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HIV and the Moral Economy of Survival in an East African City

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Based on fieldwork in the city of Kisumu, Kenya, the article examines the survival of HIV-positive people on antiretroviral (ARV) medicines and situates this within broader moral economies of their lives—in matters of food, hunger, social relationships, and networks of care, including NGOs. Through locating survival at the level of individual adherence to medication, ARV programs medicalize it. Yet their focus on the intimate relation between medicine and food also opens up spaces in which the material conditions of life can be articulated. The article follows these spaces, from the clinic to the economy of NGO interventions and community-based groups, paying attention to how hunger and material needs are visible in some spaces and invisible in others, and to how people have learned to articulate their “needs.” In this economy, HIV identities accrue moral and economic value, as through them people become visible to the flow of funds and the distribution of goods organized by NGOs.

Keywords: moral economy, HIV, hunger, biopolitics, East Africa

In the town of Kisumu, Kenya, in a small room behind a busy urban health clinic, a group of fifteen people are sitting in a circle. Some filing cabinets line one side of the room, a small table is stacked with sheets of paper files, and in a corner there are sacks of flour supplements stamped “USAID.” The group is listening attentively to a counselor called Ochieng³, a man in his early forties who is teaching them how to take antiretroviral medicines and to “live well.” He is passing around the lid of a large medicine bottle on which he has tipped out a pile of multicolored tablets. “Eating well,” he is saying, “is very important. If you don’t eat well, your body will not tolerate the medicines. These medicines are very strong. You must eat a balanced diet: proteins, carbohydrates and vitamins. What are these?” He goes onto list various foods, stressing that one need not buy expensive meat but can also eat the local fish and eggs. The group of mostly women and a few men listen attentively. Some ask questions. This is the first of three “adherence” classes for HIV positive people who are about to

start on an antiretroviral treatment regime, which, the counsellor is explaining, will be “for life.” Antiretroviral drugs will suppress the HIV virus levels in the body, allowing you to “live well”: “It is just like any other disease now. Only you must take care of your body,” by following clinic dates and checkups, taking medicines at the right time, and eating a balanced diet. These messages will be repeated in the second and third adherence classes.

During the 1990s, western Kenya experienced some of the highest HIV prevalence and AIDS-related mortality rates in east Africa.¹ At that time antiretroviral therapy (ART) remained prohibitively expensive. This situation changed in 2004, when the U.S. Presidential Emergency Fund for AIDS Relief (PEPFAR) and the Global Fund began financially supporting free ART programs for those with HIV. Between 2004 and 2008, PEPFAR dispersed \$1,346.9 million for HIV/AIDS interventions in Kenya, and access to ART increased, from 11,000 people on ART in Kenya in 2003 to almost 229,000 by September 2008, and 410,300 in 2010.² Kenya’s HIV/AIDS Strategy also included the implementation of a “Food by Prescription Program” beginning in 2006 and financed by USAID. This provided a flour supplement to undernourished HIV-positive adults and children for a limited period of three months (Food and Nutrition Technical Assistance II Project 2009).

This article explores the moral economies of survival that are taking shape around ART programs in Kenya. Based on ethnography conducted in the city of Kisumu, I ask: how do people, like those in the adherence class, survive on ART? Antiretroviral programs are bringing biomedical technologies and rationalities to populations in western Kenya on an unprecedented scale. I am interested in people’s encounters with this technology and with the ethics of self-care that accompany it. During fieldwork, however, the more important question became: how does this work out in a place where people are struggling to get enough food to eat every day?

The first half of the article addresses these questions by juxtaposing the way survival is constructed by the clinic (located at the level of patients’ knowledge about and adherence to medication and in narratives of “positive living” and self-care) with the experiences and lives of people living with HIV in Kisumu. Here, survival is located in a much broader sphere than treatment regimes—in matters of food, hunger, and poverty. However, there is a point at which medical regimes and everyday lives meet: the focus on a “balanced diet” opens up a space for the recognition of hunger and poverty in the lives of many of those struggling to live with HIV. The article follows these spaces, paying attention to how hunger and poverty become visible in some spaces and invisible in others; how they are talked about and dealt with, inside and outside the clinic.

Talk about food, medicine, and hunger pries open a broader moral economy of survival, which is emerging around HIV/AIDS interventions organized through NGOs in western Kenya. This is the subject of the second half of the article. How does this humanitarian economy shape survival strategies for people with HIV? Here I turn to questions of the changing economic and moral value of HIV, as being HIV positive opens up access to material resources. In this economy, certain identities and ways of living, certain objects and technologies take on value, and thus people work to make them visible, and to create identities around them.

Kenya's "global" ART programs put considerable work into overcoming stigma and turning HIV into a manageable condition. Such programs aim for universal access to ART, yet they have been accused of deepening socioeconomic inequities and institutional hierarchies, favoring NGOs and remaining apart from government health systems that have been devastated by structural adjustment policies. A growing body of anthropological literature examines these contradictions (e.g., Hardon and Dilger 2011; Whyte et al. 2006). In "All I do is Eat ARVs!" Kalofonos (2010) analyzes discourses of hunger among people living with ART in Mozambique. He draws attention to the "dehumanizing effects" of ART interventions, from the "torture" of increased hunger pangs brought on by ARVs in undernourished bodies to the competition for the woefully inadequate amounts of material support provided by NGOs (Kalofonos 2010:364). "By targeting a biological condition," he argues, "political and economic conditions are sidelined and local forms of solidarity are undermined, as disease-related distinctions determine eligibility for scarce resources." This argument is supported by ethnographic research on ART programs across East Africa and West Africa. Beckmann and Bujra (2010) and Boesten (2011) discuss the competition for NGO-distributed resources among the "poor and positive" in Tanzania, while Nguyen (2010) documents how positive people in Ouagadougou and Abidjan learn to frame their needs in terms legible to funding institutions.

My material similarly shows that while hunger and access to food are the most pressing concerns of poor people on ARVs, they are not adequately addressed by ART programs, even when they include nutritional support. In Kisumu, however, the result is not just competition and conflict. By exploring the ways in which hunger is discussed, where, with whom and when (not only among patients and recipients of ART but also among medical staff providing ART and in daily interactions in the clinic), I show that some forms of solidarity emerge, although they are weak, often fractured and ultimately deflected back to the NGO economy.

Moral Economies and Medical Technologies

The term *moral economy* has a lively history of use in the humanities. For James Scott (1976), inspired by E. P. Thompson (1971), it describes the sense of fairness informing economic transactions in peasant societies, which, if violated, would push people into forms of "everyday resistance" to those in power or even outright rebellion. While Thompson and Scott were concerned with class relations during "subsistence crises" (see Edelman 2005), anthropologists use *moral economy* in a broader sense to describe the shared mores and values with which people evaluate their relations with others, from economic transactions to the obligations informing social hierarchies and patterns of accumulation, including relations between political elites, states and citizens (e.g., Hagerud 1993; Lonsdale 1992; Olivier de Sardan 1995). Here, too, the contours of the moral economy become most apparent when it is breached, whether under colonialism, capitalism or structural adjustment and neoliberalism. In African societies idioms of consumption, of eating and being eaten, abound in moral commentaries on unfair profit, which are sometimes expressed in discourses on the occult (Comaroff and Comaroff 1999; Geschiere 1997; Sanders 2001). The term has also migrated to new contexts. Nguyen (2010) uses *moral economy* to describe how "confessional technologies" from

North America (see Hunt 1997) were translated in West Africa within networks of social relations that grew up around NGOs, while Redfield (2008) explores *Medicins Sans Frontiers*' attempts to create a moral economy of access to essential medicines in African countries.

In this article, I use the term *moral economy* as an analytical frame to describe what happens when the medicalization of hunger interacts with a subsistence crisis, with an AIDS economy mediated by NGOs and external donors, and with old and new ways of speaking about lack of food. I also use it to highlight the paradox of ART programs: on the one hand, they expect obedient patients to comply with medicalized regimes of care and they bracket out the material conditions that shape survival, while on the other hand, they circulate discourses of "empowerment." I show that those on ART are not victims of medicalization (Scheper-Hughes 1992) but nor are they empowered subjects. They are protagonists who seek new opportunities, albeit within heavily circumscribed limits.

My material speaks to recent anthropological literature on expanding medical technologies, which, drawing on Foucault (e.g., 1990, 2004) argues that contemporary societies should be described in terms of a modern "politics of life" or "biopolitics"—where biological, social, and political processes interrelate in novel ways. Paul Rabinow and Nikolas Rose (2006; see also Rose 2007) argue that a biological definition of life has become central to our notions of self and to politics as the site of governing bodies and groups, but also of negotiation and debate. Populations are increasingly managed through knowledge about biological identities and through scientific and bureaucratic procedures. The production sites of this knowledge have shifted from the nation-state to a heterogeneous interplay of state and non-state institutions, private and public interests and to different levels of scale, spanning transnational spaces.

While Rabinow and Rose focus on Western sites, other scholars (e.g., Biehl 2007; Nguyen 2005, 2010; Petryna 2002) examine "biopolitical" regimes that have developed in postsocialist and postcolonial societies in response to health emergencies. Here, the claims people are making to health care or welfare resources are being structured around biological conditions, creating forms of "biological" or "therapeutic citizenship." This expansion of biomedical and scientific knowledge is drawing populations into new configurations of scientific, political, and social "experimentality" (Rottenburg 2009, see also Collier and Lakoff 2005). In this context some argue that the politicization of HIV has opened up new possibilities for political claims (Robins 2004). Others point to how the focus on a single disease and the celebration of rights enacted in relation to it involves new forms of triage and exclusion (e.g., Biehl 2004; Fassin 2009; Morris 2008; Ticktin 2006) and overlooks what is lost together with more inclusive notions of citizenship: the idea of public health for all citizens (e.g., Calhoun 2009; Mahajan 2009).

The "politics of life" provides a productive framework through which to understand life in Kisumu during this time of large-scale HIV interventions. HIV used to be a death sentence, while now people are being "given a chance" to live with it. Yet ART programs have a circumscribed objective: to ensure what Arendt (1958) calls "sheer survival" (see Redfield 2005) through providing the basic necessity—medication. At the same time, they present successful survival on ART as a matter of "positive living," of orienting one's life to the goal of health. ART programs both

encourage people to think of themselves in terms of their biology, and triage survival, as they produce new forms of inclusion and exclusion.

However, the problem with reading theories of biopower into ART programs in Kenya is that one ends up seeing what one expects to see: producing ethnographies of power and subjectivity that lack historical nuance and social texture. In this article, I describe how biopolitics unfolds under specific economic and social conditions and how biopower is limited and conditioned by material needs and by hunger. Rather than seeing biomedical rationalities as either disciplining or emancipating (selves or politics), we should pay attention to the practices through which people put to work new concepts, forms of knowledge and regulatory regimes, and to the frictions of such encounters (Meinert 2011; Meinert et al. 2009; see also Tsing 2007). In this way I address the concerns of this special issue: What are the relations between biopolitical regimes of care, such as HIV interventions, and moral economies of survival? Where do the edges of biopolitics lie and what happens in these spaces? I do so through an exploration of survival—as this term points both to the *conditions*—biological, medical, material—that to a large extent determine who lives and how, and to *how people make a living*, which opens up a recognition of social actors' attempts to make a life for themselves (see Whyte 2002, 2009).

Methods and Location

Ethnographic research for this article took place mainly in the city of Kisumu from October 2008 to April 2009, with shorter visits in April 2008, December 2009, and September 2010.³ During the past 15–20 years Kisumu has emerged as an epicenter of the regional HIV/AIDS epidemic and associated socioeconomic deprivation. It has also become an important site of donor-funded HIV/AIDS interventions and medical research, by government, NGOs, and transnational organizations, which circulate global scripts of “positive living” and gender “sensitization” while implementing projects targeting HIV (Prince 2011). This hive of activity has transformed the town into a bustling city with a growing middle class and expatriate population whose privileged lifestyles contrast sharply with the poverty faced by most of its residents (Geissler in press; Prince in press). In this context, my research explored the intersections between HIV/AIDS clinics and interventions, transnational and nongovernmental organizations, local economies, and people's lives, relations and identities. I also followed the practices of patient “self-help” groups and other “community-based” groups, and their relations with NGOs and with the state.⁴ The research built on earlier ethnographic work in rural western Kenya, which took place mainly before the advent of ART and at the height of the HIV/AIDS epidemic (see Geissler and Prince 2010).

I conducted most of the research within two NGO-run and two government “Patient Support Centers” (or PSCs)—sites that are adjacent to, but physically demarcated from, health centers, where staff work exclusively on treatment and care for HIV-positive people (Sullivan 2011).⁵ Here, free ARVs are provided, along with “rapid” HIV tests, CD4 counts and sometimes other laboratory tests, counseling and medical checkups. HIV-positive people must register with a PSC to receive free medicine. I conducted 64 open-ended interviews (mostly in English; some in Dholuo) with staff members and volunteers associated with the PSCs, including doctors and

clinical officers (COs), nurses, nutritionists and pharmacists; counselors, clinic assistants, community health workers, “peer educators,” and “follow-up” staff. I also observed clinic practice including registration and routine checkups of patients, counseling sessions, and sessions with nutritionists. Over a period of four months, I regularly accompanied one of the community health workers in his “follow-up” work with patients. I visited eight patient support groups in the city (there were many more), and regularly attended the fortnightly meetings of two of these groups.

Although the clinics, NGOs, group meetings, and interventions provided the starting point of the research, I wanted to avoid being too closely associated with these activities and spaces. Therefore, I built up a network of families and individuals whom I met at the clinic or was introduced to by acquaintances, but whom I visited at home. From November 2008 to December 2011, I (and later mostly a research assistant, Bidy Odindo), made regular home visits with 20 families, all of which had at least one member who was positive or on ARVs. We visited these families weekly or fortnightly, recording details of their daily lives and concerns and followed some of them into clinics, private pharmacies and herbalists’ practices, hospital wards and also to funerals. No members of this follow-up group had any form of formal employment, and most (with some exceptions) had only partial primary school education. Although it was difficult for myself in particular to avoid being implicated with NGOs, I tried to listen to concerns beyond what people found appropriate to reveal to such institutions. My competence in Dholuo helped, as it gave me easy conversations and acquaintances with people in Kisumu.

Managing Survival through Medical Regimes: Positive Living and Self-Care

Ensuring the success of the ART programs—initiating and keeping large numbers of people on ARVs—relies on instilling particular habits and attitudes toward medicine, one’s body, and ideas of risk. At the PSCs, HIV-positive people receive medicine and medical checkups, but “doing well” requires the HIV-positive person to religiously take ARVs twice a day, on time, at exactly 12-hour intervals. Strict adherence to this regimen suppresses the replication of the virus and of mutations that can become resistant to the drugs (Laing and Hodgkin 2006). Thus, the clinic places much emphasis on self-care, and on the knowledge required to “live positively.” Health should be achieved through the patient’s close monitoring of her health and care of herself. Counseling and education about HIV and ARVs, about diet, medicines, sexuality, the importance of keeping time, and keeping one’s clinic dates—aim to produce this ideal “client”—at once obedient (to medical and clinic regimens) and “empowered” (able to take responsibility for her own health; see Government of Kenya 2006:26, 2007). The use of the term *client* underlines the attempt to shift HIV from its associations with illness and patienthood toward freedom and choice (see Mol 2008). It also points to assumptions about choice, autonomy, and self-care that do not fit the environment in which many positive people live.

At the PSC, “Clients” are continually being “educated,” beginning with the private one-to-one HIV testing and counseling session, through to the group adherence counseling sessions described at the beginning of the article, which are required before starting treatment. Much effort is put into giving “correct information.” Once they have

attended three adherence-counseling sessions, people are expected to follow the medical regimen and attend their clinic dates. That the clinic takes a negative view of those who don't "comply" can be seen in the term for those who do not turn up to appointments, who do not take their medicines, or do not take them properly: "defaulters." Although the PSC often make quite an effort to follow them up (sending Community Health Workers [CHWs] to their homes to find out why they have not come), and staff themselves are often quite sympathetic, they have to see huge numbers of people and their patience is limited.⁶ As one of the CHWs explained to me:

The defaulters are given another chance. They have to enroll again in the adherence classes and attend all three of them again. We have special adherence classes for defaulters. If they don't come, and if they drop out again, they are out.

Patient "empowerment" is, however, rather complicated. For example, although individual staff behavior toward patients or clients is varied—some are patient and kind, others more abrupt or even abusive, some are bored—the hierarchies infusing medical encounters in Kenya largely script their interactions. Patients call all levels of staff *daktari* (doctor); they are expected to act deferentially and they are aware that staff wield considerable power: "We had better keep quiet or she will not be happy with me"; "We had better not ask because she will not like it"; "She will quarrel me if I ask questions"—were all comments I often heard among patients (for health workers in Uganda, see Whyte et al. 2010; and in Tanzania, Mattes 2011).

Moreover, like clinic routines elsewhere, the formal paperwork that structures patient–staff interactions at the PSC, providing staff with a medical record, leaves little room for patients to voice their concerns. This was illustrated when we accompanied one of the families in the study, a grandmother and her granddaughter, both HIV positive, to a routine appointment at their PSC (the grandmother, MamaLouisa, was in her early sixties and spoke no English. Her granddaughter, Risper, was then nine years old. Both had been on ARV medication since 2006. The child tested positive that year, after a spell of severe illness and hospitalization). Arriving at the PSC, MamaLouisa handed in their clinic cards, and after a long wait in a crowded room, they were taken to see a nurse, who took Risper's vitals and then, with the child's medical file in front of her, questioned MamaLouisa about Risper's medicines. The interaction followed a standard script of questions and answers. As she was herself on ARVs, MamaLouisa knew the right answers. Intimidated by the situation, she did not mention that Risper was taking her ARVs only once a day, in the evening, because that was when there was food in the house. If Risper swallowed the tablets in the morning, on an empty stomach, she would feel "dizzy" and could not attend school. The household consisted of MamaLouisa, her daughter (Risper's mother, who is also HIV positive and on ARVs) and her baby, an older brother of Risper, as well as several orphaned grandchildren. The only person who made an income was Risper's mother, who cooked and sold *chapatti* (flat bread) on the pathway outside their house. She once owned a *hoteli* (kiosk) at one of the nearby markets, where she sold soda drinks and food, but it was destroyed in the postelection violence of January 2008. Although Risper qualified for a ration of specially formulated flour from the PSC, provided by USAID, this was quickly eaten up as it was shared among all the children. Despite the fact that Risper was already on second-line drugs (probably because of poor adherence in the past), there was no

opportunity at the PSC for her grandmother to discuss these problems. After another wait, the grandmother and child were called in to see the Clinical Officer. He asked Risper how she was, examined her chest, and filled in more forms. He told MamaLouisa to go to the hospital pharmacy and pick up Risper's supply of medicine for the next three months.

This incident reveals how the PSC can remain ignorant of the fact that some "clients" may not be adhering to ARV regimens.⁷ Although PSCs provide medicine and checkups, they expect people to manage their survival by proper adherence and forms of self-care. Like MamaLouisa, people learn what it means to be a "good" client: obedience to the scripts, giving the right answers. They learn that failure is the fault of the patient.

Medicines, Food, and Hunger

On one level, we see here the medicalization of poverty. The tangible poverty of "clients" is not within the purview of ART programs. Even though some people on ARTs, like Risper, receive a limited nutritional supplement, the long-term problem of families not having enough to eat does not become visible in the bureaucracy of ART programs, directed as it is toward registering and moving patients through the system, and ensuring adherence. In the patients' files there are no questions about the food a person has eaten or about daily income (although the size of the household and the occupation of its "head" is recorded at the first visit). The focus on "positive living" and the management of the self through becoming a "responsible" client overlook the structural conditions shaping a person's ability to adhere to or thrive on medication (see Greene 2004).

However, medicalization can itself open up ethical concerns. These concerns surface in day-to-day encounters, when people attending the ART clinics insist on talking about food. Those working in PSCs were well aware of the hunger facing most "clients." One Clinical Officer told me, "Hunger is a big problem. People tell me all the time, 'You give me drugs and I have not eaten.'"

Below I look at the spaces in which hunger can be articulated, paying attention to shifts between the visibility and invisibility of hunger, to the registers in which it can be articulated and those in which it is silenced or ignored. I begin with the "ordinary hunger" of many of Kisumu residents and the moral economy in which hunger and material needs can be expressed (or should be silenced). I then look at how issues of hunger may enter the space of the clinic.⁸

Ordinary Hunger: Surviving from Day to Day

In our follow-up study of people on ARVs, most of who were living in an informal settlement near the city center, their constant worry was food. People reported, to us, that they were often hungry and they often struggled to eat one meal a day, supplemented by a breakfast of porridge made with water or black tea with sugar. On being initiated on ARVs, women patients in particular (and especially those who had suffered from tuberculosis) often received a nutritional supplement from the clinic, usually in the form of flour. This gave them an initial weight boost, experienced as a

shift from being ill and weak to a feeling of increased strength and the ability to be mobile, work and function normally. However, with a weight of more than 50 kilograms, the flour supplement was discontinued and they reported experiencing a sharp rise in hunger and an intolerance of certain kinds of food. One mother told us: “Since I started taking these medicines I just want to eat a lot. But the challenge that faces me is, how do I get food? The ARV medicines need a lot of food.” Another reported: “Food is not easy to get. At times my husband goes to the market (to trade) and comes with nothing, and this makes us sleep hungry.”⁹ People told us that ARVs gave them constant hunger pangs, which they had been used to enduring more easily. “Taking ARVs without food is like committing suicide,” they said.

Many of those in the study were single mothers, living with children or grandchildren (including orphaned relatives) in single rented rooms, with roofs that leaked during the rainy season. For example, Achieng⁹, a young widow with two children, sold vegetables at the market. She earned between 20 and 100 shillings a day, and was constantly on the verge of being ejected from her dilapidated room because she had not paid her rent. Like others we followed, she often had to shift her activities, from selling vegetables to making chapattis to working as a household “maid.” She welcomed the relationships men would seek with her, as their gifts of money meant she could buy food, a school uniform, or medicine. For people in such situations, periods of sickness and especially hospitalization are not only somatically and emotionally upsetting but also plunge them into further economic turmoil, as ART programs do not cover hospital admittance or medical bills.

Hunger is not a novel experience in western Kenya. From the 1930s, labor migration combined with the introduction of maize as the staple crop led to a huge decline in food production in the area (Cohen and Odhiambo 1989; Hay 1976)—although its effects were somewhat mitigated by labor migrants’ incomes (Stichter 1982). During the last two decades, malnutrition has again risen sharply in the face of the AIDS epidemic, structural adjustment policies, unemployment and rising socioeconomic inequality: migrants’ cash remittances have dried up and households must face the sickness and death of economically productive members (Francis 1995; Whyte and Kariuki 1997; Nyambedha et al. 2003; Geissler and Prince 2010; see also De Waal and Whiteside 2003). Rural poverty has driven the movement of people into Kisumu, but apart from sugar processing and fish factories, there is little employment.

These conditions shape the lives of many Kisumu residents, not only HIV-positive people but also all those struggling to get by in the informal economy. Getting a meal a day is a challenge facing many families. However, those on ARVs reported that the medicine created an intolerance of hunger to a degree they had not experienced before. At the same time, as the ARVs signal a move toward better health, they found it difficult to claim a special need: “People will say, ‘Why you? We are also hungry!’” In western Kenya, bodily needs should not be expressed—children are taught not to complain about hunger even if they spend a day without food—and in a situation where everyone struggles to get one meal a day, it is hard to claim that having HIV gives you the right to more or better food. Self-care is not a virtue but a form of selfishness.

Talking about Food and Triaging Food

Although people on ARVs find it hard to express their hunger to those that care for them or those they care for, the focus within the clinic on the relation between ARVs and food has opened up a space for talking about hunger and thus about poverty. The link between eating well and adherence to medication is constantly underlined in the clinic. People are regularly told that for the body to do well on ARVs, eating a “balanced diet”—regular meals involving a balance of vitamins and nutrients—is vital.

Yet here again, hunger gets quickly silenced. There is a strange disjuncture in this talk about eating well. Adherence counseling is mostly conducted in Dholuo or Kiswahili, yet certain words and phrases are handed out in English, like “balanced diet” or “carbohydrates, proteins and vitamins.” The counselor usually goes on to explain that this means eating a mixture of fruit and vegetables, meat, fish and eggs, and maize, rice, pasta, bread and potatoes. She or he is well aware that few people eat much other than *ugali* (the staple, made from refined maize) and *sekumawiki* (collard greens), and many find it difficult to make one substantial meal a day for their families. Counselors themselves are often either “volunteers” or earn a small salary. Many live in the same informal settlements as their “clients.” They too experience the challenge of getting adequate food and feeding dependents. But although they often told me, privately, that “food is a challenge” for the clinic’s clients, I did not observe any of them initiating or allowing a debate about food and diet in adherence classes.

ARVs are strong medicines and can have harsh side effects, exacerbated if taken on an empty stomach. It is known that ART interacts with the body’s nutrition and its energy needs as well as its immunity (Hardon et al. 2007), and medical advice stresses that eating well is essential to doing well on the medicines (e.g., Castleman et al. 2004; WHO 2003, 2009). ART programs in Kenya recognize the interaction between ARVs and diet; children and severely underweight clients are given a ration of “fortified” flour for making porridge, in bags stamped “USAID.”¹⁰ For the adults, this flour is available only to “those who are down, down, down” as one CO explained to me. He continued: “Those who are down are given flour so as not to die tomorrow. But they are given only for a limited period, until their weight picks up. And we cannot extend this to others.” He acknowledged that the lack of a feeding program was a “huge limitation” on the aim of the PSC to promote ART adherence. “But,” he explained, “all those who are negative need food too, so it would end up being something huge” (i.e., a feeding program or generalized food aid). “Everyone will want that food. Those who really need it won’t be able to reach it, to fight for it.”¹¹ Programs supplying ARVs to HIV-positive patients cannot hand out food indiscriminately. The rationale is to look after the neediest—children and adults who would die without the food supplement. A doctor told me: “Of course, everyone recognizes that others need food, not only those whose weight is far down ... but we have to make a medical distinction between those who are on the brink of failing and those who are just surviving.”¹²

Although members of the PSC’s staff are thus confronted daily with people who do not get enough to eat, the issue of hunger has few inroads into official documentation. Although the treatment program does recognize the category of severely underweight patient, the rationed provision of fortified flour is a medical intervention directed at a patient whose body weight has dropped below what is defined as viable. It

is not a response to the ordinary hunger facing most “clients” of the PSC.

Still, the flour supplements provide some daily nutrition for some families, who fiercely cling on to them. A nutritionist told me about the arguments he had with grandmothers and mothers who refused to give up their flour supplement. One HIV-positive child in his care had been (against regulations) receiving the flour for over a year:

So this came to the attention of our funders and they insisted that the supplement should be stopped. I had the grandmother here, she could not understand. “How am I to feed my grandchild?” she asked me. I told her, “Would you die if the funders left? What were you eating before? You cannot rely on this. It is not food aid. Donors come and go.” It is difficult.¹³

Some of the families we followed had periods when they were given the flour supplement. In December 2009 we got to know Elizabeth, who had recently tested HIV positive and been initiated on ARVs. She was living with her husband (who, she said, refused to be tested) and two young daughters. The family had recently moved from a district town to Kisumu and the parents were struggling to get by through making and selling *makuangla* (a cheap form of charcoal). Because Elizabeth’s weight at initiation was 48 kilograms, she had received a three-kilogram bag of flour, to last a month. “I was told,” she said, “to prepare it for myself and not to share it with my family. But how can I do that? When I prepare it, my daughters also want some, and I do not know how to explain to the children why I am supposed to be taking this porridge myself and not with them. So I must share it. But I know that is not right according to the teaching we got from the hospital.”¹⁴ Risper’s grandmother likewise told us how the family was reliant on Risper’s supplement of flour: “It should be for Risper only but we have been preparing it for all of us,” she said, “If I don’t give my other grandchildren they cry.”

Talking about Hunger

ARVs create hunger pangs among people who do not get enough to eat. However, it is difficult for those on ARVs to ask for more food from family members or to keep nutritional supplements for themselves—particularly when, through the medication, they shift from being ill or weak to gaining strength and reentering normality. Paradoxically, the clinic becomes a place where their hunger could be voiced, because here it *was* recognized that HIV-positive people needed to “eat well” to do well on the medicine. People know it is not within the powers of the PSC to provide them with food. They know that the flour given to underweight clients and children is triaged. However, patients do bring up their hunger, if only obliquely, in informal situations, with counselors and community health workers, as they wait in the corridors. This is usually done in a humorous rather than a confrontational way. It is not easy to admit to hunger. Instead people will joke: “It is food we need, not medicine!” or “How can we take medicines without eating?!” The intent is serious, as bringing up the issue of food, however humorously, is a way of asserting that “I am not just a patient. My survival cannot be reduced to a question of taking the right medication.” In voicing their hunger, however obliquely, people pull the conditions of their survival into the clinic. They point to the gap between the forms of “self-care” expected by the clinic and their daily

struggle to get enough food, let alone a balanced diet. Humor circles around this painful truth, but hunger remains.¹⁵

Politics of Food and Hunger

During 2008 and 2009, people's concerns about food, income and hunger surfaced in a context of increasing anger in Kenya about rising food prices, and amid almost daily stories of corruption scandals among Kenya's ruling elite.¹⁶ Food was a political issue, and particularly so after the violence surrounding the disputed elections of December 2007, which drew attention to the high levels of urban unemployment and to the gross disjuncture between the consumption of the country's resources by the political elite and the daily struggle to survive. During 2008, the cost of a kilogram of maize flour, the staple, almost doubled (from 65 to 120 shillings per 2 kg pack). Adding to this tense atmosphere were frequent media reports and newspaper editorials, letters and comments about the country's food crisis calling for political intervention and control over rising food prices and the exposure of government corruption concerning food.¹⁷ During 2008 and 2009, Kenyan newspapers were full of stories of famine affecting the arid north and eastern regions, of families starving and children digging up tree roots to eat. They also ran reports claiming that politicians and government officials had sold maize at a discounted price to companies and brokers with whom they had financial links. Despite widespread food shortages, these actors subsequently hoarded the maize until prices rose.

The politicization of hunger on the streets of Kisumu made me curious about how PSC staff dealt with the disjuncture between the medicalization of patient's well being and the faces and bodies of people whom they know have little to eat. Many expressed a sense of impotence. One CO said: "People ask me 'how can I swallow those medicines you are giving me when I have not eaten this morning.' They are so many. What can you do? All I can do is prescribe medicines." A doctor admitted he feels bad taking a lunch break, which means leaving his long line of hungry patients waiting for him: "I close the front door and sneak out of the back to get a soda to keep my blood sugar up. I can't walk past that long line of people waiting for me." CHWs who work in PSC recording vitals, giving adherence classes, and visiting clients in their homes, are confronted most often with the issue of poverty. Many expressed frustration with their experiences of visiting people and seeing the lack of income and even of food, and only being able to offer advice. Confronted with a desperate situation, some dug into their own pockets: "In such a case," they told me, "If I have something, I give it."

Is survival being depoliticized here, or are spaces opened up for raising questions about responsibility and for making claims? Talk about food and lack of it shows up inequalities: I cannot take my medicine because I have no food. But its political challenge seems to stop short there. When I asked staff at a PSC whether there was any solution to the problem of food faced by people on ARVs, I was referred to NGOs. "Patient support groups could write a proposal to ask for funds from a donor or well-wisher for IGAs (Income Generating Activities)," some suggested. The challenge that lack of food poses to Kenyan politics is deflected into requests for aid from foreign funders and NGOs. In this last section, I turn to Patient Support Groups, which are key sites where HIV-positive people learn to articulate their identity and make such claims.

The NGO Economy and the Value of HIV: Support Groups

It is Saturday, and “Lets Pull Together,” a patient support group, is conducting one of its fortnightly meetings, at the back of the HIV clinic run by one of the NGOs on the outskirts of Kisumu.¹⁸ Toward midday, members (both women and men) begin to arrive, greet each other, settle themselves into the chairs available, and wait for the meeting to begin. I recognize some of the women from a support group I had attended the previous day, which is attached to another PSC. They have walked from the other side of town, in the hot sun, to attend this meeting. The meeting starts with a prayer. I am sitting next to Ochieng’, the adherence counselor I introduced at the start of the article, who is HIV positive himself and one of the founders of this group. Acting as “Chairman,” he asks the “Secretary,” a middle-aged woman, to read the minutes of the last meeting. He then suggests that the members introduce themselves and give a short history of their HIV status and ARV medication. This procedure appears occasionally in patient support groups I attended, but I came to realize it was done more often for my benefit, as a visitor who expects to hear about “support” and “sharing.” In this case, the introductions do not take long: members want to hear about a district-level meeting organized by the National AIDS Control Council (NACC) and attended by their “treasurer.” He announces the news: NACC has some funds from “donors” and is encouraging community-based groups to submit “proposals” for projects that will foster Income Generating Activities or “IGAs” (everyone uses these acronyms). The discussion turns to how the group could submit a proposal. The treasurer stresses that the group has to show it is well organized, that it is committed to fighting HIV/AIDS and that it has a project to pursue: “We are already registered” (with the government), he said, “we can show our accounts, and we have minutes and lists of members.” He suggests that these bureaucratic details be included in the proposal, as should the (un)employment and family-life situations of the group’s members. He suggests that the group use some of its collective savings to hire a proposal writer (he already has someone in mind) to apply for funds for “OVC” (“orphan and vulnerable children”) projects. Income-generating activities, he suggests, could be directed to meeting the needs of families looking after orphans, particularly as many of the support group’s members are struggling to take care of orphaned relatives. After a long discussion, the meeting ends with the secretary writing down a list of members present, and activities proposed, to be forwarded to the proposal writer.

Kisumu residents jokingly refer to their city as an “NGO city.” The number of NGOs has grown exponentially over the past decade, mainly because of the growth in HIV/AIDS funding.¹⁹ For many of Kisumu’s residents gaining formal employment in this NGO world was difficult if not impossible. But NGOs target those with specific needs; and channel their funding to community-based groups if they can present themselves as organized and accountable. This has resulted in an explosion of community-based groups of all kinds—youth groups, women’s groups, widow’s

groups, and even men's groups—all jostling to gain visibility and thus access funds. In this “city of groups,” HIV-positive “Patient Support Groups” are particularly prominent.

In 2008, every PSC in Kisumu had a Patient Support Group attached to it. These varied in size and membership, as people came and left, but usually contained a core group of committed members. Most groups try to register with the government as a “Community-based group.” Many had a similar bureaucratic structure and procedures as the one described above: Chairperson, Secretary, and Treasurer, minute taking, membership lists, and registration cards. The bureaucracy lends the group status, demonstrates its accountability, and makes it legible to organizations—governmental and nongovernmental—that control access to funds. Support groups provide a social location where people can “share” their experiences and challenges, but they have to a large extent also become locations where people can access economic support, material goods, and even training and employment opportunities.

How has this situation developed? Starting in 2000, positive lifestyles were actively cultivated in HIV-positive people by the government and NGOs in attempts to address discrimination and encourage people to get tested. HIV-positive people were given “appreciation” money to stand up and “witness” to their HIV-positive status. “Living and spreading the HIV gospel” became a career path for the early members of support groups in Kisumu, many of whom went on to receive training and even jobs in HIV-related work (see Nguyen 2010 for a similar situation in West Africa). During the same period, there was a proliferation of NGOs providing funds for “those infected or affected by HIV.” Support groups became the natural target for NGOs searching for HIV-positive people in need of material support. Sacks of food and loans of money to start up IGAs encouraged more people to join support groups and their membership numbers increased substantially. As HIV gained economic value, for those with few other opportunities, there were even reports of people claiming to be HIV positive to join a support group. One group I knew began demanding that members bring their PSC cards with them to ensure there were no fake identities!

Rather than focusing on personal narratives, support group meetings would usually be devoted to more urgent matters: worries about school fees, family members, conflicts with in-laws, and lack of food, and members attempts to alleviate these burdens through credit rotation, and, in the case of groups like “Lets Pull Together,” proposal writing. Other matters included, at various times: information about members who were too ill to attend or who were caring for sick family member, requests for contributions to funeral expenses of former group members, discussions about whether group members should form a “merry-go-round” (contribute a small amount of money each meeting to be put into a common pool and drawn on by members in rotation or when need arose), exchange of information about microcredit organizations operating in Kisumu and their requirements, and the exchange of news about which NGO or church group was this week or month supplying bags of flour, mobile phone credit or startup cash for IGAs.

Support Groups encourage a solidification of identity around being HIV positive. People learn to tell the story of their lives and to articulate their needs in terms of being HIV positive. Through joining a support group, people living with HIV become more visible to others. Encouraging this visibility as a way of combating stigma and “normalizing” HIV has been important to HIV-positive people, and to those

working to improve their lives. Yet visibility has another, economic, value, for those surviving in this NGO city. It makes you visible to organizations that control the flow of funds. NGOs respond to suffering and need, if you can gather a group about you and represent your need in appropriate form.

Conclusion

So what can we conclude about the relations among biology, economy, and politics in western Kenya at the present time? First, that these are plural, they carry on within different registers, and do not necessarily cohere. Second, the ways in which people are learning to live with HIV suggests that they are indeed enacting biopolitical frames, but that while these may be disciplining, they also open up opportunities, for revaluing one's life, for creating new social networks, for making a living. Third, people are not acting only within these biopolitical frames. Life and living constantly spill over and intrude into the biomedical and bureaucratic logic of the clinic, and shape the ways in which people approach medical regimes.

A new moral economy of "survival" is taking shape in Kisumu, as medicalized regimes of HIV treatment and NGO projects targeting the HIV-positive intersect with a heightened subsistence crisis among urban dwellers struggling to survive. Yet while its contours are clear, the directions it is taking are not. ART programs medicalize survival, linking it to individual "adherence," rendering hunger invisible. Yet through their focus on eating a balanced diet and provision of flour supplements, ART programs also create a space in which the conditions shaping survival—food, hunger, poverty—can enter and be articulated, albeit in informal ways. HIV is reducing people, at times, to the vulnerabilities of their bodies, to being ill, to needing care, to dependence on medicine and on the clinic. Yet HIV is also proving to be a resource in the humanitarian economy that is taking shape around HIV interventions. In some situations, HIV is a source of stigma, it threatens belonging, it creates social ruptures, it should be hidden. In others situations, HIV becomes an asset, it opens up spaces for recognition and for claims, it can be used to make one visible and legible to organizations that distribute material resources and triage care. People move between these different registers of invisibility and visibility, as they search for ways to make a living. Furthermore, as people learn to speak as "HIV positive," they also learn to articulate this identity through various moral registers: as active and responsible "clients," in some situations, and as needy and suffering in others. An HIV identity can accrue both moral and economic value.

Other moral economies of care, forms of recognition, relationships, responsibilities, and claims converge around the edges of the clinic and its regimes of care, which point to the conditions that shape peoples' abilities to survive: making a living, caring for one another. Patients joke about their hunger, pointing to the fragility of life. A grandmother uses the flour supplement meant for an underweight patient to feed the family; it finds its way into another moral economy of care, for how can one feed oneself instead of others, or give food to one child only? Staff berate patients for not turning up to appointments and they expect them to do as they say, yet they also put their hands in their pockets and give a mother 50 shillings to buy milk for a hungry child.

Recent ethnographies have argued that biopolitics is opening up new spaces of

recognition and new forms of politics, in which people use their biological conditions to make specific claims on the state. My ethnography suggests that in western Kenya, these claims are not about “rights” but about “needs,” and that these needs are being articulated not to state institutions but through the “NGO economy” and its interventions into HIV/AIDS in Kenya. While ART programs supply the medicines that keep HIV-positive bodies from dying, NGOs respond through specific projects to material needs. And while western Kenyans have long avoided complaining about personal hunger, considering it shameful to expose one’s inability to provide for a household (Geissler and Prince 2010; Shipton 2007; Whyte & Kariuki 1997), HIV-positive people now find that voicing the “needs” of their particularly vulnerable bodies can open up desperately needed channels of material support. As NGOs are characterized above all by their impermanence, those who are targeted by these interventions continually have to represent their needs, to different organizations, on grounds that are constantly shifting.

In spite of the occasional gestures of support that take place in encounters between clinic staff and patients in Kisumu, this material supports Kalofonos’s contention that “while biomedical coverage increases, overall living conditions worsen if the basic problems of hunger and economic citizenship are not addressed” (2010:375). It adds further substance to the argument that the focus on keeping bodies alive with medicines may leave persons more vulnerable when humanitarianism or human rights discourses fill in for a politics that can address socioeconomic inequalities and pursue a political program of change (Englund 2006; Fassin 2012; Redfield and Bornstein 2011; Ticktin 2006). In Kisumu, hunger and poverty shape people’s abilities to respond to medication. Yet the issue of hunger remains sidelined, confined to jokes in the corridors of the clinic and deflected onto NGOs. In a situation where stark inequalities lead to hungry people being given medicines that make them hungrier, a wry humor points to the limits of medical care.

Abbreviations

CO: Clinical Officer

CHW: Community Health Worker

NACC: National AIDS Control Council

NASCOP: National AIDS/STD Control Program

PEPFAR: Presidential Emergency Fund for Aids Relief

PSC: Patient Support Center

Notes

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1. Life expectancy in Kenya dropped from 60 years in 1990 to 45.5 years in 2002; adult prevalence levels were estimated to be 15 percent in 2001 (UNAIDS 2002; USAID Country Profile 2003. See also Ogot 2004, Iliffe 2005.

2. Since early 2005, ART has been delivered free in government health facilities, private and mission hospitals, NGOs, and selected “faith-based” groups. PEPFAR, the Global Fund and on a smaller scale, the Clinton Foundation and MSF, fund the treatment. See <http://www.pepfar.gov/countries/kenya/index.htm> (accessed June 27, 2010). Annual adult AIDS deaths in Kenya peaked at 120,000 in 2003 and fell to 85,000 by 2006. See <http://www.unaids.org/en/CountryResponses/Countries/kenya.asp> (accessed December 6, 2011). Approximately one-third of those on ART live in Nyanza Province. By 2010 1,384,400 Kenyans were receiving “care and support” at HIV clinics.

See <http://www.pepfar.gov/countries/kenya/index.htm> (accessed December 6, 2011).

3. Kisumu is the third largest city in Kenya, with a population of around half a million.

4. My research was affiliated to the University of Maseno’s Department of Sociology and Social Anthropology and research permission was granted by the Ministry of Higher Education, Science and Technology.

5. By 2010, there were 25 PSCs within the city (64 in Kisumu district), ranging from the large PSC attached to the provincial hospital to small clinics run by local NGOs. PEPFAR provides funds to a host of “prime partners” (<http://www.pepfar.gov/partners/103021.htm> [accessed June 27, 2010]), which organize and monitor PSCs.

6. The etymology of “defaulter”—“nonpayer,” “debtor “cheat,” “absentee from court”—illustrates the connection made in these new medical regimes between health, economy and legal regimes

7. This visit took place in March 2009. Bidy and I accompanied the grandmother and grandchild during this visit, and we went back to the nurse and explained the situation. She called a counselor, with whom we discussed the issue of food. Instead of simply reiterating the advice about a balanced diet, she suggested that I buy several kilograms of wheat flour and give them to Risper’s mother, who could then make and sell chapatti. When we left the clinic, however, MamaLouisa told us that the nurses did not appreciate our interference; they had called her back to “quarrel” with her. This made us think twice about accompanying patients to a clinic where we had not already established a relationship of trust with staff.

8. For a perspective on socioeconomic elites and inequality, see Geissler in press).

9. E. Atieno, December 12, 2009; I. Akinyi December 14, 2009.

10. See Castleman and colleagues (2004); See also Kenya’s Daily Nation “Nutrition Prescription’s plan for HIV/AIDS patients,” by Kathy Majitenyi, July 30, 2008.

11. Interview, April 2009

12. Interview, April 2009.

13. Interview with R. Ochieng’, September 27, 2010.

14. Interview, December 4, 2009. At the time of writing this (June 2010) I had just received news of Elizabeth’s death.

15. In her ethnography of Botswana’s cancer ward, Julie Livingstone similarly shows that laughter and humor are used to deflect pain and anxiety (2008, 2012).

16. See, for example, articles in the *Daily Nation*: “Maize Scandal: Briefcase Agents Profit,” by Bernard Namunane, June 27, 2008, <http://www.nation.co.ke/News/-/1056/525430/-/u1vwhs/-/index.html> (accessed June 5, 2010); “MPs Face Arrest Over Maize Scandal,” by Fred Mukinda and Bernard Namunane, January 1, 2009, <http://www.nation.co.ke/News/-/1056/517864/-/u1bugf/-/index.html> (accessed June 5, 2010); “Government Dissolves Cereals Board,” by Oliver Mathenge, January 26, 2009, <http://www.nation.co.ke/News/-/1056/519988/-/u1d9x4/-/index.html> (accessed June 5, 2010). See also in *Afro News*, “First Lady Implicated in Maize Scandal,” by staff writer, February 5, 2009, <http://www.afrol.com/articles/32359>

(accessed June 5, 2010).

17. “Children with AIDS helpless victims of Food Crisis,” by Wilfred Mlay, *Daily Nation*, November 29, 2008.

18. This is a pseudonym. Many of the support groups chose names that emphasized activities of working together for one goal, mutual support and combating stigma. Western Kenya has a long history of what is today called “community-based” or “grassroots” groups, which in colonial and postcolonial times acted as mediators between state or church authority and “community” (see Haugerud 1993; Lewis 2000; Shipton 2007).

19. The Report of the NGO Board shows that there are 907 NGOs (incl. “Community Based Groups”) operating in Kisumu (some of which are “briefcase NGOs”): see <http://www.ngobureau.or.ke/Publications/National%20Survey%20of%20NGOs%20Report.pdf> (accessed December 6, 2011). See also <http://www.kanco.org/KANCOMembers.php/> (accessed December 6, 2011).

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