Along with the lazy man, and more than he, the dying man is the immoral man: the former, a subject that does not work; the latter, an object that no longer even makes itself available to be worked on by others.

Michel de Certeau, The Practice of Everyday Life (1984, p. 190)
It is very true: if you become lazy before you die, you can expect more problems to come. Some die strong, others weak: they spend maybe three years doing nothing, just sleeping. It is better to die strongly; it is bad to be in bed for three years. It is better to struggle while we still have life – better to die with an axe in your hand (cawama ukuwfa na isembe muminwe).
Gideon Kasakula, interview in Mukungule, Zambia, 2007

1. Prologue: Grace (The funeral and after)
Grace Musolo died of AIDS on Monday, November 21, 2006. After her death, Grace’s maternal uncle, Philemon Bwalya, found a month’s worth of her antiretroviral therapy (ART) among her possessions. As people gathered to mourn Grace’s passing, a rumor began circulating: what made initial cohorts of African PLHA exceptionally adherent? To raise the pressing question of “what happens next?” Previous scholarship addressing this question has analyzed how PLHA navigate the competing moral and political economies of local kinship and social networks and global HIV/AIDS initiatives. Scholars have emphasized the afterlives of access and adherence, looking beyond survival to what “the good life” means for PLHA, and placing PLHA at the center of action and analysis. This paper flips that script, by focusing on the stories that Grace’s death spurred Mukungule residents to share. It shows how attention to and analysis of stories told not just about, but by members of PLHA’s kinship and social networks, are critical to developing a more robust understanding of exemplary adherence and treatment failure. Such understanding critically depends on paying more attention to how those living with and caring for PLHA (and especially their families) facilitate PLHA’s pursuit of good and “normal” lives – not just while, but also through, pursuing their own.

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https://doi.org/10.1016/j.socscimed.2018.01.021
Received 13 July 2017; Received in revised form 16 January 2018; Accepted 17 January 2018
Available online 02 February 2018
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moral decay in Mukungule, invoking Sodom and Gomorrah and con-
demning young women who left Mukungule “to compete to attract men
as the most beautiful,” before returning home, “where we can all see the
consequences.”

When Mr. Mumbi finished, the men began to shovel dirt onto
Grace’s coffin, and a solemn procession of friends and family laid
flowers on top of the burial mound. The crowd left the graveyard de-
bating Grace’s death. They pondered the contradictory accounts from
the funeral. Why had Grace really stopped taking her ART? Had it been
advice from church members, pressure from the Bwalya family, de-
pression over the difficult conditions of her life in Mukungule, or
something else altogether? Had she been fully aware of the con-
sequences of her decision; was this a case of suicide by non-adherence?
What did her death suggest about ART in Mukungule, barely a year
after it became available?

2. Therapeutic trajectories: citizenship, clientli
ship, and
“the good life”

The roll-out of ART throughout sub-Saharan Africa sparked con-
tentious debate, as researchers, citing the challenges facing ART ad-
herence in resource-poor (and particularly rural) settings, warned of
“antiretroviral anarchy” (Harries et al., 2001). Subsequent analyses,
demonstrated high rates of ART adherence over a range of
African sites (Mills et al., 2006), such that by the time of Grace’s death,
Nguyen et al. (2007) could assert, “the relevant research question is not
why a small minority of [African] patients are non-adherent, but rather,
why are patients so exceptionally adherent to treatment” (p. S32).

Nguyen answered this question with the concept of therapeutic ci-
izenship. Therapeutic citizenship entails a person’s ability to utilize
serostatus to “claim resources from public sector or non-governmental
organization (NGO) programmes” (Nguyen et al., 2007, p. S33), and
thus secure “position in the kinship networks that, in the absence of a
viable state, are the only available forms of social solidarity” (Nguyen
et al., 2007). Therapeutic citizenship is enabled by global HIV/AIDS
programs, which have created a novel moral economy among people
living with HIV and ART (PLHA) – one that encourages individualistic
approaches to adherence, with emphasis on self-reliance and personal
responsibility – a “responsibilisation” which, Beckmann (2013) argues,
threatens to elide PLHA negotiations over other forms of responsibility
(e.g., to their families) (pp. 161, 171). These programs urge PLHA to
work together in coping with their social and biological vulnerability,
by supporting and being responsible to one another as individuals. This
creates a novel form of social solidarity rooted in serostatus: a “biosoc-
ciality.” The demands of this globalized moral economy of HIV/AIDS
programs co-exist but contrast with demands of extant moral economies
rooted in kinship and local social networks. Nguyen employed the
concept of therapeutic citizenship to analyze the ways in which PLHA
navigate these different moral economies, striving to maintain ad-
herence to ART and advance their life goals. “Exemplary adherence,”
Nguyen et al. (2007) asserted, “should be viewed through the lens of
therapeutic citizenship” (p. S31).

As a case study, Nguyen et al. (2007) and Nguyen (2010) narrated
the story of Abdoulaye, a Burkinabé who tested positive for HIV in the
late 1990s. Abdoulaye garnered early access to ART through his lea-
dership of a small HIV/AIDS NGO, which helped him tap into global
HIV/AIDS resources. He also helped his HIV-positive aunt access ART.
The aunt died soon after, however, and Abdoulaye moved out of his
family’s compound, upset by accusations of witchcraft sparked by her
death, and his daughter’s frequent illnesses. As he departed, “Abdoulaye
told [Nguyen] he was ‘tired’ of these ‘African stories’” (p. 131). Nguyen
ended Abdoulaye’s narrative there, preserving focus on how Abdoulaye
advanced “a political claim to belonging to a global community that
offers access to treatment” (Nguyen et al., 2007; S34). Details of ev-
eryday life in Abdoulaye’s family – and the ramifications of his choice to
distance himself from his kinship network, in favor of alternative moral
economies and social solidarity – remained peripheral.

Abdoulaye’s “African stories” raise questions about how the “ther-
apeutic revolution” (Nguyen, 2010, p. 89) actually plays out in the lives
of PLHA – and the lives of those in their kinship and social networks. If,
as a therapeutic citizen, Abdoulaye reveals key dimensions of “ex-
emplary adherence,” what might this suggest about the burdens and
costs of such adherence – and who bears them? Whyte (2014) suggest a
different lens for examining these “African stories”: therapeutic client-
ship. Whereas therapeutic citizenship deals with PLHA’s claims on the
state and international actors via NGOs and other intermediaries,
therapeutic clientship emphasizes the ways in which PLHA pursue HIV/
AIDS resources within their more local networks (p. 58). “Clientship,”
they argue, “corresponds more closely to what Nguyen refers to as ‘local
moral economies,’ in which individuals call on networks of obligation
and reciprocity to negotiate access to therapeutic resources” – adding
that therapeutic clients were much thicker on the ground in their work
(in Uganda) than therapeutic citizens (Whyte, 2014). While Whyte and
colleagues position therapeutic clientship as complementary to ther-
apeutic citizenship, they observe that, pace Nguyen, the PLHA with
whom they worked “did not seem to feel caught between conflicting
moral economies … [C]lients joined groups not only for ‘self-care’ and
bio-fellowship, but also to (re)gain the ability to participate in family
sociality. In the end, that was the most important concern for most of
the people most of the time …. Those relations [of therapeutic client-
ship] were the condition for continuing life in their families” (Whyte,

Whyte’s work reflects a broader body of scholarship that moves
beyond asking, “what makes African PLHA exceptionally adherent?” to
raise the pressing question of, “what happens next?” A key strand of this
literature emphasizes the afterlives of access and adherence: looking
beyond survival to what “the good life” – thriving, not just surviving –
means for PLHA (Marsland, 2012; Meinert, 2014; Whyte, 2014). These
studies, like Nguyen’s, place PLHA at the center of action and analysis:
featuring them, primarily as protagonists, in the life-and-death dramas
they present. Family members often occupy key supporting roles, but
analyses rarely focus on them (or their stories) in their own rights.

In this paper, I flip this script. Drawing on ethnographic research on
health, development, and environment I conducted in Mukungule in
2006–7 and 2008, I analyze the stories Grace’s death spurred family,
friends, neighbors, and caregivers to share. Attention to and analysis of
these “African stories” – told not just about, but by members of the
networks and relations (kinship, social, therapeutic) of PLHA – are, I
show, critical to developing a more robust understanding of the ways
in which PLHA navigate moral economies, social solidarity, and efforts
to secure “the good life” in a world of triage and precarity. This is a world
in which PLHA – whether therapeutic citizens or clients; entrepreneurs
or patrons; or all or none of the above – are, for better and worse, not
solely responsible for decisions about who’s made to live, who makes a
living, and what makes a good life and a good death (Foucault, 1997;
Marsland and Prince, 2012; Whyte, 2014).

3. Methods

I first heard about Grace’s death on the day of her funeral. John
Musakanya, the fieldworker on my study, arrived at my home that
morning and informed me that we would need to adjust our survey
schedule. He reported that the Bwalya family had suffered a loss, and
encouraged me to attend the funeral as a show of respect.

The Bwalyas were one of 20 households in my study. I identified
those households with the help of Mukungule’s RHC and Area
Development Committee (ADC), a group formed in order to coordinate
local development projects. The RHC and ADC convened a public
meeting during my first trip to Mukungule in 2006. Meeting partici-
pants generated a list of more than 50 potential households, and guided
me in narrowing the roster to 20. All household members above the age
of 12 initially agreed to participate; one two-person household
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