AIDS and Anthropology Bulletin

NEWSLETTER OF THE AIDS AND ANTHROPOLOGY RESEARCH GROUP

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Editors:

Dugeidy Ortiz

Lisa Rose-Rodriguez

Layout and Design:

Dugeidy Ortiz

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Letter from the Chair

Dear AARG,

Topics relevant to HIV/AIDS prevention and research continue to fuel the culture wars and illuminate current social, political and historical values, fears and obsessions. Though much has changed since 1982, much has remained the same.

I was struck by the number of enduring and recognizable themes to those in the field of HIV/AIDS while reading the flurry of alternately earnest and snide "Reader's forum" responses to a *New York Times* article (April 5, 2007) exploring New York City's health commissioner's (erroneously) perceived position on promoting circumcision as a means of preventing HIV. This public correspondence reflects several recognizable topics in cultural studies of HIV/AIDS. Not surprisingly, some of the emails exhibit clear ethnocentrism (in some cases verging on more vulgar racism and egocentrism): one self-identified 'straight' man asserts that while he is not willing to undergo a procedure with an .05% chance of permanent damage, he strongly encourages it for those in Chelsea and Harlem, citing statistics on high HIV prevalence rates (and implied popular stereotypes) in both areas. Other responses share concerns about the 'body politic.' One man laments "medicine's propensity to conjure new rationales to mar men's anatomy," others warn about desexualization in the name of science and medicine, and some anticipate that any advocacy of circumcision as HIV prevention is a conspiratorial movement to forcibly assimilate ethnic, religious and cultural diversity. Other correspondents contemplate whether or not male circumcision is genital mutilation, and if so, they muse whether or not it is as horrific as female genital mutilation. Yet another reader proposes a curious folk theory about how circumcision has led so many men being gay in the first place.

In these artifacts of HIV/AIDS discourse from the early 21st century, there remain the usual implications about the impurity and exoticness of the Africans upon whom the circumcision research was based. Interjected throughout is a medical and scientific discourse, urging the nay-sayers and in some cases the proponents to examine what the study really demonstrated, calming or chiding conspiracy theorists, and, in some cases, proposing alternative and less invasive structural interventions, such as making anti-

Letter from the Editors

In the spirit of the National Black HIV/AIDS Awareness Day in February, Lisa posted a call for papers for the newsletter– asking potential authors to reflect upon the "the cultural, economic and prevention issues surrounding the disproportionate amount of HIV prevalence found within the African-American community." We received numerous papers– we want to thank all of those who submitted. Of these we selected two student papers, one by Christine Bell that looks at the impact of HIV/AIDS in the inner-city and Laurel Jacob's article which touches upon stigma in the early AIDS epidemic.

In addition, we have two more articles discussing food security in Zambia and Zaire and the challenges of implementing ARV and vaccine therapy in Nigeria.

Our next issue will be a special fieldwork issue. Please send any fieldnotes, pictures, articles and updates (stateside and foreign) from the field to aargsub@gmail.com. We look forward to your submissions!

Letter from the Chair,

(Continued from page 1)

retrovirals free to New Yorkers living with HIV. While we know this is about as likely to happen as there being no more right-wing religious leaders or conservative political leaders exposed for practicing what they proscribe sexually, it is interesting to consider how the same group of readers would respond to that scenario, and what role we as anthropologists, scholars, researchers, practitioners and activists, do, can or could have in promoting new policies, better research, and more effective HIV interventions.

Things haven't changed in another area: Puerto Rico is having trouble utilizing their Ryan White funds, and officials have in fact been accused a of misappropriating funds (NYT 6/5/07). We heard this before, in 2005, and it makes sense given Puerto Rico's than efficient governmental infrastructure (to a large extent a legacy of U.S. colonialism). Dennis DeLeon, the Director of Latino Commission on AIDS in New York City, suggests that the level of funding given to Puerto Rico is not even sufficient to "build an adequate infrastructure to handle (the epidemic)," as evidenced by the amount of unspent money returned to the Ryan White program each year. DeLeon notes that there is an effort to rectify the situation by creating a third party to handle the funds each year, rather than being forced to have their funding cut. According to the Latino Commission on AIDS, Puerto Rico has the second highest death rate per 100,000 people from AIDS related illnesses in the United States (16.4%) as compared to the U.S. average of 4.9%/100,000. The idea of the federal government cutting Ryan White funds to Puerto Rico given the reported death rate, or even applying other punitive actions, rather than partnering with Puerto Rican health officials to identify and attempt to remedy weaknesses in their health care system is unconscionable. As DeLeon has cautioned, the health care system in Puerto Rico "is collapsing before our eyes."

We have another excellent newsletter, including a report from the AAA and SFAA meetings from the past year, biosketches for some of our Steering Committee members, a case study on HIV/AIDS and food insecurity, and a report on HIV/AIDS in the inner-city. In the future, we will be returning to a bi-annual newsletter format, with newsletters coming out prior to the AAA and SFAA meetings. If you have ideas, articles or announcements you would like included in the November newsletter, please send them to me at delia.easton@gmail.com. Also, remember that student/professional paper submissions are due by October 15th**.** In the meantime, keep posting relevant and timely news about HIV on the listserv.

Be Well,

Delia

The AIDS and Anthropology Research Group

Mission

The AIDS and Anthropology Research Group (AARG), an interest group of the Society for Medical Anthropology (SMA), is a network of scholars interested in anthropological research on HIV infection and AIDS. The mission of the AARG is to support anthropological research in the fight against HIV and AIDS.

To this end, AARG

1) works to use anthropological research in the fight against HIV and AIDS, 2)advocates for AIDS research within anthropology, 3) promotes AIDS research by anthropologists within the broader AIDS research community, 4) and provides a forum for anthropologists working on AIDS to meet & communicate about their work.

AARG Announcements

Call for Papers: Aids in Culture IV: Explorations in the Cultural History of AIDS

México City, 9 - 13 December 2007

Focus for the 4th edition of the conference cycle "Aids in Culture: Explorations in the Cultural History of Aids: Aids and Otherness and Aids in Narratives of Identities

Deadline for abstract Submissions: August 15, 2007
Conference Languages: English, Castilian, German, French and Nahuatl

Homepage: http://www.aidsinculture.org

AIDS is not simply an illness or a biomedical phenomenon. The conference cycle "AIDS in Culture" organised by Enkidu Magazine in Mexico City and the International Society for Cultural History and Cultural Studies (CHiCS) in cooperation with CENSIDA (The National Mexican AIDS Council) and CNDH (The National Human Rights Commission in Mexico) seeks to examine cultural responses to AIDS in different cultures and societies across a wide range of perspectives. The conference will explore the processes by which AIDS is constructed as a cultural phenomenon and how different societies in their encounters with AIDS attempt to create meaning in health, illness and disease. The conference aims at bringing together academics working in all relevant disciplines as well as activists, artists and other professionals, and promoting innovative multidisciplinary and multicultural exchange and dialogue.

This year the conference will have a special focus on Aids and Otherness and Aids in narratives of identities. Papers addressing related issues as well as translations between cultures and re-negotiations and re-constructions of cultural identities in one way or another in relation to AIDS and HIV are particularly welcome. However, also in 2007 the conference will follow a similar model as in the previous year with several different thematic sessions addressing several different issues. Papers are welcomed on virtually all related topics and themes, independently of time, period and space, as well as interdisciplinary perspectives. Also papers of comparative phenomena will be considered.

PROPOSALS FOR INDIVIDUAL PAPERS
Abstracts are to be submitted by 15th of August 2007, along with the presenter's name, address, telephone, email, and institutional affiliation.
It is recommended to use the form here: http://www.enkidumagazine.com/eventos/aidsinculture/registration_en.htm when submitting an abstract. However, abstracts will also be accepted as e-mail attachments to info@enkidumagazine.com.

3rd AFRICAN CONFERENCE ON SEXUAL HEALTH AND RIGHTS SEXUALITY, POVERTY AND ACCOUNTABILITY IN AFRICA 4 -7 FEBRUARY 2008, ABUJA , NIGERIA

CALL FOR ABSTRACTS

The ***Africa Regional Sexuality Resource Centre (ARSRC)*** , a project of Action Health Incorporated (AHI), under the auspices of t he African Federation for Sexual Health and Rights is pleased to call for abstracts for the 3rd African Conference on Sexual Health and Rights to be held in February 2008 in Abuja Nigeria. The theme of this conference is "***Sexuality, Poverty and Accountability in Africa.***"

Individuals and institutions wishing to submit abstracts for oral and poster presentations at the conference are invited to make t heir submissions. As a requirement for acceptance, the abstract must cover the proposed thematic areas; set out the general interest for the participants at the conference; describe the contents of the presentation and its contributions to t he theme of Sexuality, Poverty and Accountability in Africa. The conference will focus especially on issues affecting women and youth. Any research undertaken must have pertinent arguments and show originality and innovation.

Relevant sub-themes and topics for the conference include, but will not be limited to:

* **Law, Sexuality and Health**
* **Poverty, Reproduction and Family**
* **Youth and Sexualities**
* **Sexuality Education**
* **Vulnerabilities, Youth and Sexuality**
* **Gender Based Violence**
* **HIV and AIDS, Rights and Accountability**
* **(Im)Mobility, Sexuality and well-**

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AARG Announcements

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being

Abstract Format:

1. Abstract should be submitted for both poster and oral presentations.

2. Abstract should be submitted in English or French.

Content of abstract:

· Conference Sub-theme under which the abstract is submitted.

· Abstract Title

· Type of presentation (oral or poster presentation).

· The names of the authors (presenting author should appear first), institutions, city, and country.

· Abstracts should be no longer than 400 words.

· All abstracts should include separate paragraphs describing :

o Background and objectives

o Issues/methods

o Findings

o Conclusions

· Abstracts reporting on scientific research should also include a description of methods and/ or materials immediately following t he introduction.

· Be sure to include 5 key words describing your presentation in t he designated box and up to 3 numbers from the scientific topics chart that best reflect the content of your proposed presentation.

· Indicate audio visual equipment required for your presentation. If you plan to use videotape, specify t he system and format.

Abstracts should be sent by **July 31 2007** to:

Conference Coordinator
3rd Africa Conference on Sexual Health and Rights

Tel: 234 1 774 3745 Fax: 234 342 5496

Email: Conference@actionhealthinc.org

THE AARG CLARK TAYLOR PROFESSIONAL PAPER PRIZE AND THE AARG STUDENT PAPER PRIZE

Two prizes will be awarded by the Aids and Anthropology Research Group at the 2007 American Anthropological Association meeting in San Francisco, one for senior researchers and one for students. The submissions are due by **October 15th, 2007**

Previous winners of the Clark Taylor Prize:

> **2005** Kathleen Erwin, PhD -- The Circulatory System: Blood Donation, AIDS and 'Gift' Exchange in China.

The Prize Committee, of Rose Jones, Jodi Nettleton and Amanda Diers Schall, was constituted at the Dallas SfAA/SMA meeting.

Student and professional papers should be evaluated according to the following criteria:

1. Potential contributions to the literature/policy/direct impact on HIV/AIDS prevention and/or treatment.
2. Originality of argument and/or data analysis
3. Relevance of cultural, ethnic, gender and/or sexual orientation issues
4. Justified use of methods (when applicable)
5. Theoretical approach (when applicable)
6. Attention to previous research
7. Presentation--grammar, style, etc.
8. Suitability for submission to peer reviewed journals or other professional publications (including Newsletters, monographs, etc.)

While all papers are judged in terms of the same criteria, judges will exercise reasonable judgment in separately assessing undergraduate student, graduate student and professional level submissions. In other words, undergraduate student submissions will not be judged against graduate student or professional submissions, and so forth. The goal of these criteria is to support the development of the highest quality submissions at all levels, while fairly judging each level of submission in terms of reasonable standards for years of experience in the field.

Please send in your paper, and encourage a colleague or encourage a student to send in a paper. We encourage interested persons to join AARG and send in a paper.

Critical Intersections/Dangerous Issues
2006 AAA Annual Meeting, November 15-19, 2006
San Jose, California

Notes from the AAA November 2006 AARG meeting

By: Doug Goldsmith

Ray handing Ralph Bolton the AARG Distinguished Service Award.

Kathleen Erwin, recipient of the 2005 Clark Taylor Prize.

The meeting was chaired by Doug Goldsmith and Ray Bucko

The meeting went well, as the 24-28 attendees (17 signed + 2 chairing + a few who stayed briefly) enjoyed the graciousness with which Ray Bucko presented the Distinguished Service Award to Ralph Bolton, and then Doug Goldsmith's joy in finally presenting last year's (the 2005) Professional Paper prize to Kathleen Erwin (and later as she drove me half way back to San Francisco she agreed to serve on the new paper prize judging committee under new Chair Delia Easton).

Doug Goldsmith then offered thank yous to all who'd served AARG in the past year (especially Karen Kroeger's continuing on as Secretary Treasurer!) and then announced that he was passing the gavel to Delia Easton as new Chair.

We then had a lengthy, unresolved discussion about what AARG would choose as the SMA "Take a Stand" topic, mediated by EJ Sobo's guidance as to SMA's intent and Janet McGrath's reluctance to see any unfleshed out idea selected. Finally, 3 people agreed to work under Delia's leadership to write up the to-be-determined topic (Kathleen Ragsdale, Penny Van Esterik, and Naomi Parekh) along with former AAB editor Janie Simmons.

We also got 4 self nominations for the Steering Committee elections (David Beine, David Turkun, Judy Benjamin, and Pollie Bith Melander). And a few people wrote and gave AARG dues checks to Ray! There was time to go around the room and hear self introductions from the 15 people remaining at the end of the meeting.

Then we walked over to a nearby friendly but inexpensive Chinese/Vietnamese restaurant (Bo Town) where the 9 remaining celebrated the 2 prize winners in their midst (Ralph Bolton and Kathleen Erwin).

Doug Goldsmith made a toast to the near 20 years that we've had to continue AARG in the face of the AIDS crisis, based on a Leonard Cohen poem song, "Tower of Song" retitled "Tower of AARG/Shadow of AARG" for the occasion.

Many friends are gone, and our hair is gray,
We ache in the places where we used to play,
We're crazy for love, and we teach prevention.
We just pay our rent every day in the tower of AARG.
We say our laments as we stay in the shadow of AARG.

Past Chair Doug Goldsmith meets with Moher Downing In San Francisco

Moher Downing was elected to serve as AARG Chair from 2006 to 2007, but due to her unfortunate stroke she was unable to assume the Chair and asked that we find another. So Doug Goldsmith stayed on as Chair for 2006, while Delia Easton was elected to her two year term beginning 2007.

In November 2006 I was able to visit Moher at her home in GlenPark, just south of San Francisco, on the Sunday evening after the AAA met in San Jose. Moher has been driven to a Wednesday evening session at the AAA meeting, which honored her life partner, Luis Kemnitzer (I think is the correct spelling), who died this past year. She regretted that she could not return to San Jose for our business meeting, mainly, as I learned, because of a huge celebration that ran from Saturday morning to Sunday evening, at her house, and for her very extended family. As clearly as I could discern it was a coming of age celebration, that she noded was like a Bar Mitzvah or First Communion, and finally called "First Blood." The celebration was continuing below us, in the lower 4 floors of her remarkable Victorian house, which was built in 1870 on such a precipitous hill, that the attic, in which she lives, is readily accessible from Miguel Street, which runs behind, and above! the house, via a walkway from an improbably simple white gate. Moher greeted me graciously, gave me a big hug, and even good naturedly signed the Act Up T-Shirt which I had made many people at the AAA meeting sign (at future AARG events the rest of you to sign it too!). We spoke for about 10 minutes, before my San Francisco friend arrived to take me to the airport, and of course he got into a deep conversation with Moher too -- he recognized the old photograph or etching she had of the Moher cliffs on the coast of Donegal, which he had seen in Ireland. I never got many of my questions answered, but was pleased to see that Moher was so well situated, and in such bouyant spirits.

AARG STEERING COMMITTEE BIO-SKETCHES

David Beine

David Beine holds a Ph.D. in anthropology from Washington State University (2000), a MA in anthropology (linguistic anthropology focus) from San Diego State University (1994) and a BA in Communication Studies from California State University, Sacramento (1986). He is currently the Director of the Oregon Summer Institute of Linguistics and regularly teaches courses in cultural anthropology at Northwest Christian College in Eugene, Oregon. He is also adjunct faculty and India area advisor for the TAFTEE program sponsored by the University of Wales, England.

Dr. Beine's doctoral dissertation, "Ensnared by AIDS: Cultural Models of AIDS and Underlying Cognitive Illness Schemata in Nepal" highlights the cultural aspects of the growing HIV/AIDS epidemic in Nepal, focusing particularly on the cultural models of HIV/AIDS that are being employed to "make sense" of HIV/AIDS in Nepal, and the underlying cognitive schemata that inform these models. He was affiliated as a research scholar with Tribhuvan University, Department of Sociology/ Anthropology, Kathmandu, Nepal during the tenure of his doctoral research (1998-2000). The findings of this research also serve as the basis for his recent book "Ensnared by AIDS: Cultural Contexts of HIV/AIDS in Nepal (2003). Dr. Beine's specialties are in the areas of HIV/ AIDS, medical anthropology, cognitive anthropology, linguistics, and the history of anthropology. His geographic specialty is South Asia (particularly Nepal and India).

Dr. Beine's interest in South Asia first began in 1988 when he traveled to India and Nepal to live for three years to conduct linguistic research that would later culminate in the publication of his linguistic anthropology Master's thesis, "A Sociolinguistic Survey of the Gondi-Speaking Communities of Central India" (San Diego State University, 1994). Following that he and his family again lived and worked in Nepal during 1995, 1998-1999 and 2000-2001. He currently resides with his family in Spokane, Washington and teaches summer courses in cultural anthropology in Eugene, Oregon. Dr. Beine also spends significant time in Nepal yearly and continues his involvement in applied anthropology and sociolinguistic research throughout the entire South Asia region.

AARG STEERING COMMITTEE BIO-SKETCHES, CONT'D

Doug Goldsmith

Doug Goldsmith was elected AARG Chair for 2004 to 2005. When Moher Downing was unable to assume the Chair, he continued as Chair in 006. Now in 2007, he is Past Chair.

As chair and past chair of AARG I've enjoyed the pleasure of meeting many people committed to their work on AIDS, and the added pleasure of renewing contact with many ongoing AARG members.

After 25 years of research with drug injectors about AIDS prevention (mostly at NDRI), and after 15 years of teaching about drug taking and risk behaviors (at John Jay College of Criminal Justice, CUNY), I am the editor (and in parts the author or co-author) of a look back at the role of advocacy in promoting AIDS risk reduction practices among NYC injectors.

For the summer of 2007, I am extending my medical anthropology gaze beyond HIV and IV behaviors. I have begun to conduct a set of community based interviews on tick borne illnesses and prevention concerns. I model my data collection on the detailed accounts we have learned to collect on the interconnected myriad of HIV/AIDS concerns and behaviors.

David Turkon

I am an assistant professor of anthropology at Ithaca College. Prior to Ithaca College I was a tenured faculty at Glendale Community College in Arizona. I have been doing fieldwork on social and political inequality in Lesotho, southern Africa since 1987. In 2004 I, along with another anthropologist, traveled to Lesotho where we met with members of the AIDS Coordinating Unit at the National University of Lesotho and agreed to collaborate in putting together and piloting a community focused, nutritionally based intervention with the goal of reducing transmission rates, prolonging the life of the afflicted, and increasing economic and social capacity. As we move forward pursuing funding, we have brought scholars from Lesotho to the US for collaboration. Two of my colleagues and I traveled to Lesotho during May, 2007 in order to better define our research protocols, visit our field site, strengthen our ties with NUL scholars, and pursue regional funding. As an anthropologist my main interests are with capacity building within communities, an area that has also drawn me also to work with Sudanese refugees in Phoenix, AZ and Syracuse NY. I am an elected member to the boards of directors for the AZ Lost Boys Center and the Association for Africanist Anthropologists (AfAA), co-program chair for the AfAA, a senior adviser to the Central NY Lost Boys Foundation, and have served on the steering committee for the Samaritan Center Resettlement Program in Ithaca, NY.

Next issue will have additional biosketches from other Steering Committee members

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

Thanks!

AARG STEERING COMMITTEE BIO-SKETCHES, CONT'D

Raymond A Bucko, S.J.

Raymond is a professor of cultural anthropology at Creighton University. He also serves as chair for the department of sociology and anthropology and program director for the Native American studies program. He graduated with a Ph D in anthropology from the University of Chicago in 1992. He specializes in Native American ethnology, particularly the Lakota people of western South Dakota and has interests in medical anthropology and museum studies. He is also a Jesuit priest, a member of a Catholic religious order founded by Saint Ignatius of Loyola. He came to Creighton in 2000 after nine years at Le Moyne College in Syracuse, New York.

Ray's involvement in HIV AIDS was initially existential rather than academic. He was in graduate school living in San Francisco and studying theology in Berkeley during the early days of the epidemic and thus grew quite aware of the crisis. Some of his friends and family members lived with AIDS although as we all remember in the early days of the epidemic that life was short and often painful. When Ray was again in graduate school beginning in 1985 studying anthropology he spent an evening a week delivering meals for people with AIDS on the south side of Chicago.

Ray first learned of AARG from a notice in an AAA publication. He immediately joined and received a paper newsletter. While he had little expertise in the field of the anthropological study of AIDS (he continues to follow the impact of the epidemic among Native American peoples) he figured he could contribute to the important efforts of the group with his knowledge of electronic communications. He was one of those technology early adopters so he offered to construct a web page for the organization and to host a discussion list. Ray was not alone in his electronic aspirations for the organization. Michelle Renauld first offered to distribute the bulletin by e-mail in March 1999. Fred Bloom took over this function in the June 1999 issue of the bulletin. Today Ray e-mails electronic versions of our newsletter to the majority of our members. He also archives past bulletins on the organization web page.

Ray set up the electronic e-mail based discussion list in the fall of 1999 wich continues to run 9 years later (aarg@creighton.edu). At the same time he set up a web page that also continues to today (http://puffin.creighton.edu/aarg). He became part of the steering committee in 2000 and became the organizations's electronic communications coordinator in 2001. He continues to serve in that capacity. Ray has enhanced the web page with the generosity of other AARG members, particularly Ralph Bolton who handed over his aids and anthropology bibliography to be electronically published and updated on the web rather than as a paper publication. AARG members also generously added to a page archiving syllabi for courses on AIDS and anthropology.

Ray was rather invisible, at least physically, to the organization until the Fall of 2005 when he first attended an actual AARG meeting at the AAA meeting in Washington, DC. It was a relief to everyone to discover that Ray was indeed a real person and not a computer program. Ray was particularly touched when he was introduced to the group and everyone stood and applauded. Ray has made many lasting friendships throughout the years and learned many valuable things from his association with members of AARG through his membership in the organization.

Ray's current electronic project is to set up a searchable database of AARG members on our web page. Any visitor to our website can search for members who has particular expertise or work in particular geographic areas-- thus enhancing our networking capacity. Members will be part of the database only if they have consented to have their information listed. Ray is working on this venture with three graduate students at Creighton University's school of business, their professor Lei-da Chen, and the AARG steering committee. We hope to have this database search engine on-line in the fall of 2007. The database will also be used to manage membership and to distribute our newsletters and other resources.

Ray happily continues in his role as electronic coordinator. His tasks include maintaining the web page and discussion lists (one for the steering committee and one for general membership). He also serves as a member of the steering committee and as the coordinator for the biennial distinguished service award (nominations are due before October 15, 2008). His biggest challenge is keeping up with changes of e-mail addresses!

If you are not currently a member of the AARG listserv or if you would like to contribute to any of AARG's electronic initiatives please feel free to contact Ray at bucko@creighton.edu.

In addition to his work as electronic editor, Ray researches traditional Lakota games.

Here he holds a "hutanakute" (winged bone) – a buffalo bone with feathered rudders that is thrown on ice for distance and accuracy.

Contested Strategies for Defining and Confronting Food Insecurity and HIV/AIDS: Case Studies from Zambia and Zimbabwe

Barrett P. Brenton* and John Mazzeo**

* St. Johns University

** DePaul University

Paper presented in the AAA Presidential Session: New Approaches for Combating HIV/AIDS and Food and Nutrition Insecurity in Sub-Saharan Africa. American Anthropological Association Annual Meetings. San Jose, CA. November 17, 2006.

Overview of HIV/AIDS and Food Insecurity

Cyclical droughts, unstable regional economies, political uncertainty, and the need for emergency food assistance in southern Africa are commonplace. However, unlike past food security crises the last decade has witnessed the growth of an HIV/AIDS pandemic that continues to exacerbate both the problems and solutions. Whether one chooses to call this relationship a "New Variant of Famine" (NVF) a "Triple Threat" (HIV/AIDS, Food Insecurity, and Lack of Government Capacity), "AIDS-Affected Famine," "Twin Peril," or some other label, it is clear that all long and short-term programs must consider both HIV/AIDS and food insecurity as inseparable for any sustainable intervention.

This short report highlights country case studies from Zambia and Zimbabwe that begin to reveal contested strategies for both defining and confronting food insecurity and HIV/AIDS. The Zambia example reviews coordinated responses to the food crisis in 2002-2003 in light of HIV/AIDS and the country's resistance to genetically modified (GM) food aid. The Zimbabwe case study is focused on food aid targeted at mitigating the affects of HIV/AIDS for rural households based on an analysis of 2005 & 2006 Household Livelihood Security Assessments.

"New Variant Famine"?

De Waal and Whiteside,[1] using analytical frameworks from famine theory, argue that unlike drought-related food crises of the past, the current HIV/AIDS epidemic in southern Africa has combined with drought to create a new category of highly vulnerable and food insecure households. This has been labeled "New Variant Famine" (NFV). The basic tenets of the theory are related to conditions arising from declines in household labor, assets, and social networks linked with the vicious synergism of malnutrition and HIV/AIDS.

Even though the concept of linking HIV/AIDS and food insecurity is nothing novel, some dispute has emerged regarding whether or not the current crisis should be referred to as a "famine." One must keep in mind that the concept was proposed amidst the call for a massive humanitarian response to the severe southern Africa food crisis of 2002-2003.

Perhaps a more appropriate critique can be found by investigating those underlying assumptions concerning the diversity of shifting livelihoods and coping strategies. For example, a restudy by Drinkwater et al. on the effects of HIV/AIDS on Agricultural Production Systems in Zambia (1993-2005) observed that the impact of HIV/AIDS on livelihoods varies widely by region in terms of traditional cultural coping strategies (e.g., matrilineal kinship system), beliefs and stigma surrounding the disease, and the degree of dependency on external inputs.

Proceedings and publications surrounding the International Conference "HIV/AIDS and Food and Nutrition Security: From Evidence to Action" held in Durban, South Africa in April 2005 provides numerous examples that further supports how diverse, complex, and unclear the interrelationships are between HIV/AIDS and food security.

Case Study: Zambia

Many nations throughout central and southern Africa continue to express concerns about the safety, political-economic, sociocultural, and legal implications of genetically modified organisms (GMOs), especially when promoted as a solution for food insecurity.

The use of genetically modified (GM) maize (originating mostly from the U.S.) as an emergency relief food to ameliorate the drought-linked 2002-2003 food shortage and hunger alert crisis became a paramount concern for Zambia, who refused to allow it into their country for distribution. The ensuing fervor that

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Contested Strategies for Defining and Confronting Food Insecurity and HIV/AIDS: Case Studies from Zambia and Zimbabwe

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resulted must also be put in to the context of the high prevalence of HIV/AIDS and food insecurity in Zambia. This created similar exaggerated conditions that led to the NVF concept being proposed in the same timeframe.

During this period Zambian officials were highly criticized by various relief agencies and governments for their "No GMOs" action. The resulting U.S. administration's political spin on the crisis led to presenting Zambia as a nation that was letting "Africans" starve rather than allowing them GM food aid.

In the end, alternative non-GM sources were found but Zambia continues to be pressured to change their position by the U.S. government and U.S.-based multinational biotech companies. Fieldwork by Brenton suggests that rather than condemn countries for limiting their acceptance of GM foods, the situation must be approached with an integrated perspective that deals simultaneously with HIV/AIDS, food insecurity, and real concerns that countries have in contesting what is seen by many as the neo-colonial imperative of biotechnology. To date there have been no reports documenting any harm resulting from the delays in mobilizing non-GM food aid.

Case Study: Zimbabwe

Zimbabwe provides another case study for exploring the complexity of a food crisis shaped by a long-term HIV/AIDS epidemic. According to the UN, the current outlook on the nation's food security for 2006/2007 is bleak. They estimate 3 million individuals, or 25 percent of the population, will require food aid over coming months. Much of this aid will be delivered through 'vulnerable group feeding' programs, which target households at risk, especially those caring for the chronically ill or supporting orphans.

To better understand Zimbabwe's food crisis, Mazzeo has been working with CARE International since the 2002 drought to monitor and address the food and livelihood security of rural households in parts of the arid southeast. A major component in monitoring is the Household Livelihood Survey; a holistic instrument used to gauge the situation of households by examining a range of indicators and outcomes. In 2005 and 2006, information was collected from households representing all areas in which CARE currently has programming (n=6,500).

Results of the 2006 assessment demonstrate that although Zimbabwe is facing a food shortage for 2006/2007, it is not nearly of the scale to be described as a famine. Because of the 2004/2005 drought, last season's food situation was a far greater emergency. The 2006 data show that one-third of households are food insecure – they cannot meet their basic cereal consumption needs based on own account production and other sources. Of those households facing a shortage, the average food supply is expected to last seven to eight months. However, the food security crisis is significantly worse for AIDS-affected households.

Based on a 25 percent prevalence rate and course of HIV/AIDS, it is estimated that nine percent of the population will be chronically ill (CI) at a given time (Mazzeo finds that seven percent of the population is chronically ill and symptomatic of AIDS and another ten percent have lost an adult member to a chronic illness during the past twelve months). A cross-sectional comparison of affected and non-affected households in terms of access to cereals during non-drought (2006) and drought (2005) years shows that although drought has the greatest impact on household cereal access, the presence of AIDS in the form of chronic illness or recent death significantly intensifies food shortage. The intensified food security crisis among affected households leads to more drastic types of coping strategies (e.g., livestock and asset divestment) that reduce resilience to future drought.

Incorporating HIV/AIDS into targeting programs poses three important challenges in the case of Zimbabwe. First, selective targeting of affected households during widespread crises can increase stigma and discrimination. Second, the loss of labor associated with HIV/AIDS increases dependence on social networks; especially those with elders and well-off kin. Third, as households fall apart from HIV/AIDS,

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" According to the UN, the current outlook on the nation's food security for 2006/2007 is bleak."

Contested Strategies for Defining and Confronting Food Insecurity and HIV/AIDS: Case Studies from Zambia and Zimbabwe

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members are being absorbed by other units; not just orphans, but also sick adults unable to care for themselves. Tracking individuals is resource intensive and methodologically problematic.

Conclusions

Many of the issues in Zambia and Zimbabwe are very similar, as they are for most of southern Africa. This allows us to move ahead and promote some best practices for understanding gaps that encompass the inter-relationship between HIV/AIDS and food insecurity. To avoid the pitfalls of over-generalizing the crisis, as may be the case with the "New Variant Famine" hypothesis, we must take in to account factors that can help to reveal the diversity of responses. This includes: 1) Realizing that the interaction of HIV/AIDS and food insecurity are two way and synergistic; 2) Being cautious of a focus on smallholder farming in high HIV prevalent countries since it is often short term and concentrated on households which may obscure community level and above dynamics; 3) Recognizing that an overemphasis on passive victims and documenting the failure to cope without capturing the innovated strategies used to survive is dangerous; and 4) Promoting an assumption that the crisis is so different from any other that we need to invent an entirely new set of responses adds to a prevailing sense of hopelessness.

In conclusion, it could be argued that one downside of a NFV label's focus on a famine model approach to monitoring a progressively eroding system of coping strategies in some ways de-emphasizes the constantly shifting nature of those mechanisms and resilience ongoing at both the household and community level. It is also problematic to try to make the model fit situations where it might not be completely appropriate.

Still, as anthropologists we are well aware of how important a label is for instilling an emotional impact. Even though the use of the word 'famine' might better help to mobilize humanitarian aid and support for a crises that no one denies will have a devastating impact on future generation to come, at what point do the generalizations hinder our relief efforts? This is question of hope that we would welcome for further discussion in the anthropology and AIDS community.

Barrett P. Brenton, Department of Sociology and Anthropology, St. John's University, Queens, NY 11439 USA; brentonb@stjohns.edu.

John Mazzeo, Department of Anthropology, DePaul University, Chicago, IL 60614 USA; john_mazzeo@yahoo.com.

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HIV/AIDS in the Inner-City: A Need for Change

Christine Bell* and Dr. Carlos del Rio, MD**

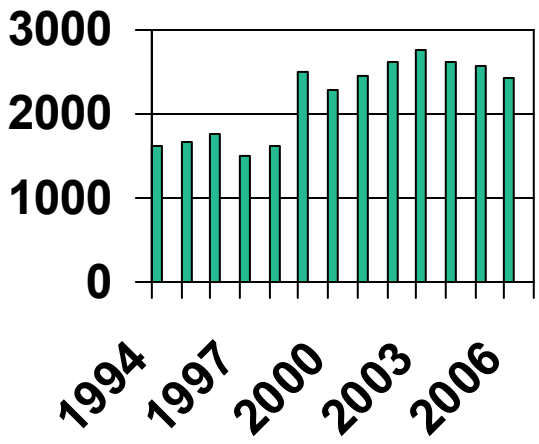
* Rollins School of Public Health, Emory University

** Emory University School of Medicine

Hi, Ms. Jones? We are doing a study your doctor thought you might be interested in. Would you like to hear about the study for a second?' The patient rolls over and slowly glances in my direction, her eyelids heavy and hair matted from lack of sleep. Her face is cross as I introduce myself but softens as I slowly describe the study's intervention for connecting HIV patients to outpatient care, and education for risk-reduction and peer prevention advocacy. She motions to the chair next to her bed and I begin to screen her for the study. She unravels her story as I systematically ask questions, describing her treatment, sexual and drug histories. Despite being diagnosed with HIV in 1996 she still has not been seen in the HIV outpatient clinic. She is sleeping on the street and her daughter lives with her mom. She has had two sexual partners in the last 6 months and is not sure of their HIV status. Crack cocaine is her drug of choice.'

This case comes from the medicine wards of a large public hospital in a major urban center in the Southeastern U.S. It represents common conversations had with HIV patients on a **daily** basis, as there are usually 3-10 HIV patients admitted per day. Many patients are unable to talk, due to severe illness and symptoms. Others are affected by dementia or have an altered mental status and are not able to give accurate histories. Several patients have been newly diagnosed with HIV during the same hospital admission and are still in denial about their test results. But most HIV patients admitted in the hospital are simply not in care and thus have not received highly active antiretroviral therapy (HAART). If taken correctly, HAART can prolong the lives of HIV-infected patients. Additionally, HAART has been made available basically free of charge in the U.S. through the CARE Act and the AIDS Drug Assistance Program (ADAP). Yet, despite the availability of HAART, at our hospital, as well as many others in the inner-city, AIDS continues to be a leading discharge diagnosis and no significant decrease in admissions has been noted (Figure 1).

Figure 1: HIV/AIDS Admissions to GMH 1994-2006



Most of these patients that fill inner-city hospital beds live in the inner city, are African-American, have not received any education beyond high school, are unemployed, are uninsured and actively use drugs, in particular crack cocaine. Ironically, many were born in the same public hospital and will likely die here.

To mainstream society, these cases of HIV/AIDS in public U.S. city hospitals are for the most part invisible. These patients come from marginalized populations and high risk areas and the mainstream society in this country does not directly identify with them. These patients are often believed to be HIV-infected as a result of their drug use and/or risky sexual behaviors. Unless one happens to be a healthcare provider or other professionals working with HIV patients, the general population is rarely exposed to the issue of AIDS in the inner-city. Thus, it is not surprising that, for the most part, the general public is not alarmed by the present picture of HIV/AIDS in city hospitals. Once presented in historical context,

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the presence of HIV in the urban environment is more familiar.

HIV/AIDS has historically been a disease affecting urban environments and populations. In 1980-1981, the AIDS epidemic was first recognized as clusters of *Pneumocystis carinii* pneumonia (PCP) and Kaposi's sarcoma (KS) occurring in men who have sex with men (MSM) in Los Angeles, New York and a few other U.S. cities. Twenty-five years later, HIV/AIDS rates remain highest in urban areas, specifically in inner-city populations. In 2002 the highest AIDS case rate of 1685.8/1,000,000 was in the District of Columbia, and among States New York had the highest rate of AIDS at 400.8/100,000 persons. Specifically, HIV/AIDS infection is becoming concentrated among African-Americans in inner city populations. In 2002 HIV/AIDS was among the top 3 causes of death for African American men, aged 24-54 years old, and was the number 1 cause of death for African American women, aged 25-34 years. In 2004, while representing 12.3% of the total U.S. population, African Americans accounted for 19,206 (50%) of the estimated 28,730 new HIV/AIDS diagnoses. Finally, in the same year CDC estimated that 50% of all children under age 13 living with AIDS were African-American, with perinatal transmission causing infection in 91.4% of pediatric cases. While race and ethnicity alone are not risk factors for HIV infection, African-Americans who live in inner-city populations are exposed to multiple factors associated with risk for HIV infection, including low socioeconomic status, lack of awareness of HIV serostatus, unprotected sexual intercourse, substance use, a higher rate of sexually transmitted disease, and stigmatization toward MSM behavior.

In order to address this increasing trend of HIV/AIDS in inner-city African-American populations and reduce burden of disease to society there must be bold action and change. Specifically, HIV/AIDS prevention must be carried out based on previous HIV/AIDS lessons learned, medical advances and strong political will. Preventive interventions focused on safe sex practices and reduction of high risk behaviors must be communicated at the community level in inner city neighborhoods, and for HIV-infected patients in the clinical setting. But this is not enough. Harm reduction interventions for drug users and structural interventions that address the high risk conditions in the inner city and community awareness and involvement are also urgently needed. Also needed are preventive measures targeted to reduce HIV/AIDS transmission in incarcerated populations. Incarcerated persons are at greater risk for HIV infection, due to unprotected sexual contact, tattooing practices and drug use. Protecting inmates against HIV/AIDS infection during incarceration will help to reduce HIV exposure and disease.

Finally, there must be strong political will for reducing HIV infection and mortality in the United States. In the Institute of Medicine's 2001 report, the Committee on HIV Prevention Strategies noted a lack of a 'comprehensive, effective, and efficient strategy for preventing the spread of the human immunodeficiency virus.' Given the challenges of addressing HIV risk behaviors, the Committee insisted that in addition to scientific evidence and ethical considerations, strong political leadership will be essential to HIV prevention. Reducing HIV/AIDS transmission and illness in urban populations will be possible, and we have been given all of the tools needed to get the job done. Now we just need as many members of society as possible to join in.

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*Patient names have been changed to maintain confidentiality

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A Deadly Cocktail: Stigma, Ethics, and the Early AIDS Epidemic

Laurel E. Jacobs

University of Arizona Mel and Enid Zuckerman College of Public Health

With twenty five years of hindsight in which to reflect upon the actions that might, could, or should have been taken to stem morbidity and mortality in the early years of the AIDS crisis when so many were dying so quickly, the government's response in the U.S. to the emerging AIDS crisis in the 1980's has been condemned as delayed, uninformed, stigmatizing, and ineffective. Inaction was the ethical response of our government leadership based on stigmatization of those afflicted rather than the medical fact that people were dying. A deadly cocktail of stigma, ethics, and the early AIDS epidemic defined our nation's initial response to the crisis and shaped the future interpretation of and policy towards HIV in our nation.

It took President Ronald Reagan five years to mention AIDS publicly, all while thousands fell ill and died. The extent to which President Reagan first ignored the emerging AIDS crisis in the early 1980's and then failed to respond to the nation's concerns illustrates how pervasive the early AIDS ethical framework was steeped in stigma that linked the virus to transgressive behaviors such as needle use and homosexuality. The tragic trajectory of disease and death itself was compounded by fears among Americans about whether they could catch AIDS through casual contact, as well as further stigmatization of those who were infected due to their perceived immorality. The fact that President Reagan refused to calm fears and mediate stigma during the early years of the crisis not only suggests his moral judgment upon those affected but also illustrates that the ethical framework within which he justified his inaction played a primary role in delaying lifesaving public health efforts that may have curbed the crisis before it became epidemic.

Reflecting on the AIDS crisis within the dominant ethical framework of our culture is important because HIV, more than many other infectious diseases, is transmitted through behaviors that are highly stigmatized. The fact that the virus spreads during behaviors such as illegal drug use, sex between two men and prostitution that so deeply and widely violate the definitions of the nuclear family and normative behavior in our society makes it a fine example of how deeply entrenched health policy is in the values, ethics, and morals of our times. Those who believe that medicine or public health can be apolitical need only look to the AIDS crisis of the 1980's to see that the public health response often seemed paralyzed by the political climate from providing a real and meaningful response.

By the end of the first decade of the AIDS epidemic, silence and inaction had not proven to be adequate prevention or treatment tactics, while at the same time the rapid development of a cure or vaccine seemed unlikely. The most profoundly ethical response to the crisis was the legislation passed to treat AIDS patients through the Ryan White Care Act in 1990. There are a few reasons that the American public and its leadership deemed passage of such legislation, which provided federal funding for AIDS treatment and care (even for homosexuals and drug users) as morally acceptable.

First, Ryan White was a child. His plight as one of AIDS's youngest victims, described in the national media as "an extraordinary young man; brave, tolerant, and wise beyond his years" played a major role in successful passage of the legislation. Also, his Hemophilia diagnosis and consequent infection with HIV through contaminated blood transfusions defined him in the eyes of the American public solely as a victim of the disease rather than a social deviant. Within the country's moral framework of the time, homosexuals and drug users only had their own actions to blame for becoming infected and were therefore undeserving of government assistance. Ryan White, however, was purely a victim, infected with HIV through no fault of his own. It is hard to imagine that The Ryan White CARE Act, which still remains the bed-

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rock of HIV treatment and care for the indigent almost 20 years later, would have been passed if a homosexual adult had been its representative. The legislation needed a child victim considered morally pure in order to fit within our society's value framework at the time and gain the public support necessary to pass.

In terms of the populations affected, the AIDS epidemic now is so much different than in the early days of the crisis. Currently, young heterosexuals are among the fastest growing groups to be infected in the U.S. Globally, AIDS has killed over 25 million people, and is now seen by many primarily as the plight of the African continent. These days it is poverty and AIDS that are perceived as going hand in hand rather than homosexuality or drug use and AIDS. However, the fact that HIV spread so quickly through the gay and needle using communities in the early years of the epidemic determined how our society ethically categorized and then responded to the epidemic and continues to define our health policies today.

Our government's current official policy on HIV prevention is based on the promulgation of abstinence, which fits well with an historical ethical framework condemning homosexuality and drug use. As the epidemic has shifted to heterosexuals, however, our government has adapted the same ethical framework of condemning that which it deems immoral by equating HIV infection once again with transgressive sexual behavior, although this time via heterosexual sex outside marriage. Early stigmatization of homosexual and drug using HIV infected persons has simply been adapted to include anyone infected through their own immoral actions. Thus, the ethical framework within which our official government policy is steeped has not changed very much from twenty five years ago, only the umbrella under which immorality is defined has been widened.

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Shadows in Shades: Challenges of Massive Scale up of Antiretroviral Drugs in Resource Constrained Communities of Nigeria

Aliyu Aminu Ahmed,

Alibella Consulting Limited[1]

Twenty Six years into the epidemic, Human Immunodeficiency Virus(HIV) still threatens the welfare and well being of people throughout the world. It is estimated that over 39.4 million people are living with HIV or Acquired Immune Deficiency Syndrome (AIDS) and in 2004, 3.1 million died from AIDS-related illness. Africans had viewed HIV/AIDS as a disease of the West, linked to the weakness of family structures, liberal social values and moral decline but with the passage of time, and for diverse reasons, in most countries of the world, AIDS has come to be associated with sub-Saharan Africa. Today, Sub-Saharan Africa is the region of the world that is worst affected by HIV and AIDS, with an estimated 25.4 million people living with HIV and approximately 3.1 million new infections occurred in 2004 . By the end of 2004 the epidemic has claimed the lives of an estimated 2.3 million people in sub-Saharan Africa. It is also estimated that around 2.0 million children under 15 are living with HIV and more than twelve million children have been orphaned by AIDS in this region.

Nigeria is the most populous Sub-Saharan African Nation and HIV is now a generalized epidemic in Nigeria. Disease burden in Nigeria is very high and the prevalence rate of HIV/AIDS increases rapidly with 1.8% in 1992 ,3.8% in 1994 , 4.5% in 1996,5.4% in 1999 and 5.8% 2001. The prevalence rate in 2003 was 5% which declined slightly to 4.4% in 2005. However, it should be noted that these prevalence rate is a national median and that a high prevalence of 12% is recorded in Cross River State of Nigeria. Generally, prevalence rates increase rapidly and decline slowly and that the decline of this prevalence is not necessarily sending a good message instead it could be that the prevalence is reduced by higher mortality of the People Living With HIV (PLWHA) with corresponding lower incidence rates, among some groups. The disturbing fact is that adolescents and women are having the highest prevalence and most at risk of contracting the virus. The burden of the disease is largely on women , grand mothers, the girl child and children orphaned by AIDS and it is not uncommon to see single mothers and girl child headed households and this puts the candle of hope out in the winds.

With a population of over 124 million, there is an estimated 4 million people living with HIV/AIDS (PLWHA) in Nigeria and substantial part of the Nigerian population are affected directly or indirectly by AIDS. The total population of PLWHA in Nigeria is larger than the entire population of some African countries and larger than the combined total HIV population of at least seven worst affected countries, excluding South Africa.

Although HIV has brought enormous public health challenge and the world has unanimously committed both human and material resources to fight and overcome its treats but this tiny virus with less than two days life cycle has defied and belittled the might and prowess of human intellect and consequently there is yet no known preventive or curative vaccine for HIV. It has been widely accepted that Antiretroviral drugs could help in improving the chances of survival of people with AIDS and prolong their life expectancy. Combination of several (typically three or four) antiretroviral drugs known as Highly Active Anti-Retroviral Therapy (HAART) has proven to be very effective in HIV treatment and this in widely accepted by both developed nations and resourced constraint communities such as Nigeria.

The HIV virus has two types HIV-

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1 and HIV-2 and three groups which are, the "major" group M, the "outlier" group O and the "new" group N. Within group M there are known to be at least nine genetically distinct subtypes (or clades) of HIV-1. These are subtypes A, B, C, D, F, G, H, J and K. These three groups may represent three separate introductions of simian immunodeficiency virus into humans and all these groups are found in Africa and arguably Nigeria. The virus is highly variable and mutates constantly and this means that infection do become resistant to antiretroviral-drugs and that treatment becomes more complicated and prognosis may deteriorate.

Anti-HIV medications are categorized into four or five classes: Nonnucleoside Reverse Transcriptase Inhibitors (NNRTIs) which bind to and block the action of reverse transcriptase, a protein that HIV needs to reproduce, Nucleoside Reverse Transcriptase Inhibitors (NRTIs) which are faulty versions of building blocks that HIV needs to make more copies of itself. When HIV uses an NRTI instead of a normal building block, reproduction of the virus is stalled. Protease Inhibitors (PIs), which disables protease, a protein that HIV needs to reproduce itself and Fusion Inhibitors which are newer treatments that work by blocking HIV entry into cells and Integrase inhibitors inhibit the enzyme integrase, which is responsible for integration of viral DNA into the DNA of the infected cell. The drugs are also classified as first line drugs and second line drugs. Treatment guideline are varying across countries and there is no one "best" regimen, however World Health Organization(WHO) recommends that in most cases a first line regimen should consist of two drugs from the nucleoside/nucleotide (NRTI) group and one drug from the non-nucleoside (NNRTI) group. Drugs from the protease inhibitor (PI) group are generally less suitable for starting treatment in resource-limited settings for a number of reasons including, availability, safety, dozing ,monitoring, cost, toxicity and the particular side effects that occur with the protease drugs. Nevertheless these second-line drugs are vital and necessary in treatment combinations after prolonged usage, drug resistance and treatment failures of the first line drugs.

Consequent upon the Summit of African Leaders on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Abuja in April 2001, The Federal Government of Nigeria formally announced its determination to commence an ambitious antiretroviral treatment (ART) programme. The program was to provide life-prolonging treatment to 10,000 adults and 5000 children living with HIV/AIDS. Under the Nigerian programme, three first line generic drugs - Lamivudine (also known as 3TC), Nevirapine and Stavudine (AZT) - were purchased from two Indian pharmaceutical firms, CIPLA and RANBAXY and Government doctors at more than 60 federal and state health centers were trained to administer the trial treatment to about 15,000 People Living With HIV/AIDS (PLWHA).

The initial plan to start distribution of the drugs September 2000 was postponed for 'logistics reasons', and a December 1 (World AIDS Day) was also not feasible. The distribution of these drugs was interrupted several times due to storage and other logistics problems after commencement. In January the drugs were distributed to 25 sites across the country. At the initial quota of 25 patients each which was expected to be met before the end of March 2002, after which each centre was expected to expand its capacity in order to provide treatment and care for between 200-250 clients who were officially paying one thousand Naira (N1, 000) to receive treatment on a monthly basis in addition to bearing the costs of routine laboratory tests such as viral load, drug resistance and treatment of opportunistic infections which are unaffordable due largely to the fact that majority of the Nigerian population are indeed living below poverty line and people infected or affected are more susceptible and vulnerable and with the associated stigma and discrimination they are at the mercy of their own lonely prayers and whispers of long lost ancestors.

The Nigerian government said it aims to quadruple the number of people on antiretroviral drugs (ARVs) by mid-2006, enabling up to 250,000 HIV-positive people receive the medication and this and other HIV response

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efforts has received gracious support from the Global Fund, the US President's Initiative (PEPFAR), the World Bank , Bill and Melinda Gates Foundation and several other implementing partners. Nevertheless, considering the fact that antiretroviral therapy (HIV treatment) is used continuously and that treatment interruptions are not encouraged even when guided by certain parameters such as CD4 counts. There are several issues and gaps in the ARV program of Nigeria and the recent scale up efforts has problems that relates quality assurance of government provided ARVs which are generic drugs , unclear long term financing plan , poor procurement planning ,inadequate quantity of drugs provided ,un-reliable channels of distribution and how the drugs are distributed ,un standardized drugs storage especially at states level , fewer number of personnel available and trained to manage and administer the drugs and care for patients and most importantly unguided enrolment of patients into treatment centers and poor follow-up and home based care services . There are also issues that relate to the drugs such as purchase of about to expire drugs , toxicity, poor treatment adherence, treatment interruptions, unavailability of drugs in some centers ,poor accessibility by especially rural dwellers and unaffordability of treatment related monitoring costs ,these issues and the necessary sustainability strategies are not adequately and appropriately articulated in both the initial plan and the scale up plan.

People living with HIV/AIDS (PLWHA) in Nigeria have very poor health seeking behavior and low purchasing power and due to stigma and discrimination most of the PLWHA resort to using private or self medicated anti-retrovirals without standardized rules for their application. There is a problem of sub -optimal dosage and abrupt treatment interruption due largely to ignorance and the lack of financial resources.

Although Nigeria is an oil rich country but in view of the perceived high level of corruptions and erratic government policies there is a problem of actually resource allocation and sustainability of the entire national program beyond the current political dispensation and the support from private sector and international donor agencies may be limited as it will be highly unlikely that any donor would be willing to continue providing these expensive drugs, the necessary health care personnel capacity building and routine patient monitoring ,patient management and treatment of opportunistic infections and a co-infections such as TB and hepatitis.

Generally HIV/AIDS in Nigeria has not only posed a threat to public security but also the consequences of massive roll out without any clear blue print for sustainability and mainstreaming the roll-out program into the health system would indeed pose epidemiological challenge to Nigeria and consequently the Sub-Saharan Africa and Global Fight against HIV/AIDS and would have impact not only on the prevalence rate but also the incidence rate and transmission of multi-resistant and mutated viruses across the globe.

[1] Contact Information: Suite 303 2nd Floor, Samuel Akintola Blvd, B. M. House Near Platinum Bank Garki II, Abuja. Nigeria

www.alibellaconsulting.com, aah-med@alibellaconsulting.com ,

aliyuaminuahmed@yahoo.com
+2348056155435

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Department of Anthropology
University of Connecticut
354 Mansfield Road, U-2176
Storrs, Connecticut 06269-2176

Phone: 860-486-4514
Fax: 860-486-1719
E-mail: aargsub@gmail.com