being sidelined in decision making and/or participate in policy making, in programs planning in the fight against AIDS. Young people need to be involved in addressing this vulnerability and should be included in formulating policies, decision making, and interventions.

Young people: Key to the development of successful HIV/AIDS policies and interventions.

HIV is one of the greatest challenges facing the world today. And we, young people, remain at the centre of the epidemic in terms of transmission, vulnerability, impact, and potential for change. Our (my) generation has not known a world without AIDS.

As young people need to be recognized as pillars in the fight of the pandemic, we, the young people are the crucial component in the effective response to HIV/AIDS. We ask to be regarded as assets, not as liabilities, our diverse voices need to be heard and our talents cultivated so we can be instruments for change. We therefore need to be part of the development process of our communities, exercise the fundamental human rights and be essential to the development of successful policies and interventions in the fight against HIV. Not just being labelled…

"AIDS in Africa is like the plague in slow motion. Today as the country we are suffering the devastating onslaught of the HIV/AIDS pandemic at a level unprecedented in history. Throughout the country, the AIDS pandemic is reversing gains built up over the years in the economic and health infrastructure of our society. Teachers, police, lawyers etc. have been
lost, families broken apart, villages decimated, life expectancy has plummeted. How does one define vulnerable on this mentioned group? Is it some or most of the young people? Let us enhance human life".

The million-dollar question is whether the new generations along with the present ones will have the means to protect themselves in a world where the balance and involvement of young people in policy making and innervations still tilts heavily against them? The answer will be decided not only in the slums of African continent but the capitals of the world's wealthiest nations and in the halls of great international institutions, to see the great involvement of young people in the development against AIDS.

It is by questioning; expressing young people's views and having their opinions taken seriously that young people develop skills, build competencies, acquire confidence and form aspirations towards the collective fight against this international crisis. The more opportunities a young person has for meaningful participation, the more experienced and competent he or she becomes on matters related to the AIDS/HIV question. Youth participation leads to better decisions and outcomes. One of the most profound difficulties facing young people around the globe today is illiteracy about HIV/AIDS and the inability to become an HIV/AIDS activist due to lack of skill and information on ways to curb the pandemic. This is an issue of widespread concern at the national and international levels.

Our ignorant isolating, stigmatizing, discriminating and labelling people as "vulnerable group" in particular young people, the society will lose a substantial fraction of the people who currently keep the wheels of commerce and the state turning, and from ranks the next generation of leaders will emerge. That means investment and future of the country is lost. Somewhere the epidemic will intrude on all our lives and a selfish attitude will only make matters worse. Young people have a body of experience and knowledge unique to their situation, and they have views and ideas that derive from this experience. They are social actors with skills and capacities to bring about constructive resolutions to their own problems.

AIDS and Anthropology Research Group 2006 Membership Form

AARG continues to work hard to enhance its position as an active site for networking and organizing among scholars like you. This includes developing new and expanded opportunities for you to network with colleagues who share your commitment to the use of anthropology in understanding, preventing, and reducing the harm caused by HIV/AIDS.

As an AARG member, your benefits include:

… access to the AARG listserv, which allows you to send and receive email messages about conferences, job announcements, calls for papers, publications, etc.;
… access to the AARG website, which contains valuable information including course syllabi, important links, upcoming conferences, and publications like the AIDS and Anthropology bibliography;
… the quarterly AARG Bulletin, distributed to national and international scholars, including social scientists and medical professionals;
… AND the AARG Membership Directory, including names, institutional affiliations, addresses and research interests for all AARG members, available in both paper and electronic formats.

Membership is open to all interested persons. Persons do not have to be members of either the American Anthropological Association or the Society for Medical Anthropology to join AARG. Regular membership is $20, and student membership is $5 per year (January 1-Decmber 31). Free membership is available to non-U.S. based researchers.

Remember, even if you are a non-paying member, we must hear from you once a year to know that you are still active (a note through email for our international members is fine!). If you would still like to continue your membership with AARG, please remember to renew and support AARG by paying your annual dues.

✂ -

Please Print or Type **New Member** **Renewing member**

Name:________________________________**Affiliation:**____

Mailing Address:____

____

Office Phone:___________________________**FAX:**__________________________**E-Mail:**____________________________

Website:____

Regular Member - $20.00, Student Member - $5.00, Free Membership (available to non-U.S.-based members, or financial hardship)

Please provide up to five key words about your research interests:

1. ________________ 2. _________________ 3. _____________________ 4. ___________________ 5. _________________

Please briefly describe your current project/s:

____

If given the option in the future, would like to receive the AARG BULLETIN by e-mail? Yes ____ No ____

Would you like your email address to be added to the AARG listserve? Yes ____ No ____

Please send this form and a check or money order (made out to AARG in U.S. funds only) to:
Susan Pietrzyk, 126 Chapin Street #122, Binghamton NY 13905, (607) 723-2256, Email: spietrz1@binghamton.edu

NOTE: FOR OVERSEAS MEMBERS, ELECTRONIC APPLICATIONS ARE AVAILABLE ONLINE
(see http://puffin.creighton.edu/aarg/form_new_membership.html).
SAVE YOUR POSTAGE -- FILL OUT THE APPLICATION AND EMAIL TO: spietrz1@binghamton.edu

AIDS & Anthropology Bulletin

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