

Becoming a target of HIV intervention

The science and politics of anthropological reframing

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Abstract

This think piece asks readers to consider how the science of anthropology has contributed to (re)categorization and imaginaries of gender, class, and the state in the context of public and global health interventions. Anthropological work on HIV has since its inception questioned the public health categories of those considered at highest risk for HIV, while simultaneously helping to reconstitute those categories, as well as definitions of risk, especially in relation to the concept of vulnerability. While anthropological research on HIV is replete with critiques of categorization as a mode of governance, most often in reference to global health and development apparatuses, anthropologists rarely reflect on the role the discipline might play in co-creating those categories to ‘make up people’ and reproduce geopolitical norms. The propositions I lay out in this think piece stem from my experience researching the emergence of public and global health categories in various national settings in eastern and southern Africa in the context of HIV interventions.

Keywords

categorization, class, global health, Kenya

While conducting HIV-related research in Kenya and elsewhere in Africa (Eswatini, Ethiopia, Tanzania, Uganda, South Africa) over the last two decades, I have become increasingly interested in how the categories of ‘class’ and ‘the state’ are wielded in global health discourse, research, and intervention sites. Taking part in a panel entitled ‘Sorting, Typing, Classifying: The Elephants in “Our” Ethnographic Rooms’, organized by Claire Beaudevin and Katharina Schramm at the 2018 European Association for Social Anthropology meeting in Stockholm, gave me the opportunity to reflect on this further.

The ‘elephant in the room’ metaphor suggests that there are elements at work in any given context, which most people present are aware of even they are not acknowledged. Said elements, or elephants, may be the result of intentional silencing for the sake of political expediency, especially if acknowledging the elephant might deflect attention from the immediate political or economic goal at hand. As an anthropologist who likes drawing attention to metaphorical elephants, this has more than once resulted in me being politely uninvited by colleagues from meetings where our research was being discussed with people who had a say over future funding opportunities. To be fair, however, my penchant for pointing out elephants has also on occasion earned me a seat at the table.

Given the high-stakes game of global health funding, the fact that some ideas are strategically ignored while others are foregrounded is not particularly surprising. Some elephants may also be ignored due to shared moral embarrassment regarding their existence. The failure of the global health establishment to respond sufficiently or quickly enough to HIV despite the availability of effective treatments has regularly been attributed to various forms of discrimination (racism, homophobia, classism, sexism, etc.). These exclusionary dynamics are best not mentioned unless trying to leverage the moral high ground to shame people, organizations, or governments into coughing up more money for medicines, health care, or social services.

The propositions I lay out in this think piece stem from my experience researching the emergence of public and global health categories in various national settings in eastern and southern Africa in the context of HIV interventions. I am most interested in the categories of class and the state, but getting to those somewhat hidden categories requires me to begin with gender, a global health category that is more visible, at least when it comes to HIV. For the last few years, I have been coordinating a multisited research project that attempts to understand shifting gender norms in Nairobi, Johannesburg, and Dar es Salaam by looking at masculinity.¹ Most recently my own research has focused on the Kenyan national response

1 For more information, see www.becoming-men.org.

to HIV as a site where specific types of masculinity are foregrounded to foster better targeted HIV prevention and treatment programs (Moyer and Igonya 2018). Working together with Kenyan colleagues,² I have been investigating how Kenya's HIV prevention apparatus targets differently positioned men. Specifically, we are examining the ways adolescent boys, men who have sex with men, and expecting fathers are, following Ian Hacking (1985), 'made up'.

Anthropology of HIV and the management of elephants

Anthropological work on HIV, especially in Africa, has since its inception been an ongoing project of pointing out various elephants in various rooms, of which there are many. Less common has been asking how the science of anthropology might be complicit in helping to conceal various elephants. Certainly, one favorite trick of the anthropological trade is to draw attention to elephants presumably concealed by governing apparatuses; in the case of HIV we generally take on global health and development apparatuses. Rarely do we reflect on the role that anthropology might play in co-creating hiding spaces for said elephants.

Using various theoretical approaches that inevitably trace back to Foucauldian critiques of biopower, neo-Marxist critiques of inequality, or Deleuzian critiques of fixity, we anthropologists show how categories are discursively and historically constructed and reconfigured through daily practice. We illustrate how categories are strategically and affectively embraced and mobilized by various individuals and groups to achieve desired ends. We also show how categories can reinforce stereotypes and result in new forms of social exclusion. We are always sure to insist upon the inherent instability of categories, which we ethnographically portray as in flux, relational, and contextual. With so much ink spilled in discussing categorization – even if not singled out in Foucault's *The Order of Things* (1970) – anthropology surely must be one of the most prolific disciplines contributing to the *reordering* of things.

² My thinking around the topic of categorization, global health, and the state in Kenya has come about through a process of collaborating with Kenyan PhD students David Bukusi, Carol Egesa, and Lucy Mung'ala, as well as Emmy Igonya, a former PhD and postdoc with whom I have published about the ways that male sex workers have emerged as a public and global health category in Kenya (Moyer and Igonya 2018). I am extremely fortunate to be able to work with this team of researchers.

From risk to vulnerability: Anthropology and reordering in global health

By ‘reordering’ I mean the ongoing processual way that science, including anthropological science, attempts to make sense of messy worlds. Although anthropologists critiquing biomedical, global health, and development interventions regularly draw attention to how people targeted by interventions reconfigure, resist, and strategically embrace biomedical and social categories in daily practice, we pay less attention to how the scientific disciplines that inform global and public health interventions also continually refine their categories to increase the impact of interventions as well as the ability to measure that impact. Yes, people have agency and resist categorization, but organizations are savvy and there is much at stake financially, prompting those responsible for global health interventions to also recategorize, to reorder. In the context of HIV, the continued refinement of what are essentially epidemiological categories has intensified in recent years as data-driven responses and ‘value for money’ discourses have increasingly come to shape interventions. In Kenya and in most other African countries that benefit from global health funding for their HIV response, the result has been an unprecedented effort to measure and model the HIV response to get the right pills into the right bodies in the right places.

Although the most recent recategorizations, resulting in what are often referred to as ‘key populations’, have primarily been driven by epidemiological data, anthropology has also played an important role. The critiques we have offered of previous categorizations have led to new categories intended to be less exclusionary, less discriminatory, less damaging. Since the 1980s anthropologists have been shaping epidemiologically informed HIV-risk categories. In the United States, the Centers for Disease Control and Prevention initially defined four populations at risk for AIDS: homosexuals, heroin users, Haitians, and hemophiliacs. Almost immediately, anthropologists living and working among these soon-to-be-targeted risk groups joined forces with community-based activists to resist. For example, Richard Parker and Manuel Carballo (1991) drew on their ethnographic research in Brazil to help develop the category ‘men who have sex with men’, or ‘MSM’, to replace the category of ‘homosexuals’. Merrill Singer (1996) drew on his research in Hartford, Connecticut, to recategorize heroin users as ‘intravenous drug users’ or ‘IDU’, and later as ‘people who inject drugs’ (PWID). He also introduced the concept of syndemic, which thirty years on, *The Lancet* (2017) has finally seen fit to suggest is an important way to theorize disease vulnerability in relation to broader social, economic, environmental, and political contexts. Similarly, Paul Farmer (1992) drew on his ethnographic work in Haiti to theorize the relationship between inequality and HIV risk, so that Haitians and eventually sub-Saharan Africans were no longer seen as being ‘at risk of’ but rather as ‘vulnerable to’ HIV. Brooke Schoepf (1992), working in what was then Zaire, and Janet McGrath and colleagues (1992),

working in Uganda, helped to refine the category of prostitute, contributing to the categories of sex worker and transactional sex on the one hand, and the disempowered and thus vulnerable African woman on the other (see also Farmer, Connors, and Simmons 1996).

We can see in these reorderings how explicitly anthropological conceptions of HIV risk and vulnerability have led to new public and global categories, which in turn have led to the terms ‘MSM’, ‘IDU’, ‘PWID’, ‘sex worker’, ‘vulnerability’, and even ‘syndemic’ being introduced into public and global health interventions, policies, and practices, though often in ways that simplify anthropological understandings of these categories as unstable and contingent. In fact, these categories often come to serve as indicators of the ‘social’ in public and global health interventions that are otherwise biomedically reductionist (Adams et al. 2019). Ironically, these very categories, in part invented via the science of anthropology, have become the objects of ethnographic critique in the contemporary era (see for example Boellstorff 2011; Lorway, Reza-Paul, and Pasha 2009).

Elephants in the room: The middle class

I would also argue that anthropological conceptualizations of how HIV vulnerability and gender intersect in Africa have contributed to the concealment of HIV risk among African men, quite often portraying them as the victimizers of vulnerable and victimized African women (for example, Susser 2009). It is no coincidence that until quite recently men have very rarely been the targets of HIV or other health and development interventions. While I consider the concealment of men’s HIV risk in Africa as troubling indeed, rather than focus on gender in this think piece, I want to foreground class.

HIV in Kenya and elsewhere in Africa is widely described in global discourses as a disease of poverty that most widely affects the lower classes, generally referred to simply as ‘the poor’. As mentioned, the figuring of HIV as a disease of economic vulnerability is as much a consequence of anthropological ordering as anything else. Further, I would argue that this portrayal is central to the politics of pity enmeshed in the continued flow of funding for HIV interventions. Although anthropologists have repeatedly argued that the proliferation of HIV can be tied to economic inequality – to poverty in the face of wealth and not just poverty alone – we have also relentlessly focused our ethnographic attention on how the poor and most vulnerable have been affected by the disease. We must ask ourselves: to what extent have our ethnographic accounts, in attempting to ‘put a human face on AIDS’ or ‘give voice to the voiceless’, also contributed to portraying the poor as not only victims but also as the *only* victims, even as we do our best to demonstrate their agency and resilience? What is more, we must ask: how has anthropology contributed to concealing the HIV-related

experiences of middle- and upper-class Africans, and even worse, the existence of middle- and upper-class Africans as deserving of life-saving medicines and other HIV services?

Accompanying the elephant of class here is one of race: HIV vulnerability in Africa and elsewhere has largely been conceived by US-based researchers employing a neo-Marxist framework in which vulnerability is tied to poverty. Add to this Euro-American imaginaries of Africa as a continent beset by poverty, and the result is the exclusion of the middle and upper classes in Africa from most HIV interventions. What might be gained by recognizing and engaging with the elephant of class from a perspective of public and global health? Might we begin to understand how people with a bit of money are excluded from obtaining free HIV medicines in public clinics, how they are bankrupted as a consequence of a class position that requires them to spend large sums on more expensive second- and third-line treatments in private clinics, thereby rendering first-line treatments ineffective? Further, what happens to anthropological theories of gender inequality, stigma, agency, risk, and vulnerability if we reconfigure African middle-class people, specifically middle-class men, as 'at risk' for HIV?

Seeing class-based inequalities as a driver of HIV among differently classed people and not just 'the poor' is threatening on several fronts. Many global health HIV interventions operate on the presumption that poor African women are deserving of international help because they are framed as virtuous victims, exposed to HIV by cheating husbands and unscrupulous older men, and through economically necessary sexual transactions with men who refuse to use condoms. In these scenarios men's gender power is equated with economic power, even, or perhaps especially, at the household level. African women's power, economic and otherwise, is ignored in service of normative global health discourses. Financially, the stakes are very high; the donors who fund HIV interventions (and the tax-paying voters of bilateral donors especially) must justify their expenditures. More than thirty years into the epidemic, the poor African woman (and her children) remains a powerful justification for intervention.

Ignoring the state in global health

The second categorical elephant I want to shine the spotlight on is the state. Unlike class, gender, and race, 'the state' is not an identity-based category and thus operates in a fundamentally different way in the context of global health HIV interventions. But, like class, the state, especially 'the African state,' is often hidden, lurking in the background, threatening to unsettle the good work of global health via corruption, poor governance, or the failure to 'take ownership' of internationally funded interventions. It would seem too that African women are not just let down by African men but also by their political leaders.

As a category, the state intersects with the categories of class and gender, resulting in national statistics that allow for comparing one state to another. These statistics and the ability to produce them for (and often together with) donors affects whether a country will be seen as ‘good’ for global health investments. Comparing the different countries where I have worked, it is clear that some countries are considered more deserving than others, primarily because it is easier to show measurable results in those countries. Similar to the figure of the poor African woman, countries that can demonstrate the positive effect of internationally funded HIV interventions, like Kenya, help to keep the money flowing. Beginning in the mid-2000s, Kenya quickly advanced its reputation in this regard, leading the way in the African region in terms of scaling up access to antiretroviral treatment, collecting fine-grained nationally representative statistics, and partnering with international agencies and organizations to trial and provide evidence for new HIV-prevention technologies, both medical and social. Scientific work carried out in Kenya and often by Kenyans has also led to the recategorizing of HIV risk, shaping the Kenyan response to the disease. This Kenyan science is also increasingly shaping the global HIV response and categories of risk beyond Kenya.

As powerfully important as state buy-in is for the success of a public health response, anthropologists very rarely study the state as an important player in global health interventions. With few exceptions (for example, Crane 2013; Geissler 2015), anthropologists who take global health as their object tend to divide the world into global and local players, with global players located in North America and Europe (sometimes Japan), and local players located in Africa, Latin America, and Southeast Asia. In this regard, ‘the local’ perspective in Africa can be equated as easily with that of a remote rural village chairman, the minister of health, or anyone in between.

We rarely study the local Euro-American worlds of international NGOs or take seriously the global trajectories and entanglements of Africans who work in the HIV world (Benton 2016; Elliott 2017). We see our ethnographic field as the location or the population targeted by global health, and our ethnographic task as one of translating between the global and the local or reporting on cultural misunderstanding. But where is the state in our research? Certainly anthropologists have documented the emergence of new forms of biocitizenship in the context of HIV, but to a large extent such research has emphasized the unreliability of the African state when it comes to providing HIV-related health care and the consequent need for both activists and expert clients to appeal to international organizations for care (Nguyen 2010; Whyte 2009). Where is our analysis of bilateral exchanges, the exportation of gender and sexual norms from one country (and not just the United States) to another, sovereign muscle flexing, and plain old-fashioned nationalism? Global health responses are justified by the presumption that some states cannot or will not fund public health, that they

do not have the capacity to organize an effective public health response, or that certain diseases pose too great a threat to donor countries to leave them in the hands of recipient countries. Enfolded into such presumptions are elephants galore, well worthy of anthropological investigation.

Anthropologists could learn a great deal from investigating the silences we help to perpetuate, the elephants we collude to conceal. What politics are at stake in our failure to ‘study up’ in global health, in our failure to take the class or the state seriously in our research?

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References

- Adams, Vincanne, Dominique Behague, Carlo Caduff, Ilana Löwy, and Francisco Ortega. 2019. ‘Re-imagining Global Health through Social Medicine’. *Global Public Health* 14 (10): 1383–1400. <https://doi.org/10.1080/17441692.2019.1587639>.
- Benton, Aida. 2016. ‘African Expatriates and Race in the Anthropology of Humanitarianism’. *Critical African Studies* 8 (3): 266–77. <https://doi.org/10.1080/21681392.2016.1244956>.
- Boellstorff, Tom. 2011. ‘But Do Not Identify as Gay: A Proleptic Genealogy of the MSM category’. *Cultural Anthropology* 26 (2): 287–312. <https://doi.org/10.1111/j.1548-1360.2011.01100.x>.
- Crane, Joanna. 2013. *Scrambling for Africa: AIDS, Expertise, and the Rise of American Global Health Science*. Ithaca, NY: Cornell University Press.

- Elliot, Denielle. 2017. 'Transnational Scientific Projects and Racial Politics: The KEMRI Six Case against the KEMRI-Wellcome Trust Research Programme in Contemporary Kenya'. *Medizinethnologie*, 7 August. <https://www.medizinethnologie.net/the-kemri-six-case/>.
- Farmer, Paul. 1992. *AIDS and Accusation: Haiti and the Geography of Blame*. Berkeley: University of California Press.
- Farmer, Paul, Margaret Connors, and Janie Simmons. 1996. *Women, Poverty and AIDS: Sex, Drugs and Sexual Violence*. Boston: Common Courage Press.
- Foucault, Michel. 1971. *The Order of Things*. New York: Pantheon.
- Geissler, Paul Wenzel. 2015. 'Introduction: A Life Science in Its African Para-State'. In *Para-States and Medical Science: Making African Global Health*, edited by Paul Wenzel Geissler, 1–44. Durham, NC: Duke University Press.
- Hacking, Ian. 1985. 'Making up People'. In *Reconstructing Individualism*, edited by Thomas C. Heller, Morton Sosna, and David E. Wellbery, 161–71. Stanford, CA: Stanford University Press.
- Lorway, Robert, Sushena Reza-Paul, and Akram Pasha. 2009. 'On Becoming a Male Sex Worker in Mysore: Sexual Subjectivity, "Empowerment", and Community-based HIV Prevention Research.' *Medical Anthropology Quarterly* 23 (2): 142–60. <https://doi.org/10.1111/j.1548-1387.2009.01052.x>.
- McGrath Janet W., Debra A. Schumann, and Jonnie Pearson-Marks. 1992. 'Cultural Determinants of Sexual Risk Behavior for AIDS among Baganda Women'. *Medical Anthropology Quarterly* 6 (2): 153–61. <https://doi.org/10.1525/maq.1992.6.2.02a00070>.
- Moyer, Eileen, and Emmy Igonya. 2018. 'Queering the Evidence: Remaking Homosexuality and HIV to "End AIDS" in Kenya'. *Global Public Health* 13 (8): 1007–1019. <https://doi.org/10.1080/17441692.2018.1462841>.
- Nguyen, Vinh-Kim. 2010. *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS*. Durham, NC: Duke University Press.
- Parker, Richard, and Manuel Carballo. 1990. 'Qualitative Research on Homosexual and Bisexual Behaviour Relevant to HIV/AIDS'. *Journal of Sex Research* 27 (4): 497–525. <https://www.jstor.org/stable/3812771>.
- Schoepf, Broek. 1992. 'Women at Risk: Case Studies from Zaire'. In *In the Time of AIDS: Social Analysis, Theory and Method*, edited by Gilbert Herdt and Shirley Lindenbaum, 259–86. London: Sage.
- Singer, Merrill. 1996. 'A Dose of Drugs, a Touch of Violence, a Case of AIDS: Conceptualizing the SAVA Syndemic'. *Free Inquiry* 24: 99–110.
- Susser, Ida. 2009. *AIDS, Sex and Culture: Global Politics and Survival in Southern Africa*. New York: Wiley.

Whyte, Susan Reynolds. 2009. 'Health Identities and Subjectivities: The Ethnographic Challenge'. *Medical Anthropology Quarterly* 23 (1): 6–15.
<https://doi.org/10.1111/j.1548-1387.2009.01034.x>.