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Temporality and Positive Living in the Age of HIV/AIDS--A Multi-Sited Ethnography

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Abstract

Drawing on comparative ethnographic fieldwork conducted in urban Mozambique, United States, and Sierra Leone, the article is broadly concerned with the globalization of temporal logics and how specific ideologies of time and temporality accompany health interventions like those for HIV/AIDS. More specifically, we explore how HIV-positive individuals have been increasingly encouraged to pursue healthier and more fulfilling lives through a set of moral, physical, and social practices called “positive living” since the advent of antiretroviral therapies. We describe how positive living, a feature of HIV/AIDS programs throughout the world, has taken root across varied political, social and economic contexts and how temporal rationalities, which have largely been under-examined in the HIV/AIDS literature, shape communities’ responses and interpretations of positive living. Our approach is ethnographic and comparative, with implications for how anthropologists might think about collaboration and its analytical possibilities.

In a June 2001 interview with the *Boston Globe*, USAID director Andrew Natsios famously remarked that antiretroviral therapies—then, a fairly new and effective regimen for treating people diagnosed with HIV/AIDS—were not appropriate for Africans because “they don’t know what Western time is. You have to take these (AIDS) drugs a certain number of hours each day, or they don’t work. Many people in Africa have never seen a clock or watch their entire lives” (Donnelly 2001). Natsios’ comments infuriated many, sparking opinion pieces in major news outlets, scathing academic critiques, and condemnation from Africa-interested activist groups (Herbert 2001). Natsios was rightly critiqued for the racist assumptions about African capacities in his remarks; however, the critiques also highlighted how Natsios’ ideas about “African time” reflected a commonly held assumption among US development industry elite, which ultimately shaped global health policies and practice (Kahn 2001).

Under-examined is how less overt—but equally significant—conceptions of time and temporality configure and reflect power relations in global health, and how conceptions of time embedded in public health programs directed at HIV-positive people mediate and conjure notions of difference, health, and the self. Today, a public statement like Natsios' would be unthinkable -- or at the very least, inarticulable -- in mainstream global health circles, which now accepts the basic premise that effective therapies for common deadly diseases should be accessible to the world's poor. Yet time and temporality, as functions and expressions of power, continue to figure prominently in such programs' architecture and execution, shaped by the logics of a past envisioned as one where a gay, white, and Western social movement succeeded in gaining access to lifesaving treatment and a future characterized by the ideals of living a lifetime with HIV/AIDS.

In this paper, we draw on a multi-sited approach to trace how time and temporality circulate with HIV/AIDS programs along routes marked by steeply graded inequalities and propelled by perceptions of radical difference. Specifically, we focus on the temporal orders and sited (dis)placements that shape, guide, and organize positive living—orders that are central to understanding biopolitical, biosocial, and citizenship claims related to experiences of living with HIV/AIDS. To do so, we draw on fieldwork conducted in three field sites: Kalofonos in Chimoio, Mozambique (2003–2010), Sangaramoorthy in Miami, United States (2004–2006), and Benton in Freetown, Sierra Leone (2005–2007). While we planned and conducted our research projects independently,¹ we had similar guiding questions for our research: how do HIV/AIDS programs and ART rollout operate in settings where populations had been considered “resource-poor,” “difficult-to-reach,” or “high risk?” How do these populations make certain kinds of claims through the platform of HIV/AIDS prevention? What does this reveal about the complex entanglements between everyday practices and broader logics of power operating in the field of “global health?”

Kalofonos (2008, 2010, 2014) was based in Chimoio, a provincial capital in central Mozambique. He conducted participant observation with associations of people living with HIV/AIDS, networks of community home-based care volunteers, in clinics, administrative offices, and the mundane spaces of daily life: church, homes, neighborhood streets, and community events such as weddings and funerals. Sangaramoorthy (2014) worked with HIV/AIDS experts, public officials, and Haitians in Miami, Florida. She conducted fieldwork at county and state health departments, clinical sites such as large hospitals and community-based clinics and service organizations in Little Haiti, amongst community advocacy groups and coalitions, and within everyday spaces (e.g., homes, churches, “petit magasins”). Benton conducted her fieldwork in Freetown's HIV/AIDS support associations and governing bodies, as well as clinics, public spaces and private homes. She attended workshop and training sessions, worked for non-HIV/AIDS health and development projects, and participated in day-to-day activities (e.g. visiting markets and neighbors, observing religious holidays) and community events.

¹For additional information about theoretical frameworks, methodology and findings, as well as specific epidemiology and political economic concerns for each of the three field sites, please see Kalofonos (2008), Sangaramoorthy (2014), and Benton (2015).

Despite the distinct differences among our field sites, we found that positive living, as a basic framework within HIV/AIDS programs, was a constant across them, with implications for how we think about the relationships among time, power, and subjectivity across multiple geographic sites. In each of our sites, positive living entails: disclosing one's HIV-positive status to potential sexual partners, family members, and friends; practicing "safer sex;" eating well and abstaining from drinking and smoking; and regularly taking medications. More intangibly, positive living, as the name suggests, also requires a marked positive change in attitude and self-perceptions, and demonstrable levels of self-sufficiency, responsibility, and expressed concern about self-care among HIV-positive people. Positive living's temporal logic entails *synchronizing* the rhythms of everyday life with HIV/AIDS treatment and behavioral regimens—and by extension, with viral replication and CD4 counts. While the rhythms and tempos of everyday life are not confined to those operating under the logics of HIV/AIDS programs -- and may also include temporalities of commerce and labor, migrations, and family life more generally - - we focus on those related to HIV/AIDS programs for the sake of providing sharp comparative analyses of positive living as a *globalized* phenomenon that makes analysis of time and power possible.

These geographically dispersed communities share another feature: their social location vis-à-vis an HIV/AIDS apparatus largely built up and fortified in the Global North. They are frequently the "targets" of intervention and subject to a range of educational and clinical prescriptions and proscriptions about how to manage and live with what has come to be known as a chronic condition. As we traced positive living's path into our sites, we found that the social production of difference, refracted through the notion of the post-colonial, accompanied it. Here, we do not use "post-colonial" to simply refer to a time period, location, or group of people (though it may refer to any or all of these); nor do we mean to insist that all relations to which we will refer are mediated through reference to European and American variants of colonialism and imperialism (though many are). Rather, we use the term to signal a temporal and spatial specter haunting each of our field sites: notions of the objective, the authoritative, and the universal have been shaped by a history of (Western) technoscientific intervention that have influenced assumptions about difference, modernity, and the future (see Childs and Williams 1997; Anderson 2002).

The "post-colonial" also signals a set of historical relationships and enduring connections among our research sites vis-à-vis political economy, state-building, and "development." It provides a shorthand for the common characterization of these spaces in terms of scarcity, lack, and absence, and that temporalizes them in relation to these characterizations (Mbembé 2001:5; Fabian 1983). Notions of progress—economic, social, political, and even epidemiological ones—that separate West from Rest enable a denial of coevalness of people living where these health projects multiply. In essence, the reason Miami's Little Haiti (sometimes derisively said to resemble Africa) can be analyzed alongside distant and undeniably African Freetown and Chimoio is because it bears the persistent burden of radical otherness in the US popular and public health imagination. It is a West that is not the West (Niranjana 2006). What is glossed as "global" simultaneously visibilizes the West's "success" in fighting an epidemic, while it also obscures places like Little Haiti from view in its past and ongoing failures. Conceptualizing these sites and projects as post-colonial offers

a corrective to conceptualizations of the “global” in global health that marginalize discussions of health inequalities and social injustice within the West.

We argue three related points linking power, temporality, and positive living. First, positive living transcends multiple contexts in which it operates by and through post-colonial rationales and global health sentiments as discussed above. Failure of certain groups to live positively in a manner that aligns with program goals, often results in accusations of backwardness, of living in a time “out of time,” of squandering a life on “borrowed time” provided by life-lengthening drugs.

Second, a logic of scarcity undergirding HIV/AIDS programs, characterized by uncertainty over the future availability and effectiveness of antiretroviral therapies, temporalizes and moralizes responsibility of HIV-positive persons to intimate partners and distant others. This logic is expressed as *project time*; in all three sites, patients enrolled in treatment and prevention programs were subject to the shifting and ephemeral political commitments and agendas of donors and government officials. Poor patients, in particular, were beholden to ideologies of donors and officials that denigrated them and circumscribed the conditions of their participation. These can be seen in changes over time in global and national strategies for HIV prevention, treatment and care each of the three countries. Specifically, we argue that these fears of treatment failure and potential scarcity engendered positive living programs and approaches that require poor HIV- positive individuals to synchronize everyday life to treatment and behavioral regimens and social obligations, a phenomenon we call *adherence time*.

Third, we maintain that positive living practices occur within ruptured and cyclical temporalities. These represent experiences of time. In all three sites, living positively with HIV/AIDS offers not only opportunities for a “second chance” (Das 2007; Whyte 2014) to reimagine and enact a moral life within and outside the context of their biological affliction, but also to erase or forget perceived past moral failures that might have led to infection in the first place. However, these practices articulated the effects (and affects) of these temporalities differently across sites, owing largely to these sites’ distinctive political, economic and social realities. In Chimoio, many of the precepts for living positively were similar to those encouraged in Pentecostal churches, where seroconversion and religious conversion shaped and regimented journey from illness and immorality to improved health. In Freetown and Miami, positive living stimulates moral questioning and debate about the normalization of safer sex, raising questions about reproductive desires in Freetown and about abstinence as deliverance from past and present struggles in Miami—all in the promise of a second chance at a better, more disciplined life.

Positive Living and the Uses of Time

At an indoors rally against HIV/AIDS stigma and discrimination, organized by a national consortium of HIV support groups and held at a public meeting space in central Freetown, Sierra Leone, four men and seven women from two of the city’s HIV support groups, emerged from the left side of the room, singing and playing handheld drums. I (Benton), had been visiting public events for HIV-positive people for months, in an effort to understand

how government and NGOs communicated HIV-related messages among HIV-positive people and their families. Together, the performers sang:

take the doctor's advice,
eat and drink well,
don't smoke cigarettes,
take your medicines, and
drink clean water.
you have to take responsibility for yourself
give us the directions so we can help you.

Performances designed to communicate health-related messages are commonplace in Sierra Leone and throughout the so-called developing world, and their origins can be traced to colonial era public health campaigns throughout Africa (Vaughan 1991). While HIV/AIDS-oriented messaging long tended to focus on prevention for the uninfected—condom use, abstinence, sexual intercourse with a proven HIV-negative partner—programs have increasingly targeted HIV-positive individuals themselves. Indeed, the primary message being communicated at this rally was not how to prevent becoming infected with HIV/AIDS (in the imperative mood, no less), or even anti-discrimination, but rather, how to be a good HIV-positive person. Significant to being a good HIV-positive person is an acquired preoccupation with and aspiration to “living positively.” While the origins of the positive living model has been located in the West, it emerged in Uganda as early as 1987 and spread elsewhere on the continent (Dilger 2001; Meinert and Whyte 2014; Whyte 1997).²

It has become a taken-for-granted part of many programs for HIV-positive individuals, owing largely to the global circulation of HIV-oriented experts, material culture (e.g. pamphlets, campaign slogans, etc.) and institutions (Beckmann 2013; Collins and Freeman 2009; Levy and Storeng 2007; Prince 2012; Van Dyk 2008). Positive living has also been explored within the anthropological literature in terms of its affective, epistemological, disciplinary, biosocial and biopolitical dimensions (Benton 2015; Boellstorff 2009; Kalofonos 2008; Marsland 2012; Nguyen 2010; Sangaramoorthy 2014). Much of this work addresses time and temporality, with the most explicit discussions of temporality being concerned with narrative notions of time—past, present, and future glossed in terms of hope,

²The roots of positive living can be traced to at least four crucial moments: (1) the rise of positive thinking, rooted in the late 19th and early 20th century Christian Science and “New Thought” movements; (2) the growth and expansion of humanistic and positive psychology from the 1950s, which emphasized ethical values and intentions as the primary determinants of human behavior and viewed people as inherently driven to maximize their sense of liberty, awareness, and life-affirming emotions (Maslow 2011; Rogers 2003); (3) identity-based rights and health activist movements of the 1970s that called for the democratization of health care, increased engagement of the public in health and medical discourses and preventive health behaviors, and questioning medical experts’ absolute authority (Mort et al. 2009; Petersen and Lupton 1997). Black and gay liberation movements focused on resignification—dissolving negative group-level stereotypes and to create more positive perceptions of collective and individual identities were among the identity-based movements (Dilger 2001; Whyte 1997); (4) the promotion of increasingly expansive definitions of health and well-being by formal international health institutions has also contributed to positive living’s growth. The link between good health and the “positive self” has been legitimized through its explicit articulation in formal international institutional discourse, like the WHO Preamble (1946). This definition—that health is not merely the absence of disease and exceeds the limits of biomedicine and pathology—has become foundational to the expansion of global health beyond biomedical interventions and clinical concerns and have also institutionalized and formalized an intrinsic link between good health and “positivity.”

anticipation and precarity (Prince 2014; Whyte 2002). Too few of these studies, however, move beyond the disciplinary and biopolitical effects in terms of self-care and self-management. Given the transition of conceptualizations of the disease from acute to chronic, we feel perspectives which directly focus on the technologies and “uses” of time under these regimes are critically needed.³

The advent of highly active antiretroviral therapies (ART) in 1995 marked a dramatic shift in HIV/AIDS care, making it possible to imagine extended life with HIV/AIDS and in particular, after an HIV-positive diagnosis. With the availability of ART, moreover, treatment access advocates leveraged a rhetoric of “dying from” to “living with” HIV/AIDS, suggesting that lack of access to these drugs amounted to a “death sentence.” Such rhetoric also signals the pre-eminence of treatment without a cure—of chronicity induced by biotechnological advances (Smith-Morris 2010). Put another way, biomedicine in the form of ART synchronizes the “life” of the virus and its human host; it can transmute the “natural” course of disease so as not to fully disrupt the rhythm, tempo, and duration of an individual’s natural life course. This relationship defines a disease’s chronicity and an individual’s experiences of it. “Living with HIV/AIDS,” in this case, signifies an ongoing, symbiotic, productive, and coterminous relationship of an individual with the virus over the course of a lifetime. This relationship between interior bodily space and viral circulation and replication is mediated through and managed by ART, as it is also amplified through behavioral interventions that promote continual pursuit of a healthy lifestyle.

When “positive” modifies “living,” then, the presence or possession of personal attributes favorable to cohabiting with HIV/AIDS circumscribes the conditions of possibility for care, recognition, and improvement. The modifier “positive” has multiple meanings, with implications for understanding the temporal dimensions of living with HIV/AIDS. For example, to be positive is to be certain about something, and when placed alongside living with HIV/AIDS, highlights an under-acknowledged aspect of the miraculous properties of ART: even with the increased availability of effective therapies, little is certain after diagnosis. This is particularly true in so-called resource-poor settings where lack and deficiency are central organizing concepts for understanding HIV- positive individuals’ plight and their care.

Among concerns for many of our interlocutors in all three sites were: For how long will drug supplies last? How long will existing therapies be effective? What are the long-term effects of these drugs on the body? And how does one manage the medicine’s side effects and conditions that often accompany prolonged use of ART—from hunger and appetite loss to insulin resistance and diabetes? The first question highlights what we call *project time*, the uneven distribution of resources within and across the three field sites, in which concerns about impending scarcity are prefigured by past experiences with underfunded programs, shifting donor priorities, and governmental oversight and abandonment. The extent to which this scarcity is experienced and deeply felt is linked to social hierarchies of nationality, class, gender and/or race. The other questions emphasize concerns about the effectiveness of ART over a lifespan of global health projects, of pharmaceutical therapies, of individual lives. A

³Whyte 2002 and Prince 2014 suggest frameworks in this direction.

common response to all of these questions by providers and programs, like the skit and song in Freetown suggests, is to focus on what an individual can change in the (recurrent) near-future, to synchronize everyday life with HIV/AIDS to the life of an HIV/AIDS program: “Keep a positive attitude and follow our directions. Take responsibility for yourself and we can help you.” The charge of positive living, therefore, is to establish HIV/AIDS as a chronic condition and to affirm its presence for the duration of multiple time scales. It is also, paradoxically, to insist that HIV-positive individuals focus on self-sufficiency while also enlisting support from others for as long as they are living with the virus.

Time is a disciplinary technology—one of control, management, and subjectification (Braun 2007:11; Thompson 1967). It is also a moralizing one. Links among timing, time frame, tempo, and sequence are crucial dimensions of temporality for examining these modes of discipline as it relates to positive living (cf. Adam 2005). One of the primary concerns of the positive living paradigm is ensuring adherence to treatment regimens. This is an issue of *timing*, or synchronization. Treatment adherence entails syncing daily life to *adherence time*, planning one’s routine around dosing schedules and within the limits of a bureaucratic apparatus that monitors and documents pill counts, enlisting social and technological support systems for taking medications, and viewing ill health post-treatment as an individual’s failure to comply with these regimens. The rapid deterioration of an individual’s condition opens them up to retrospective moralizing about past behavior.

Within the realm of global health, with which each of us has been engaged for more than a decade, timing and tempo have been linked to the social and political production of (in)difference. Depending upon whose temporal frame of reference is privileged in judging appropriate pace of a response to a public health problem, for example, perceptions of tempo may have serious consequences in the realm of politics. The pace at which national epidemics are said to get out of control or to have been contained may result in praise or condemnation for world leaders. Scholarly and public deliberations comparing Uganda’s apparent success in reducing new infections and stabilizing prevalence to South Africa’s seeming failures and the biting criticism that followed, for example, reflect this reality (Bor 2007; Parkhurst and Lush 2004; Thornton 2008; Youde 2007).

It is also a factor in how the United States and much of the West is assumed to have solved their HIV/AIDS problem, even as numbers of new infections increase among Latino and African American men in the US, and as HIV-positive people in France continue to experience high levels of food, housing and job insecurity (Benton 2015: 120). These problems are ‘scaled up’ to the global, as the division of nations or communities on the basis of whether they have successfully halted or slowed transmission maps neatly to rankings and indices of developmental progress and social improvement. These maps and indices obscure differences within countries or localities in relation to social status based on age, race/ethnicity, class and citizenship (Brada 2011; Wendland 2012; Sangaramoorthy 2014).

Hierarchies and divisions among nations with respect to their official responses to HIV/AIDS include an implicit statement about *sequencing*. For HIV/AIDS program planning under resource constraints, this might mean establishing a system of triage, in which perceived severity or vulnerability may shape the nature, intensity, or scope of responses

sequenced in time (Nguyen 2010). In our field sites, ordering and ranking people according to their espousal of positive living principles represented another form of prioritizing, of putting some people before others. Personal and professional advancement may hinge upon those orderings and rankings (Benton 2015).

Health initiatives for poor people, like those for HIV/AIDS care in our sites, often operate within a *time frame* delineated by donors and government agencies, though extensions and renewals are also a part of their operating lexicon. These bounded time frames can be understood as *project time* (Sangaramoorthy and Benton 2012); in places where donor agendas shift regularly, a disruption in project time may very well disrupt various processes, including regularly taking medicines, maintaining a healthy diet, and life itself. If we are to consider the advent of ART a critical event that challenged how we theorize HIV/AIDS and the lives of its human hosts, our “ethnographic burden”— and the primary aim of this paper —is to expose how public health institutions “obscure that technological conceit in favor of pathologizing individuals and their behavior” (Wolf-Meyer 2011). This process of masking, in part, can be attributed to “the uses of time” which “give form to relations of power and inequality” embedded in positive living (Fabian 1983: ix).

Adherence time: Antiretroviral Anarchy, Social Obligations and Debt

Treatment adherence has been deemed essential for preventing an individual’s resistance to ARVs and the spread of ART-resistant strains of HIV—what some have called “antiretroviral anarchy” (Harries et al. 2001). While ART was available to people living with HIV/AIDS in rich countries, and specifically to those who could pay for the then- expensive drugs, the delayed roll-out of ART for the poor was not simply about the profit motives of pharmaceutical companies. Health experts worried that poor patients, hampered by their assumed ignorance, lack of education, and chaotic lives, could not comply with the complex treatment regimens (Crane 2013; Farmer 2004: 317, n. 11). Because the virus was said to mutate rapidly when inadequately treated, noncompliance would render the relatively inexpensive first-line, generic medications obsolete. This fear of obsolescence links circulations of donor funding and profit, public health knowledge, and the retrovirus with the viral logics of mutation and resistance. The relationship among pathogen, individual, and population and the transnational efforts to control and manage this relationship is a relation of time and power, dictating who may rightfully access ART, for how long and when, and the length of their indebtedness for such a privilege. Such relations necessitated vigilance over HIV-positive individuals’ adoption of positive living ideals.⁴

Even with the reduced costs and increased accessibility of ART over the past two decades, clinical treatment and public health protocols are structured around fear of viral disorder, and are focused on synchronizing patients lives with what we are calling *adherence time*. The processes by which this is achieved, however, differs across the three sites. In Chimoio,

⁴Vigilance has its own temporal dimension, in that it refers to the persistent act of keeping watch over who falls ill and who thrives, of who participates in HIV/AIDS-related meetings and interventions and who does not, and so on, and of seeking causal links between perceptible markers of well-being and failure to live positively— a kind of autopsy of the living unwell. While these acts of vigilance easily uncover individual failures, they also require selective viewing; persistent watchfulness over adherence to the positive living standards makes economic and sociopolitical vulnerabilities and individual suffering barely perceptible.

HIV-positive individuals were placed on a probationary period for adherence when ART first became available free of charge in 2004. Anyone enrolled in ART had to meet the biological criteria; they then had to demonstrate their ability to adhere to medications, first, by arriving for three clinical appointments, and then, by attending appointments every day for the first two weeks of treatment. In Freetown, ART became available in 2005 for patients who met biological criteria. Rather than being placed on trial as in Chimoio, patients in Freetown were enrolled in an enduring system of adherence surveillance, where counselors met with patients on a monthly basis and counted their remaining pills. Patients who, by these crude metrics, appeared to be taking their pills regularly were given a two- to three-month supply, requiring fewer visits to the counseling and treatment office during the course of the year.

In the United States, the Ryan White Comprehensive AIDS Resources Emergency Act was authorized in 1990 (and reauthorized in 2009) to provide funding for low- income, uninsured, and underinsured individuals living with HIV/AIDS, including ART through AIDS Drug Assistance Programs. Eligibility for these programs requires stringent guidelines including proof of residency and income documentation. Program beneficiaries are furnished with monthly supply of medications. They must initiate contact with pharmacy when they need a refill and pick up medications in person. Their eligibility must be checked regularly, or else they risk losing coverage.

However different in process across the three sites, the point of creating guidelines for administering ART exceeded considerations of biological need and focused on establishing patients' trustworthiness and cooperation. Program logics were hinged upon properly timed arrivals and appearances over a duration dictated by donors, technical advisors and administrators. Whether one is able to synchronize one's habits and daily practices to adherence time, then, is largely circumscribed by bureaucratic suspicion of poor HIV-positive patients, based upon program managers' fears of treatment failure and of potential scarcity in the future of philanthropic projects.

Treatment programs also encouraged individuals to synchronize to adherence time by building on existing social networks or if necessary, establishing new ones and showing indebtedness to donors, activists, and others who make access to ARTs possible for the poor. In Chimoio and Freetown, existing social supports are mined for their unrealized potential. Individuals beginning treatment were encouraged to select a "treatment partner," called a *testemunha* (witness) in Chimoio, such as a spouse, family member or friend, who could support that individual's adherence by offering moral support, accompanying them to the clinic or serving as an intermediary between the individual and the clinic. In Chimoio, if the individual could not bring a treatment partner, they were assigned one from clinic staff or a community-based association of people living with HIV/AIDS. When existing networks proved insufficient, networks established through HIV/AIDS programs themselves offered the potential for care.

Self-sufficiency or solidarity: Debt relations between patrons and clients

Precarity and scarcity marked these interactions, where appeals to patron-client relations and solidarity ironically produced either of two predictable outcomes: outright rejection of patron-client relationships on the grounds of self-sufficiency and submission to the

rationalities of scarcity; or outpouring of support built upon the need for solidarity under conditions of scarcity. A patient in Chimoio, for example, appealed to a social worker for transportation fare, referring to him as “our father, our chief,” thereby positioning himself as a subordinate in a patron-client relationship. The social worker, unable to provide the requested fare, urged the patient to look to himself for the needed resources:

It is your responsibility to come in to the hospital. You are the ones who are sick and need care! What will happen when this little program that gets you free treatment ends? I am not giving life to anyone. You have to live, for yourself, for your responsibilities. You have ARVs, don't you know that you can live for 20, 30, 40 more years? I always ask you, on each day that is born, think and say 'I love myself'. Don't stay afflicted! It is you that must get through each week! We know that what we provide isn't enough, but they are the conditions that exist. You can't leave here sad.

This brief interaction illustrates the thick temporal dimensions of the tension between two models of self-fashioning arising from the demand to live positively: one, of the responsible, self-sufficient citizen who must affirm self-love daily, endure each week, and “doesn't leave here sad” because he or she accepts conditions of scarcity and two, of the client looking to receive help from a patron upon recognizing his inability to gather resources (Whyte et al. 2013). In this way, positive living is a “highly expressive negotiation of a neoliberal ethos” of self-sufficiency under receding or crumbling state social services (Ghosh 2012: 83), where scarcity is not simply the logic— or the driver— of interaction, but also the context. The context shapes how a pre-patron might respond to being called to act in the capacity of a patron or “chief,” but also the need to ground claims in these terms. The social worker also reminds the patient of the realities of *project time*, that the availability of free treatment is subject to the uncertainties of donor priorities and flows of aid. The social worker was used to seeing aid-driven projects begin and end abruptly, and counseled self-responsibility as a means to prepare for this eventuality. The relentless self-management of every day, every week, and the ever-moving time horizon of drug efficacy are explicitly mediated through the discourse of positive living.

Obligation to metaphorical kin

In Freetown, demands for adherence time also drew HIV/AIDS support group members into a metaphorical kin relationship with the institutions imposing these demands by proxy, and with a marked emphasis on precariousness of future resources. It revealed an intense awareness among poor HIV-positive individuals about their reliance upon international donors and of the ways in which their lives as HIV-positive people are circumscribed by institutional frameworks and positive living ideals. For instance, Alfred, the head of AIDS Support Association (ASA), officially opened the meeting with words of disappointment because only eight association members, a small fraction of the people who are officially registered with the organization, attended: “I am sad to see so few faces. The date is set for the first Monday of the month. We didn't meet during World AIDS Day events, and in January because of the holidays, but I expected that people would remember the date.” He launched into a discussion with the group members about their relationship to the organization itself and its donors: “ASA is a *kombra* (nursing mother) to its members,”

Alfred explains. By using *kombra* to describe the organization, he focused on organizational nurture that was not limited to physical well-being but also included social and emotional support. Extending the parenting metaphor, Alfred related a story about a couple who have four children. Two of the children are very well behaved, while the other two are a constant source of problems for their parents. “When *sababu* (opportunity) time comes,” he asked the group, “and the parents have to choose which children to take with them to America, who should they take?” A couple of the members replied, “The ones that are good.”

“Exactly. Global Fund, who has been providing funds to help the group,” he said, “will see people not doing well from the resources that they provide, and, then, they will leave.” Alfred, hinting at his own sacrifice for the sake of people living with HIV/AIDS, then told ASA members that the government gives free ART, so there was no reason for him to belong to the organization. But he felt that his having been hired as the head of the organization was a *calling*. He encouraged the members to behave responsibly, suggesting that as long as they “lived positively” donors would continue their support. Such support was ordained by a higher power: “God is praised through our good use of things given to us.” He returned to the story about the good kids: “the ones that try hard are the ones that we take.” To close this agenda item, he warned, “Do not waste mother’s and father’s resources.”

Debts to those who came before

In the everyday work of the HIV/AIDS clinic in Miami, positive living programs’ representatives encourage their beneficiaries to faithfully maintain adherence time not simply because of the life-saving and life-giving properties ART embodies, but also because ART is seen as a benefit not afforded to hypothetical others located elsewhere. For instance, during a routine clinic support group, a nurse lectured an HIV-positive patient who complained of the rising cost of medications: “It’s a beautiful thing that you can get meds for free. Many people in the world don’t have meds and they would do anything for this opportunity.” HIV-positive individuals are indebted not only to the purveyors of ART and their affiliates, but also to the “people who came before” and struggled in the early years of the HIV/AIDS epidemic. The debt incurred from receiving access to ART is repaid, in part, through living positively. Expectations about the timing between receipt and repayment and the debt’s terms, however, are mediated in such a way that reveals the power operating in logics of blame and responsibility under regimes of positive living. Chris, an African-American HIV-positive man living in Miami, lamented the public’s complacency about HIV/AIDS and its reluctance to increase aid for ART at a class for positive living. He said, “Society has blinders on over their eyes, mufflers over their ears, and a gag over their mouth.”

Ramon, a social worker, asked Chris, “How long have you had the disease?”

Chris answered, “I was diagnosed last year in May.”

“And before then, what did you know about AIDS and what did you do about AIDS?” Ramon interrupted.

Chris replied calmly, “I didn’t know nothing about the disease until I got it.”

Ramon shouted at Chris and the rest of the class members, all of whom were either Haitians or African Americans:

There were a lot of people who fought for what you have, Chris. There are a lot of people who died for you. Many people went to Washington and tied themselves to flagpoles so that we could have the medication that we have today... When everything is gone is when you'll start complaining. People like you are complacent and just don't care... So when you want to complain about how you don't have this or that or when this and that is getting cut, you have no one to blame but yourself!

Ramon's accusations of complacency and indifference assumed and pre-supposed that everyone *should* fight for access to treatment— as if it were a badge of honor, and as if responsibility for quality health care lay solely with the sick individual. It also assumed that they should do so in acknowledgement of past struggles. Chris's lack of knowledge pre-diagnosis is conflated with current inaction; his presumed inaction is conflated with passivity and negligence borne of willful ignorance of history. In light of the shortcomings and personal failures Ramon attributed to members of his class, Chris and the others are blamed not only for failing to recognize how the past struggles colonize and produce a nominally secure present, but also, in so doing, for losing resources for current and future HIV-positive individuals. Chris's inaction, in these accusations, was a moral failure to fully acknowledge the stakes of his biological affliction, of a life lived with HIV/AIDS, and of the sacrifices embedded in such an acknowledgement. In addressing his concerns to a Haitian and African American audience, Ramon, like other providers in Miami, projected persistent moral failures to act onto this group, linking pathological dependence and passivity to racial and class difference.

In Chimoio, Miami, and Freetown, living with HIV/AIDS is now a lifelong experience of disorder interposed with critical moments. These moments are not only biological (e.g. symptoms reemerge, side effects flare up, and so forth) but also socioeconomic, intensified by the ongoing threat of scarcity and obsolescence of maintaining a life of treatment without cure. Against the backdrop of increasing global, national, and individual economic insecurities, the logics of scarcity at our sites were articulated through the rationalities of positive living. These rationales were conveyed in terms of uncertain treatment futures and rooted in anxieties about and vigilance over racialized others and a "culture" of poverty that challenged not only the efficacy of these biomedical technologies, but also the sustainability of global health interventions themselves.

Punctuated Time and Subjectivity

The acceptance of positive living after an HIV/AIDS diagnosis entailed a change in individual outlook and perspectives, which was common among the three sites. One HIV-positive man on ART in Chimoio, Gonçalo, explained:

A positive life is a life in which a person leaves their old habits and passes into a new life. Life has to start over, practically from the start. You change your behavior, you have to abandon your vices and consider your future. I used to be out of control, didn't pay attention to how I ate. I used to drink a lot of beer, stayed up all

night, I smoked, I didn't care about condoms. If you had a lot of partners, you have to just stay with one. You have to use a condom as your basic tool, and also to not have sex frequently. You have to have a balanced diet, you can't be up all night. Also to not upset yourself too much, to not create stress, and to not visit the *curandeiro* [traditional healer]. When a person can live according to these rules, then a person is living positively, and he may live longer.

Similarly, Henry, living in Freetown, explained how his HIV/AIDS diagnosis and his subsequent introduction to positive living changed his attitude, daily habits, and approach to sexual relationships:

Yes, my feeling about myself was that, one... I have really changed a lot in my attitude. I used to smoke, I used to drink. I've stopped smoking. I drink at times, but only stout. After two weeks, or a month, I drink a pint or two. I used to drink spirits before. I drank alcohol so much [interruption]. I used to take a whole lot of alcohol, spirits especially. I've stopped taking that. and, uh, well. I was fond of several things, and I am not doing much of these things. I was modest in the love relationship. I did not make new loves. The saddest part of being HIV-positive is that because of my status, I can't go far with anyone.

Like Gonçalo in Chimoio and Henry in Freetown, Mona, a Haitian woman in Miami who had been living with HIV/AIDS for nearly two decades explained how her HIV/AIDS diagnosis and her subsequent introduction to positive living changed her outlook:

In the beginning, when I first get the news, I was existing and I didn't want to go to the beauty salon to do my hair because I knew I was going to die, so why am I wasting \$50 on my hair. Then I see weeks pass by, I'm still living...months pass by, I say "OK, I need to go to the beauty salon now." I make sure I choose the positive things and I say prefer to feed myself on the positivity. I say "OK. I have to make a choice. I want to live" and I decide to live. I search, I get with the doctors, I go with alternative way, change my diet, exercise, read all the positive books that I can find. The only thing that I would tell people is "Do not worry about dying because death will take care of itself. You better take care...you better live instead of worry about that. When death come, you won't have to make a move so now you living. Enjoy life."

Gonçalo's, Henry's and Mona's statements about positive living resemble the "punctuated time"—a break with the past—associated with prophetic and evangelical Christian denominations (Brodwin 2003a; Guyer 2007; Lewis 2004; McCarthy Brown 2001; Meyer 1998; Shaw 2007; van Dijk 2009). Seroconversion, specifically, provided patients an opportunity to leave behind the mistakes that they felt led to illness and associated stigma; it also offered them the chance to reclaim their status as moral individuals who moderate their excesses and "decide to live." In such discussions, the language of choice and responsibility acquires a moral valence, where good health and the decisions of the individual are intimately intertwined.

The language of responsibility and choice, as many have argued elsewhere, also has a less desirable side: individuals experiencing ill health can also be blamed for their condition;

temporally speaking, they are subject to a kind of post-mortem of the living unwell. When one well-known Chimoio-based activist suddenly became ill, for example, rumors began to circulate about his drinking, smoking, and promiscuity, calling to mind a lengthy anthropological engagement with moral readings of illness and, specifically, the claims of causality arising from “vernacular” epidemiologies (Douglas and Wildavsky 1982; Evans-Pritchard 1937; Farmer and Good 1991; Nguyen and Peschard 2003). In the following subsections, we outline some of the ways that “choice” and responsibility produce differing interpretations and subjective experiences of punctuated time across sites. In so doing, we highlight the contradictions of “progress” tropes within logics of positive living and the precariousness of life on ARVs for those without economic means to live without treatment programs.

Sin and conversions in Chimoio

In Mozambique, retrospective moralizing tapped into Protestant ideologies of civilizational and moral purity that have at times accompanied the modern state-building project (Arnfred 2004) but which also resonated with contemporary Pentecostal church movements in Chimoio. Indeed Gonçalo, like many others, followed his seroconversion with a religious conversion. He joined an Apostolic church, reasoning that many of the precepts for living positively were similar to those encouraged in Pentecostal churches: “It is recommended to frequent church because it is based on mutual respect. When you go there, you forget about your vices. The church prohibits drinking and smoking, and you can’t just wander any which way you want. That’s why a person should enter a church, to correct these difficulties.” Gonçalo and other association members saw church membership as a way to build the self-discipline required for living positively. Together, seroconversion and religious conversion shaped and regimented their journey from illness and immorality to improved health. Such testimonies highlight the religious resonances of *Vida Positiva*, while it emphasizes a temporal modality of religion in which forgetting is key. Metaphors of space and directionality aligned with these temporal modalities focus on preventing “wandering” from a righteous path.

Erasing and timing sex in Miami and Freetown

The language of transformation and rebirth, as expressed by Mona in an earlier section, particularly pervaded discourses of safer sex after an HIV-positive diagnosis, because having safer sex—or, more accurately, using condoms and other barrier methods during sexual intercourse—is a fundamental to positive living programs and considered “normal” and “natural.” During a class titled “Sex for Positives” in Miami, for example, a health educator declared: “You have to [have sex] physically because the need is biological, because your body has to release the fluids; otherwise it’s bad for you.” Providers and programs de-emphasize moralizing arguments for safer sex to counteract previously explicit associations between HIV/AIDS and the so-called immoral behaviors that facilitate transmission. But in so doing, these same providers and programs reinscribe morality as the dominant framework through which behavioral interventions, particularly those centered on positive living, are implemented and interpreted.

Many Haitians, however, rarely endorsed these ideas about sex as “normal,” “biological,” or “positive.” They discussed safer sex in moral terms, aligning morality, specifically, with abstinence. Renée remarked, “I have a husband, but everybody sleep in their own bed. As soon as you get virus, you shouldn’t have sex...I feel like that.” Helen felt similarly upon receiving her diagnosis: “I get a disgusting feeling when I think about sex. My husband gave it to me, and I feel bad with life when I found out for a long time. But now I’ve given my life to God.” Avoiding all sexual activity is a crucial component of moral rebirth and transformation for Renée and Helen. For many Haitians, to “choose” abstinence was to negate and reject— at least symbolically— the practices through which infection had originally occurred, and to reaffirm a new moral social identity, one that is divorced from historical injustices steeped in blame and negatively marked hyper- sexualized and diseased characteristics.

Abstinence is not wholeheartedly embraced in Freetown, however. Earlier ideas about HIV/AIDS’ role in disrupting biological and social reproduction have been reversed by the availability of ART. Saio, a counselor in Freetown, often noted in workshops and in informal conversations, that once people started ART and feel better, they wanted to know when they can have children. This desire to reproduce post- diagnosis was often framed in terms of African “cultural” pronatalism. Whatever the reasons for wanting children, counselors in Freetown discussed the possibility with their clients once they expressed a desire for children. They did so by focusing on timing; individuals with undetectable viral loads have a reduced likelihood of transmitting HIV/AIDS. While the counselors acknowledge and even encourage their interest in having children, they are also ambivalent about positive living programs’ emphasis on “protected” sex and their own inclination to facilitate their patients’ desires to resuscitate a sense of normalcy in the everyday.

Wasted Time: Hierarchy, Tradition, and Notions of Progress

As a part of most positive living curricula and programs, HIV-positive individuals were expected to— and often did— portray themselves as responsible, enlightened, and “modern” individuals. Whatever challenges they faced— in fact, the more, the better— role models made appropriately timed appearances at meetings, spoke out at rallies and public events and took their medications “on time.” Notably, they do not “waste time” and money going to traditional healers, as Gonçalo noted earlier, or they openly regret doing so. In addition, these individuals demonstrate their “progressiveness,” their forward-thinking, when they espouse positive living ideals. The individuals who seem to fail to exhibit the characteristics of positive thinking (by “grumbling too much”), or of self-improvement (by not actually showing marked improvement in station or in health) are further excluded, marginalized and deemed “backward” and unworthy of the resources allotted for improving their condition. Positive living, in this way, both creates and (re)inscribes hierarchies amongst HIV-positive people in all three sites through a temporal trope of backwardness.

The accusation of “backwardness” has a long history and continues in contemporary discourse within and about people living within our field sites (Brodwin 2003b; Farmer 1992; Kaplan 1994; Sangaramoorthy 2014; West 2005). To denigrate individuals’ actions as “backward” in the context of HIV/AIDS programs was also to suggest that individuals who

actively engaged with positive living initiatives, prevention programming, and HIV/AIDS associations were forward-looking, educated, and cosmopolitan. Such denigration aligned with the perspectives of development, public health and biomedical institutions that, in their official literature, also blamed “culture” for rates of HIV/AIDS transmission and many of the complex, seemingly intractable problems of contemporary Africa, Haiti, and spaces like Little Haiti in the United States (Farmer 1992; Ferguson 1999, 2006; Pigg 1996; Whyte 2002).

In Chimoio, this break with the past was often performed by new support association members who introduced themselves to the associations using a common narrative that included: falling chronically and persistently ill, seeking care with traditional healers and being fooled and wasting time and money before finally being referred to be tested by a health professional, a home-based care volunteer, or family members or friends who were HIV-positive themselves. It was also common for them to lament the poor treatment they suffered at the hands of family members while in the worst stages of illness and to blame this on “*tradição*” (tradition) or “*cultura de África*” (African culture).⁵

While the traditional healer was not part of the introductory narrative in Miami or Freetown, frequent complaints by providers and program staff about patients’ reliance on alternative “traditional” therapies in these sites highlighted a time-space displacement. Providers in Miami frequently positioned Haitians’ “cultural tendencies” — dependence on voodoo in Miami and during trips to Haiti to combat the ill effects of ART and HIV/AIDS— as incommensurable to positive living ideals (Sangaramoorthy 2012, 2014). In Freetown, disappearances of patients from hospitals to “the provinces” (rural areas outside of Freetown) to seek treatment when ART made them sick, or when they failed to get better, signaled the patients’ going back in therapeutic time.

In sum, HIV-positive individuals in our three sites invoke morally reasoned notions of rebirth, regeneration, and transformation, triggered by a diagnosis and the call to live positively (cf. Sharp 2006, 2013). Time structures these narratives of salvation; it also organizes transitions from immoral pasts to righteous futures and desires to tame chance, reverse accusations of backwardness, and reproduce the next generation. Seroconversion and positive living signal ruptures and promissory yet open-ended futures through which HIV/AIDS sufferers can claim a new beginning by expunging perceived past moral failures and enacting a moral life with and outside the context of their biological affliction.

Conclusion

This paper emerged from conversations amongst the authors over years of fieldwork and writing about our research within the global HIV/AIDS industry. For anthropologists trained to seek “particularities” of place in understanding how HIV/AIDS programs travel and are reworked in particular ways, we were struck by the ways in which this *did and did not*

⁵Yet, the clean break with tradition is not as clean as one might assume. Many who “lived positively” decried the time and money they wasted with *curandeiro*, but nevertheless could not rule out the possibility of seeking their assistance under the right circumstances—partly because it was not always completely up to the sick individual to decide their care (Kalofonos 2008). Indeed, several members of the association in Chimoio were or became healers themselves.

happen across our sites. In other words, while the communities where we worked were experiencing very different epidemiological, political, and economic challenges, they were also united by three interconnected concerns related to their exposure to HIV/AIDS interventions: their “cultural difference” in relation to a normative Euro-American “West;” their role as “targets” of HIV/AIDS interventions via that difference; and a spatiotemporal order of positive living that exploits and reproduces global and regional hierarchies -- as it also serves to obscure their constitution. Our ability to see these commonalities comes from thinking about our work as multi-sited ethnography, in which our analyses (if not our specific projects) “follow[ed] the thing” (Marcus 1995). As we traced positive living’s path into our sites, we found that the social production of difference via spatiotemporal logics of power accompanied it. In particular, these ideas about difference are “enacted and disturbed, in the performance of technoscience” (Anderson 2002: 644), and refracted through the temporal and racialized organization of global health.

Unlike Fabian (1983), to whom we are greatly indebted, however, our focus is not on coevalness in relation to an ethnographic (re)present(ation); rather, we have addressed the uses of time in positive living within HIV/AIDS programs. One of those uses is expressed in terms of the anticipatory logics of a “global health future” represented by speculative epidemiologic projections and models coalescing around HIV/AIDS’ chronicity and positive living ideals. The other is a “global AIDS past,” which frequently positions US-based upper-class, white, gay men as having led the charge and won the battle against fear, discrimination and prejudice— of having conquered Reagan-era biopolitical refusal to make live and willingness to let die (A Closer Walk 2003; France 2012; Epstein 1996; Treichler 1999). The cases we presented here point to particular ideologies of temporality that circulate with global health interventions - in this case the globalization of a positive, productive life. Although HIV/AIDS has been characterized as a humanitarian crisis, humanitarian interventions are frequently framed as responding to an imminent crisis with a short time horizon (Bornstein and Redfield 2011). The HIV/AIDS treatment interventions we describe here potentially offer a lifetime of treatment and evoke a very different spatiotemporality that simultaneously synchronize with and oppose other social rhythms (Wolf-Meyer 2014).

Positive living has pervaded the work of global HIV/AIDS prevention and treatment programs, suggesting a mechanism of standardization and normalization of knowledge, technologies, processes, and identities across sites. Standardization and normalization serve to produce and reify difference. Because they are processes, they necessarily involve a temporal dimension, in which time both disciplines and moralizes in ways that reveal these differences to be premised on relations of power along geopolitical, racial and economic lines. The synchronizing and continued production of difference through public health raises important questions about the kind of relationships and institutions that persist and endure over time and space, and the types and scales of political, economic, and cultural work that must be done to standardize programs and normalize disease identities across sites and contexts. In many accounts, this cultural work has been primarily analyzed for its biopolitical, biosocial, disciplinary and citizenship content, with less extended attention to the various technologies ordering this content. We have argued that in addition to focusing on the disciplinary and biopolitical effects of HIV/AIDS programs in terms of self-care and self-management, a perspective which focuses on the technologies and “uses” of time in

producing standards and difference is also needed to better describe the mechanisms through which these effects are produced. The ordering of time is a relation of power; power is exercised through temporal orders, shaping lived experiences. A multi-sited approach, moreover, provides the opportunity to think through experiences and interpretations of temporal orders across sites.

Specifically, we highlighted how positive living, as a disease-based identity movement, is explicitly *made to* transcend geographical, historical, and political contexts in which it operates by attempting to synchronize and coordinate post-colonial rationales and global health sentiments vis-a-vis Euro-American norm of progress. These synchronizations are framed in terms of scarcity and uncertainty expressed as *project time*. Logics of scarcity were nested within earlier histories of social services programs that were subject to the ephemeral political commitments and agendas and ideological orientations of donors, which we described as project time. The fragile public health and social safety net systems and conditions of profound economic uncertainty, in particular, made it nearly impossible for HIV/AIDS program workers to guarantee long-term support for ART and related services. Thus, even though there was no actual shortage of ART and access to less complex and more effective regimens was improving, speculation about shortages persisted. Such speculation engendered and perpetuated a logic of scarcity, shaping the experiences of time as “borrowed” or “punctuated.”

Fears of obsolescence buttressed a logic of scarcity. The delayed roll-out of ART in poor countries was not simply about the profit motives of pharmaceutical companies. Health experts worried that poor patients, hampered by their assumed lack of education and ignorance of Western standards of time, could not comply with the complex treatment regimens (Farmer 2004:317, n. 11). Because the virus was said to mutate rapidly when inadequately treated, noncompliance would render the relatively inexpensive first-line, generic medications obsolete. This fear of obsolescence links circulations of donor funding and profit, public health knowledge, and retrovirus with the viral logics of mutation and resistance. The relationship among pathogen, individual, and population and the transnational efforts to control and manage this relationship is a relation of time and power, dictating who may rightfully access ART, for how long and when, and to whom they are indebted for such a privilege. Such relations of indebtedness -- again, experienced in terms of living on borrowed time -- necessitated *vigilance* over HIV-positive individuals' adoption of positive living ideals.

Furthermore, speculation about availability and accessibility of ART presages the accumulation of debt by those receiving medicines in settings of scarcity. HIV-positive individuals are indebted to donors and others responsible for ART access, but also to AIDS sufferers and activists of the past who made treatment a reality. By living positively, those who are HIV-positive can repay some of this debt but time and temporality mediate the terms of debt and repayment through the logic of blame and responsibility.

Hierarchy and progress, directional and temporal concepts, inflect collective responses to positive living programs in the places where they are instituted. Political and social realities of localities also surface in relation to time wherein ideas about regeneration, rebirth, and

transformation are uniquely expressed across sites. Positive living's portability across varying geopolitical contexts strengthens its standing as a universal standard in the global health response to HIV/AIDS. Yet the everyday contours of how positive living is received and interpreted (re)introduce unsettling queries about the social production of difference that accompany the global health enterprise. Positive living is guided only in part by behavioral modifications and transformative attitudes in pursuit of a healthy lifestyle. The promissory nature of HIV/AIDS care, support and treatment in the post-ART era also lays bare anxieties about therapeutic scarcity, uncertainty, and obsolescence. These anxieties, driven largely by a preoccupation with the (potential) failures of racialized others, foreground the HIV/AIDS crisis as a crisis of time.

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