THE ANTHROPOLOGY OF AIDS

C. David Pitt


Keywords: Anthropology, AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus), Pandemic, Social and Cultural Context, Mythologies, Sexuality, Drug Use, Power, Poverty, Applications, Biomedical Models, Prevention and Control, Methodologies, Policies, Planning, Future Trends.

Contents

1. Introduction
2. History and Origins
3. Geography and Social Structure.
4. Models and Mythologies
5. Applications and Policies
6. Conclusions and the Future
Glossary
Bibliography
Biographical Sketch

Summary

This chapter provides an indicative archive of different approaches from anthropology, broadly defined, to the HIV/AIDS pandemic. Although there has been some interest from biological anthropologists in the history and origins of the pandemic, including the relationships between the virus and the syndrome, the major thrust of research and action has been from social/cultural anthropologists and ethnographers concerned with cross cultural constructions of disease and a critique of biomedical models and praxis. There has also been an advocacy of more use of cultural elements in all health programs and more widely in education and sustainable development. Much attention has focused on two main modes of transmission of HIV in which there are risky behaviors, ie sexual contacts and injecting drug use. Important too has been the politico-economic (neo colonial) context, particularly relationships to power and poverty, the lowly position of women often in situations of war and socio-economic turmoil. Anthropological criticism has been most concerned to combat stereotypes, prejudices and mythologies concerning "those living with AIDS", (especially where infection is most prevalent in sub Saharan Africa) including misinformed assumptions about tradition, magic and sexuality inter alia. The anthropological narrative has argued that some quantitative epidemiology and much health policy has hindered rather than helped the understanding, prevention and control of the pandemic, whilst local, culturally appropriate "health and development from below" movements are more often successful than officially recognized. Increasingly anthropologists of AIDS are working in applied settings especially in international agencies providing cross cultural perspectives and advocacy, promoting qualitative methodologies and contributing to major planning exercises such as the Millennium Development Goals.
1. Introduction

The purpose of this chapter is to present an indicative archive illustrating past and present research and action in the anthropology/ethnography of HIV/AIDS (and from allied social sciences) as well as future perspectives. HIV/AIDS has been called the first global epidemic, a series of epidemics, or pandemic, where definitions and policies have been the product of international organizations as well as the biomedical professions. Anthropology is broadly defined to cover all those disciplines, however labeled, which derive much of their data from close ethnographic observation of structure, culture and mentalities at the grass roots (or from intensive historical ethnological study), often in small scale societies, using models which reflect local mentalities and customs focusing not only on the big political/economic/ ecological events but also on what Chauvier calls the "la vie ordinaire". A main contribution from the anthropology of HIV/AIDS especially, has been to present alternative cross cultural perspectives especially from developing countries, notably in sub Saharan Africa where there is most infection. Strongly applied, anthropology has striven to make health and sustainable development programs more effective, "from below" where communities and the oppressed within them, notably women, should be empowered to become more self reliant.

The focus of anthropology has been then on "other " cultures, communities and behaviors, often characterized (mainly by outsiders) as exotic (ie non Western), erotic (e.g. derived from alternative sexual identities and practices) or deviant(e.g. based on drug/substance abuse).Culture includes " ways of life, representations of health and disease, perceptions of life and death, sexual norms and practices, power and gender relations, family structures, languages and means of communications -- art and creativity" (UNESCO 1982).In the plural, cultures are distinct social entities which constitute an alternative cartography to a world based on ~ 200, mostly multicultural, nation states which may however attempt to impose a single national culture, or in the health field, apply international norms derived from the dominant biomedical sciences strongly influenced by especially American pharmaceutical industries.

UNESCO counts more than 6000 cultures based on languages, many disappearing, whilst others have doubled this figure and have added a very wide range of what are often called sub (neo) cultures which rapidly form not least in the context of the HIV/AIDS pandemic so prevalent in migrant communities, as well as more amorphous, and often evanescent, (including virtual) networks, a process somewhat like the spread of the disease. Other social factors e.g. religion or presumed ethnicity may make cultures distinct structurally, whilst oppositions are common (counter cultures), producing much conflict. Where there is less multiculturalism there are still marked behavioral differences in relation to the pandemic based on space (regions, localities e.g. China), time (e.g. generations) or structure (e.g. class in America and Europe) or gender. Outsiders who seek to prevent and control the pandemic are also a subculture(academic, scientific, health policy etc), whilst anthropology, which Eric Wolf called the most humanistic of sciences and the most scientific of humanities, tends to straddle the structure as well as championing bottom up processes from the "other " cultures. An essential task is to improve cross cultural communication, horizontally as well vertically top down and bottom up.
The popular stance has meant that anthropology has often been critical of perceived top down tendencies whether in the biomedical professions, government policies or capitalist business practices often seeing postcolonial globalization continuing to be unjust and inequitable if not abusive. The late Jonathan Mann (who brought several anthropologists into the WHO programs on HIV/ AIDS) talked of a third, and even more serious epidemic in addition to the virus and the syndrome, that of fear where and when human rights were ignored or flouted, where populations panicked and phobias were ubiquitous, and stigma was an important obstacle to treatment.

The anthropology of HIV/AIDS had its roots in several strands from Enlightenment humanistic and humanitarian ethics in which, in the traditions of Virchow and Durkheim, the disease was seen as social or more precisely of society, ideas that were continued in the "practical anthropology" of Malinowski in colonial settings and by his student, the doyen of contemporary applied anthropologists Fei, working in, and from China. Levi Strauss has argued that this humanism passed through aristocratic and bourgeois directed stages to populist, universalistic ethics (such as the international Health etc for All programs), changing to present efforts to find a reconciliation between humans and a nature which constantly and ultimately controls. The anthropological models of HIV/ AIDS were less derived from Pasteurian germ or immunology theory, which relied often on a sometimes statistically suspect quantitative epidemiology (and some confusion of cause and effect) and which had largely failed to explain or contain the pandemic, or provide a cure or vaccine. Rather there emerged in anthropology alternative qualitative models such as those derived from the structuralist "mythologies" of Levi Strauss, and the power theses of Foucault (himself a victim of AIDS) who argued that sickness is a degraded and oppressed status in itself, and bolstered other discriminations e.g. as demonstrated by one of his students Rubin in relation to gender and sexual subcultures. These models also established the worth and equality of the "other", cultures and subcultures so often summarily dismissed by too often ethnocentric, nationalistic, western institutions dominated by so called "tribalist" " Africanist " "orientalist" "machismo" etc ideas, which were not a solid or sympathetic base for effective health programs.

In an age of globalization anthropology also added new dimensions to the somewhat static, colonial cartography of a multicultural, tribal, world by looking at more fluid phenomena. These included both newly emergent, if transient, sub cultures but also egocentric networks which often lie under the radar, often tabooed e.g. for their assumed "deviant" sexualities, or simply "invisible" whether in the heart of a Conradian rural darkness, or outside the door in the ubiquitous urban slums, or in the concentration of camps housing so many refugees displaced by continuous war, violence and the degradation of nature and society. Anthropologists were less quick however to study the implications of the telecommunications revolution, and the virtual world of the internet, where even if the great majority of the world's population is now on line, and young people are major users, there remains "digital divides".

Although HIV/AIDS is largely a poor third world problem (even if first noticed in America) there are growing disparities too in the rich world, and the former socialist societies " in transition ", sometimes called an excluded fourth world (the term is also
applied to indigenous peoples), ravaged by crime, prostitution and drugs, emanating from outside which helped potentially spread the disease to all classes.

To help in all situations anthropology has made the case arguing for not only the imperative of top/trickledown "aid for AIDS", for more health and welfare, but also to recognize the many traditional and/or grass roots organizations, often unrecognized success stories which should be built on. A model described by Staugaard and his colleagues is Ipelegeng (do it yourself) in Botswana (the country which even if relatively wealthy has the highest rate of HIV in the world) where ideas and actions "bubble up", adapt coexist, cooperate, collaborate and cope, building on local initiatives, traditions (albeit sometimes syncretic), the strength of women, widespread will power and the potential of a mix of placebo and phytotherapy etc.

Methodologically the anthropology of AIDS has continued to use classic intimate, empirical, participant observation, rejecting the "quick and dirty" questionnaires of much quantitative epidemiology, even if such field work became ever more difficult and dangerous. Added to this, heavily influenced by Triste Tropiques (Levi Strauss) were literary (Proustian), rather than literal interpretations, even irrationalistic (Elster). Adieu au voyage then to use Debaene's phrase. More and more insiders and local people became analysts instead of simply being interpreters or informants, and an important AIDS fiction and poetry has emerged particularly from the American gay community rather than from Africans or Afro Americans who apparently did not want to be associated with what some saw as a gay white disease. Many social scientists as well as health professionals and notably journalists used ethnographic techniques whether or not labeled as anthropology, which remained, largely because of its colonial connotations, a politically incorrect word in some places. Indeed the corpus of knowledge was catholic in scope drawing not only, on portmanteau anthropology itself (social, cultural, physical/biological etc) but also the tripartite Kagan cultures (natural/social sciences and humanities) and significantly popular proverbs and wisdom, whether or not of crowds, notably and increasingly in the wikiworld and google globalism on the Internet. In explanation and application the focus expanded from the synchronic world of a year or so in the field to historical dimensions (and a futurology useful for planning), drawing e.g. on the inspiration of Evans Pritchard. Often employed in health and development agencies, anthropologists also turned their nano techniques on those who dispensed aid and advice. Galtung talked of United Nations "tribes" dominated by rituals as much as rationality, even Turner said witchcraft, part from the problem rather than the solution.

The concern was not only with observation of behavior but the mental constructions that preceded and followed from it. Thus much attention was paid to language following Wittgenstein, to words as much as things to use Gellner's phrase, (e.g. Higgins), discourse, dialogue, metaphors (of decay e.g. Sontag) or even apocalypse (Palmer). These notions in the mind (noosphere) influenced both those living with AIDS (as patients were called in the official language) and those who cared for them adding to the climate of fear that Mann had talked about even though metaphor (and dialogue) in the anthropological literature (e.g. Beck) were seen to act also as mediating mechanisms in the healing process along with proverbial traditional wisdom and beliefs in the magic
and supernatural e.g. in the book "Man Cures, God Heals" by Appaiah Kubi, who advised WHO on the Akan of Ghana.

2. History

Anthropologists were amongst the first to comment on the arrival of AIDS when it was classified in 1981 and when the presumed causal agent HIV was identified in 1983. The first victims in the USA cut down by a devastating collapse of the body's immune system accompanied by rare and bizarre opportunistic co-infections like Kaposi's sarcoma were homosexuals/drug takers in the gay community part of an innovative postmodern so called "queer" movement which challenged all orthodoxies and which had succeeded the narrower hedonistic largely heterosexual libertarian philosophies of the sixties and seventies. The heterosexual HIV/AIDS phase particularly in sub Saharan Africa, (in 2007 21 out of 33 million world wide, ∼ 25 million dying from the outset of the pandemic) also quickly attracted the attention of the anthropologists who had from colonial times worked extensively in the field there. Some ethnological research pushed back the dates when HIV/AIDS arrived, in one case to the Middle Ages when a survey of portraits supposedly revealed the black spots of Kaposi's Sarcoma in a time when an even more devastating plague, the Black Death, carried off far more than HIV/AIDS. Although medieval immune responses were undoubtedly low because of bad weather (the Little Ice Age), poor harvests, constant (e.g. the 100 year) wars, cruel crusades, economic depression (land prices did not rise between the 11th and 17th centuries) in times of personal sadness (the Middle Ages were called the vale of tears), the arrival of the HIV/AIDS epidemic was somewhat different. The present is a period of global warming, economic boom and bubble if occasional bust, relative peace or cold war (even if more have been killed since World War 2 than in it), enough food even if some become obese whilst others starve, more aspiration and legislation for human rights even if there is widespread abuse. HIV is a slow (lenti) virus possibly present for millions of year, with a wasting syndrome, controllable by ARVs even if many cannot obtain access to them, where the human is the vector through limited contact of body fluids, different then from the sudden Black Death due to the bubonic bacillus transmitted by rats and fleas though droplet infection was important in the pneumonic phase. It is not known if this pneumonia was the opportunistic Pneumocystis carinii typical of HIV/AIDS which was discovered as early as 1909 amongst malnourished children

Mann estimated that there may have been as many as 100,000 cases of HIV/AIDS before 1980. HIV may have originated amongst primates in Africa in the late 19th century as SIV (Simian Immnuodeficieny Virus), probably amongst chimpanzees in the rain forests of SE Cameroon and in the Democratic Republic of Congo who although carriers had evolved a resistance. In the "hunter" theory the virus jumped to the human population when bush meat was cruelly and unhygienically butchered sometimes involving rare and endangered species. Very little is known however on how the disease was transmitted before 1980, though wasting anorexias (slims) and PUOs (Pyrexias of unknown origin) had been widely and long noticed in Africa. The earliest possible cases identified by symptoms date from the 1950s including several sailors (though not all had visited Africa) and the tissue analysis at Tulane University School of Medicine in 1987 of Robert R., an Afro American who died in 1969. Some blamed the arrival of HIV in
the Americas on a Haitian migrant who had worked in the Congo though Farmer argues convincingly that this accusation has more to do with prejudice than hard evidence. Similarly the idea that a promiscuous Canadian Flight attendant, Patient O, brought in the virus owes more to the journalist Randy Shilts' account (and the Hollywood film) "And the Band Played On" not least since the disease was well established before Patient O, whilst his sexual prowess was probably more bragadacchio than bordello. At first the condition was called GRID (Gay Related Immune Deficiency) but this was quickly changed (1982) when it was realized that up to half of cases were not gay but hemophiliacs, intravenous drug users or heterosexuals. The widespread image of promiscuity e.g. in Africa as we shall see is arguably mainly myth, based on misconception and prejudice if not manufactured in the media.

There are many popular theories on the origins of the virus which the biomedical profession usually discounts. Many local people in Africa believe in insect vectors, especially as there is much propaganda to avoid being bitten by e.g. mosquitoes in malaria control. Others who are deeply suspicious of the West and the Americans in particular, regard AIDS as a designer disease concocted by the CIA as part of a eugenics program or germ warfare, escaped or liberated from a laboratory. There is widespread feeling too in Africa that vaccinations and injections are, whether or not intended, harmful and there is indeed much data on the adverse consequences of dirty needles and syringes. Hooper has blamed misguided polio vaccinations for the epidemic itself whilst Weinstein argues that stopping smallpox vaccination was a cause of HIV infection. Whether or not these explanations of origins are true the fact they are widely disseminated, not least now on the web, and widely believed, is very important. Conspiracy theories indicate a wide social distance between health authorities and communities which certainly impedes communication, effective prevention and control. Many locally blame poverty and continuing colonial tendencies for sickness generally. Not all alternative theories have remained only at the popular level. When Mbeki succeeded Mandela as President in South Africa much credence was given to explaining AIDS by poor socio economic conditions rather than the HIV virus drawing on the works for example of Duesberg who denied links between the virus and the syndrome, which he thought was largely iatrogenic or the result of recreational drug taking, whilst others claimed infection rates did not necessarily translate into infectivity.

Up to 2005 there had been a steady progression in the numbers of those living with AIDS from ~ 10 million in 1990 to + 40 million. Since then a decline of ~ 20% has been signaled, with more than this in some countries most recently Zimbabwe. Optimistic health agencies, especially UNAIDS, saw this as a result of wise and successful policies and programs despite funding cuts and especially by the use of ARVs championed by the pharmaceutical multinationals who made huge profits from their sale. But others, especially critical anthropologists, were suspicious that the reported success story was needed to secure ever more difficult funding sources, and less sure for example about the explanations e.g. ABC, involving more stable sexual relationships, more use of condoms, as well as cheaper generic ARVs, which were the bulwark of the campaigns e.g. in Uganda where there has been a rise in incidence amongst married couples since 2006. Many poor countries and communities could not afford the somewhat toxic, and complicated ARVs long term, despite the token largesse of free distribution in some cases. There were too examples of increases in infection (e.g. Cuba) as well as
epidemics of other sexually transmitted diseases in developed countries which were a portal for potential HIV infection. Finally there were doubts that the statistics were good enough to make judgments and indeed the range of estimates officially admitted was more than the decrease in many cases.

3. Geography and Social Structure

Much research in the anthropology of AIDS has been concerned with explaining the evolution of the pandemic in its geographical variation and socio-structural associations. Of central concern is the spatial distribution of the virus. According to UNAIDS about 2/3 of those living with AIDS are in Subsaharan Africa with concentrations in Southern Africa. In 2005 (2010 in brackets when available) the leading countries in terms of (adult) prevalence rates (with a similar pattern for AIDS death figures) were in descending order (rounded figures)-- Swaziland 33% (26%), Botswana (24%), Zimbabwe 20% (15%), Lesotho (23%), Namibia 19% (15%), South Africa (18%) and Zambia 17% (15%). In terms of numbers India (~5.7 million) leads the field followed by South Africa (~5 million) and Nigeria (~3 million). Anomalies in terms of regional averages, though of much less prevalence (around 2%) are found elsewhere (e.g. Haiti, Guyana, Belize, Suriname, Thailand, Ukraine with conversely low rates in eg Gambia, Cuba, Mauritania). Some popular explanations (in the media) for high rates are coarse grained emphasizing poverty or environmental conditions (e.g. Chernobyl for the Ukraine) and for the lower rates Islam or socialism (Cuba) because of respectively constraints on relations between the sexes and better health services.

The first criticism from anthropology has been to query both the size and accuracy of figures. Probably they are far too low, perhaps by Himalayan proportions as the environmentalanthropologist Michael Thompson put it when talking of deforestation (x 40) in that region. In the health field recent studies in India of malaria deaths reported by Dhingra et al in the Lancet (www.thelancet.com - on line 21/10/10) claimed that WHO figures were underestimated by 13 times. If the malaria analogy is used the numbers living with the disease would exceed half a billion. In many countries people are reluctant to take tests because of denial, stigma, fear and the very real chances they may lose their jobs, and even if tested do not seek treatment. The serological status of only about 1% of the population in Africa is known. Death certificates too, if available are often vague. The situation is further complicated in the case of AIDS by changing definitions, or intricate scoring systems for often rare symptoms as in the Bagui (so called after a meeting in the Central African Republic) classification. Countries may manipulate official figures down so as to protect their image and especially their tourist industry, which may be the largest source of income though occasionally figures are exaggerated to secure funds. Exaggeration is more common amongst the hordes seeking research grants who anticipate success only when they are dealing with big problems and of course the sensationalist media, leading Chin to conclude that numbers are considerably overestimated, though not the lethality of the pandemic. The nomenclature reflects the different assessments. The term epidemic is used for lesser expectations moving through global epidemic to pandemic and beyond to end of the world imagery. By the same token the recent decline in numbers may be more apparent than real, part of international agencies trying desperately to show progress particularly in meeting the millennium development goals where combating the epidemic is a priority.
A fundamental difficulty is that country figures are collected and presented in national frames, from which international comparisons are extrapolated. There are about 200 officially recognized nations but anthropologists record many more cultures which are the context in which the pandemic evolves and which show a very considerable variation in probable prevalence rates within and across countries. Globalization, migration and above all the telecommunications revolution have created new subcultures with distinct behavioral characteristics of relevance to the pandemic. Many of these are networks, often transient and fluid, rather than discrete communities, in which individuals may have several coexisting identities and belief systems with for example notably different attitudes to risk.

Some cultural characteristics may be critical in understanding the pandemic. For example anthropologists have noticed a markedly lower prevalence rate amongst some cultures which practice male circumcision explained by a hygienic benefit, though the procedure itself outside clean medical facilities may be a risk in itself. But the coincidences are not always exact. For example Uganda and South Africa have similar rates of male circumcision (~ 20%) but markedly different infection rates. The effects of female circumcision customs are not clear. Pemunta shows amongst the Ejagham (Cameroon) how there is much marriage between those who do, and do not, circumcise girls. Most argue that female circumcision is a dangerous practice and a gross abuse of women's rights though some traditionalists locally think that low rates of HIV amongst some of these peoples is explained by keeping women apart e.g. by female circumcision practice, or the burka and other forms of purdah.

Lower prevalence rates may also be associated with those cultures which have strong traditional health systems such as Chi (Chinese) or Ayurveda especially the phytotherapeutic elements Western medicine is said to use ~ 70,000 plants familiar to traditional medicine. Staugaard has shown in the heart of the pandemic in Botswana (and Green more widely), that traditional health practitioners so often derided by western medicine as witch doctors, play valuable therapeutic roles not least as herbalists, as well encouraging the placebo effect.. Traditional healers, and midwives may anyway be the only contact point where there is no western doctor or nurse, or community health extension worker, and often can adapt their traditional modes to western interventions or coexist with them. Very often traditional medicine may be not so much a competing as a complementary philosophy explaining ultimately why a person becomes sick or will die in terms of a familiar symbols and rituals which does not preclude or exclude the practical proximate rationalism of germ theory. Many AIDS sufferers return to their villages anyway since there are few facilities for terminal care in the places to which they have migrated.

Anthropologists have also studied closely the socio structural as opposed to the broader cultural characteristics of the pandemic. An important early contribution was that of Udvardy (in Sterky and Krantz) who proposed 28 hypotheses of the link between social organization and HIV/ AIDS with case studies from the Haya (Tanzania), Digo (Kenya), Kpelle (Liberia), Kikuyu (Kenya) and from Burundi. Certain attitudes and behaviors in relation to marriage, gender, sexuality, inequality, etc were suggested to favor or impede the spread of infection. Udvardy noted that there was a coincidence in reports of the disease with descent systems notably the matrilineal societies in Bantu
cultures where the so called female principle was important, broadly located in a belt across central Africa in the Congo, Zaire, Angola, Zambia and Mozambique. In these societies there were lower bridewealth payments than in patrilineal societies which were more polygynous and had institutions such as the levirate. There was more chance of divorce in matrilineal situations since less bridewealth had to be returned to the husband's kin. Women had more independence including in the sexual sphere. However these theories did not take enough account of the massive nature of urban migration when traditional marriage systems and controls broke down, nor of prostitution, concubinage, homosexuality etc in towns Nor of course did the matrilineal model explain the great concentrations of infection in Southern Africa. In Lesotho according to the World Economic Forum women have more liberty than most other countries but Turkon (from the ARG) has argued that high incidence may be explained rather by the constant squabbling of NGOs and community groups.

4. Models and Mythologies

A focus of anthropological interest has been a critique of the ideas about the pandemic which are often called mythologies i.e., culturally constructed models about the processes, logical as systems in the sense of Levi Strauss, but not necessarily factual or useful (i.e., myths). It is possible when seeking to explain the pandemic and its epidemiology to distinguish different, if overlapping, kinds of models or mythologies. First there is the official version enunciated e.g. in the publications of UNAIDS which since 1996 has coordinated the efforts of particularly 10 international agencies (UNHCR, UNICEF, WFP, UNDP, UNFPA, UN Office on Drugs and Crime, ILO, WHO UUNESCO and the World Bank) as well as increasingly NGOs and so called civil society, broadly the rest of society and its spokespersons. The official models rarely mentioned anthropology, though to be fair anthropologists did not read too much of what was described as an often tedious, turgid, superficial and glossy, official literature either. In the official version there were two main risky modes of transmission, (sexual activity and injecting drug use) and four target groups (sex workers (prostitutes), MSM - men who have sex with men (homosexuals), injecting drug users and prisoners.

Other routes however even if less of a priority (e.g. neonatal) were considered and the wider socioeconomic context was taken into account if not the focus that it was for a second mythology the "critical medical anthropology" as Whelehan called it. In the official model there was a tendency to pass on the blame for the pandemic to the "other" societies who were assumed to be, more or less, inherently deficient in attitude and behavior, e.g. promiscuous, hedonistic, amoral, weighed down by kin, tradition bound, corrupt, with magical rather than scientific explanation. etc. All this may be seen as part of a general stereotyped colonialisit legacy and prejudice (called variously africanism, tribalism, orientalism etc ). In particular it was assumed in the official model that there was an insufficient understanding of biomedical science. When those with HIV/AIDS lived in so called "developed" countries they tended to be labeled "patients" a degraded status category, whilst seropositivity became a form of a inferior biological citizenship (e.g. restricting travel) part of what Fidler has called microbial politik, a stigmatized state which added to the adverse effects of stigma already existing within societies. Nguyen in important West African studies has argued that the pandemic has created a
new type of sovereignty in the community where in the distribution (triage) of care and treatment some individuals through devices such as accusation, confessions etc may secure life saving advantages.

Local mythologies added a new tier to classification and explanation. In Malawi HIV is given two names, one for the infection in the official propaganda, the other for a more general evil which has an origin in malicious people and forces which causes a breakdown in social harmony, similar to Kahungo reported by Morgensen in Zambia. Among the Bahaya of Tanzania the term Eukiuka refers to both "slims (ie the anorexia of AIDS) and a withering disease of bananas, a staple crop whose disappearance leads to famine, malnutrition and a decline in immune systems. A key feature of local models was their holism, their metatistic qualities, and influence of mind, whether placebo or nocebo, as well as a Jobian recognition of cruel fate in life, which biomedical models such as WHO's cartesian International Classification of Diseases did not easily incorporate. In local situations and for specific groups, such as women or children a most distressing aspect of the pandemic, and a potent source of discrimination, was the stigma attached to those sick, or thought to be carriers of the disease, or of evil in general (Deacon et al 2006).

The anthropological models generally denied the official and biomedical model versions, though not always, not least because many anthropologists could not risk their grants and employment by being heretics. Anthropology however did lean heavily on popular, often traditional interpretations in the local language, idiom and concept, seeking often to espouse and champion its causes. Popular models were far more ranging in explanation and scope sometimes not even classifying the syndrome as a disease, logical where many if not most people have AIDS, better explained by enemies and evils whether natural or supernatural.

In the official biomedical version sexual transmission is said to account for about three quarters of all cases of HIV, and the prime task of programs is to lessen risk through such preventive means as condoms, which also satisfied the underlying, thinly veiled motive in many programs of birth control (aka euphemistically family planning). In the official version there is often, even if not stated an assumption of widespread promiscuity as a key causal factor, to be found in the "other" cultures and countries, usually in the third or fourth worlds, as well as amongst those classified as deviants, deranged, criminal or otherwise different or dissident.

The stereotype of promiscuity has however been difficult to document not least since sexual behaviors are often private affairs whether or not in gay closets) or public exaggerations e.g. the label of machismo cultures for young (and not so young) males. The assumption of promiscuity may derive from a western mass media permeated with pornography and scientifically suspect surveys such as Kinsey, Hite, Masters and Johnson etc or a Freudian literature based sometimes on the neuraesthetic fantasies of the odd menopausal woman on the couch. Much of the evidence from anthropology at least for traditional societies in such archives as the Human Relations Area Files (as described by Frayser) albeit recorded mainly often by white male foreign observers, is a canvas of complexity with many rules and rituals. Freeman in Samoa (a key case study) showed the rigidity and controls over virginity and generally dismissed much of
Margaret Mead's picture of permissiveness, though his intention seems rather an attempt to "trash" her reputation a compliment recently returned by Shankman. Possibly both Mead and Freeman were right in different times and places, (even two countries) in what Shore anyway calls a mysterious culture of the mind. In an important study Shore has shown the dichotomous nature of thinking in Samoa (and elsewhere) with alternating zeitgeist of permissiveness and prohibition. The obsession with sex in Samoa is anyway not so much right or wrong as irrelevant for HIV/AIDS since infection rates are so low, some say locally because there is no malaria even if much filaria.

Recent work in Africa has also shown that love, as much a sex, was an important motif and fidelity which has been an explanation of recent declines in infections e.g. in Zimbabwe, whilst Emprecht argues that heterosexuality was a stereotype in itself. Heider in New Guinea describes the Dani as a low energy sexual system apart from occasional periods of mayhem. Western sexuality, at least before the heterosexual and homosexual "revolutions" of the 60s, 70s and 80s, as described by Aries and his colleagues was a chronicle of tortured abstinence as much as fornication sometimes to be only found in times of license after lent or during the all too frequent wars. On the contemporary scene Lafont in the work edited by Aries in an exhaustive study of machismatic Paris gangs found that there was hardly any sexual activity at all in the incessant wars despite all the strutting of the stuff. The emancipation of women, (even if more apparent than real), the pill, the decline of the extended family may have lessened opportunities as well as urges whilst eggs (and male sperm) counts declined dramatically probably due mainly to environmental factors.

The widespread migration to towns led by young unmarried males did open the door to a huge, uncontrolled sex industry and widespread venereal diseases whose lesions were frequent entry points for HIV. The demand for wage labor was largely dictated by capitalist inspired authorities who had also destroyed self subsistence in villages which became dependent on remittances. Here too it seems as if female prostitution at least was driven by economic necessity as much as sexual urges, precautions were common, and there was sometimes a resistance to the virus (e.g. in the Gambia). In the case of drug (and drink) users the intoxication, notoriously diminishing libido, was the object of the exercise. Anthropological research, often by outsiders working on short term basis, however had shortcomings in describing sexual situations. A good example comes from China. In Yunnan Hyde described in her research in 1991 a situation of increased HIV infection where the majority Han population feared the disease was caught from infected prostitutes of the ethnic Dai minorities. Jin Jung who knew the area over a longer period from his base in Tsinghua University showed in 1995 most of those infected were Han and that even the prostitutes who mostly grew in numbers with the expansion of the market economy and migration were Han too, even men who dressed up as Dai.

As for the homosexual component gay pride was so hounded and harried, including in hot beds of promiscuity such as armies, that opportunities were limited and being often well educated precautions such as condoms were often used and risky practices such as anal sex avoided.. Certainly in prison populations sexual harassment was part of patterns of dominance but this situation was caused, less by testosterone, than by the
high proportion of prisoners in the population (led by the United States) produced by inefficient legal and judicial systems, incarcerated in cramped and unsanitary quarters. Much sexual activity was forced on populations, especially women, whether in ubiquitous conflict situations, where rape was a weapon of war, or in the camps for refugees and those otherwise displaced where abuse even involved UN officials. Sex tourism, a rapidly expanding industry was another example where the dynamic came from outside rather than inside cultures but even here the internet was making such pleasures virtual or sometimes(e.g. stripping) heuristic.

In addition to images of promiscuity in the western narrative was what Banfield had called amoral familism. In these models the burden of tradition and especially large families and extended kin obligations was said to impede the attainment of development based on the Weberian ideal type spirit of capitalism derived from a protestant ethic of hard work, thrift and consciousness of good health. Konaté from Mali has argued in Africa that there is a kind of schizophrenia in which opposed to modernism is corruption and degradation of women for example through female circumcision (genital mutilation). There is however a very large social science literature which shows how capitalist success as well as and health awareness (or low HIV/AIDS incidence) can be attained in a wide range of religious and social settings from Schumacher's "small is beautiful" Buddhist economies to communism in China as well as poor "health without wealth" least developed countries like Samoa. What probably deprived many traditional communities of their dynamic was rather the replacement of a redistributive subsistence and reliance on the human capital of large families, by commercialization and globalization in a cash economy driven by the need for villagers to meet outside demands for taxes and imported goods. Migration to urban wage labor slums left villages, inhabited largely by children and the elderly reliant on remittances. In Africa women were deprived of their leading role in subsistence (which increased the possibilities of famine and malnutrition) as well as power, even if informal, being reduced often to poorly educated, sexually subservient roles in urban settings where their HIV/AIDS infection rates were the same as men, who were the main vectors of the disease even when the women stayed at home in the villages.

There has been a good deal of discussion as to whether modern capitalism, especially the so called casino variety is any longer, if it has ever been, the most appropriate milieu for the prevention and control of HIV/AIDS or other health problems even if privatization has had some success in some contexts. Capitalism is characterized by cycles of boom and bust. The most recent (sub prime) crisis which led to the worse depression since the 1930s was largely the product of widespread and excessive borrowing and risk taking by governments, banks and individuals. The collective mentality which produced pyramids and ponzies also underlay attitudes to sex, drugs and other behaviors relevant to the transmission and incidence of HIV/AIDS. Heavily indebted, cash strapped governments undertook austerity programs in which reduction of health services was important. Individual behavior involved widespread risk taking including unprotected sex as well as other gambles in life and social relations.

The western commentaries on women have failed also to appreciate the cultural construction of gender whatever the biological facts. In many, perhaps most societies there are important roles for homosexual, bisexual and transgender relations which are
culturally defined. An extreme case is provided by Herdt amongst the Sambia of New Guinea. In this culture babies are born genderless. Whether biologically male or female they acquire female status through their mother's milk. Men only become male when they prepare for war by absorbing the semen, and hence the power of other men, by fellatio.

Similar mythologies to those concerning promiscuity and amoralism were important in the analysis of injecting drug use, which was judged to be the second most important mode of infection (~20% of all cases), not least because sexuality was intimately connected usually with drug behavior. In the Weberian narrative drug taking, like all substance abuse was hedonistic. But the important context was that of criminality and related violence and corruption forcing drug taking underground (as in the case of prostitution) through, in most countries ineffective, draconian legislation.

The critique of prejudice and discrimination in western narratives by anthropologists did not only target ideas about individual behavior, which derived essentially from Freud or Weber, (or the haughtiness of the biomedical profession), but also included a Marxist element in which explanations of the pandemic and reactions to it were set in a wider political and economic capitalistic context. Farmer, following Foucault claimed that HIV/AIDS (as well as other associated diseases such as TB) was a "pathology of power". In a neo-imperialistic, globalized world a large proportion of the population were made poor, even absolutely poor with little access to services which would satisfy their basic needs, notably health. Solutions, if not revolution, required regulated public social welfare not the market as well as peace from the incessant post colonial wars and the ubiquitous violence.

Not all the criticisms of western policies were from left field. Edward Green, who had been a adviser to President George W. Bush put forward what he called a contrarian view. He felt that the attempt, particularly on the part of the Americans, to impose democracy on the world had been counterproductive looking for high tech solutions and had not taken enough heed of the values of different cultures. His approach to the prevention of HIV/AIDS was less intrusive, advocating the use of traditional healers for example and supporting behaviors like ABC in a context of what he considered in Africa were often sexually repressed, homophobic societies.

Inequalities in power were most marked in the gender field where there was an important anthropological contribution. Women, especially young women were particularly vulnerable, and relatively deprived, not only in the developing world, despite the efforts of international agencies. In Africa many of the problems of hunger, (which greatly lowered immune resistance) and food supply were related to the decline in female participation in, and direction of small scale subsistence agriculture. Opportunities in the cash economy, especially in the urban slums were too small, commercialized or compromised (e.g. in the risky sex trade or the black market), whilst the growing female participation in small businesses was hindered by inadequate micro-financing. Women were too often relegated to dependence on male urban migrant remittances, waiting at home in the villages, even if they performed huge services there looking after those suffering from AIDS especially in terminal phases when people came home to die. Other inequalities, though much less studied by anthropologists,
related to young people. According to an important study from WHO in 2006 (Ross) 15 to 24 year olds now account for 40% of new infections. Another neglected group are the elderly where there are +4million infected, often poor in the over 50 age group (Negin and Cummings). As global populations age greater numbers are expected depleting the grandparent generation who play a vital role in looking after both the dying and those orphaned by the pandemic.

Global inequalities were then expressed in health as well as political and economic terms the "have-nots" having too few resources to seek care even if most aid went into military budgets and much of the rest was wasted. The flow of refugees and migrants seeking better health care as well better standards of living was greatly restricted. Being seropositive, (even if restrictions have recently been lifted in the United States) was a major obstacle and became a form of biological citizenship, or rather lack of it. Rarely for migrants was seropositivity an entitlement to treatment which in France was sometimes refused by those who were trying to resist deportation to take advantage of a loophole in the law which did allow the sick to stay, if only temporarily.

Not all of the anthropology of AIDS has been a critique of western models, which in the process of dialogue are somewhat mirror images of what is criticized. There have been important constructions of popular narratives too, derived as Soyinke argues from the authenticity of the indigenous (as opposed to the post colonial ) and the local (expressed as Sontag showed in the West metaphorically) An important alternative is provided in these popular philosophies (related in stories, proverbs etc) to the basic thrust in the biomedical models of disease as an extraordinary event which must be prevented (e.g. by vaccination ) or cured (which of course is not possible presently in the case of HIV/AIDS). For example very often a sickness like HIV/ AIDS is regarded as a normal part of the life course, albeit a liminal disordered chaotic state (in terms of Van Gennepian rites de passage) between two states of harmony, where even death may not be the ultimate stage. The person then living with AIDS is in a state to use Achebe's famous phrase where "things fall apart", true for the individual's health as for the transition state from e.g. colonialism (or even states of pollution in Mary Douglas sense of reverse power including environmental degradation). These were often situations where the absence of law and order favored the spread of the pandemic. The task of the traditional healer or shamans in small scale societies can be seen as leading people through this wilderness. A good study of this alternative cosmology is from Zambia (Tonga) in Morgensen's book AIDS is a form of Kahungo, a syndrome which covers both AIDS and the general anxieties of living in liminal, unsettled political and economic state. The Mot Luuk syndrome of Thailand (described by Boonmorighan et al in Good) shows how illness such as AIDS or cancer are idioms of extreme distress for which succour can best be found in traditional rather than biomedical treatments. The need for a return to the ordinary, to demystify the science and pathology of HIV is also covered in anthropological studies in West (e.g. Chauvier in France).

Above all the focus on the reality of everyday life emphasizes the complexity of social situations and any attempts at behavior change as Helen Epstein, Thornton and others have shown in Uganda which had been rated as a HIV/ AIDS success. Here rates have risen amongst married couples recently explained by complacency once ARVs were available but also complex cultural factors (e.g. the Catholic opposition to condoms, or
the institution of the "side dish" where feckless husbands had other partners). There is a key role however not only for culture, social structure or networks but the influence of what Bourdieu called habitus, the whole style of life that evolves in the life course, including upbringing, education, peer groups, food and the accumulation of small rituals, in a specified place (Dovey) or time (zeitgeist). Government policies which react holistically and positively (despite the new fad of happiness indicators) to this big picture are often lacking in a mosaic of fast changing situations. There has been a revival of alternatives to AIDS explanation and care in new often syncretic religious organizations/sects (Diliger).

5. Applications and Policies

There has been a long history of anthropologists helping health authorities both in the colonial period (including "internal" colonialism e.g. through the Bureau of Indian Affairs in the USA) continuing into the postcolonial phase notably at WHO (e.g. George Foster), even if there was considerable mistrust and misunderstanding on both sides. Before the AIDS pandemic a boost to the anthropological critique, or at least support for the grassroots coincided with the WHO (headed by Halvdan Mahler) UNICEF Health for All (and forever) program emphasizing primary health care signed in Alma Ata (former USSR) in 1978. A major role in drafting was performed by (Joe) Cohen, who had been a ship's doctor on the Exodus after the holocaust. He went on to play an important part in drafting the Global Programme for AIDS (GPA) which started in WHO in 1984 and which gave prominence to what were called social and behavioral factors. GPA ultimately morphed (1996) into the United Nations coordinating agency (UNAIDS) with the anthropologist Michel Caraël playing a key role.

A specific impetus came from Goran Sterky, who, funded by the Swedes (SIDA/SAREC) brought into the Maternal and Child Health (MCH) unit of WHO from 1976-81, or later his program on AIDS at the Karolinska Institute, Stockholm a number of anthropologists including Manuel Carballo, Frantz Staugaard, Annika Johanssen and David Pitt, some of whom went into WHO/GPA. Some of the Sterky group had earlier being involved in establishing at the IX th Congress of the International Union of Anthropological and Ethnological Sciences (IUAES) in Chicago/Oshkosh (a Wisconsin lakeside town) (1973) under the patronage of Sol Tax, Margaret Mead and Claude Levi Strauss the Oshkosh network of anthropologists (and other social scientists) committed to the idea of "development from below", which drew on the concept of "another development" at the Dag Hamarskjöld Foundation in Uppsala, Sweden. Sterky produced at MCH in the early eighties a series of publications (together with the NGO Defence for Children Geneva) called Iketsetseng a word from Lesotho meaning roughly do-it yourself, which during the AIDS pandemic under the editorship of Staugaard, influenced the Ipelengleng (a similar word from Botswana) series published in Gaborone, Botswana, and by the Nordic School of Public Health. The IUAES initiated in 1988 in Zagreb, former Yugoslavia, the formation of a Commission on AIDS which later (2002) was supported by UNESCO/ICSU to prepare a cross cultural companion to the pandemic.

UNESCO, with anthropologists and those recognizing the worth of culture playing an important role, set up (1998) an innovative program which engaged a strategy to enable
populations to fight against HIV/AIDS from their own cultural resources, thus adding a focus on cultural diversity to the biomedical programs. Case studies (from 13 countries), methodological handbooks and training tools were produced including open learning materials which drew on traditional means of communication (e.g. theatre, music etc) and notably a comprehensive annotated bibliography (Culture, HIV and AIDS 2006) in the Division of Cultural Policies and Intercultural Dialogue with the Social Science Research Council (New York) edited by Vim Kim Nguyen, Jenifer Klot, Alton Phillips and Catherine Pirkle.

The American contribution to the applied anthropology of AIDS was considerable with the involvement especially from the AIDS and Anthropology Research Group (part of the American Anthropological Association (AA) network, Society for Applied Anthropology etc (in the tradition of the earlier Action Anthropology of Sol Tax etc) based at the Jesuit Creighton University in Omaha which published on line a series of bulletins, conference reports and discussions including leading authors such as Douglas Feldman,, Patricia Whelahan, Edward Green, Helen Epstein, David Turkon, Ray Bucko amongst others. Especially important was a very extensive bibliography of nearly (2011) 5000 items which built on the earlier work of Bolton and Orizico (1993) for the AA complementing the incisive abstracts form H. Robert Malinowsky at the University of Illinois Chicago (1995- 2005).

AIDS was first noticed (1981 )and protocols prepared to study it at the Centers for Disease Control (CDC) in Atlanta Georgia which became a basis for research at WHO first in the GPA under the direction of Jonathon Mann and later in UNAIDS. Considering that North American universities produce large numbers (currently ~ a thousand annually) of anthropology graduates it is not surprising that many found their way into CDC style programs even if often called by other names such as social psychologists, and even if some aspects of the CDC culture were not to their taste. The models emerging from CDC were hard headed, biomedical attempts to organize (with management if not military analogies) efficient and effective prevention and control often funded privately by profit seeking pharmaceutical companies (but also including philanthropic capitalists such as Bill Gates) as well as a wide public. A Global Fund for AIDS, Tuberculosis and Malaria was established (2001) though generally it was the World Bank rather than WHO or UNAIDS which provided leadership even if somewhat compromised, from time to time, by accusations of partisanship, bias and corruption.

The idea was to maximize testing, prevention, control and treatment, (once ARVs were available) though (claimed) shortage of funds and low popularity/uptake/compliance prevented extensive coverage. Social marketing techniques were used (e.g. focusing on the condoms as the lead brand) with advertising slogans such as ABC prominent. The CDC models were carried world wide by USAID and other foreign assistance programs as well as in the international agencies and NGOS as well as throughout the multinational corporate network publicized in such places as the World Economic Forum Network from Davos, though anthropologists rarely found their way into such James Bond like scenarios. In Europe the links between business and anthropological research were not strong generally as can be seen in the history of the Anthropology and Social Associates in United Kingdom led by Paul Stirling at the University of Kent Canterbury, much stimulated when the American Society of Applied Anthropology
circus came to town (Edinburgh) in the 1980s, or in France in the AMADES group chaired by Jean Benoist in Aix en Provence.

Anthropological insights too were important in socialist, as well social welfare systems contending with the pandemic, even if there were suspicions that cultural diversity equated with dissidence. Soviet experience (e.g. the Felshers) and the Chinese barefoot doctor scheme, which owed much to the ideas of Fei were fundamental to the Alma Ata agreement even if in decline by then. The adoption of the Chinese system to capitalism was a success story though not without its critics. Bouee has explained success by a continuing legacy harmonious of Confucian ideas extolling the virtues of assiduous work, pragmatism, welfare concerns supported by firm law and order combined with enterprise and gung ho.

But even if the barefoot doctors are a nostalgic memory and there are grumbles about human rights. the Chinese program of "Four free, - One care" is being hailed as very promising most of all in African settings The freely available items include ARV, (especially taken to rural areas and the urban poor, free, voluntary counseling and testing, free care and medicines for seropositives, notably pregnant women and their babies, free assistance for households with those living with AIDS, free schooling for those orphaned. The IUAES which held its International Congress in Kunming, in 2009 chaired by Peter Nas and Jang Jijao presented a wide range of materials showing the impressive response of anthropologists to the pandemic, especially at Tsinghua University in Beijing. In Africa there were a wide range of projects based on traditional models and modern ideas such as the successful Grass Roots Soccer Charity which turned AIDS prevention into a game for young people or the traffic light model (Stop, Ready, Steady, Go) of the UNAIDS task force on youth which targeted projects in key areas such as schools, health services, sex workers, prisons etc.

Many anthropologists in the Cold War period and its aftermath found themselves in situations of violence and other disasters which, even if sometimes of natural origin, generally were accompanied by various forms of inequality oppression. Intervention in local affairs ostensibly for humanitarian reasons created awkward dilemmas especially when associated with force, not least when dealing with HIV/AIDS. Fassin (in Good) of Médecins sans Frontières talks of an ontology of violence in which anthropologists became privileged agents of oppression. The violence was also structural in the sense of Galtung extending beyond abuses to discrimination in every aspect of life especially for the displaced even when development was well intentioned. For Farmer this is the malaise which underlies the whole HIV/AIDS pandemic and requires root and branch reform starting with a rethinking of basic ethics. He argues that there is a need for a liberation theology starting with a reformulation of the Hippocratical oaths, the international ethical codes and the WHO proclamations of the 1940s and the more recent Tavistock principles (named after the square in London where they were expounded ) where health was recognized as the basic human right Saillant et al in the Lausanne Manifesto ( 2011) call for a non hegemonic anthropology freed from occidentalist bias and control, promoting and privileging a local based cultural diversity.

More realistically there is a recognition of the need to adapt the system e.g. building on the long standing programs in WHO (Bodeker et al 2006) to use traditional medicine
much more, to stimulate self care where there is no doctor, to expand education using
the telecommunications revolution, or the idea, (which has a long history e.g. in Brazil,
the Philippines and Thailand) of "task shifting" ie providing rapid training for notably
women to take on community health extension roles, presently very weakly developed
in more than 50 countries mostly in Africa. In all this a need was recognized (e.g. by
Hsu et al 2007) to work for a holistic ecology of AIDS at once interdisciplinary and
intersectoral.

6. Conclusions and Plans

Even those skeptical, like Chin, about the incidence of HIV/AIDS admit that "it is one
of the most severe infectious disease pandemics of the last millennium", potentially
more fatal than the Black Death of medieval times or the so called Spanish influenza at
the end of the First World War. And there are the coming plagues as Garret calls them
including new retroviruses (e.g. XMRV), depressive disorders (notably of the immune
system), as well as an explosion of sexually transmitted diseases generally. To this
should be added what has been called in China AIDS-phobia, ie patients who are
seronegative but show many of the symptoms of AIDS possibly a new variant but more
likely a product of the fear, even crowd panic spreading in times of great uncertainty
and anxiety. Vaccines despite media scoops remain mostly pipe dreams if only because
of cost.

Future plans to combat the HIV/AIDS pandemic are high on the agenda of global
politics in such ambitious programs as the Millennium Development goals (notably to
eliminate poverty) or the follow up to the Millennium Ecosystem Assessment (which
wants to stop pollution and environmental degradation), even if targets are not on
course and funds are faltering amongst donors ever more disenchanted. But the roles
for anthropology are neither detailed nor demanded by the elites who control research
and development. To use Shula Mark's phrase the anthropology of AIDS, like most
anthropology is considered to be a pseudoscience, and worse the champion of dissident
minorities wearing cultural masks with their own political agendas likely to disturb the
notion of nations which has existed since the Treaty of Westphalia.

What has been suggested by anthropologists have been some modest plans. For
example Fassin (2009) suggests enlarging the focus from medical anthropology,
(though still trying to reach the medical schools), to a broad interdisciplinary
cooperation integrating the local and the global, the poor and the rich. The Commission
on AIDS in the IUAES wants an encyclopedic, wikipedia like compilation of the
different cultural responses drawing on for example the wisdom of traditional healers,
well as a critical ethnography of international health and sustainable development
programs. Whelehan and the AARG want to build on successful models of
anthropological interventions, with early responses, comprehensive strategies, culturally
sensitive, adaptable programs, using local leaders and resources, enhancing especially
the role of women. In the international agencies UNAIDS has advocated the limited use
of anthropology and other social scientists in specific interventions such as universal
access to ARVs to be implemented throughout the UN family. UNESCO has however an
important list of planned projects with a strong multicultural red thread stressing open
and e learning taking advantage of the internet and the telecommunication revolution,
utilizing better the fact that there are now nearly as many mobile telephones as people on the planet, as well as reaching more young people through the existing education system. The YAH network which plans to prepare a multimedia platform for youth involving Canadian and South African universities are good examples of culturally sensitive efforts. UNESCO plans to target countries of high incidence e.g. in Southern Africa as well as groups, notably women at highest risk and most disadvantage. Together with the Swiss Tropical Institute, lest the wheel be reinvented, there are plans to survey the considerable number of projects which have attempted to construct culturally appropriate programs.

Efforts are being made to prepare anthropological contributions as at the June 2011 United Nations High Level Meeting at the General Assembly which drafted a road map towards a zero approach (to new infections and discrimination) as well as providing many more condoms (though usage is often problematical) and ARVs, where infectivity is claimed to be massively reduced. Qualitative supplements are being advocated in important projects such as the UN Taskforce on Young People or WHO's Active Ageing program which hitherto have relied overly much on a narrow range of quantitative surveys. This complementary anthropological approach uses the jurists and historians arsenal of tests to determine credibility, insight and usefulness (Pitt 1973) even for the dodgiest data. New theoretical ideas are being scanned e.g. Simon Baron Cohen's Empathy principles which replaces "autistic" modes, violence and conflict with more friendly, positive, cooperative models as was pioneered in the Happiness projects in Bhutan and updating Huizinga's Homo Ludens ideas.

Some critics have argued that all this is too little too late, necessary but not sufficient and that plans should seek to involve more effectively the war and disaster organizations both in the UN Family (e.g. UNDS) or NGOs (e.g. the Red Cross) as the spread of the virus, like previous pandemics such as the Black Death or the Spanish flu, are much affected if not determined by the ever more threatening, greater plague of war and violence, which may once more to convulse the planet. There may well be a case as Malloch Brown amongst others has suggested for a wholesale reform of international institutions to take greater account of the new multicultural world where the anthropologist's cartography would be essential or, at least, a through going devolution privileging the small scale and self reliant in the community, highlighting individual rights and roles, for AIDS care, health generally and much else. The baby should not be thrown out with bath water however. Archer has argued for a reflexivity in which individuals react creatively to the structure, ideas common in e.g. some neocapitalism (e.g. Soros). There are many elements of past and present ideas and institutions that should and could coexist with the reforms, whether evolutionary or revolutionary, and a middle way, that is fundamental to many of the world's religious systems, should be the aspiration. Gorbachev has called (in Samson and Pitt 2000) for a "new synthesis, of the valuable elements of existing perspectives including -- liberal and socialist values, individualistic and community ideals" in the context of the noosphere, the constructive realm of mind where there is a reconciliation following Levi Strauss not just of cultures and humanity but also with a primordial nature which includes virus, syndrome and society a nature, primordially living with HIV/AIDS.
Glossary

ACTUP : The AIDS Coalition to Unleash Power, an influential nongovernmental organization founded in New York (1982) to assist those living with AIDS.

ABC : Prevention campaigns which stress Abstinence, (Be) faithful as well as the use of condoms.

AIDS : Acquired immune deficiency syndrome, a multiple condition of widespread infections and cancers in which the body can no longer resist disease usually following detection of HIV the human immunodeficiency virus the presumed causal agent.

ARC : AIDS related complex, diseases commonly associated with AIDS such as Karposi's sarcoma, Carinian pneumonia etc

ARG : American Anthropological Association - AIDS and Anthropology Research Group

ARVs : Antiretroviral drugs used to contain AIDS or slow the onset of symptoms.

Applied Anthropology : The branch of the discipline concerned to work with health and other programs, often in a governmental or international context stressing action as much as research.

Bisexuals : Those people who have sexual relations with both their own or the other sex.

CDC : The Centers for Disease Control and Prevention, the Atlanta (USA) based institution which provides definitions, protocols and standards for diseases including HIV/AIDS.

Chemotherapy : Treatment by chemically based medicines as opposed to radiotherapy, phytotherapy (plants) or surgery.

Civil Society : Institutions in the broad society outside government (e.g. NGOs)

Cofactors : Conditions which occur in conjunction with HIV/AIDS and/or increase risks of infection

Complementary Medicine (CM) : Also known as alternative medicine CM has different models and practices to western Pasteurian germ theory and chemotherapy, surgery etc relying rather on phyto(plant) therapy and homeopathy drawing often on traditional non western medicine.

Condoms : Protective devices, usually male, which prevent conception and contact of infected bodily fluids.

Conspiracy Theories : Explanations of pandemics such as HIV/ AIDS in terms of human evil e.g. that the (designer) disease was created in laboratories as a weapon of biological war.

Critical Anthropology : The body of knowledge and action which seeks alternatives to usually capitalist and top down health and sustainable development structures by stressing bottom up, community based, alternative
| **Cultures** | Groups with shared languages, beliefs, rituals etc or in the singular the ideas, arts and similar activities of such groups which may be studied internationally (cross culturally), or in opposition to mainstream ideas (counter culture). |
| **DALY** | Disability Adjusted Life Years - a measure of high disease burden and reduced expectancy of life. |
| **Denialism** | The statements, including by governments which attempt to minimize the extent of the HIV/ AIDS pandemic or the disbelief of patients on diagnosis. |
| **Development** | Generally social and economic progress to increase standards of living including health and the environment (sustainable development) whether "top down" from government hierarchies and commercial business, or "from below" in communities in terms of their own cultures. |
| **Discordance** | When one partner is seropositive the other not. |
| **Endemic** | A disease which is widely found in an area or culture. |
| **Epidemic** | The rapid outbreak of an infective disease locally or globally (global epidemic, pandemic) in contrast to chronic conditions often presumed to be non-communicable. |
| **Epidemiology** | The study of the geographical occurrence of disease and its causes. |
| **Ethnicity** | The assumption, not necessarily demonstrable, that a group shares a common gene pool, derived from (usually misplaced) feelings of superiority (ethnocentrism) leading to (often violent) racist actions. |
| **Expectancy of Life** | Statistical estimate of average time a person may live at different ages or stages of disease. |
| **GRID** | Gay Related Immune Deficiency - the name applied to AIDS in the early 1980s when it was thought that the disease was confined to the gay (male homosexual) community. |
| **HAART** | Highly Active Antiretroviral Therapy. An often toxic and complicated treatment for HIV/ AIDS. |
| **Heterosexual** | Persons attracted to the opposed sex in contrast to those (homosexual) involved with the same sex. |
| **HIV** | Human immunodeficiency virus. HIV+ (seropositive) are those who have antibodies to the virus. |
| **IDU/IVD** | Injection Drug Use/ Intravenous Drug Use, carries a high risk of infection when needles are shared. |
| **Living with AIDS** | people who are seropositive or showing symptoms of AIDS |
MDG: Millennium Development Goals are targets advocated by the United Nations in 2000 to be achieved by 2015 (though currently end 2010 not on track) including the reduction of the incidence of HIV/AIDS. The MDG replaced the millennium targets of e.g. the Alma Ata Health for All program which were meant to be (but were not) reached by 2000.

MEA: Millennium Ecosystem Assessment. A major study coordinated by UNEP, published in 2006 which examined relationships between health (including AIDS) and the environment.

Metanalysis: Methodology which uses qualitative data.

MSM: Men who have sex with men.

Narrative: An account (discourse) of social processes which may contain mythologies (culturally based explanations rather than models derived from empirical evidence), dialogues, or other (usually) qualitative, discursive discussions.

NGO/QANGO: Non governmental organizations/ quasi autonomous NGOs, the latter often a front for government activities.

Refugees: People forced to flee their homes usually from war situations often internationally, includes internally displaced persons within a country, contrasted with migrants who move more voluntarily but who also have a high risk of infection.

Safe(r) Sex: Practices such as abstinence, fidelity and condom use which reduce the risks of transmission of HIV.

Self reliance: Institutions whereby individuals or communities help themselves.

Seropositives: People in whom antibodies to HIV have been detected.

Slims: Popular name for people with the wasting (anorexia) often associated with AIDS.

STD: Sexually transmitted disease.

Substance Abuse: Usually drug taking or excessive alcohol intake, which can heighten risk of infection.

UNAIDS: The United Nations agency which coordinates international efforts to combat the pandemic.

WHO: World Health Organization

Bibliography

AARG (AIDS and Anthropology Research Group - affiliated to the American Anthropological Association the AARG produces an informative bulletin, and a regularly updated bibliography containing (2011) more than 5000 items which can be accessed at http://groups.creighton.edu/aarg or www.medanthro.net ]


Amit, K. and Dyck, N. eds (2011) *Young Men in Uncertain Times*. Oxford: Bergbahn [Studies from China, Ethiopia, Kerala, Caucasus etc]

Anthropology and Medicine - (2004) v 11.1 [Special issue on the relevance of the work of Foucault and Bourdieau.]

Anthropology On Line - A valuable index of several thousand periodical references on anthropology and AIDS from nearly 800 journals at the Royal Anthropological Institute and British Museum Centre Access on line at http://aio.anthropology.org.uk


Benoist, J. (2002 et ff) *Petite bibliothèque d'anthropologie médicale*. Aix-en- Provence: AMADES. [A most valuable francophone collection of more than 200 reviews in Volume 1 many discussing HIV/AIDS supplemented to 2011 in volume 2 by a further 100+ items which appears only on line at http://classiques.uqac.ca ]


©Encyclopedia of Life Support Systems (EOLSS)


Campbell, C. (2003) *Letting them Die*. Bloomington: Indiana University Press [Why prevention programs fail e.g. in South Africa when help is available].


Cros, M (2005) *Resister au SIDA*. Paris: Presses Universitaires de France. [Cases from Burkina Faso (Loki) where the disease is metaphorized as traditionally (a spider)].


Duesberg, P. (1996). *Inventing the AIDS Virus*. Washington DC: Regnery. [The argument that AIDS has causes other than HIV which may even be a consequence of (e.g. recreational) drugs and/or treatment].


Foster, G. (1969) *Applied Anthropology*. Boston: Little Brown [Foster was influential in introducing action anthropology ideas into WHO].


Green, E. C. and Herling-Ruark, A. (2010) *AIDS Behavior and Culture*. Walnut Creek: Left Coast Press [Argues that prevention proceeds best by encouraging behavior change e.g. delay in having sex, faithfulness and giving up injecting drug use. Green was a member of the Presidential (Bush Jr) advisory group on AIDS].


Herdt, G. Anthropology and AIDS. Anthropology Today 3(2) 3-5 [An early clarion call]


Jing Jun (2007) An ethnographic study of HIV/AIDS in China. *The Lancet* v 970 no 9604 [A critique of Hyde from the Director of the AIDS Policy Research Center Tsinghua University claiming that more recently that the majority Han Chinese were main sources of infection].


Livingstone, J.(2009) *Debility and the Moral Imagination in Botswana*. Bloomington: Indiana University Press. [Shows how both colonialism and development since independence have favored high rates of infection]


McKegancy, N. and Barnard, M. (1992) *AIDS, Drugs and Sexual Risk*. Milton Keynes: Open University Press [Makes the important point, from close observation that there are many misconceptions about the risky behaviors and complex situations of drug taking].


Nguyen V. (2011) *The Republic of Therapy*. Chapel Hill: Duke University Press [A most important study from West Africa which analyzes major changes in sovereignty created by the pandemic, and differential rights in the distribution (triage) of scarce resources for care in the pandemic]


Rosenheim, M. et al (1992) *AIDS in the Industrialized Societies*. New Brunswick: Rutgers University Press. [Case studies of different national responses to the pandemic ranging from denial (Spain) through indifference (Japan) to action (Canada) and panic (USA)].


Thomas, F. et al eds (2009) Mobility, Sexuality and AIDS. London: Routledge [Stresses the complexity of migration/travel situations and warns against simplistic " promiscuous " explanations].


**Biographical Sketch**

David Pitt was born in New Zealand, educated there, in the United States (AFS Scholar California) and at the University of Oxford (Balliol) obtaining his doctorate in social anthropology (1966). He held Professorships in Canada (Victoria) and New Zealand (Auckland and Waikato - Foundation Chair of Sociology) before coming to work for the United Nations in Geneva (1980), initially at WHO including a period in the Global Programme on AIDS. Since 1988 he has been Chair of the Commission on AIDS, International Union of Anthropological and Ethnological Sciences supported by a grant from ICSU/UNESCO. He was elected to Fellowships of the Royal Anthropological Institute and the Royal Geographical Society (UK) From 1983 he has also been Chargé de recherches at the Institut Internationale pour la Paix à Genève (GIPRI) elected to the Honorariat (2008).