



Antiretroviral therapy and reproductive life projects: Mitigating the stigma of AIDS in Nigeria

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ABSTRACT

As millions of people infected with HIV in Africa are increasingly able to live longer and healthier lives because of access to antiretroviral therapy, concerns have emerged that people might eschew protective practices after their health improves. Extending beyond the notion of sexual “disinhibition,” researchers have begun to analyze the sexual behavior of people in treatment through the perspective of their marital and childbearing aspirations. This article explores the reproductive life projects of HIV-positive men and women in southeastern Nigeria, showing how actions that contradict medical advice are understandable in the context of patients’ socially normative desires for marriage and children. Based on in-depth interviews and observations (June–December 2004; June–July 2006; June–July 2007) of people enrolled in the region’s oldest treatment program, we argue that broadly held social expectations with regard to reproduction are experienced even more acutely by HIV-positive people. This is because in Nigeria the stigma associated with AIDS is closely tied to widespread perceptions of social and moral crisis, such that AIDS itself is seen as both a cause and a symptom of anxiety-producing forms of social change. Specifically, in an era of rapid societal transformation, Nigerians see sexual promiscuity and the alienation of young people from traditional obligations to kin and community as indicative of threatened social reproduction. For people who are HIV-positive, marrying and having children offer not only the opportunity to lead normal lives, but also a means to mitigate the stigma associated with the disease. Four ethnographic case studies are provided to exemplify how and why social and personal life projects can trump or complicate medical and public health priorities. These examples suggest that treatment programs must openly address and proactively support the life projects of people on antiretroviral therapy if the full benefits of expanded access to treatment are to be realized.

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Introduction

Over the past several years, antiretroviral therapy (ART) for HIV and AIDS has become widely available in poor countries, with millions of people benefiting from increased donor commitments, lower drug costs, and expanding governmental and non-governmental programs. This enormous increase in access is laudable for enabling people to live longer and healthier lives despite HIV infection. However, it also creates a whole range of new possibilities and problems, as those receiving treatment re-imagine and forge their larger “life projects” – that is, the socially attuned and culturally inflected aims and aspirations they have for their life course. In particular, as people realize that HIV infection is no longer a certain death sentence, they strive to actualize their most important priorities, which in Nigeria (and elsewhere) almost

always include sexual relations, marriage, and childbearing. Yet even as ART enables men and women living with HIV to embark on the life projects of marriage and reproduction, they also face numerous social, ethical, and medical dilemmas as they try to live out their ambitions and live up to social norms. Although ART permits people with HIV to hope for and undertake these life projects, it also complicates them, as the medical consequences and public health implications of sex and reproduction conflict with personal priorities and social expectations. Conversely, achieving their reproductive goals frequently impinges on people’s capacity to stay on therapy, follow recommended treatment regimes, and take adequate precautions to protect others (and themselves) from further infection.

As in many parts of the world, life-saving antiretroviral drugs (ARVs) have only recently become more widely available to Nigerians. Africa’s most populous country, with more than 140 million people, has an adult HIV infection rate estimated to be 3.1 percent, translating into approximately 2.6 million people currently

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living with the virus (UNAIDS, 2008). The Nigerian federal government launched a small-scale treatment program in 2001 that enrolled fewer than 10,000 people over four years. In late 2005, in conjunction with the increased support for antiretroviral therapy provided by international donors such as The Global Fund and the U.S. President's Emergency Plan for AIDS Relief, Nigeria's President Olusegun Obasanjo announced that all people in the country who need ART (defined in Nigeria as people with CD4 counts below 200 or who present with AIDS) would receive drugs free of charge. The initial goal was to reach 250,000 people by June 2006. While this ambitious target was not achieved, 2008 estimates indicate that approximately 200,000 Nigerians are receiving treatment through the scaled-up program, and enrollment continues to grow.

As ART has expanded, attention has begun to turn to the implications of treatment with regard to prevention, and specifically the sexual behavior of recipients (Cusick & Rhodes, 2000; Lurie et al., 2008; Moore & Oppong, 2007; Seeley et al., 2009). Part of the motivation for studies of the sexual behavior of people on ART is a fear that successful treatment will lead to sexual "disinhibition" – that is, with the availability of successful treatment, people may eschew protective behaviors. Research in developing countries has mainly addressed behavior identified as risky by utilizing quantitative data from surveys (Bateganya et al., 2005; Loubiere et al., 2009; Moatti et al., 2003). More recently, studies have considered the sexual behavior of people on ART from the perspective of their marital and reproductive goals (Cooper, Harries, Myer, Orner, & Bracken, 2007; Homsy et al., 2009; Myer, Morroni, & Rebe, 2007). This trajectory of research suggests that the conduct of people in treatment for HIV must be understood through a lens that connects sexuality to gender, reproduction, and larger social contexts (Gruskin, Firestone, MacCarthy, & Ferguson, 2008; Hirsch, 2007; Laher et al., 2009; Persson & Richards, 2008). But surprisingly little ethnographic research has been undertaken on the topic (for exceptions, see Castro, Khawja, & González-Núñez, 2007; Watt et al., 2009; Ware et al., 2009). An anthropological approach can provide the wider social perspective and the intimate details of individual lives that are necessary to make sense of behaviors that would otherwise be difficult to understand.

This paper reports on ethnographic research conducted among people on ART in southeastern Nigeria, focusing particularly on the intersection between the therapeutic itineraries of individuals on treatment and their reproductive life projects. Four emblematic case studies are presented to understand how marriage and childbearing are particularly salient in explaining why people's larger life projects can complicate and even trump medical and public health priorities in Nigeria and beyond. In an era of rapid social change, anxieties about the future of traditional kinship are widespread. Ordinary Nigerians often interpret HIV and AIDS as symptomatic of a general sense of social and moral crisis in which perceptions of unfettered promiscuous sex abound. In response to widely shared apprehensions about social reproduction, young Nigerians – regardless of their HIV status – commonly experience intense pressures to marry and have children. But for people who are HIV-positive, these expectations are even sharper, not only because ART makes possible the desire to reclaim normal life courses, but also because part of AIDS's social stigma derives from its moral association with the breakdown of pro-kinship values that are widely perceived to be essential to stable social reproduction. For people who are on ART, successful marriage and childbearing are inextricably tied to protecting their social reputations, hiding their HIV-positive status, and avoiding stigma. Marrying and having children offer path to normalcy, but also a way of countering the popular perception that people contract HIV because they behave in ways that flout widely accepted moral notions that

connect sex and social reproduction. Marriage and fertility fulfill these obligations of social reproduction, contesting the idea that AIDS is a cause and a symptom of social and moral failures. In Nigeria – and arguably in many African settings where the situation is similar – successful expansion of treatment and continued efforts at prevention require policies and programs that more readily acknowledge and more explicitly enable people's larger life projects.

Research setting and methods

The findings presented in this paper are the result of several years of work and study by the authors with patients receiving ARVs from the Federal Medical Centre (FMC) in the southeastern Nigerian city of Owerri. Until recently, FMC-Owerri was the only facility in the region offering ART. The hospital initially enrolled 450 adults living with HIV, and from 2002 through 2005 these individuals received drugs at a highly subsidized rate (less than \$10 per person per month). In 2006, following the new policy of free drugs and the plans for a massive scale-up, FMC-Owerri began expanding its government-supported program with a target of 2000 patients. By 2007 this target was achieved.

The first author has worked in southeastern Nigeria since 1989, initially as a public health advisor based in Owerri for three years, and since 1994 as an anthropologist. He has studied Nigeria's HIV epidemic since 2000, and from 2004 to 2007 conducted extended interviews with people receiving ART through the FMC-Owerri program. In 2004, he led the Nigeria component of an NIH-funded five-country comparative ethnographic research project, "Love, Marriage, and HIV," in which the marital and reproductive experiences and plans of people on ART became an important sub-theme of the larger study (Hirsch et al., 2009).

The second author founded the Owerri-based non-governmental organization, Community and Youth Development Initiatives (CYDI), in 2001, with the principal aim of addressing Nigeria's AIDS epidemic by mobilizing local people and resources to increase effective prevention, offer counseling, and provide care and support for individuals living with the virus. CYDI has worked to organize prevention activities for hard-to-reach populations like urban non-school youths, created the most prominent and popular center for counseling and information about HIV and AIDS in the city, and helped to found the first support group in Imo State for people living with HIV, called the Association for Positive Care (AsPoCa), which is comprised of dozens of individuals receiving ART through the FMC-Owerri program. The second author has counseled scores of people who are HIV-positive.

The findings in the paper are the result of the observations, interviews, and experiences of the authors working with HIV-infected people receiving ART. Participants were recruited through information provided about the study on clinic days and at meetings of a local support group for people living with HIV. This opportunistic sample included a range of ages and marital statuses, equal numbers of men and women, and individuals who had been on treatment for as long as four years and as briefly as six months. Interviews were conducted by the authors, in mixtures of English, Pidgin English, and Igbo, with 22 people receiving treatment. Interviews were transcribed (and, where necessary, translated into English) and coded using the qualitative software data organizing program, Atlas.ti. Interviews were supplemented by observations and interactions with study subjects outside the context of formal interviews. All of the names of the individuals whose cases are described are pseudonyms, and aspects of their stories have been disguised to protect their anonymity. Each interviewee provided formal consent to participate in the study and IRB approval for the research was obtained at Brown University in the USA and at Abia State University in Nigeria.

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