Social Science & Medicine 190 (2017) 75–82

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The Islamification of antiretroviral therapy: Reconciling HIV treatment and religion in northern Nigeria

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ARTICLE INFO

Article history:
Received 23 January 2017
Received in revised form
14 August 2017
Accepted 16 August 2017
Available online 18 August 2017

Keywords:
Nigeria
HIV/AIDS
Islam
Antiretroviral therapy (ART)
Medication adherence
Prophetic medicine
Fasting
Ethnography

ABSTRACT

Access and adherence to antiretroviral therapy (ART) are essential to HIV treatment success and epidemic control. This article is about how HIV-positive Muslims and providers balance ART with religious tenets and obligations. I conducted 17 months of multi-site ethnographic research between 2007 and 2010, including participant-observation in an urban HIV clinic in Kano, Nigeria and a support group for people living with HIV, as well as in-depth interviews with 30 HIV-positive men and 30 key informants with caregiving, clinical, or policy roles related to HIV/AIDS. Patients migrated from Islamic prophetic medicine to ART when it became more widely available in the mid-2000s through the U.S. PEPFAR program. At the same time, a conceptual shift occurred away from considering HIV immediately curable through spiritual and herbal-based Islamic prophetic medicine toward considering HIV as a chronic infection that requires adherence to daily pill regimens. Hope for a complete cure and encouragement from some Islamic prophetic healers resulted in some patients forgoing ART. Patients and providers adapted biomedical treatment guidelines to minimize disruption to religious practices also considered essential to Muslims' wellbeing, irrespective of HIV status. Providers discouraged patients on second-line ART from fasting because such patients had fewer treatment options and, often, poorer health. However, patients' medication adherence was affected by the desire to fulfill fasting obligations and to avoid questions from family and friends unaware of their HIV-positive status. This study is one of few ethnographic accounts of HIV treatment in a Muslim-majority society and contributes to understanding the significance of religion for HIV treatment in northern Nigeria. It has implications for public health programming and clinical approaches to HIV treatment in medically pluralistic Muslim societies.

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1. Introduction

1.1. Cultural influences on HIV treatment and epidemic control

Achieving and maintaining viral suppression with sustained antiretroviral therapy (ART) is critical to the long-term health and survival of HIV-positive people. ART is paramount to controlling the HIV/AIDS epidemic because infected individuals who achieve viral suppression are at exceedingly low risk of transmitting HIV to their sexual partners (Cohen et al., 2011), from mother-to-child (Chi et al., 2013), and otherwise. Expanding ART is therefore the foremost priority in the effort to control the global pandemic (Piot et al., 2015; UNAIDS 90-90-90; UNAIDS Global AIDS Update 2016).

Sub-Saharan Africa bears nearly 70% of the global burden of HIV/AIDS despite having only 15% of the world population (WHO, 2017a). Following years of grassroots activism, a 2001 emergency exception to the World Trade Organization's Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPs) has made possible the manufacture and sale of generic antiretroviral drugs in developing countries (WTO, 2001). This spurred the establishment of major international treatment programs that have averted millions of deaths and new infections across sub-Saharan Africa alone, where treatment gains have been largest. Whereas only around 100,000 in the region were treated in 2003, by 2014 there had been over a 100-fold increase to 10.6 million people on ART. Despite these gains, ART access in the region was only 41% as of 2014. (WHO, 2017b).

In addition to the macro level factors of sustained treatment access involving clinicians, infrastructure, and reliable supply chains, successful treatment depends upon the behaviors of infected individuals. International HIV program guidelines for achieving

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http://dx.doi.org/10.1016/j.socscimed.2017.08.017
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medication adherence typically emphasize patients' psychosocial readiness to adhere to daily regimens for the rest of their lives. However, as with treatment for many other conditions, significant proportions of HIV-positive people have difficulty with long-term adherence to ART; this contributes to the continued high burden of HIV/AIDS morbidity and mortality and the perpetuation of the epidemic (Bangsberg et al., 2001; Ortego et al., 2011). In the continued absence of a long-lasting injectable or implantable treatment or a vaccine, viral suppression continues to be contingent upon individual patient adherence to daily—often several times daily—oral ART.

HIV treatment success thus depends on macro-level infrastructures of care and on the individual behaviors of HIV-positive people. Less frequently the analytic focus of treatment studies but no less important are meso-level cultural factors, which include shared practices, symbols, and beliefs. Cultural factors are important to health outcomes and the course of epidemics because they shape collective perspectives on illness etiology, the natural history of disease, treatment efficacy, and the moral dimensions of illnesses and illness responses. From this perspective, taking medication is a socially-organized and strategic practice, situated in everyday experiences of illness and life (Conrad, 1985). Cultural factors are particularly salient when illnesses are heavily imbued with moral meaning and perceived as a risk to the social order. HIV/AIDS, because it is primarily sexually transmitted and fatal when left untreated, continues to be highly stigmatized and imbued and with moral significance (Treichler, 1999). This has been particularly the case in communities where HIV is strongly associated with sexual behaviors that are prohibited by religious doctrine and social norms (Smith, 2014).

This article is about how a group of Muslim patients and providers in Kano, Nigeria navigated adapting ART to the context of their social-religious life. Specifically, it addresses how the beliefs that God has a cure for every disease he creates and that ultimately only God can cure are interpreted and lived with as people use ART to manage, but not cure, HIV. It further addresses how patients and providers endeavored to reconcile religious fasting obligations with ART. As such, the article centers on how the shared cultural beliefs and practices of a Muslim-majority community have shaped the implementation of a transnational treatment program, influenced patient adherence, and affect an epidemic.

1.2. Global treatment programs, local moral worlds, and the limits of biopower

Biopower, the "numerous and diverse techniques for achieving the subjugations of bodies and the control of populations" by modern nation-states (Foucault, 1976: 140), has been a useful construct for social science analyses of HIV/AIDS, including but not limited to conceptualizing the management of HIV in individuals and populations with ART. Yet, the biopower deployed to control HIV in contemporary African populations has not emanated primarily from African states, which for the most part have remained weakened and subordinate in the global political economy. Instead, African states' roles in HIV control have been largely reduced to "para-statal" functions (Geissler, 2015): dependent upon resources from a patchwork of foreign governments, international organizations, and NGOs, and their implicit agreements with African governments to achieve ends typically associated with states (Nguyen, 2010; Peterson, 2014). This "discriminate biopower", whereby population health is subject to the prerogatives of external organizations and foreign governments (Fullwiley, 2004), has long characterized numerous public health campaigns in Africa; HIV treatment epitomizes this dynamic.

Most notable has been the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), which currently operates in 65 countries worldwide delivering treatment to 11.5 million people and is the most expensive bilateral program to address a single disease in history (PEPFAR, 2016; PEPFAR, 2017). Since its inception in 2004, PEPFAR has accounted for about 90% of funding for HIV treatment in Nigeria (U.S. Embassy & Consulate in Nigeria, 2017). PEPFAR has increased ARV coverage dramatically to 820 sites across all 36 Nigerian states plus the Federal Capital Territory with an estimated 23% of HIV-positive Nigerian adults aged 15 or older on ART in 2014 (UNAIDS, 2015). Thus, despite considerable treatment scale-up and hundreds of thousands of deaths averted since 2004, approximately 77% on HIV-positive Nigerian adults remain without access to ART.

Biomedical treatment guidelines, including those for ART, are intended to direct patient behavior irrespective of location or cultural background. In actuality, standardized treatment guidelines and the global health programs that undergird them—which are themselves based upon culture-bound assumptions about diseases and treatments—are encountered by people in varied societies, where diverse belief systems and social rules guide daily life. When the premises and practices of biomedicine are perceived as conflicting with religious and other cultural precepts, adherence may be compromised, with consequences for health and epidemic control. As such, the biopower exercised by transnational interventions to address HIV and other diseases depends upon the social and moral priorities established by communities, families, religious organizations and leaders (Dilger, 2012; Renne, 2010; Dilger et al., 2014).

In some cases, religious ideologies—or at least certain people who assert authority based on interpretations of religious beliefs—have led to questions about the moral acceptability of ART (Dilger et al., 2014). In recognition of this, recent ethnographic research on ART in sub-Saharan African contexts has emphasized how patients' "local moral worlds" extend beyond and may inhibit treatment adherence (Mattes, 2012), how patients' understandings of their own 'responsible behavior' encompass social concerns that at times overshadow the narrower behavioral expectations of biomedical treatment guidelines (Beckmann, 2013), and how the embodiment of normalcy is of paramount concern as people navigate life and treatment with a highly stigmatizing disease (Rhine, 2016).

Africans, like people elsewhere, have looked to religious and spiritual approaches as a way of understanding and coping with the suffering and mortality caused by HIV/AIDS. Responding first to HIV/AIDS and then also to the massive scale-up of biomedical treatment, African religious organizations have confronted existential concerns such as divine healing that ostensibly secular global health programs generally do not consider, addressed the ethics of health resources including the provision of medicines, and have also initiated policies and programs to support ART (Dilger, 2009; Dilger et al., 2014). At the same time that religious organizations have sought to alleviate concerns through doctrinal pronouncements and policies, adherents of particular faith traditions living with HIV face everyday challenges incorporating treatment into their lives while maintaining—in their own minds and in the perceptions of their religious communities—the integrity of their religious personhood.

1.3. HIV treatment in Muslim communities

Research on HIV in Islamic societies has focused on two main concerns. The first has been the effects of religious tenets and social practices on HIV transmission. HIV prevalence in predominantly Muslim societies is generally low, possibly due to a range of factors, including the universal circumcision of Muslim men, prohibitions

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