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HIV/AIDS and Democracy in Nigeria: Policies, Rights, and Therapeutic Economies

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Abstract

This dissertation is an analysis of the political economy of HIV/AIDS in Nigeria. This dissertation traces Nigerian democratic imaginaries and shows their intertwined connections to national and international AIDS policies, constructions of rights, and the production of therapeutic economies for which features of local, national and international forces merge to produce the materiality of AIDS. In particular, the dissertation analyzes a) the relationship between Nigerian AIDS NGOs and the development industry and how definitions and discourses of AIDS translate into problematic policies; b) ethnographically Nigerian coming into compliance with the TRIPs Agreement, and subsequent vying of power among international and local actors; c) global drug pricing practices and their relationship to drug distribution infrastructures as well as new biosocial relations that form around lack of treatment access; and d) a case study of HIV/AIDS cure claims over which the veracity of such claims were publicly debated and how ideas of democracy and forms of nationalism informed these debates.
This dissertation project grew out of many life-long experiences and interests, something I did not expect and something that I only realize now. While HIV/AIDS, illness and disease, health and healing, and pharmaceuticals are now commanding a great deal of new and rigorous intellectual attention, my own interest in these subjects grew out of my experience as an experimental trial subject for new chemotherapies in 1969. This experience over time led to the development of many interests, and for some reason I cannot stop myself from returning to the science and politics of health.

While working at Genentech as a microbiologist in 1992, I was studying for a master’s degree in women studies, where I was getting my first thorough training in postcolonialism and transnationalism. I became interested in a company down the road from Genentech, called Shaman Pharmaceuticals that was engaged in cross-border research, popularly known as bioprospecting. I proceeded to do research on this company that led me to several places including Ecuador, Kenya, Nigeria and Cameroon. I was fascinated by bioprospecting’s newly emerging conundrums including changes and new definitions of the law, global trade, as well as the accompanying technological advancements that were enabling these new concepts. But I was also interested in how bioprospecting was being constructed as a messianic potential to uplift the marginalized out of poverty through the re-linking of local products and people to the global market.
I proceeded to conduct research on bioprospecting in Nigeria, a project that fell apart after an initial two-month stint of fieldwork. I was left with funding, but no project. However, after this short period in the field I encountered something that I was not expecting. I arrived at the very beginning of Nigeria’s newly established civilian state after decades of military rule. In the streets and in the media was talk and great hope for the new Fourth Republic to finally bring about democracy and democratic reform. I became curious over the ways in which Nigerians imagined democracy or what is commonly called democracy dividends a welfarist vision and how it fit into already existing cultural dynamics. As the new regime was establishing itself, the issue of AIDS, formerly buried under militarization and severe repression, was in the beginning stages of gaining public attention. I switched my project to the study of the political economy of AIDS mostly because, like bioprospecting, the politics of treatment was subject to the same intellectual property and trade regimes with which I was familiar. The link between culturally pronounced understandings of democracy and AIDS at this point was only intuitive. I knew that there was something important here, but did not know what it was at the time.

Later, I found that what people were and still are saying about democracy in Nigeria is a near perfect mirror for how people living with HIV/AIDS talk about themselves and their own predicaments how they have no medicine, no food, how they suffer, how they have been sent adrift from the promises of a social contract. Slowly, the imagined constitution of a social contract in all of its desires and impossible apprehensions became clear. This dissertation traces the
contours of democratic imaginaries and shows their intertwined connections to national and international AIDS policies, constructions of rights, and the production of therapeutic economies for which features of local, national and international forces merge to produce the materiality of AIDS.

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Introduction

HIV/AIDS, Suffering, and Democracy

HIV/AIDS has served as the clearest marker to modern capitalism. It has served as the clearest index to modern imperialism. It has revealed more than ever the wide difference and the wide gap between the poor and the rich. It has separated in clear terms the opinion of the policy makers. It has shown clearly, that there is no single country in Africa that is independent, that we only have this illusion of independence. It has shown clearly that, more than ever, the various international agencies are still very much in control, and African nations, I mean the leaders of African nations, are totally incapable of administrating their countries. It has shown again the complacent nature of African people: the lack of will the lack of power and energy of African people to actually control their own will. It is quite unfortunate that HIV/AIDS combined with the high level of illiteracy, poverty, ignorance and the general social-economic conditions of Africa have made life extremely difficult for us today. If society is not reorganized socially, economically, politically, and people empowered, become self-determined, become independent in the full sense of the word, I do not know how any of these [AIDS] programs can be successful.

-Dr. Wole Daini Liberty, HIV positive Nigerian medical doctor¹

Anthropology: the unending search for what is utterly precious.

-Tongues Untied, Marlon Riggs

Suffering and Democracy

On a rainy day in Lagos, after interviewing a worker for a global pharmaceutical company, I stepped outside in hopes of finding a taxi after a long and exhausting day. The taxis were not stopping but the buses, as usual, were waiting to fill up and move out. I was in an industrial part of Lagos, Apapa, which I normally do not frequent, and was unfamiliar with the bus routes; so, I went searching for a bus that would take me home to Ikeja, a suburb of the sprawling city. I maneuvered through the wet ground, past the many men and women etching out a living selling fruit, CDs, drinks, and hot food. When I met
the driver and conductor, I quickly noticed their unusual smiles and vibrant energy, something one never encounters at the rush hour peak. I was invited to climb in the front of the bus next to the driver and was the first on board the van that would eventually fill with sixteen others.

What followed was more surprising, perhaps only in the immediacy of the moment, perhaps not in hindsight. As the bus filled with those heading home, the warmth and easy-goingness of the driver and the conductor was infective, for the usual sleepy silence of the riders spontaneously transformed into a lively discussion on suffering and democracy in Nigeria. Suffering is about salaries, how nothing works, the inability to eat and procure medical care, how things are getting worse. And democracy, more often referred to as democracy dividends by both the public and the government, is the hopeful, yet elusive means to alleviate suffering a suffering woman, family, economy, infrastructure, nation. Unlike suffering, democracy is elusive, intangible, idealized, yet both suffering and democracy immediately depend upon and refer back to each other in every space where it is discussed. A personal disclosure of suffering is not necessarily part of a common parlance, but rather, suffering is formulated through the use of vague pronouns or referents such as they or people. It is constructed in abstract ways such as how people can't eat, or how there are no jobs available. Rarely does anyone substitute people for I or no jobs available for I have no job.

One of the men on the bus said at one point can we just agree that there is no one in Nigeria who can do anything to turn things around? Everyone was is
in full agreement an agreement that was greeted with smiles and nods, even a small rupture of laughter. Not that anyone found this funny, but laughter, in this moment, served as the knowing conveyance and intermittent reprieve of what is already understood, something that words can no longer articulate as representative of what is felt. I have heard these conversations before, in offices, in barbering salons, in front of suya stands, in the overlapping spaces of the home and the communal zone of the streets. But this night was different. As this hour-long bus ride made its stops, people got on and off the bus; and remarkably, the discussion exchanged between comers and goers and strangers about democracy and suffering never once was interrupted in its smooth flow, as those boarding the bus knew exactly how to enter into this rehearsed dialogue. Democracy, which has so little and so much meaning, is a longing for something utterly precious, yet it remains terribly out of reach.

This discourse of suffering not only invokes the feel of material stress, but more importantly it refers to the failure of Nigeria to implement its original promise its social contract under a welfare state at the beginning of independence in 1960. The discourse of suffering is the manifestation and articulation of this loss. Suffering is also the site for which national identity and national unity are articulated. Although any Nigerian can point to the country's colonial history, there is no consensus on what constitutes the cultural basis of Nigerian unity. Fortes and Evans-Pritchard (1940) have pointed to the embeddedness of culture (and even identity, although they would not use the term) in both centralized and decentralized African political systems. I would assert
that they were able to set the stage for understanding the dynamics of cultural and ethnic nationalism or unity in a post-independent era. However, they were unable to foresee the possibilities for how a national cultural politics and unity could be determined and analyzed. For example, I was once visiting the parents of my housemate, who are professors at the University of Nigeria, Nsukka. One night I was talking to her father about Nigerian politics and at one point he leaned in and said to me, well, you know, I am an Igbo man. Even to an outsider such as myself, this statement spoke volumes. It pointed to feelings of the after-effects of the Biafra state and civil war, to the perceived marginalization of the Igbo people, and local Igbo politics and culture, such as the return of the Igbo secessionist movement. However, when one says, I am Nigerian, such a statement has no commonsensical meaning or value. The discourse of suffering that points to material stress as well as sentiments over the loss of a social contract, is perhaps the only marker that gives content to a what it means to be a Nigerian today; the use of abstract referents indeed point to collective and familiar experience. No other ethnic, cultural or religious markers contribute to such a sense of national unity as much as these exchanged articulations of suffering.

Now with the end of nearly thirty years of military rule since 1998, suffering has seeped out of what was once private and self-protected spaces (when suffering, as a critique of government, could be construed as sedition) into the realm of the public. However, calling for the delivery of democracy dividends as an imagined national alleviation sometimes blends into what Richard Joseph (1987) has called prebenda politics which he describes as enabl(ing) divergent
groups and constituencies to seek and accommodate their interests. At the level of the individual, it is a pattern of social behavior that is quickly learned and adapted (10). Although the discourse of suffering proliferates in public spaces, there is also talk to a lesser extent of how people don't care which is a nearly opposite assertion. As an example, I was driving with my Nigerian advisor, Professor Johnson Ekpere, from Lagos to the University of Ibadan to go to our department (Agricultural Extension and Rural Studies). As we approached the outskirts of Ibadan, there was something ahead blocking the road. Prof said to me, I hope it isn't human and he slowed down to drive around the remains of a man splattered on the road. Nearby people carried on with their daily business. When people talk about a lack of caring and particularly about dead bodies on the road, it is curious to note that this is one of the only moments that government is not seen as responsible or the culprit. While it may be a comment on shame and demoralization, the divide between acknowledging suffering and not caring about suffering is near perfect metaphorical apprehension of how one encounters the state and practices of governance in Nigeria.

As will become clear, the state at the federal level, particularly under a new civilian regime, has made two conflicting promises, one to a public who is increasingly and aggressively demanding their democracy dividends, and the other to international forces (such as debt repayment) that severely weakens the state's ability, and perhaps desire, to effectively devise and implement a welfarist state paradigm. As will be shown, the state is negotiating how to be more squarely inserted into the global political economy, while it attends to rebuilding
what military rule and structural adjustment destroyed, a financial and political dream holding on more to fantasy than possibility.

HIV/AIDS has reached pandemic proportions in Nigeria where over four million people are now infected. HIV/AIDS has revealed the conflicting ideas and understandings of democracy that mark a potent political moment on the African continent. While the discourse of democracy dividends appeals to the imaginary promise of a welfarist vision, a neoliberal paradigm marks the agenda of the new civilian regime and its international partners. These competing forms of democracy are not always addressed by Africanists who are interested in democracy since the major democratic transitions that swept the continent in the 1990s. Samuel Huntington (1991) asserted that the massive movement toward democracy was inspired by the fall of the Soviet Union, which he referred to as the democratic wave that would diffuse throughout the developing world. Michael Bratton and Nicholas van der Walle (1997) have rightly asserted that the notion of regime transition (not to be confused with the current U.S. idiom of regime change), a popular and rather over-utilized yardstick of democratic praxis in Africa, has yielded very little as an analytical tool of democracy on the continent. However, they fail to recognize how factors external to the state have played just as great a role as internal factors in influencing pro-democracy movements. Jean-François Bayart (1993) has argued that the internal political life of Africa cannot be separated from the international environment to which its belongs, for the post-colonial state is the meeting point for the notion of Africa and the rest of the world. Following this work, as well as Abrahamsen (2000) and
Mbembe (2000), I assert that internal and external factors synthesize the state and were equal in force in bringing about demands for democratic rule. In particular, Abrahamsen has argued that in addition to military/one-party rule, International Monetary Fund (IMF) structural adjustment (SAP) and foreign aid conditionality that created massive capital flight, widespread poverty and severe infrastructure decline were both strong factors in generating pro-democracy movements in the 1990s in Africa. This is certainly true for Nigeria. When the initial implementation of the SAP was carried out, there was a great deal of widespread resistance to which the worst military repression was the response; soon after IMF resistance grew into a pro-democracy movement (Edozie, 2002).

Since IMF implementation in the 1980s, democracy is increasingly viewed by scholars and policy makers as a measure of free and fair elections and market liberalization. However, not one of my informants ever named these issues as comprising democracy or democratic practices in interviews or in informal conversations. In fact, when I met a long time AIDS activist for the first time, I asked her about democracy and she immediately broke down in tears. She talked about suffering and the enormous amount of work that needs to be done. As she spoke further, and indeed as others have indicated to me, what was missing was the need to be deeply noticed, a burgeoning democratic ideal among people living with HIV/AIDS (PLWHA) in Nigeria. When I asked others, what is democracy? I was told by a medical doctor:
As far as I'm concerned what we have today is just government of the people for some people (laughs) and not by the people (laughs) This country! There are records that show that they have stolen from the government treasury and have not been tried. These are the people that they're recycling in government. So what is democracy all about? I want to believe that the basis for all government, democracy or otherwise, is a life better for the people of the country. And it is clear beyond any form of doubt today things have become worse for people. At least for the masses, life has become more horrible, more devastating. Democracy to them is even more enslaving than the military era or colonialism itself. I want to believe that colonization would have been more profitable for Nigerians than what we have today--what we call independence, which is not really independence because most of our politics are directly guided not by Britain alone, but by all the Western, European countries and America. It is most unfortunate. This country is not mature enough for independence struggles or democracy.

a lawyer:

Democracy is supposed to be government of the people, by the people, for the people. Fela [Kuti, the late musician] says it is a demonstration of craze. Demon-crazy. I am worried that some other structures which we should be developing are not being developed. Our judicial system, legal system, our police and socials adjustments that the success of the nation depends on must come from everyone of us, not just the government. Unless we abandon and give up maybe one-tenth or one-twentieth of our time as individuals and organizations towards the common good of everyone, democracy will be a joke in Nigeria.

a pharmacist:

Government of the people, for the people, by the people. People have been deprived for so long, and some of us are very impatient. People want garri [a West African food staple derived from cassava], they want beans and rice. Garri used to be the cheapest food in Nigeria. We produced so much that there wasn't enough to buy. The government has stated that it wants to produce silos to store the food, and right now you can't buy or sell the excess. The US has more influence on Nigeria. It is the only country that can make an impact on democracy in Nigeria.

KP: Why is the US the only country that can help Nigeria?

Capitalism. Nigeria loves America and wants to copy everything American. The UK doesn't have the resources to help. Only the US can finance or underwrite and support us with resource people. Such as training in the military [sarcastically put] let's do military maneuvers like the Americans. Or civil service courses here and there and people are happy. What I don't like about the West is all the negative things they say about Nigeria. And if this democracy
collapses now, there will never be democracy in Nigeria because people feel they are being managed once again by the military. Everyone expects that government will invest in infrastructure but they will not invest in manufacturing, they will leave that for [US] private investment to take over.

an AIDS activist:

Democracy is what Africans practiced before colonial rule. That’s democracy. It was where people identified with specific rules in their society, where the governance was contributive. Families were identified with [pauses] families were industries. They generated their food, their income. You see that it was more of a democracy.

KP: What do you think the average Nigerian’s vision of democracy is?

Emancipation. They want to be emancipated from this--anything but this is democracy. With that said, democracy to me is freedom. Democracy to me is the ability to be part of the process and the ability to contribute to that process and be recognized in that process.

In all these statements on how suffering indexes the status of democracy, it can be seen how features of the national and international are firmly intertwined. As they point to who directs governance, the rebuilding of infrastructure, procuring food, or the legacy of colonial rule, suffering marks conflicting obligations that the state has to domestic and international democratic politics. These concerns over democratic dispensation greatly overlap with the concerns that many have over the problems of HIV/AIDS. Conducting an ethnography of democracy as it pertains to AIDS, therefore, is meant to show how neoliberal and welfarist visions of democracy, and by extension, governance, set the stage for a policy vision toward combating the AIDS epidemic. Since the close of the 1990s, there is no doubt that current polices and questions of treatment access fit into an extended and more consolidated network of state/international interests. AIDS has brought together the development industry,
trade regimes, debt regimes, private capital, the state, and civil society, all into the same space; and here the welfarist vision of a democracy dividend is losing ground to neoliberal democratic agendas. AIDS policies not only are directed by neoliberal economic and political paradigms, but they serve international and state (at the federal level) interests.

AIDS Policies, Rights, and Therapeutic Economies

The dissertation ethnographically delineates the intersection of these structures by analyzing the circulation and deployment of AIDS policies, rights and therapeutic economies. AIDS policies are highly prescribed and imagined as lying solely within safe sex practices that the development industry (the single largest funder and director of AIDS policies in Africa), and local NGOs (nongovernmental organizations) institutionalize and fund. But AIDS policies are developed and implemented within larger political, economic and cultural frameworks. As most of Nigeria's trade partners and creditors are also Nigeria's AIDS funders, the notion of an AIDS policy must include not only institutionalized awareness and prevention strategies but also debt and trade regimes, and capital flight patterns that fundamentally determine the nature of an AIDS strategy.

Chapter one provides background on Nigeria's capacity to develop AIDS policies by analyzing how IMF structural adjustment has impacted the state of health care in Nigeria, and how the debt regime severely weakens the state to autonomously design and implement its own AIDS policies. Chapter two briefly describes the way in which capital flight and wealth accumulation patterns are
organized by interconnected relationships between the development industry, global trade regimes, and the debt industry. Implicit or explicit agreements are made among these three entities, which I call the regulatory contract, which shapes relationships on the ground, including the rise of an elite NGO class that conducts business with both the development industry and the state. These relationships blend into existing environments that produce tension among different actors as well as differing beliefs in, and understandings of, the AIDS crisis. I illustrate this by analyzing contradictory beliefs in poverty and HIV. Development agencies, such as UNAIDS, view poverty as an outcome of AIDS, while AIDS activists see poverty as a precursor to contracting HIV infection. Such beliefs and understandings are firmly connected to one s (or an institution s) relationship to policy-driven financial flows and capital flight patterns and as such largely determine a policy solution. That is, because poverty is put forth as an AIDS outcome, the development industry predominantly pushes prevention-only strategies as opposed to treatment access. In doing so, it protects existing capital flows, such as debt sustainability (which serves the interests of creditors, who are also Nigeria s AIDS funders) and trade related intellectual property laws (that serve pharmaceutical industry interests, which are closely tied to Western nation-state interests). Therefore, policy directives that erase treatment as an option are highly contentious. Ultimately, the direction of global AIDS policies may prove to be another great international development disaster.

The dissertation employs the generalized term, rights, to show how both individual and national rights constitute the non/ permissible circulation of
biological artifacts that include AIDS policies, drugs, and HIV bodies. In terms of AIDS, the rights of an individual and a nation are determined by the presence or absence of drugs for HIV and opportunistic infections. Discussed in chapter two and chapter five, human rights violations carried out against PLWHA cannot be simply reduced to a specific cultural formation, as the very absence of drugs and pharmaceutical capital constructs HIV as a curse as opposed to an infection. In response to the widespread discourse of HIV as curse in Nigeria, AIDS NGOs have broadly deployed the notion of the right to life. In contrast to civil rights, which in Nigeria implies freedom from state violence, the right to life is adapted from Western human rights language to articulate positive rights such as health care entitlements. While the right to life parallels the idea of democracy dividends, it nevertheless encounters contradictions because it interacts with existing environments where cultural forms of status and social hierarchies play out even in AIDS activist circles. Moreover, the state at the level of the presidency is developing rights-based policies for PLWHA. But these policies do not translate easily within other systems of governance, as the judiciary and medical practices toward PLWHA conflict with ideas of rights at the highest level. Therefore, there is little consensus on the very meaning of rights in this newly democratic era. To further illustrate this assertion, in chapter five I discuss a well-known HIV cure claim case and subsequent public debates. AIDS activists asserted that their rights needed protection not only from the state, but also from the fraudulent practices of cure claimants. Cure claimants asserted that they could freely treat PLWHA without state interference. AIDS activists and
HIV cure claimants evoked the right to life and neoliberal ideas of democracy, respectively, to support their arguments for or against HIV miracle cures. In the process, both sides declared drastically different notions of rights, which matched each of their democracy paradigms. These debates sparked nationalist sentiments in the public, which were biologically marked and reflected a post-IMF redemption, where an AIDS cure derived from Nigerian sources was imagined as reclaiming a better international image as well as commanding new and significant means for the country’s GDP. HIV was deployed in a manner similar to how discourses of an imagined cultural unity are often apprehended, where some cultural myths are reified as more valuable than others in outlining the cultural truth of a nation. Specifically, while the nationalist discourse embodied an imaginary of Nigeria’s redemption, it also allowed room for the discourse of HIV as curse, rather than infection, to proliferate. It was not grounded in any outcry over the four million infected, or for any regard to the real problems faced by PLWHA. Rather, the nationalism itself was grounded in ideas of a Nigerian medical science that would rely upon indigenous sources to find an efficacious drug for HIV. That is, an HIV cure, and not the HIV body is what enabled a cultural dream of redemption in this nationalist discourse.

Chapter three is an ethnographic rendering of Nigeria coming into compliance with the Trade Related Intellectual Property (TRIPs) Agreement of the World Trade Organization (WTO). The TRIPs Agreement gives proprietary pharmaceutical companies exclusive twenty-year manufacturing, pricing and distribution rights on their drug patents. TRIPs represents a global regulatory
mechanism that concentrates the circulation of pharma-capital outside of Africa, leading to extreme difficulties in accessing drugs. The current debate among TRIPs signatories is over whether a country such as Nigeria, which has little capacity to manufacture drugs, can legally import generic drug products. At stake is the right of a nation to locate and claim biological urgencies, that is, national health emergencies, the need for drugs, and subsequently the rights of individuals to seek treatment. But moreover, the chapter demonstrates the difficulty in ascertaining the contours of rights as the debate on treatment access does not simply boil down to wealthy and powerful pharmaceutical companies right to deprive treatment to weak and poor people living with HIV/AIDS, as many global AIDS activists may insist. Rather, erased in this popular paradigm are many local actors competing for power, where the legitimacy of the nation, elites vying for foreign investment clients, the drawing of unexpected alliances, and the culture and obstacles of civil service can quickly dislodge re-imagining the flow of pharmaceutical pathways as a rights paradigm in TRIPs negotiations. I examine several different social and interests groups, including lawyers, government policy makers, musicians, AIDS activists, and the US Department of Commerce, who all claimed different forms of rights and rights violations while they advocated for a new intellectual property (IP) law that would represent each of their interests. Even if favorable intellectual property laws were in place, countries such as Nigeria would still have a difficult time competing on the global level, as it has no technological capacity to actually research and approve patents. Moreover, it has no capacity to enforce international IP laws. While especially
the US is insisting upon proper IP enforcement, it is also insisting upon continued state-downsizing and market liberalization, which are major conditions of foreign aid. It is unclear how the US expects post-colonial states to enforce IP, when in fact foreign aid conditions contribute to weakening their capacity to do so. Therefore, the dissertation demonstrates how the notion of rights has been coopted in both international and local spaces to make conflicting claims over human, commercial, and national entitlements.

Vinh Kim Nguyen defines a therapeutic economy as the totality of therapeutic options in a given location, as well as the rationale underlying the patterns of resort by which these therapies are accessed. The notion of therapeutic economy emphasize(s) the link between therapies and wider economic and social relations (Nguyen, forthcoming: 1). Following Nguyen, the dissertation discusses how global pharmaceutical flows and existing national medical and research budgets structure biosocial, subjectivity, and expertise formations.

Chapter four outlines the available therapeutics in Nigeria (such as counterfeit medicine, expensive and out-of-reach proprietary drugs, traditional medicine, faith healing, and HIV cure claims) and the constraints that shape therapeutic negotiation, options, and itineraries. In this environment, biosocial formations what I call African biosociality come into being not because of the non-existence of therapeutics as Paul Rabinow (1992) describes, but rather because of non-availability of existing drugs. The chapter argues that biosociality in Nigeria is largely determined by pharmaceutical capital flows, through which fundable and profitable research agendas are slated for those who can afford
treatment for diseases/ailments like heart disease or erectile dysfunction, as opposed to the exclusion of other diseases, located in spaces of poverty, such as tuberculosis and malaria. Additionally, both drug regulatory mechanisms and drug manufacturing have completely declined since IMF implementation. National budgets for these activities are scarce to the point that most drugs (about 80%) in Nigeria are imported and there are little resources to regulate their entry or circulation. In this environment, existing and available therapies actually determine subjectivity, experience and reception. To illustrate, in chapter four I describe how a culture of self-medication and patronization of illegal markets are primary ways that patients gain medical and drug knowledge. In chapter five, I use the example of cure claims to show how competing forms of clinical knowledge are an outcome of medical and drug pluralism. Moreover, in institutional settings, such as the military or AIDS NGOs, one's subjectivity in relation to therapy can change over time, in which receiving treatment from a cure claimant and believing one may be cured can transform into being influenced by Western paradigms of drug efficacy.

Drug and medical expertise are also structured by global drug circulation patterns and national medical and research budgets. In chapter four, I describe how pharmacists have lost ground to drug counterfeit businesses where the status and prestige of the profession no longer hold its former resonance. In the process, pharmacists have compensated for this loss in several ways, most importantly by engaging in questionable prescribing practices that do not allow for a patient to actually know what medication s/he is taking. I argue that this is a way for
pharmacists to attempt to regain control of an environment where prescription substances are freely sold and self-medication is a widespread practice. As with pharmacists, in chapter five I discuss how medical doctors have lost ground to cure claimants and traditional healers, which the majority of the population visits for their primary medical care; indeed traditional healing is the standard of care for most in Nigeria due to low cost and accessibility. Expertise is then inculcated in this sense of loss, where hospital doctors objectify and re-objectify themselves in contrast to people who are sick and deviant. That is, a sense of professional loss is channeled into an idea of medical expertise, which is equated with medical purity and medical invincibility juxtaposed against an radically imagined other the HIV positive patient. The most dangerous outcome of this is that PLWHA who visit doctors in clinics and hospitals are often turned away or not treated due to their status, as it is never imagined that medical workers themselves may or could be infected. The lack of sensitivity toward HIV positive patients is therefore a combination of factors that include symbolically configuring expertise under conditions of professional loss. This in turn produces an understanding of an objectified purity that interacts with existing stigma to produce clinical institutional cultures that foreclose discussions and knowledge of HIV in the workplace.

A Biological Measurement of Postcoloniality

In writing about why AIDS policies fail, why rights cannot find a place of uniformity, and why treatment for AIDS is confined to the realm of hope, I have been repeatedly dragged back to what feels like an ethnographic haunting. The
daily encounters with democracy and suffering in all their rehearsals, performances, and lived experience are Nigerians haunting appraisal of the post-colonial state. HIV/AIDS situates this appraisal by showing how the biological HIV bodies, drug circulation, medical/clinical knowledge, and HIV epidemiological awareness versus treatment policies represents and encompasses the organization of global capital and its effects in the realm of the everyday.

In understanding how the biological functions in this capacity, it is important to trace what exactly is meant by the global or globalization as it is experienced in Africa and as AIDS clearly indicates. This relationship between the biological and capital circulation points to a globalization that does not take manufacturing or financial capital as a primary mode of analytical intervention, as manufacturing bases and financial markets do not exist as such on the continent. Indeed, globalization paradigms that theorize flexible capital, flows (media, migration, technology), global cities, cosmopolitanism, and local-global relationships (such as Lee and LiPuma, 2002; Appadurai, 1990; Sassen, 1991; Cheah and Robbins, 1998; Grewal and Kaplan, 1997) do not hold here. Instead, the global considers the organizational structure of policy-driven financial forms that interact with other forms of capital circulation that perhaps more accurately describe the post-colonial state in Africa. Achille Mbembe (2000), for example, has asserted that under the tutelary government (74) of international agencies, the collapse of external state power generates a fractionated sovereignty (74). As such, the shift from a state-centered to market economy has
reconfigured the role of citizen, as well as the relationship between rights and duties/obligations to the state. He further writes that

(t)he hegemony of state administration has thus broken down partly under the impact of structural adjustment policies. But neither the promised restructuring of the system of productive capital accumulation nor the reintergration of Africa into world markets has occurred. The compromises rules, rights, obligations that, though costly, ensured the stability of certain postcolonial models of governance (until the first oil shock) have been disrupted. The resulting disorder and apparent chaos is amplified by the interaction between, on the one hand, social protest and the weight of inertia, and, on the other, the increasingly ineffectual efforts of local tyrannies to end dissent by force. But what in the short run has every appearance of chaos represents, in the long run, a violent resurgence of struggles over inequality and control of the means of coercion. This is evidenced by the brutality with which, at every level of society, relations of loyalty and submission, relations of exchange, reciprocity, and coercion, and the terms of exclusion and incorporation in short, all the modalities of legitimate subjection are being renegotiated.

Therefore, the sources of (state) legitimacy (75) have been undermined and in turn so have the sources of accountability. That is, the decisions made by international agencies that dictate fiscal and political policies are quite invisible to the public, but it is the state that must answer to the consequences of such policies. The result is an increased conflict over the redistribution of state wealth and conflicting ideas of what constitutes a political or social community (Mbembe, 76).

AIDS policies, therapeutic options, and the reification of HIV bodies and their biologically based rights are integrated into an already conflicted postcolonial environment, where the biological uneasily manifests contentious meaning and value. As will be shown in the chapters that follow, the political and economic conduits of the biological have shaped rights discourses, biosocial changes, subjectivities, expertise, and political dynamics; and it brings all these
issues more firmly inside the imaginative borders of what essentially counts as political, economic, and even cultural.

But one may not have to look too far or even deeply inside local spaces to see how broader economic and political structures organize social changes. The fact that forty million Africans live with HIV/AIDS does indeed index multiple forms of political and economic power as the opening epigraph suggests. What will be the fate of Nigeria as it is highly touted and paraded as a newly emergent and democratic state? AIDS may be one of the best indicators of the status of Nigeria’s Fourth Republic as citizens and the state itself actively reflect on past failures and the prospect for new beginnings. That is, the failure of the African state to deliver on the promise of development; the failure of the development and debt industries to understand how and why poverty indexes have worsened, after fifty years of calculating the emergence of African states into the global economy. The prospect for new beginnings that reconcile and move beyond past failures is in the midst of being imagined. But it is an imagination for many that is competing with time, pharmaceutical regulations, development strategies, and capital flight patterns that mimic past policies while it is ironically being put forth that new paradigms are being ushered in for the African continent.
Chapter One

Health Care Delivery, IMF, and Debt

Treatment Access and HIV Landscapes

This chapter provides a brief background to how the demands for treatment access came into being and also introduces the scope of infection throughout the world and within Nigeria. The chapter then provides background on the state's health care infrastructure, which has not drastically changed since colonial rule. The impact of the International Monetary Fund's structural adjustment implementation is analyzed in terms of health care in which I demonstrate how both international forces and state civil service agencies have contributed to the serious decline of health care delivery. It concludes with an examination of Nigerian measures to reorganize health care infrastructures that attempts to re-negotiate the country's now enormous external debt in order to meet the needs of people living with HIV/AIDS (PLWHA) as well as health care infrastructures.

Currently, there are nearly 40 million PLWHA in Africa; in Nigeria over four million people are HIV positive and less than 1% of all infected have access to treatment. Access to medicines for the poorest in the world became high profile in the international media in the last five years. This has been a direct result of the emergence of HIV antiretroviral (ARV) medication, which largely came into being due to activism in Europe and North America that demanded funding for treatment. While five pharmaceutical giants have made billions of dollars in
yearly ARV sales, the existence of ARV revealed, in all its starkness, the global gap between the rich and the poor.

In the early 1990s, the first anti-retroviral treatment for HIV became available. The first line of drugs called reverse transcriptase inhibitors (RTIs), targeted reverse transcriptase, an enzyme that allows RNA to transcribe into DNA, the virus key mechanism of replication. This monotherapy was not found to be long-lasting in its efficacy and, soon after, a new line of drugs called protease inhibitors (PIs) were developed which also targeted a replicating mechanism. As HIV responded by slowly resisting to PIs singularly used, drug combination therapy was pursued. By 1995, clinical trials were seeing dramatic results with mortality cut in half in the first year of experimental treatment. Highly active antiretroviral therapy (HAART) is now the standard line of treatment and, if sustained, the general prognosis is that one should live indefinitely. In a ten-year period, what started as a fatal and stigmatizing sudden death illness, became as manageable as diseases such as diabetes.

Outside of North America and Europe, multilateral organizations, particularly the development industry, and the pharmaceutical industry considered antiretroviral medication as unthinkable for Africa (Nguyen, forthcoming). Claims of cost-effectiveness and poor infrastructure have been (and continue to be) the main claims to not extend treatment to Africans. Ironically, the high cost of medicine in the West is never put up as a comparative point, and the billions of dollars that the pharmaceutical industry commands in profit each year is not connected to global price-gouging tactics. Moreover, as medical and health care
infrastructure is dilapidated throughout most of Africa, the very organizations that supported structural adjustment packages leading to public health declines are the very ones denouncing inadequate infrastructure for the delivery of antiretrovirals.

It was not until the 2000 International AIDS conference held in Durban, South Africa, that the epidemic faced some of the first visible global inequalities in terms of the demand for drug access in the developing world. It was at this conference that South African president Thabo Mbeki declared that HIV does not cause AIDS, creating a huge outcry that lead to the formation of stronger AIDS transnational links and coalitions (Nguyen, forthcoming). The development industry lost control of AIDS policy and agendas and by the end of 2000, to which WHO and UNAIDS switched its stated objectives from prevention only strategies to increased promotion of treatment access.

As a result, access to drugs campaigns have sprung up around the world in the last five years. These campaigns have involved institutions such as local and transnational non-governmental organizations (NGOs), United Nations (UN) agencies and the private sector all of which have responded (albeit differently) to the problem that one-third of the world's population and the majority of the poorest in Africa still lack access to essential drugs. According to the World Health Organization, treatment access should cover therapeutic, physical and financial aspects of priority health problems, and should be within easy physical and affordable reach to all.

The latest figures from UNAIDS (UNAIDS, 2000) shows that 36.1 million people worldwide are estimated to be living with HIV/AIDS: 1.4 million children
under 15 years of age and 34.7 million adults of which 16.4 million are women. It is estimated that 70% (25.3 million) of all HIV/AIDS worldwide can be found in Sub-Saharan Africa: 3.8 million new infections occurred in this part of the world in the year 2000. Of the three million deaths due to HIV/AIDS during 2000, 2.4 million occurred in Sub-Saharan Africa (UNAIDS, 2000). Access to quality drugs for general health care and HIV-related opportunistic infections, is difficult for the average Nigerian (defined as average income which is N7500 or about $65 per month; however, about 70 million live on less than $1/day). Quality anti-retroviral medication for HIV/AIDS is accessible to less than 1% of those in need.

The first case of HIV/AIDS in Nigeria was reported in 1986. In 1991, the Federal Ministry of Health (FMoH) conducted the first sentinel sero-prevalence survey in Nigeria. In this and in subsequent surveys conducted in 1993, 1999, and 2001, populations selected to determine HIV sero-prevalence were pregnant women attending ante-natal clinics, patients with sexually transmitted infections (STIs), patients with tuberculosis (TB), and female commercial sex workers (CSWs). These surveys show a rise in HIV infection in Nigeria: 1.8% in 1991, to 3.8% in 1995, to 5.4% in 1999, and 5.8% in 2001 which means that the latest statistics equals about 3.5 million Nigerians between the ages of 15 and 49 who are infected with the HIV virus (National AIDS/STD Control Programme/FMoH, 2001).

HIV infection rates are diverse across communities and states. Within every geo-political zone in Nigeria, there exist HIV hotspot states where the
HIV prevalence rates are much higher than the national average. In the recent Federal Ministry of Health 2001 Sentinel Survey, over 10 out of the 85 sites studied returned results of HIV prevalence above 10 per cent (see Table 1) (National AIDS/STD Control Programme/FMoH, 2001). Moreover, HIV infection among youth is growing perhaps more rapidly than among any other social group, and currently runs highest nationally between those who are 20-24 years old (see Table 2). Opportunistic infections (OIs) in a person with HIV are the products of two factors: the person’s lack of immune defenses caused by the virus, and the presence of microbes and other pathogens in the environment. Table 3 shows Nigerian frequencies of OIs, the drugs for which are highly out of reach for the average Nigerian.

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
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<td>39,149</td>
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<td>56,510</td>
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<td>279,466</td>
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<td>3.2</td>
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<td>State</td>
<td>Median HIV Sero-prevalence (%)</td>
<td>Hot spot State and Sero-prevalence rate among youth (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------</td>
<td>-------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaduna</td>
<td>11.6</td>
<td>5.6</td>
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<td></td>
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<td>Lagos</td>
<td>6.7</td>
<td>3.5</td>
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<tr>
<td>Nasarawa</td>
<td>10.8</td>
<td>9.1</td>
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<td>4.5</td>
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<td>2.5</td>
<td>3.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ondo</td>
<td>2.9</td>
<td>6.7</td>
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<tr>
<td>Osun</td>
<td>3.7</td>
<td>4.3</td>
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<td>Oyo</td>
<td>3.5</td>
<td>4.2</td>
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<tr>
<td>Plateau</td>
<td>6.1</td>
<td>8.5</td>
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<td></td>
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<tr>
<td>Rivers</td>
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<td>9.7</td>
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<tr>
<td>Taraba</td>
<td>5.5</td>
<td>6.2</td>
<td></td>
<td></td>
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<tr>
<td>Yobe</td>
<td>1.9</td>
<td>3.5</td>
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<tr>
<td>Zamfara</td>
<td>2.7</td>
<td>3.5</td>
<td></td>
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</tbody>
</table>

**Sources:** National AIDS/STD Control Programme/FMoH. 1999, 2001

**TABLE 2. HIV prevalence rates by region, youth and hot spots**

<table>
<thead>
<tr>
<th>Geo-political Zone</th>
<th>Median HIV Sero-prevalence (%)</th>
<th>Hot spot State and Sero-prevalence rate among youth (%)</th>
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</thead>
<tbody>
<tr>
<td>South East</td>
<td>5.2</td>
<td>Ebonyi (9.3)</td>
</tr>
<tr>
<td>South West</td>
<td>3.5</td>
<td>Lagos (6.7)</td>
</tr>
<tr>
<td>North West</td>
<td>3.2</td>
<td>Kaduna (11.6)</td>
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<tr>
<td>North Central</td>
<td>7.0</td>
<td>Benue (16.8)</td>
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<tr>
<td>North East</td>
<td>4.5</td>
<td>Taraba (5.5)</td>
</tr>
<tr>
<td>South South</td>
<td>5.2</td>
<td>Akwa Ibom (12.5)</td>
</tr>
</tbody>
</table>

**Source:** National AIDS/STD Control Programme/FMoH, 1999

**TABLE 3. Most common symptoms/opportunistic infections in Nigeria**

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prolonged Fever</td>
<td>73.12</td>
</tr>
<tr>
<td>Chronic diarrhea</td>
<td>53.05</td>
</tr>
<tr>
<td>Chronic cough</td>
<td>50.19</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>15.15/ 43% Taddebe et al.</td>
</tr>
<tr>
<td>Disease</td>
<td>(2000)</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------</td>
</tr>
<tr>
<td>Dermatitis</td>
<td>2.52</td>
</tr>
<tr>
<td>Lymphadenopathy</td>
<td>39.92</td>
</tr>
<tr>
<td>Herpes Zoster</td>
<td>9.88</td>
</tr>
<tr>
<td>Genital ulcers</td>
<td>8.03</td>
</tr>
<tr>
<td>Candidiasis</td>
<td>6.58</td>
</tr>
</tbody>
</table>

Source: Akinsete, 1998

The main mode of transmission of HIV in Nigeria, as it is in the rest of Sub-Saharan Africa, is heterosexual contact. There are many factors that contribute to increasing rates of HIV spread in Nigeria, such as maldistribution of global resources, capital flight patterns, and trade regimes that are directly linked to poverty, gender disempowerment, social and financial inequality, social and religious norms, and political and social changes such as labor migration as well as lack of knowledge and information. Vulnerable groups cited by Family Health International [FHI (2000)] include: sex workers, truck drivers, businessmen, port and dock workers, blood transfusion recipients, youth, TB and STI patients, and children (due to mother to child transmission MTCT) and orphans. Surprisingly, with the high economic disempowerment of women and a thriving sugar daddy culture in Nigeria, married men/couples are not considered a vulnerable social group and/or at risk for transmission.

Since 1986, and until the advent of the Obasanjo civilian regime in 1999, interventions targeted at combating the epidemic had been initiated largely by civil society organisations (NGOs, CBOs etc.) with major assistance from donor agencies and to a lesser extent from the Ministries of Health at both the federal and state levels. The Government of Nigeria established the AIDS/STDs Control Programme (NASCP) in 1987, (under the Federal Ministry of Health)
with assistance from the WHO Global Programme on AIDS under the Medium Term Plan Initiative (MPTI), which ran from 1992—1997. The scope of the program was too narrow and the reach was limited, making it impossible to achieve a broad-based impact across the nation. This weak public sector response was further impeded by the dual factors of the turbulent national political climate, increasing poverty and a declining economy, which characterized the 1990s in Nigeria. During this early phase some federal ministries, notably Defense and Education, developed mono-sector programs targeting the audience of their respective ministries. These programs were largely ineffective because they were not linked to a larger response outside of the different ministries but more importantly there was no backbone national multi-sector program to provide strategic direction, support and coordination. The constellation of factors outlined above acted as major constraints to undertaking interventions that are viewed as effectively controlling the spread of HIV. However, since 1999, the situation has changed, with the new government giving high priority to HIV/AIDS, although the response at state and local levels is still sparse. President Obasanjo has assumed personal responsibility for leading the response to the epidemic, and has since conducted a public campaign similar to the leaders of Senegal and Uganda. The Presidential AIDS council (PAC), chaired by President Obasanjo and the National Action Committee on Aids (NACA), have been appointed with representation from all ministries, community based organizations and NGOs, academia, the private sector and the constituency of people living with HIV/AIDS
(PLWHA) forming a multi-sector committee to oversee the national response to the epidemic.

Working in consultation with stakeholders, NACA adopted a two-pronged approach to the development of a long-range national Strategic Action Plan for the country and an immediate response to the epidemic, the HIV/AIDS Emergency Action Plan (HEAP), which includes the following: advocacy, locally and nationally; establishment of national, state and local government areas control program; targeting specific groups and the general population; blood safety strategies; condom social marketing; development of national policy on HIV/AIDS/STI control; guidelines on counselling; case management; STI management; integration of HIV/AIDS/STI control activities into primary health care; establishment and support of NGO and PLWHA networks; and intervention in public schools.

*Nigerian Health System and Primary Health Care*

The national health care system is organized under the Federal Ministry of Health (FMH) and its structure and design were largely carried over from the colonial era. Over the years, some reform has taken place, although the scope and culture of the system itself is a remnant of British indirect rule in Nigeria. Primary health care in Nigeria is the basis of the national health care system. Medical care within the system is provided in three types of institutions: 1) Primary Health Care, under the jurisdiction of the local government area (LGA), is designed to be available and accessible to all Nigerians in their communities; 2)
Secondary Health Care is under state control at districts and zonal levels and largely receives referrals from primary health care; and 3) Tertiary Health Care is the responsibility of the federal government and provides more specialized medical care and intervention through federal medical centers, teaching hospitals, and other specialist hospitals.

The actual implementation of the primary health care system faced considerable constraints over the years. By 1982, the National Health Policy (NHP) was drafted (and then later in 1988 and 1996), which explicitly stated that the premise of primary health care is based upon principles of social justice. Its goal was to provide health care to all Nigerians by the year 2000, in which primary health care (PHC) was at the center of national health care strategies. At the time, the NHP required nearly 50% of the then national budget for effective implementation (Musa 1991), and subsequently failed for at least three reasons: a) lack of human resources, money and facilities, as well as poor planning that did not meet the individual needs of each community; b) political will waned, and there was no political base intact to run the health care delivery adequately. Moreover, LGA activities came under the supervision of their respective states which occasionally led to conflicts and poor distribution of funds; c) other aspects of the social economy such as clean drinking water, housing, environment, education, etc., were not in place as solid preventive health care measures (Musa 1991; Ekunwe 1993). Therefore, the objectives of NHP were not always well implemented, and there were severe national performance gaps.
Additionally, the NHP failed to meet very specific criteria laid out in the document that was meant to facilitate the implementation of PHC. These factors include the fact that curative services currently predominate at the expense of preventative services, mismanagement of resources, minimal community involvement, poor health information system, and no evaluation or monitoring of basic health services because there exists inadequate to no statistical data (NPHCDA 1995) (see Table 4 for additional information). In financial terms, most health institutions spend nearly 80% of total annual budgets on personnel and the improvement of drug provision and facilities are left behind. Additionally, decreasing federal government allocation of funds on health (less than 2% of national budget) has led to shortages of personnel, drugs and support services (Campbell 1998a). This has created a strenuous maldistribution of resources where over 70% of health care workers and facilities are located in urban areas (Campbell 1998b). Facilities in the rural areas are dilapidated mostly because there does not exist enough funding to enable medical clinics to function properly (Musa 1991).

The current NHP does list the mounting problems such as acute shortage of essential drugs, shortage of PHC personnel and inadequate facilities, but provides no direct suggestions for alleviating primary health care constraints as required by the Alma Ata Declaration on world public health. Also, there is no law that lays out health functions (legislative or otherwise) of the different levels of government in the current 1999 Constitution.
### TABLE 4. National human resources for health care and medical facilities*

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<tr>
<th>HUMAN RESOURCES</th>
<th>TOTAL NUMBER</th>
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<tr>
<td>Dentists</td>
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<td>Community Health extension workers (now JCHEWs or Junior community health extension workers)</td>
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*Source: Federal Office of Statistics, 1991*

*Nigeria’s population is estimated to be 90 million at the time of this survey*

The reasons for such disarray are numerous and include the decline of funding since the demise of the oil boom in the 1970s, military regimes (and sometimes civilian) creating unaccountable structures, and a set of outdated civil service rules that organize the entire system. What is stated on paper is not necessary managed in practice; and there are extremely complicated networks penetrating the FMH, as in other ministries. This has led to a number of problems,
including lack of clarity regarding legislative versus functional powers for all levels of government. As a result, there is a lack of understanding of the internal workings of the FMH, the civil service rules, budgets, and expenditure, leading to a lack of accountability on the part of the managers (Crisp et al., 2000).

The federal arm sets policy and is responsible for implementation, which is carried out at the local government level through the allocation of state funds. Under the federal and state health ministries, there exist separate civil service entities. The Federal Civil Service Commision (FCSC) is empowered to set the design and structure for all departments. But in practice, it is just an employment agency for the federal ministry and parastatals (discussed below) where salaries and benefits are located in another commission. The organizational design is the function of the Office of Establishment in the Ministry for Federal Civil Service. One problem with this particular centralized design is that respective offices, and not the ministries themselves, determine organizational designs of the ministries and their departments (Crisp et al., 2000). Any sort of reorganization desired on the part of the ministry would have to be taken up with the President and the Federal Executive. Managers within the different departments are not empowered to hire and fire. The Ministry of Health is only responsible for hiring health workers such as doctors and nurses. For example, it cannot hire accountants on its own, as this is the responsibility of the Accountant General. Therefore, a department must utilize someone that it did not hire and it is unable to terminate an appointment (Crisp et al., 2000). Moreover, once hired by the Ministry, there are no incentives or disincentives on the job as there exist no terms of contract.
Promotion simply comes by length of stay. Employees working in the FMH are effectively civil servants, contracted by many different departments, and therefore their conditions of appointment come from outside of the FMH, to which the FMH has no accountability. Therefore, there is very little leeway to actually manage the human resources and operations of each department. Furthermore, managers do not see cost provisions, as budget allocations are scattered among different government branches leading to an organizational culture in which services are secondary to the employment of staff. The lack of decentralized accountability is compounded by a lack of financial and human resource auditing (the federal arm is not accountable to the state branch, and the state does not need to show how it spends the federal money allocated to it) which not only has led to confusion over roles in the FMH, but also accusations, traded back and forth between the federal and state levels, of money disappearing (Crisp et al., 2000). Although cash flows may end up being highly irregular, the structure of the system does not enable managers to be disciplined for failure to control budgets, leading to a culture of corruption (Crisp et al., 2000) which I talk more about below. But additionally, there is no incentive to manage or contain costs, as part of the budget is out of the manager's purview.

One other major issue is that the new 1999 Constitution does not mandate, nor is it explicit about the functions of health. As a result, the FMH's organizational design is not based upon a set of statutory responsibilities (even though the national treasury continues to fund policies that do not fill existing statutory obligations). This leaves the FMH with virtually nothing to monitor and
no recourse to intervene when there is deviation from budget allocation and expenditure. Additionally, parastatals, legally mandated federal agencies charged with policy implementation, exist alongside other implementing agencies. This is actually in contradiction to the federal branch's traditional role of making policy (not implementing it) and creates tremendous overlap with the state and LGA implementing structures. However, because the parastatals are mandated by law and have their own boards and a political authority, they are actually elevated above the FMH in terms of political power. This essentially means that officials responsible for health policies and statutes have no power to oversee their implementation, as these become the responsibility of the parastatals. There exists a great deal of tension, if not resentment, among all parties, which has led in the past to a failure to cooperate and implement policies (Crisp et al., 2000).

Waiting at the very bottom of this system is the LGA. Nigeria has 776 LGAs that comprise as little as 50,000-70,000 people and are expected to carry out all primary health care. With the great duplication of services (parastatals, state, and LGA implementing agencies), and a lack of accountability, fragments of numerous agencies intersect at the LGA level either duplicating services or failing to comprehend the gaps and needs in the communities of which many then go without services. The small economies of scale at the LGA level also work against being able to support integrative services, leading to very crucial problems (Crisp et al., 2000) such as managing and sustaining the national vaccine program, through which currently only about 10-15% of all children receive childhood vaccinations.
Health care provided at all levels of government is sparse in terms of human resources and facilities are overburdened. Very few have training in HIV/AIDS epidemiology and care, and knowledge of infection control within facilities is minimal. An HIV positive nurse tells me about her experience working in a private hospital:

There was nothing ever mentioned about HIV/AIDS. We use to hear that there was something like that. But in that place in particular [the hospital], there was no precautions about it. Nobody knew anything. We used to handle all the patients as if everybody is OK. Even packing blood with our bare hands; even sometimes when there was operations being delivered, we were the ones who would pack everything, wash with our hands without being afraid of taking any infection. Even with some patients that are just in the bed and cannot help themselves, we are the ones who would help them. We would help them out, change their bedding, give them bedpans, wash everything, without being afraid of contamination.

In many cases, PLWHA are not allowed entry into some hospitals, or are segregated with little attention from the rest of clinical and hospital populations. Also, mandatory HIV testing is more often favored over universal precautions. Access to drugs is therefore very difficult to achieve in environments where PLWHA are shunned or disregarded. In nearly all hospitals, there is no pre- and post-test counseling. Some clinic and hospital workers claim, and I agree, that informed consent for testing often fails because they can offer little adequate treatment; also, due to stigma and discrimination, patients prefer not to know their sero-status.

In the case of opportunistic infections, the cost of drugs is often out of financial reach or completely unavailable. When they are available, programs such as directly observed treatment (DOTS) especially for tuberculosis, which is the most common OI are not carried out as a primary health care regimen. With
few exceptions, ARV treatment is almost nonexistent in many of the teaching and secondary hospitals and the cost of care is out of reach for those who are HIV positive. (MSF/COCSGACM, 2001).

Without downplaying the level of frustration (the desire for accountability and transparency) that corruption and its impunity poses for the majority of the people, it is important to point out that the very colonial structure of state ministries was meant to extract wealth and labor by its subjects. The structure itself did not change at the time of independence (1960), that is, it was deracialized and not democratized, as Mamdani (1996) asserts, and the state has thus continued to be a primary means to access wealth. Therefore, what was considered legitimate under colonial rule is now considered corrupt in the post-colonial era. As one AIDS activist told me: the health care structure in our society is very unique. It is unique, yes, because to the extent, I do believe, that we’re still trying to transit from colonial rule to civil rule. Moreover, the state largely runs under the tutelage of international financial institutions. The financial direction of government policies are often decided upon by unknown World Bank bureaucrats for which the state is held accountable by the public for the consequences of such policies.

In writing about the delivery of public health care and the organizational culture of the Federal Ministry of Health and, as well as other state structures that are connected or involved with treatment access, the idea of corruption has to be addressed on two levels. First, while international fraud letters infamously marks Nigerian corruption, the perception of corruption in the country takes on a
far different trajectory. Corruption in Nigeria should not be seen solely as a dysfunctional aspect of state organization, (but rather) as a mechanism through which the state itself is discursively constituted (Gupta 1995:376). The collective stories of state medical corruption and marginalization experienced and articulated by PLWHA make up both a discourse of the state and more importantly, a sense of entitlement to rights. Rights violations are one of the primary reasons that AIDS NGOs constitute themselves in Nigeria for which they attempt to seek redress, or work with the state in asserting that PLWHA are citizens and are entitled to such rights.

The second is an anti-Orientalist rendering of corruption. A Western perception of corruption presupposes that there is a clean divide between state and civil society; and Jurgen Habermas (1989[1962]) notion of the public sphere is a naturalized product of this divide. But the public sphere marks a particular European bourgeois social formation born out of feudalism, the European experience of capitalism, and the formation of urban landscapes a formation that does not translate easily in the post-colony (Gupta, 1995). The term civil society is often employed by both local NGOs and the international development industry to describe, not the grass roots or an idea of a public, but NGO activity and formations. This assumes that civil society is the mere existence of autonomous organizations (although they are not such in Nigeria) or simply society (Mbembe, 2000). This designation of civil society is a misnomer because the boundaries between both the state and the public overlap in many ways. As Claude Ake asserts:
the state in Africa is autonomous of form and content. A person who holds office may not exercise its powers, the person who exercises power of office may not be its holder, informal relations may override formal relations, decision making power may not rest in formal hierarchies of bureaucratic power, positions of power may not be held by persons, but by kinship groups, public may be privatized and private may by publicized and two or more political systems and political cultures in conflict may coexist in the same social formation (Ake, 1996).

Therefore, civil society, as it has been constituted under the European experience, does not exist as such in Africa. As Achille Mbembe (2000:39) states: (t)he process through which what is acknowledged as the common or general interest comes to be defined implies the existence of a public sphere that cannot be assimilated purely and simply to the official sphere. Further, the notion of civil society refers to a theory of social stratification and the procedures by which a minimum of acceptance of that stratification is established. As the ethnographic work will show, tracing the boundaries of the state and civil society becomes extraordinarily difficult through the lens of human rights violations as well as government-NGO, and government-scientific network dynamics. Throughout the dissertation, state and individual forms of corruption will be apparent. But following Gupta (1995), it takes an anti-Orientalist approach to corruption by rejecting the presumed easiness of the state/civil society dichotomy in order to get at the nature of social formations and cultural understandings emerging in the context of AIDS.

*IMF Structural Adjustment and Debt Regimes*

There is, furthermore, a transnational aspect to corruption as a discursive articulation of the state that does not necessarily draw on direct connections to the
local level. The International Monetary Fund (IMF) policies, the management of Nigeria's current debt regimes, trade (discussed in chapter three), and development (discussed in chapter two) have an impact on the discursive and material articulation and structure of the state, and is especially clear in public (and sometimes even government) understandings of the state health care system. Structural adjustment programs (SAP), carried out by the IMF, and debt have the most immediate impact on domestic budgets, which has lead to the decline of state health care, for which the development industry has circuitously attempted to fill in the gap.

In 1986, General Ibrahim Babangida, then head of state, raised the debate of IMF loan conditionality in the country. Under President Buhari's regime, (who was ousted by coup d'etat by Babangida) almost all the austerity measures were rejected. Moreover, in the midst of oil price decline and climbing external debt, the public overwhelming rejected IMF loans and conditions. With pressure from creditors who insisted that austerity measures would lead to a more viable balance of payments, Babangida initiated the IMF deal by October 1986, and the World Bank monitored compliance. The IMF assumed that the free play of market forces would produce an acceptable pattern of investment, production and trade, as well as create growth in production and employment if not disturbed by government intervention (Anunobi, 1992). It also assumed that internal and external imbalances, such as inflation, are caused by excessive internal demand. State policies were targeted including a plan for privatization, which did not take
into account the fluid and differing meanings of the state in which the interests of a few social groups are represented.

The three most important conditions that were agreed upon and that had the most devastating impact on the economy and indeed health care were the devaluation of Nigeria's currency, the naira, trade liberalization, and the removal of petroleum subsidies. Within one week of implementing SAP, the naira, which was stronger than the dollar during the 1970s oil boom, was worth $.25 (and currently $1=N140). The devaluation of the naira lead to decreased earnings and food prices nearly quadrupled. It furthermore did not bring about a predicted increase in export revenue (as global prices were also falling at the time) or reductions on import expenditures, but rather to a shortage in consumer goods; and nor did lower prices available to foreign consumers lead to an increase in purchases (Anunobi, 1992). The state was downsized for its excessive demands and because it was and still is the single largest employer in the country, multitudes of civil servants lost their jobs and wages decreased by 20%. The desire to enhance export agricultural economies, which at the time constituted nearly 75% of foreign exchange, (now it constitutes less than 2%, with oil at 98%), has literally collapsed, as farmers switched to more subsistence farming. A 30% tax on raw material imports was imposed and the cost of manufactured goods increased several fold. Currency devaluation along with the tax on raw material imports (plus increased value added taxes), which were designed to create import restriction measures, lead to a two-thirds divestment of the pharmaceutical industry, which continues to decline. Public spending was
rigorously curtailed. Education was no longer free and available to all. Primary health care services also collapsed, which impeded the IMF's stated goal of building self-reliance (Salako 1997), as the Fund envisioned total cost recovery from patients who could not afford even basic food stuffs. Balance of payments deficits, the primary justification for SAP, that the IMF imagined as stabilizing only worsened with this crisis.

After these conditions were implemented, Nigeria faced increased black market expansion, heightened poverty, increased crime, food riots, and worker strikes. At the time, Babangida praised the restructuring and nearly fifteen years later, in 2001 at Nigeria's fourth debt rescheduling conference, current president Obasanjo stated: "Once you owe money, you lose an element of sovereignty. But I want to make it clear, that they cannot tell me what to do in Nigeria. I have stuck my neck out. You want openness, I'll open up. You want transparency, I'll give you transparency. After that, what else is the West asking me to do? Cut my neck? Bleed Nigeria to death?"

In 2002, Nigeria's external debt stood at US$ 28.6 billion, which represents approximately 80% of the gross national product or 186% of export earnings. Nigeria's debt relative to national income is ninety-one percent. The majority of this money is owed to the Paris Club, which amounts to US$ 22.1 billion³ (Atta, 2002). Nigeria adopted a policy of keeping its debt payments to a specific percentage of net oil revenue. However, in 1993, the military dictator General Sani Abacha broke off relationships with the Paris Club creditors, which lead to the accumulation of large amounts of high interest on arrears and
penalties. In real terms this meant that in 2000, Nigeria was expected to pay $3.1 billion to its creditors, but paid only $1.7 billion out of a total of US$28.1 billion of total debt. Now, the principle balance is $8.4 billion (30%), the arrears on the principle balance and interest amount to US $14 billion (53%) and US$4.9 billion represents late interest (17%).

The payments made in 2000 represent nine times (see table 5) more than its total health care spending. About 40% of the outstanding principal balance was loaned to past military regimes. These loans were allocated with the full knowledge that much of it would be siphoned off and deposited in the banks of creditor countries (Atta, 2002), yet these countries are not faulted for not establishing credit worthiness with their clients. General Sani Abacha reportedly stole over $6 billion and possibly much more from the national treasury. Between 1986 and 1991, Nigeria’s debt was rescheduled three times (in 1986, 1989, and 1991) all of which failed to alleviate the burden of poverty on the country. Economist Jeffrey Sachs has argued that Nigeria should qualify for the Highly Indebted Poor Countries (HIPC) Debt Initiative, a 1999 initiative of the IMF and the World Bank that requires structural adjustment reform in order to create more sustainable debt management.  

Nigeria is not on the HIPC list due to its oil resources, the revenues of which, according to Sachs are not calculated in real per capita. The average per capita income of the twenty-two qualifying HIPC countries is US $360 per year. However, Nigeria’s per capita income stands at US$300 per year. Moreover, Sachs argues that Nigeria’s per capita income has declined far more severely between
1980 and 2000 that the other countries. Sachs estimates that Nigeria produces about $50 million worth of oil per day. However, half of this is allocated to the foreign companies and the rest to the Nigerian National Petroleum Corporation (NNPC). Calculating conservatively that the NNPC is allocated $30 million, Sachs estimates that the oil wealth amounts to $91.25 per person per year, dispelling the myth of an oil-rich country. (Sachs, 2001:3). However, unlike most African countries, oil revenues create an easy flow of money that make it easy for creditors to grab money which otherwise could be channeled into public health and education.

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Reorganization of State Services, HIV/AIDS Programs, and Debt

The very presence of HIV/AIDS has generated a move to reorganize state structures, a move that is imagined as circumventing existing problematic infrastructures, particularly civil service organization. This has come about due to the World Bank's Multi-Country AIDS Program (MAP), to which a loan of $90.3 million is being disbursed to Nigeria's HIV/AIDS Emergency Action Plan.
(HEAP) over a three-year period. The criteria that the Bank has outlined to receive MAP loans include three components: 1) the establishment of a high-level HIV/AIDS coordinating body, with broad representation from all sectors including NGOs, and the different levels of government; 2) evidence of a strategic approach to HIV/AIDS developed in a participatory way, in which NACA is working with UNAIDS, and a long-term strategic plan is being developed through a consultative process; 3) government commitment to quick implementation arrangements, including channeling grant funds for HIV/AIDS activities directly to communities, civil society, and the private sector. Nigeria has complied with these measures and has additionally created an HIV/AIDS fund for these purposes. Moreover, it has created new government structures at federal, state and local levels to implement the HEAP. NGOs are also configured in this strategy and all parties have their specific roles, implementation and auditing mechanisms that check back and forth, in sometimes complicated ways, between both existing levels of government and the newly created structures. Moreover, there are elaborate mechanisms in place for financial management, accounting, budgeting, auditing, new communication strategies, information technology management, and disbursement processes, heretofore non-existent for government structures.

Through a number of negotiations with the Bank, the Nigerian government along with input from AIDS NGO coalitions have negotiated for an atypical free hand in monitoring the process of fund allocation to NGOs who apply for funding of projects that meet certain criteria, such as work in rural areas, capacity building for small NGOs, and ensuring community-based work. The
structure enables NGOs to work alongside state agencies to implement projects. Treatment access is also included as possible funding options.

With the large amount of fake NGOs in the country (discussed further in the chapter two) and a civil service structure that enables a lack of accountability, a new system has been devised to ensure transparency that is now being tested in other ministries. If an NGO applies for and is awarded funding for a project they receive 30% of their funds (allocation is marked by a 30%-30%-30%-10% disbursement pattern over time). If the idea is tried and it does not work, then the same NGO can apply for funding for a new idea. If it is just pilfered away, then the same NGO will not be funded again. Therefore, there is a built-in monitoring system. However, there has been great competition between NGOs to access not only grants, but also to control funding pots as different NGO members vie for different positions of power, creating incredible tensions among all actors.

With this mechanism in place under the MAP, the presidency has created a second phase to HIV/AIDS funding that impacts both AIDS issues and issues outside of AIDS. This mechanism is called due process, which is not set under policy or law, but rather is undergoing pilot testing. Prior to due process, the federal ministries, state governments, and parastatals could make unilateral decisions within their realm of activities. Now, under due process, a structure has been designed in which all major policy decisions must undergo a consultation process both within the different agencies, as well as with the targeted groups that will be affected. The idea is to create a structure that, in theory, eliminates blame trading for government implementation failures and replaces it with an
evaluative process that examines how implemented policies work or do not work. There have been several complaints from the different branches of government over this level of transparency. For instance, one worker on the National Project Team for the MAP loan told me that when he showed up to get a report from Eboyni state, they were quite forthcoming with the fact that they have been taking funds for personal purposes. Subsequently, Eboyni, has undergone what the technocrats at MAP call an embargo for embezzling funds, which means they are currently off the list to receive MAP funds. But the same worker also told me that some ministries have stated that this mechanism takes accountability out of their hands, which usually lies at the top, as described above, and provides them relief from making unilateral decisions. Now, some government officials are even advocating that due process be implemented across all government ministerial lines. Due process therefore attempts to implement an immediate structure that works both within and around civil service structures in order to establish transparency and accountability. However, this may only be seen as a reform measure that does not get at the heart of the problems of civil service.

In August 2002, a proposal among AIDS NGOs (in Nigeria and abroad) and the Nigeria government was drawn up to appeal to creditors for debt conversion, in order to free up funds that will be directed to HIV/AIDS activities. This proposal is considered the third phase of a connected effort to reorganize state systems. Nigeria states that it needs $500 million per year for the next five years (2003-2008), which is about 1/4 of its debt payment, in order to direct funds into awareness, prevention, counseling, and access to treatment. The proposal is
significant because it recognizes that underlying problems of capital flight and the maldistribution of resources are fundamental explanations as to why AIDS is so easily reproduced in resource poor environments. It uses debt conversion as a means to assert a national right to autonomously direct Nigeria’s engagement with globalization (indeed Nigerian policy makers often reflect on how Nigeria can reap the benefits of globalization); and both NGOs and government assert that debt conversion will enable increased financial empowerment to direct AIDS programming in the country. However, so far, there has been little action or movement toward the realization of this proposal.

Although it appears that government efforts are underway to reorganize state structures, and scale up activities to combat HIV/AIDS, it is really left to be seen how these efforts will materialize as both conflict and cooperation have been encountered at this nascent stage. However, I now turn to evaluate some of the existing relationships that make up AIDS policy in Nigeria. These have come into being with the reestablishment of donor agencies since the inauguration of Obasanjo in 1999, and along with them have appeared new and large funding pots for HIV/AIDS work that did not previously exist under military rule. As will be seen, the financing that brings the state, NGOs and development industry together in working relationships has altered the primary focus of AIDS work, while at the same time, it has generated conflicting paradigms of the problems of AIDS in Nigeria.
Chapter Two

AIDS development policies and discourses in Nigeria

Introduction

In 1986, Nigeria was preoccupied with two pressing issues under then head of state, General Ibrahim Babangida: the transition to civilian rule promised by the military administration under a five year plan and the ushering in of International Monetary Fund structural adjustment. Implemented against the widespread wishes of the public, structural adjustment policies such as currency devaluation, quickly eroded the earning power of Nigerians and led to the massive attrition of the middle class. The military government continued to alter its five-year transition-to-democracy plan, bringing about general discontent and eventual disbelief that the military, as before\(^5\), was not serious about civilian rule. Together, these issues gradually proved to be utter failures that sparked the beginning of a national pro-democracy movement. By 1992, Chief Mosood Abiola, a wealthy businessman, backed by the US, contested the office of the presidency and won the majority popular vote. General Babangida quickly annulled the election results. The following year General Sani Abacha took over by coup d'état and carried out what is widely considered the most repressive era of military rule in Nigerian history. Abacha’s rule led to repressive activities against the pro-democracy movement, the severing of many diplomatic ties, and the flight of foreign aid institutions.\(^7\) The year 1986 was additionally significant in Nigeria because the first case of AIDS was diagnosed. Progressive increase in
HIV/AIDS infection rates started to be recorded in 1992, but soon after the Abacha takeover and subsequent political crises, AIDS very quickly became a moot issue.

Stella Iwuagwu woke up on June 7, 1998. It was the morning that Moshood Abiola died in prison during a meeting with a US team to Nigeria that included Thomas Pickering and Susan Rice.\(^8\) Stella, a nurse and volunteer human rights activist, decided that she should go to work because she figured that the riots would lead to an overload in the hospitals and help would be needed. She worked two shifts back to back. When she got off work, she entered a bus, sat down, and fell fast asleep. She woke up to find that she was in a warehouse, had been drugged, and dressed in white. She realized instantly that she had been kidnapped for a ritual killing. Shortly, the priest for this ceremony called for her and two men brought her from the next room. When the priest found that she was dressed in white, he admonished the men saying that she was not to be dressed as such, and told them to get rid of her. She was blindfolded, put in a car and dumped on the street.

This is the story that Stella tells me when I first asked her how and why she got involved with AIDS activism in Nigeria. It was the simple realization that life is short and precious that propelled Stella to pursue what had been on her mind for a long time: create the first health rights non-governmental organization (NGO) in Nigeria. In less than two weeks, she completed the grant applications and started up the Center for the Right to Health (CRH). CRH tasks itself with
support groups and counseling for people living with HIV/AIDS (PLWHA), provides educational workshops, a testing center, and has filed suits against government and others for human rights violations of PLWHA.

I first met Stella just after she completed shooting a narrative film funded by the MacArthur Foundation on HIV/AIDS, and gender and generational relations in her village. As I was leaving the field, the film had just been edited and I was able to see the final version, all in Igbo. All of the actors were amateurs from the village, some of whom delivered stellar performances. When she showed a rough cut of the film to the village, the village council declared that practices that damage women should now come to an end. Stella is now studying in the US at NYU, for which she received fellowship funding from Oprah Winfrey.

With the inauguration of Olesugun Obasanjo in 1999, just after the death of both Abacha and Abiola, the problem of AIDS was rediscovered, but only this time, the prevalence rates had increased at what could be considered tremendous levels for such a populous nation of 120 million. While the Obasanjo regime spent much of its time in the early years traveling around the world spiffifying-up Nigeria’s torn image, the development industry⁹ (Kankwenda, 2000) made its way back into the country; and for those organizations that remained in Nigeria throughout the Abacha years, they now stepped up efforts to combat the virus. By 2001, Nigeria received financial commitments for HIV/AIDS totaling $442 million, where none previously existed under the Abacha regime. Primary funding comes from the World Bank, USAID, DFID, UN agencies, and Gates
Foundation (administered via Harvard University's School of Public Health). These pledges total about $250 million while the Nigeria state and federal governments have pledged just over $40 million. About $30 million has been promised to Nigeria from other private and public donors.

This chapter examines how the development industry contributes to hindering drug access for HIV/AIDS. The idea of an industry is influenced by the work Mbaya Kankwenda (2000), although he refers to it as the development merchant system or DMS. For Kankwenda, DMS is a market with its supply and its demand. The demand side are developing countries and the supply side are the developed countries and their financial and political institutions that are regarded as producers and marketers of development products, such as products, equipment, project ideas, know-how, human expertise and material technology. The development market, therefore has its wholesalers and retailers also.

Kankwenda describes the development merchant system as having several features, the most important of which is a new category of development merchandise (good) [which] has become more and more important: economic reform policies. These are special goods because they are not limited to being just consumed like the others, but they shape the development route, the future and the destiny of African countries, defining the nature of development and the mode of integration in the global economy. They open and speed up business for the other development products and services and are therefore largely and quickly financed by the development merchant system. Africa's right to define its own development path, to chart it, like every other major being without paternalistic interference, whether business or marabout, is not recognized. It [DMS] is not yet democratized even during the historic period of democratization in Africa.

Expanding upon this work, I assert that the development industry and it AIDS financing policies fits into a larger network of policy-driven and other financial forms (such as debt, pharmaceutical capital, trade related intellectual
property) that regulate capital flows in and through Nigeria and Africa. The majority of AIDS financing is favored toward prevention and education programs rather than widespread treatment because these programs leave capital flight patterns completely intact. Prevention and education programs construct HIV as a single entity whose management lies individually with those who are infected. Assuming a level of empowerment that most poor people do not possess (like condom negotiation), as well as individual commitments toward long-term health concerns rather than concerns over immediate survival, AIDS policies often become disconnected from broader problems of inequalities and resource distribution. Such inequalities are generated by current and past wealth extraction practices (including structural adjustment, corruption, currency devaluation, etc.), which are left behind in policy agendas. In order for Nigeria to source funding for the procurement of widespread treatment, the function of debt and trade regimes would have to be reconfigured in a manner that frees up money to properly allocate funds a task that Nigeria's creditors, which are also Nigeria's AIDS donors, are currently unwilling to do.Privileging prevention and education programs, while forfeiting treatment strategies and ignoring structural constraints, fails to ask how and why HIV/AIDS continues to proliferate within resource-poor and structurally dilapidated settings. It additionally fails to ask why infection rates continue to rise despite the massive inflow of funds, the enormous presence of AIDS NGOs, and increasing AIDS activism.

Within this broad structural framework, the chapter proceeds to analyze relationships forged between the development industry and local AIDS NGOs.
These relationships are both cooperative and contentious. But more importantly, both industry efforts and local NGOs manage such relationships in a way that erases treatment as a primary mode of action, even though access to drugs remains a top priority for activists and, at least rhetorically for some workers in the development industry. As an example of how the erasure of treatment operates, the chapter analyzes how definitions of, and solutions to, the problem of AIDS are differently generated by industry and activist interests (and within each activists and industry space, no universal understandings of such problems and solutions necessarily exist). In particular, I analyze how poverty gets defined in relation to AIDS. The way that either the industry or activists define poverty is followed by radically different suggestions for policy intervention, which is directly tied to problems of drug access. Lastly, the chapter ethnographically analyzes development industry and AIDS NGO perceptions of state response and political will, and the implications that such perceptions have to development and NGO AIDS work.

HIV/AIDS and Development Paradigms

Claude Ake (1996) asserts that development in Africa never failed because it never actually began. The development project was born out of national liberation struggles that were quickly besieged by divisions among elite groups. The post-colony, dominated by a highly statist and bureaucratic structure (nearly identical to the bureaucracies under colonial rule) was the primary means to access power, for which fractionated elites contended and competed. Although Ake does not differentiate between direct and indirect rule and differing forms of
governance under the British, French, or other empires, he does state that competition for power left little room for the implementation of development or even national plans for development; yet at the same time, development was the primary rhetoric that justified elites in power and the existence of single-party rule and military governments.¹⁰

Eventually, the idea of development served the interests of both government and their external patrons with the ideology that economic transformation would fit the needs of the international economy, over and above the welfare of the people. There has been a great deal of controversy over the failures of development on the African continent, especially expressed in forums over the last fifty years that have demonstrated great animosity between pan-African organizations and their African government members on the one hand and Bretton Woods Institutions, particularly the World Bank, on the other.¹¹ While the Bretton Woods institutions have recently admitted (the World Bank more so than the IMF) that macro-economic approaches, especially structural adjustment programs, have failed to alleviate poverty, the strategies to address such failures are rapidly turning to foreign direct investment.¹² These strategies represent an increasing disdain for foreign aid (even though capital flight greatly outweighs foreign aid assistance in Nigeria) where it is imagined that foreign investment could raise the African continent up and out of poverty. But really, these ideas are simply extensions of structural adjustment policies state privatization that may actually consolidate a stronger relationship among African elites and private corporations and international institutions. As IMF
structural adjustment on the African continent has historically shown, the increased entry of private capital (with fewer funds available for public projects) could prove disastrous for HIV/AIDS and health care.

Meredeth Turshen (1999), in commenting on the privatization of health care in Africa, has stated that the developmentalist contract has replaced the social contract. In terms of treatment access and health care, multilateral health care organizations such as the World Health Organization (WHO) and UNAIDS have consistently backed away from any measures that might threaten pharmaceutical industry profits, particularly intellectual property rights protection (Nguyen, forthcoming; Peschard, et. al., 2001). In fact, these organizations work closely with the global proprietary companies, under the UN-orchestrated Accelerated Access Initiative, where consultants are hired to negotiate pharmaceutical price reductions for individual nation-states. Through these negotiations, the companies can then gain exclusive market shares while simultaneously pressuring the receiving countries to adopt stringent intellectual property protection. Even with global companies drug price reductions, generic competitors still market antiretroviral products that remain lower in cost even after negotiations with big pharma. What truly drove the prices of these proprietary products down, sometimes by as much as 95%, was the very existence of the generics industry, a point rarely recognized by either the WHO or UNAIDS. The Accelerated Access Initiative, whether intentionally or not, in part undermines the success of these generic companies. Moreover, under the US Bayh-Dole Act, the WHO has had the opportunity to easily access proprietary
drugs, but has declined this option. This Act allows for the WHO to obtain expensive drugs that were invented under government patents and subsequently turned over to the private sector. The WHO has repeatedly emphasized the need for intellectual property protection, while at the same time advocating for the fair and easy access to drugs (usually called health care safeguards under trade-related intellectual property protection) in the developing world. However, this rhetoric has not actually come to be reality, as the WHO continues to cater to the interests of the global pharmaceutical industry and the current incarnation of multilateral trade regimes, favored by the US.

Not only does the development industry cater to pharmaceutical industry interests, but it also accommodates debt regime interests. Since the late 1980s, rescheduling debt to make payment more sustainable has continually failed, as rescheduling holds many countries to austerity measures that have not made a significant difference for the freeing up of public funds even under the HIPC initiative, discussed in chapter one. The US has probably been, at worst, the most hostile to debt forgiveness, and at least, unreflective of it policy conflicts. For example, at a meeting The Second Wave of the HIV/AIDS Pandemic (addressing the concern of new infections exponentially increasing in India, China, Nigeria, Ethiopia, and Russia) at the Center for Strategic and International Studies in Washington DC in October 2002, the Nigerian contingent gave a presentation on debt repayment and the need to free up the money for HIV/AIDS work. They included a proposal, created by a coalition of Nigerian NGOs, AIDS NGOs abroad and the Nigerian government, to convert one-fourth of its existing
debt repayment (about $500 million per year) for HIV/AIDS programs and treatment in the country. The last panel to address the conference was USAID who largely ignored the concerns and points that these countries shared and instead gave a rundown of the successful meetings that they have had in the five countries, how they have been leaders in this fight, as well as a breakdown of increased funding for HIV/AIDS. A respondent from the Ethiopian contingent said, Well, I have to report back to my local USAID office and frankly, I have nothing to tell them. When the Nigeria team pushed the issue of debt conversion, namely stating, if we just had debt conversion, we wouldn't need funding from USAID or the global fund, the point was ignored. One member of the team ran outside and tracked down the USAID respondent and said, you didn't answer my question. The USAID official replied that it was not her area and that she would put him in touch with someone else who could help.

While in the field, I discovered that USAID is funding both AIDS activism as well as the US Department of Commerce to assist Nigeria in complying with the Trade Related Intellectual Property (TRIPs) Agreement to which Nigeria is a signatory (discussed at length in the chapter three). TRIPs gives proprietary pharmaceutical companies exclusive twenty-year manufacturing, pricing and distribution rights on their drug patents. The US has submitted its own drafts of a new Nigerian intellectual property law to the Nigerian government. The drafts clearly show that the US desires a law that favors US businesses while it wipes out legal provisions to import less expensive generic drugs. This is an act usually referred to as TRIPs-plus because the
TRIPs Agreement does allow for health care safeguards, which are options for legal provisions that secure the possibility of importing lower-cost generics. Nigeria still has not complied with TRIPs, but is expected to do so in the next year. The outcome of compliance will in part determine the future of generic drug access in the country. But more importantly, it will stipulate whether the government's free antiretroviral program that serves 15,000 PLWHA will remain legal. Nigeria sources all of its antiretroviral drugs from the generic company, Cipla, in India; and the US and some European states are currently pushing to outlaw exporting generic drugs. While USAID funds the US Department of Commerce it simultaneously funds a great deal of local AIDS NGOs to carry out prevention and education programs. To some AIDS activists, there is the appearance of a USAID policy contradiction which supports AIDS activism yet also works to severely curtail drug access. But there may not in fact be a contradiction, as prevention and education campaigns are located in the realm of individual empowerment and responsibility, drawing attention away from the legal structures that generate obstacles to pharmaceutical flows.

AIDS activists and NGOs have objected to the relationship between the Nigerian and US governments. But this relationship demonstrates a conflict that the state itself has with multilateral organizations. That is, the state opposes US and European stances on treatment access at global trading negotiations, but at the same time attempts to meet the pressure to comply quietly behind the doors of federal ministries. This represents an increasingly common strategy utilized by the US, whereby a) it capitalizes on the lack of communication between
ministries, and between ministries and Nigeria's Geneva representatives, and b) bilateral and regional (trade or otherwise) agreements become the alternative avenue and means for compliance when global negotiations continually fail. Yet, the difference between Nigeria's position at global negotiations versus local implementation, represents the state's conflicting desire to be more squarely inserted into the global economy. At the same time, the Nigerian government represents itself as one of Africa's leaders in the fight against AIDS that includes fulfilling promises of an imagined social contract, including treatment and care, to especially people living with HIV/AIDS.

These examples of the development industry's working relationships with debt and trade interests are but a small indication of the resistance on the part of creditors to convert or eliminate debt. But such actions must be contextualized in a broader structure whereby international development organizations represent the same interests of creditors, as both the bulk of AIDS financing comes from the very same countries who administer and receive yearly debt payments (including the World Bank, Paris Club, and the US).

I argue that multilateral organizations that are in the business of AIDS development come to diplomatic agreements or understandings that recognize and interact with the regulated flow of capital via trade and debt regimes. Here, the development industry is committed to, and part of, what could be called a regulatory contract for which pharmaceutical capital and the HIV body are regulated as distinct and separate spheres with little overlap between the two in Africa, leaving treatment options unattainable. In enabling the cohesion between
debt and trade regimes, the regulatory contract positions the development industry within a very narrow frame of options in dealing with the AIDS epidemic; and the most favored mode of development intervention that leaves the regulatory contract, and thus capital flows, completely intact are HIV prevention and education strategies. What this means is that, while HIV infection is recognized by the development industry (and by NGOs in Nigeria) as an economic, social-cultural, political and indeed Africa's greatest development problem, it is rarely recognized as a medical problem that requires proper treatment interventions. This leaves HIV constructed not as an infection, but rather as a curse or taboo. Certainly prevention and education make up part of any medical paradigm. That is, unwanted pregnancies, heart disease, and even malaria, for instance, stress prevention strategies, but for all of these medical issues, treatment constitutes part of the medical paradigm. Therefore, I am asserting that without treatment options included in health care paradigms, HIV/AIDS cannot be fully constructed as a medical problem in Africa.

Preventing HIV as a singular and narrow focus via condom use, abstinence, and education, as this chapter demonstrates, will perhaps stand next to other great development disasters such as dam building and food drops. One activist went so far to tell me that education campaigns as a singular approach are nothing more than an imperialist agenda. Furthermore, the very absence of treatment generates other biologically located concerns such as stigma and discrimination, questions of biological citizenship, and human rights violations. And it is these concerns that largely consume AIDS NGOs, for which they either
cooperate or become embattled with the state. An AIDS activist working in the public schools:

In Nigeria, AIDS is still a question of being defined as a punishment. You follow? Irrespective of the manner of the acquisition of that illness, it is just an illness. And once we get to that point where it is defined as an illness in its entirety, then we will be able to solve a lot of the illness. But there's so much social issues connected with the illness, that it loses its face as an illness, and now becomes a social problem.

In Nigeria, there is no international development agency that includes treatment and care as a primary means to combat the virus. There are NGOs in the country that have minimal treatment options, but usually only for opportunistic infections, and even those funds are limited to the treatment of handfuls of PLWHA at a time. As will be seen in chapter four, the availability of medicines to treat opportunistic infections is extremely limited by both cost and availability, and therefore, beyond traditional healer treatment options, NGOs, and clinical trials become the primary avenues through which PLWHA attempt to find and source drugs. Moreover, the Nigerian government began one of the first federally sponsored antiretroviral programs (for 10,000 PLWHA) on the continent and currently there are no external matching or contributing funds for this project.

Through the production of a non-medicalized AIDS paradigm, the regulatory contract represents and produces relationships between NGOs, the state, and the development industry that are organized around prevention and education agendas, which accommodate the inflow of transnational AIDS money for these purposes. Foreign aid money allocated to NGOs has generated an elite NGO class aligned with the development industry that views their relationships with successful NGOs as lucrative. This has empowered both NGOs and
foreign aid organizations to put pressure on the state to build new state infrastructure that accommodates these prevention and education agendas, becoming a wheel in the anti-politics machine described so well by James Ferguson (1990). As one UN project coordinator told me:

the fear that I have is that a number of us are just talking and not doing anything. And we’re training more and more people about talking about it [HIV/AIDS]. So you’ll meet thousands of people in this country who are saying we’re doing peer education, but what does it do? What is the message that goes out? Abstinence. Does it work for you? Not at all. So a lot of money is being put into that.

*AIDS Development and AIDS NGO Activism*

Since the fall of the military regime under General Abacha in 1998, Nigeria has seen a return of international organizations, such as UN agencies and NGOs. As a result, financing has enabled a number of new Nigerian NGOs to spring up mostly in urban areas. The relationship between HIV/AIDS activism and development has been a primary concern of these NGOs. The new civilian regime has displayed equal concern by demonstrating relative openness and sensitivity to the problem of HIV/AIDS in the country at the national level although less so at the state and local government levels. Several foreign organizations and institutions are newly financing HIV/AIDS work, enabling a new form of AIDS activism to emerge, organized primarily within local NGO structures. By 1999, a variety of AIDS activists came together, many (but not all) of whom had either human rights activist or military backgrounds. Although these were two contentious groups under the former regime, military personnel and human rights activists are now literally working in the same offices and multi-ethnic coalitions. The civilian government and these latter organizations and
institutions have all recognized the urgent need to build and renovate medical infrastructure for the delivery of medicines to people living with HIV/AIDS. Yet, actors in these different institutions frequently disagree about methods and priorities, about how best to cope with external debt and trade rules impacting drug access, and even about what sorts of problems the HIV/AIDS epidemic poses.

There are currently over 1000 AIDS NGOs in the country. During the Abacha era, there were significantly fewer and there was no structured funding system. NGOs were on their own in terms of soliciting small amounts of money to run local operations. But since Obasanjo came to power in 1999 and the institutionalization of democracy, NGOs became coordinated into networks and along with the availability of large funding pots, more donors and money have entered the country. The national development of NGOs came about due to the lack of government AIDS programs in place and they have assumed an important function in providing assistance to PLWHA. Moreover, creating NGO structures in localities was viewed as needed to lobby government. In 1999, the Civil Society Consultative Group on HIV/AIDS in Nigeria (CISCGHAN), the largest AIDS NGO network in Nigeria, was founded, which pulled together a core group of NGOs to negotiate for increased space in making country-wide policy decision on AIDS. CISCGHAN continues to sit at all meetings that include both funders and government and has direct input into policy making. Additionally, it linked up with other NGOs and community-based organizations around the world, as
well as with African AIDS networks. The current vision is to create a continent wide network that could lobby the African Union.\textsuperscript{13}

The primary activities of AIDS NGOs are to conduct prevention and education campaigns, for which funding from the international organizations is allocated. (There is virtually no money allocated for treatment or the rebuilding of medical infrastructure.) The education campaigns include many activities such as community education workshops, condom demonstrations in large transport depots, meetings with private sector officials on HIV/AIDS, art and performances, school presentations, youth activism, counseling PLWHA, and doing outreach in markets and other highly trafficked areas, to name a few. Or there can be occasional spontaneous street discussions. For instance, one night two AIDS activists, Wole and Bisi, came by my place to go visit a friend of theirs nearby. We sat outside drinking beer and coke, talking to the friend's brother who was curious about their AIDS work and how they came to find out that they are HIV positive. A man approached with a Bible asking if he could preach to us. In absolutely no mood, I said to him, you can, if you can tell us what you think Jesus would have to say about AIDS. Not two minutes into his spiel, and what seemed like a competition for preaching topics, Wole took over the Bible agenda by asking the man, excuse me sir, have you ever had unprotected sex?

Awareness campaigns also comprise HIV/AIDS agendas, as some Nigerians believe that AIDS does not exist. For example, I was once in a taxi going to a youth conference in Lagos on HIV/AIDS. The driver asked me what I
was up to and after I explained he said to me that AIDS does not exist. He told me that he believed that malaria existed because you can see the mosquito.

An AIDS activist on HIV awareness:

In terms of information, education, and general awareness, it is definitely worse in the rural areas. The link is not even there in the first place. Most of the NGOs we have in the country are urban-based. The government is doing little to nothing in the villages and the rural areas. You'd be surprised that in some parts of this country some people have not heard anything about HIV/AIDS before. Because superstition is still very rampant in the rural areas, the people who are positive there, or have features of HIV/AIDS, are often considered a victim of witchcraft or some form of enemies, and all the rest. So ignorance is still high in the rural areas. There is no doubt about it. If we look at the statistics in Nigeria, you see that the North central part of the country has the highest prevalence rate. That falls so much with the prevalence rates of an uneducated people in Nigeria too. Some of them live in villages and farms, very far away from the town, and so they're not getting information.

Disbelief in the existence of AIDS is not uncommon, and neither is the conviction that the West invented HIV, that is, not as a discursive invention, but rather a genetically engineered one. The most incredible public articulation of these sentiments that I had the pleasure of witnessing was made by Libyan president, Muammar Al-Khadafi, at the OAU African Heads of State Summit on HIV/AIDS in June 2001 in Abuja. Khadafi was designated to give the vote of thanks, usually a ten-minute closing remark speech that he extended for forty-five minutes, in which he systematically debunked the green monkey (HIV teleological) theory in favor of CIA invention, a moment in the speech that prompted the US team to leave the premises. (He also critiqued the conflicting interests between public health and pharmaceutical industry profits.) Many Nigerians and other Africans asked me what I thought of the speech, their
questions laughingly, perhaps nervously, implying that the man is a bit crazy. But when I told them that it was the highlight of the meetings for me, their approach changed and they talked about why such a speech was so uplifting for them. This was mostly due to the perception that the West is not actively intervening in the AIDS epidemic when it has the means to do so. With large numbers of PLWHAs and the millions who have died or have been left behind as orphans, the explanation that the pharmaceutical industry or some Western scientific institution is engaged in a conspiracy becomes one of the best possible explanations for the inattentiveness to what is often referred to as genocide. Moreover, beliefs in the non-existence of HIV/AIDS or the widespread belief in a conspiracy is most prominent in environments where HIV/AIDS is not treated or constructed as a treatment/medical problem.

As factions during post-independence competed for state power and for direct access to wealth, AIDS NGOs now compete for and access power and financing through the development industry. AIDS activists located in NGO structures, who at one point may have previously been working in institutions such as the military, health care, or studying at a university, now have access to funds and indeed power previously unimaginined, especially for the leadership. Flows of new funding also generated access to high levels of political leadership and indeed transnational AIDS networks along with international travel, previously unattainable. This has created the rise of an NGO elite class and an exploration of the possibility of new societal relations.
Mohammed Auwalu Farouk was a soldier in the Nigerian army during the Babangida and Abacha military regimes. He guarded the current head of state, Olesugun Obansanjo, while he was imprisoned and also worked for military intelligence. One night in a bar, he told me the story of how he got out of the military. Mohammed's wife Lucy, became pregnant with twins. She went to the hospital to seek prenatal care and undergo an initial exam that included a compulsory HIV test. She was discovered to be HIV positive and so Mohammed was immediately tested. Once the army found out that he was HIV-positive, his superior locked him up in a shed every time he reported for work. After nearly a week of this, Mohammed got a knife and threatened him. It was a bloodless incident after which his sergeant let him go. At this point, he legally escaped from the army, which he described as dashing down a narrow path when everyone's backs were turned. With no support from the military, he went to the internet and typed the acronym AIDS in a search engine and he was shocked when nearly four million results were retrieved. He read everything he could about HIV/AIDS and shortly formed the Nigeria AIDS Alliance, which to this day receives generous funding from international donors. Mohammed was one of the first people to come out publicly as HIV positive in Nigeria, began to circulate in the highest levels of government, and by July 2001, was dining with Obasanjo, the former political prisoner whom he guarded ten years before. He also addressed the OAU Heads of State Summit on HIV/AIDS.

During the Eid Al-Adha holiday (marking the end of the Hajj season) I was with Mohammed first in his office and then later in his barracks with him and
his wife, where they were still living, a year after he left the army. They showed
me pictures of their traditional wedding and he pointed to her belly and said
those are the twins we lost (in a bus accident). He had slaughtered a ram earlier
in the day and we took a dressed leg to the beach where we would sit with several
other AIDS activists and have some beers. There is a fee to enter the public
Lagos beach but Mohammed pulled out his (inauthentic) military ID, stated he
was in charge of this entire patrol, and got us in for free. The beach is a very
lively place with a long row of shaded outdoor bars, loud music, barbecue,
horseback rides, and musicians moving up and down the beach. There are people
selling everything possible from candy to secondary school practice exams. One
Rastafarian came up with his guitar and played for about twenty or thirty minutes.
After he finished we asked him to join us along with a few other musicians.
Stella asked the guy if he knew about HIV/AIDS and how people get it. He said
something about contracting it from animals and but thought that one couldn’t get
it from sex. She asked if he had ever met anyone who is HIV-positive. He said,
no. Stella replied: Well, over half of the people at this table are HIV-positive.
Mohammed then looked at the man and said, Do you recognize me? Do you
know who I am? The man replied, yeah, you don bust us up (you arrested us
[for drugs]). Yeah, I was the one who did all the cleanup around here. What
happened to Baghdad Charlie who used to sell cocaine down there (pointing to
the other end of the beach)? The musician replied that he’s not around and he’s a
very stupid guy. Mohammed said, No man, Charlie is a very smart guy ... but
this is all beside the point, my friends, because we’re talking about AIDS and
AIDS no dey show for face (you can't tell if someone has HIV just by looking at them). I will tell you right now the you have shaken the hand of people with HIV/AIDS and you have taken money from them. Then Stella cuts in and says, you could really deliver an important message if you get the right information. I want you to come to my office, and she gives him her card. Then Mohammed start singing AIDS is real, AIDS is bad, AIDS is bad and it can kill. AIDS can wipe out entire generations overnight, protect yourself and join the fight. A drummer then joined in the jingle with a musical improvisation. Then he called the guitarist over and Stella laughingly demanded AIDS music. The guy already had a rift to play that started like this: Daddy no vex over dem condom you don find in girl purse. Her sugar daddy don give her, to protect her sexuality. (Daddy, don't fret because you found a condom in your daughter's purse. Her sugar daddy gave it to her to protect her from AIDS). This was the gist and they played and played. The guitarist then told us that the song was already recorded on a CD and that he even went to the U.N. to give it some play. They weren't interested and he was totally frustrated by this, and my immediate feeling was that the UN could not handle the lyrics or were simply dismissive of any prospect. The song was actually quite a progressive vision because it's not often that sugar daddies will agree to use condoms at all (and certainly sugar daddies do not comprise the development industry's list of social groups who are at risk for getting AIDS). Girls and young women who come from poor families find themselves pursuing sexual liaisons in which they can get money for basic needs like food and clothing and in some cases a nice Western-like lifestyle; that is, multi-partner sexual
relations are often structured by economics. Even university women, market women, and elite professionals are forced into similar situations and for those who land a good sugar daddy may feel entitled to an apartment, car and full maintenance.

Gender relations often receive many nods (in public, it might be referred to as gender equity) by male AIDS activists, but one night when I went out for some pool with Mohammed, he said in a conversation about gender, this is Africa, a resignation that gender equality is just a vision, or a form of rhetoric he picked up from his funders, and not tangible either personally or in society at large. We left when it started to rain.

The state, in turn, is reorganizing, described more thoroughly in chapter one. New bureaucracies under existing structures are being created in order to address the epidemic, again primarily for prevention and education efforts. Nearly the same time that CISCGHAN was founded, the government created the National Action Committee on AIDS (NACA), which answers to the presidency. Concomitantly, the state and local government areas created action committees (LACAs, SACAs). Numerous policies pertaining to HIV/AIDS has been developed including the HIV/AIDS Emergency Action Plan (HEAP), a five year plan financed by the World Bank, the Nigerian government and others, as well as HIV/AIDS National Policy. Plans to rebuild primary health care are being discussed and initial plans have been implemented; some are arguing that the state health care system reorganize itself so that HIV/AIDS is at the center of these
programs. Moreover, several discrimination lawsuits are entering the courts, challenging the state to declare that PLWHA are full citizens under the Nigerian constitution.

Together, the state, development industry and NGOs make up an emergent biopolitical formation. This formation reveals that a culture of calculating HIV subjectivities and scarce funding for a large population that is competing with other kinds of biopolitics, namely human rights concerns, biologically located, and lack of treatment availability. In the absence of an AIDS medical paradigm, lack of appropriate medical infrastructure, and constructing prevention and education strategies as a singular strategic approach to the epidemic, human rights abuses and a lack of awareness and proliferate. NGOs then become consumed in addressing these issues, leaving treatment nothing more than an idealized vision.

An AIDS activist comments:

I do not think that their [development industry] response is right at all. There is no prevention campaign that you can do, that can make people change their behavior, except know that there’s something on ground to take care of them [referring to treatment access]. Trying to propagate prevention campaigns will continue to moralize the issue and see people who are infected as being atavistic or being morally inferior, or being deviant of sorts. It cannot help issues. It can only make issues worse and as a matter of fact that’s what is a gravitating the epidemic. And I don’t believe that the people from other parts of the world—I mean Western Europe and America—would continue to indulge in all these hypocritical sympathies until everybody dies off in Africa.

The words most commonly used by AIDS activists, although less often by funding agencies, to describe the relationship between local NGOs and foreign aid institutions were master/servant. This issue does not necessarily polarize funders and NGOs, as many workers for the development industry recognize the
problems of their own strategies. While funding organizations do often set the agenda, the notion of master/servant is far more complex than its dichotomy may suggest. One project manager working for the UN explains by analyzing the state of NGOs in Nigeria:

Well, they're treated as charity organizations. And the one who gives is the master and the one who takes is the servant. That is the way some funding relationships work and the working relationship is also like that. There are all these [funding] proposals [points to a huge stack of documents about one-and-a-half feet tall, on her desk] that I have to look at. They are coming in tons and tons and tons. And most of them ask the question "what you want us to do? And if that is the case, that means that there's nothing on the ground because a non-governmental organization needs to be grounded in a society for which they look at the needs of that society, and say okay this is what we want to do now--who is the agency that is going to support us in this work? It doesn't happen like that. I have money, I want to spend it, I want to find an NGO who wants that money, I will give them instructions on how to spend that money, and they will spend it. So there's no accountability.

What does it mean for NGOs not to be grounded in a society? Perhaps two issues could be explored here. First, establishing an NGO in Nigeria is often looked upon as generating profit, and both funders and NGOs are aware of this. Such lucrative opportunities have been available in the past, but with the ushering in of democracy and the discovery of an AIDS explosion since the early 1990s, more money is now available to start up NGOs. The same UN project manager recognized that accessing an additional income is contextualized by that fact that government salaries are low (if at all paid), by the declining economy, and by the system, meaning basic infrastructure like electricity, telecommunications, and health care, as well as state bureaucracies and even the private sector, do not function. So if I am a fake NGO, what will I do? I will not work. I will just take somebody's money and take it and send my children to school or feed them and
that s it. So the material basis, required for this worker s consistent reference to ethics, does not exist.

The second issue is an interesting socio-cultural one that an AIDS activist working with youth pointed out to me: Nigerians have not identified with HIV/AIDS because they have not yet identified with themselves. He interestingly explained this to me through an analysis of Nigeria s major crises. He told me that when there is a riot or when vehicles begin to cue up at petrol stations (due to fuel shortage), everyone knows about it from the man on the street or the woman in the market, and they all begin to panic. (This is something that is not simply witnessed by an ethnographer as an isolated event, but certainly witnessed and experienced as an ongoing, if not daily, experience that generates a discourse of suffering). My friend referred to this as a collective reality with which everyone can identify, that is they are all in it together now. Even though HIV/AIDS has affected nearly every family in the country, and certainly every community in Nigeria, no one panics, as HIV remarkably remains the invisible and silent threat, even though everyone may be in it all together. When HIV/AIDS comes to light, the rise of stigma, discrimination, and human rights violations not only represent this lack of self-identification, but also may in fact mirror the very sentiments over the disjuncture and questions of what Nigerian unity actually constitute (discussed in the introduction).

An AIDS activist on NGOs:

NGOs are doing their best. Their best as defined by their funders. That is the best way to define it. It’s just that to gain relevance, NGOs have now made themselves the solution rather than the means to the solution. Because everybody wants to be seen now as doing something, and so what they now do to achieve that is address or direct all activities in their own
environment, such that they are identified as the solution. So if you want to talk about AIDS with these people, rather than saying that this community is doing it for themselves and this NGO is facilitating it, they are now saying that it is this NGO that is doing it. And that is wrong. And the funders, this is fine with them, because the funders want to see the NGOs working in the communities, attracting all the community to themselves Rather, what I would have thought was, well, this is our problem, this is what we can do, and try and build from our mistakes. People are willing to fund a mistake but not willing to fund a solution.

Prior to the entrance of transnational AIDS money, most AIDS NGOs worked for several years in communities in which they evolved mechanisms that work for their environments. Even though they have been working in limited ways due to lack of funding in the past, many small-scale projects have been, according to many, quite successful. With the arrival of donors AIDS agendas, lengthy reviews and assessments have been conducted in which funds were offered that do not cater to the needs of the community. This has not only altered the profiles of NGOs but has also created a new community of people PLWHA who are not dissolved into local communities, but rather polarized out of community settings. Some AIDS activists have commented that this kind of polarization actually generates further human rights violations, as the community is left without any awareness building strategies. The result of new funding structures is that NGOs struggle to secure money by trying, as one activist put it, to get a roll-call of people living with HIV/AIDS to themselves. This leaves the funders no choice but to work with an NGO that claims to have high numbers a strategy that is viewed as problematic by those NGOs or community activists who receive little or no funding from the multilateral institutions.
You now see non-governmental organizations fighting for people living with HIV/AIDS, whereas there’s no NGO in Nigeria that can boast of the thousand people living with HIV/AIDS. There’s not one. What they have are trickles of 30, 100, 200, at best 500 people that they really have even made contact with. Whereas in the communities where these people come from, you have over 300,000, 400,000 people living with HIV/AIDS and are not even getting any attention.

There are two primary reasons why prevention efforts are being paid to relatively few PLWHA in Nigeria. First, the funding structure itself enables these relationships. In order to receive develop funding to do any HIV/AIDS work, an NGO must be registered with the government. Several people I know who are not working in NGO structures but are instead simply conducting AIDS organizing via community-based organizations, tell me that it costs too much to register and they end up becoming volunteers in their own work. Moreover, one must have a board of directors, and ideally, but not prescriptively, should have an office and a professional staff, which incurs further costs. So the money that is allocated to NGOs becomes primarily a business relationship with project disigns and proposals. The more PLWHA and successes that an NGO can claim, the more lucrative it is for an international organization to work with these local NGOs. Therefore, the idea that one should access a community, rather than handfuls of PLWHA coming through NGO offices, is something that the funding structure completely impedes.

Furthermore, a hierarchy of worthy NGOs, determined to be such by the funders has also been generated, with the exception of the more recent World Bank loan. For example, the Ford Foundation gave its largest funding to a Lagos-based NGO and would only grant money to smaller NGOs after clearing it with
the leadership of this NGO. Without being familiar with the internal politics of this NGO, about which a great deal of dissatisfaction was being expressed by its members on how the leadership was managing its activities, these financial politics only further exacerbated divisions among members and indeed between it and other NGOs competing for similar funding. At one point, this same NGO received an additional generous grant from Ford and the leadership went to Cotonou, Benin to buy three new vehicles, including new SUVs, declaring that the vehicles were for the office. This very much angered the members who wanted to be able to at least secure bags of rice after their monthly meetings.

The second issue has to do with how the notion of impact is defined. The ability to reach PLWHA in the community is one of the greatest markers of impact. But what actually happens once those people are reached or once they come into these offices? The best that many PLWHA can hope for in seeking out AIDS NGOs is some counseling, finding someone to talk to so that they know they are not alone, perhaps retaining community, family or workplace intervention when encountering stigma and discrimination, and in very rare instances finding medical treatment for opportunistic infections. If PLWHA get actively involved with NGO activities, there is the possibility of seeking employment or at least participating in workshops and conferences where further contacts can be made for individual and other purposes and per diems can be used to secure medical care or other financial obligations.

Finding someone to talk to is perhaps the greatest service that NGOs can offer. In the absence of medical treatment, they are one of the last spaces of resort
for PLWHA who feel depressed and isolated, with the stigma and indeed human rights violations that they encounter and endure. As one counselor in an NGO told me:

When we have clients that are afraid, that they’re thinking that they will soon die, and when I’m called upon, and they see me, I tell them that I am HIV-positive. It helps to give them courage to see somebody who is still strong, and able to do some work, gives them hope.

But very occasionally, the level of disclosure is limited, as some PLWHA often just wanted to talk on the phone or even wanted to talk to me instead. Indeed, my cell phone number did get passed around, at first without my knowing, and I received calls from people, most often when a family member was close to death. This desire to speak to me was due to my former life as a counselor in US shelters, but more importantly it was also due to the fact that as an outsider, I am not subject to the disciplining of local social norms or the circulation of gossip, and therefore was also privy to the internal problems of NGOs.

The presence of HIV/AIDS in the country and the financing of prevention and education strategies have led to the creation of support groups that are based upon Western counseling models and directed primarily by NGOs. Vinh Kim Nguyen (forthcoming) found that support groups in Cote d’Ivoire were not very successful as they contrasted with any cultural precedent that would enable PLWHA to engage in a process of disclosure. However, in Nigeria, support groups were often far more dynamic, perhaps due to a common public discourse of suffering. As stated in the introduction, suffering is verbalized only in its relation to public discussions of democracy, or democracy dividends. A personal disclosure of suffering is not necessarily part of a rehearsed or common
parlance, but rather, suffering is formulated through the usage of vague pronouns or referents such as they or people. Also, it is constructed in abstract ways such as how people can't eat, or how there are no jobs available. Rarely do people speak from personal experience and substitute people for I or no jobs available for I have no job in public spaces. The support group is a space where the expected verbal boundaries around suffering and democracy have been opened up. This is due to perhaps two reasons. The first is that facilitators who are influenced by Western models of disclosure and talk therapy encourage people to tell their stories, especially if a facilitator is HIV positive and shares his or her own experience. Secondly, because the support group is one of the few, if not only, spaces to talk about HIV, disclosure becomes entirely permissible. The entire purpose of a support group is to do what its name implies give and receive support for stigma and discrimination and human rights abuses that proliferate in the absence of a medical paradigm. Indeed, in nearly all my discussions with PLWHA who are affiliated with NGOs, I was told about how they have lost their jobs and homes, how their children were expelled from school as a result, and about abuse and attacks encountered by neighbors and medical workers.

In January 1995, John and Angela Ibekwe celebrated their traditional wedding. A couple months later they were to have their church wedding in Onitsha. The Catholic Church required that they undergo compulsory medical tests, including an HIV test without pre- or post-test counseling. Angela was found to be positive and John negative. The Church told them that the wedding
would not be conducted but after both their parents insisted, the Church conceded. The archbishop, with whom they both became close, referred John and Angela to an Argentine doctor who was implementing Family Health International’s community-based home care project. Their situation improved and several years later, John became the program officer for this program, which is now an NGO in Onitsha, the Humane Health Organization. Later that year, Angela won an American visa in the lottery and they were instructed to go to St. Nicholas hospital in Lagos to conduct medical tests, including an HIV test. Angela tested positive and, this time, so did John. They were denied US visas based upon their sero-status, as the US discriminatory practices do not permit PLWHA to enter the country. Soon afterwards, John attended a national meeting on HIV/AIDS in Nigeria and he granted press interviews that were widely published in Nigeria. His employer heard about John’s sero status via the newspapers and subsequently terminated his appointment, giving him two months salary in lieu of notice. During this time, Angela became pregnant which coincided with the 1998 World AIDS conference in Geneva that John attended and where for the first time, he became familiar with preventing mother-to-child transmission. He saved enough money from his food allowance to buy ARV medication for Angela and the baby. Upon returning to Onitsha, they had a long and rather drawn out battle with the hospital staff to administer care for Angela as she was abandoned in the clinic due to her sero-positivity. But eventually, the baby was delivered by caesarian section and, nearly five years old now, remains HIV-negative. During his first trip to Nigeria in September 2000, President Clinton heard John give a talk on his own
story at a large gathering on HIV/AIDS in Abuja. Clinton reports having been so moved by the talk that two weeks later he invited John as well as President Obasanjo to attend the United Nations Millennium Summit in New York. John told me that when he went to the US embassy to get his visa, the first question that asked was: Why do you want to go to the United States? He replied, It's not that I want to go, but your president has invited me to come visit him and I have accepted his invitation.

But perhaps what has been unforeseen in support groups are the dialogues that move out and beyond them. The issues most discussed in support groups, at least in Lagos, were the inability to procure medicines for opportunistic infections and if able, the inability to eat properly while taking drugs. In other words, the stress and the desire to relieve poverty and access treatment were at the heart of these discussions.

The eventual vision for support groups is to establish them throughout the country and procure medical care that can be easily monitored. But in the meantime, support groups aim to help PLWHA live positively, meaning how to provide nutritional and medical support, something hard to accomplish for most; how to resist internalizing stigma and discrimination; and creating epidemiological awareness. Living positively also includes the ability to practice safe sex and to create educational paradigms that are based on Western models of HIV prevention. Even though NGOs give instructions on condom use in a number of different public and private fora, there are plenty of obstacles that
impede this aspect of living positively and indeed constitute, in some cases a resistance to the regulation of the HIV-positive body. A former military medical doctor on religious obstacles:

there must be massive education, so that so that we can begin to educate on behavioral change. People who do not believe [that HIV/AIDS exists] yet will not change their attitude. I went to a church to deliver a talk to the pastor and the other members of the church, and they’re still so worried about talking about condoms because--I understand what they’re saying--that they do not allow casual sex. OK, but I was telling him that we should not close our eyes, you have been preaching over the years, and you been telling your laypeople to abstain from casual sex, but if they are not abstaining, should you just leave them and let them die? I was trying to tell him that he must still teach them the right things --in order to live right, in order to avoid [the virus].

An AIDS activist who works with youth:

for every new infection, half of it are young people between the age of 15 and 29 years or so. You know? And I know that half of Nigeria’s population is in that category of people, which makes the whole thing ridiculous, you know? And it’s very unhealthy to see what Nigeria will look like in another five the six years. It is quite disheartening. I think the youth are really, really infected. They are really infected considering the fact that sex is being peddled on the streets like they peddle biscuits. Yes.

When I asked him why he thought sex is peddled on the street like biscuits, he responded in the same way that many others, including both AIDS activists and the development industry, respond about children, poverty, and sex.

[In our society] the changes so far have made a need for both parents to earn a living and as a result the child is also expected to earn a living. You understand? The child is not given that parental guidance and care. Particularly, the child is not even equipped with the resources of life. The skills to handle situations of life. And because of this, the child now has to explore firsthand, a lot of issues. And it is a sad that those times is when they have to come into contact with those experiences [sex work] that brings them into contact with HIV/AIDS.

An medical doctor and AIDS activist on condoms:
How long can you tell somebody who is physically mature, who is biologically prepared for reproduction, to abstain from sex, just because of the social under-development of society has been imposed on him or her? For how long can you continue to be able to mechanize sex [through condom use]? It won’t work. Condom cannot work. They must reorganize society, people must have jobs, they must be educated, people must have social security. They must be able to eat well, they must be able to clothe well, they must be able to recreate themselves. Because of the way society is disorganized, recreation is not there again, leisure is not there again, and sex has become the cheaper one to indulge in. And they still say we should mechanize our sex. It won’t work and it is not been working as far as I’m concerned. We need to be more frank with ourselves if this epidemic will not wipe out people in time.

Indeed conducting education and prevention campaigns and living positively are seriously ineffective under the regulatory contract that is limited in defining HIV/AIDS as a primary medical urgency. In the same way that modernization theory ignored the specificities of political, social, and economic context, the regulation of the HIV-positive body assumes potential success, devoid of socio-cultural and economic constraints. While there is much talk, and indeed much financial investment, committed by the development industry toward analyzing these constraints, little is done to actually radically redraw strategic approaches to HIV/AIDS. One reason for this is the problematic way constraints get determined. Prescribed answers to HIV answers that conflict with policy or problematically ignore methodological problems are tied to the divide between drug capital flows and African HIV-positive and HIV-negative bodies. On the one hand, the development industry produces beliefs about HIV that coincides with its contractual obligations to regulate capital flows and on the other, PLWHA articulate the problems and challenges of HIV that coincide with the reality of their lives, a topic to which I now turn.
Poverty and Differing Beliefs about the HIV Crisis

There are both common and divergent beliefs between the development industry and NGOs on the root factors contributing to the epidemic. If the development industry and NGOs are in agreement on these root causes, often the details or understanding of how these issues play out do differ. These beliefs include: ignorance, lack of jobs, gender inequality, lack of human rights, multiple sexual partners, the increased vulnerability of certain social groups, constraints on government, early-age sex, blood transfusions, and poverty. This section focuses on the last of these poverty in order to show how development industry beliefs on the relationship between HIV and poverty are largely flawed.

The configuration and role of poverty put forth by the development industry and AIDS NGOs is one of the main issues that demonstrates conflict between the two. The development industry's official line is that AIDS worsens poverty (although some workers, especially in UNICEF, do contend this) and for those living with HIV, poverty is the very precursor, or risk factor, to HIV. I assert that both are true, but it is important to note that the development industry's notion of the relationship between poverty and AIDS is generated by the regulatory contract and becomes not only the primary means to intervene in the epidemic, but also structures the funding agendas and working relationships between NGOs and the development industry. That is, because poverty is believed to be the end result of HIV infection, the call for poverty alleviation programs by NGOs largely go ignored by the development industry. Calling for poverty reduction in a serious manner would mean examining the processes of
capital flight patterns, something that the development and other industries are unwilling to do.

The arguments against poverty as a precursor to AIDS are as follows: the probability of having a non-regular or commercial sexual partner rises with education, potentially increasing exposure to contracting STIs, including HIV. The demand for commercial sex and/or the ability to support multiple partners would rise with income. Also, persons with higher education and higher incomes have more disposable cash and are more likely to travel thus having more opportunities for casual sex. (Adeyi, et. al., 2001:43; cited especially are Ainsworth and Semali, 1998; Deheenefee et al., 1998; Filmer, 1998; the first two sources are from the same volume of background papers for the World Bank. Interestingly, the background papers in this volume, which draw stronger links to poverty as a precursor to HIV infection, are not mentioned).

The early studies on HIV do show that there is an increase in HIV infection among elite or those with higher than average income, meaning that disposable cash is available for what is usually referred to as commercial sex or non-regular partners, and less often referred to as steady multiple partners that can serve, especially for women, as a sustained means of financial support. But the methodologies of these studies assume a number of problematic issues and, for sake of brevity, I refer to the ones cited above by the UNAIDS document AIDS, Poverty Reduction and Debt Relief. First, the sweeping notion of commercial sex work needs to be theorized as a small part in a larger economy of casual and multiple-partner sex. The basis of this economy is the economic disempowerment
of women, which UNAIDS and others certainly acknowledge, but there are far too few analyses in the development industry as to how gender disempowerment actually materializes to generate increased likelihood of HIV infection. In Nigeria, even elite women are faced with incredible obstacles. For example, without connections a woman coming out of university will be faced with the choice of giving a number of sexual favors in order to land a job. More than likely, sexual favors are not a guarantee in a country of deep high unemployment, but rather just an entryway to an interview or a let's talk situation. In fact, my housemate, at the time I was in the field, was looking for a job for a year and a half, and each and every time, sexual encounters were expected even from the middle men who were to hook her up with the employer. At one point she was considering a job in a bank (not what she wanted) but the only option available to her was in marketing departments. And you know what women are expected to do in the marketing department, she once told me. For some of these women, getting a job is not dissimilar from making it through the university. I have heard countless stories of women who at university have been faced with shortages of money whereby the dormitories (called hostiles) themselves become havens of sex work. At the University of Ibadan, with which I was affiliated, men stand outside the hostiles with pictures of the women living there and those passing by can choose. Another example was told to me by my cousin who is a Catholic priest living in Ibadan, who got involved with a case on campus in which a young woman refused to have sex with her professor. Even with intervention, she failed her course and was not allowed to graduate.
One can only imagine what happens to women who are not elites. For women who are petty traders and working in the markets, they are rarely marked by the development industry as commercial sex workers but there is a silent common knowledge that they are hustling sex to make ends meet. Rarely are such women in a position to do condom negotiation. For example, a PLWHA in the navy, Ekpe, once told me about his neighbor who came to him rather distraught, after he found out that his teenage daughter was pregnant. The neighbor had five children and was living on N5500 per month (about $45). Perhaps, counter-intuitively, one of the first things that Ekpe asked him was whether he procures sanitary pads for his daughter. Surprised, the man replied that he leaves that to his wife. Ekpe then asked whether he thinks his wife has the funds for sanitary pads and then continued on by asking him, where do you think she is going to get the things she needs (implying that a sugar daddy is her most reasonable option)? Several months later, the baby was born with HIV infection and died within three months. The young mother died about five months later. For women, finding a sugar daddy is often the best avenue out of poverty and may provide the most lucrative chance for a steady income. Even for those who know the risks of contracting HIV, the immediacy of the moment getting food on the table or attending to other economic urgencies may compel poor people to take risky chances.

Even for professional sex workers, options outside of sex work are very limited. I spent some time with a young HIV-positive sex worker who was coming in and out of one of the AIDS NGOs. Through sex work, she has
supported her entire family parents and siblings who knew perfectly well how she made her money, but once she became HIV-positive, nearly all disowned her. The NGO was trying to transfer her out of sex work and into another viable occupation. One woman in this office wanted her to learn a trade and pushed the idea of being a tailor. I didn't blame her for not wanting to be in, most likely, a market setting under the beck and call of a mistress making less money than before. She wanted to do petty trade, although not as lucrative as sex work. She told me that someone had arranged a visa for her to Italy where she would do sex work but turned it down. Through our conversations, I could tell how torn, if not distraught, she was about this decision and most days I felt the sadness of the trap she was in. One activist commented in the state of sex work in Nigeria:

An average sex worker in Nigeria is involved in that profession because there's no other meaningful thing that can sustain her, or hire her. When you say that somebody's doing sex work, and as a result of that it is being condemned, what alternatives are provided? Education up until today in Nigeria is a luxury. People finish their schooling and they cannot get jobs. People are ill and they want to eat, they need clothing, they need a house and all of these things are missing. What is undone in terms of social security is that people will take to behavior that they use to sustain themselves. When we look at HIV/AIDS in general, it is the same story. There is nothing on the ground for them. And deviant behavior is what they call deviant here. Deviant in quotes. As far as I'm concerned these are just survival strategies.

Second, the idea that those with higher income and more education have higher infection rates needs methodological reconsideration. Taking the primary citation entitled Who is most likely to die from HIV/AIDS? utilized by UNAIDS as an example, Ainsworth and Semali (1998) argue that socio-economic status correlates with higher HIV infection rates, citing twenty case studies in the 1980s and 1990s. Their own study sampled nearly 4,000 persons in 800
households in Tanzania to which yearly income distribution ranged from $118 to $357, a range that does not represent elites, although it has to be assumed that the high end of this scale is what the authors consistently referred to as wealth. Also, they accounted for varying education and occupations such as farming, traders, fishers, and white-collar workers. They did not measure sero-prevalence and instead determined AIDS mortality by household members' descriptions of dying family member's symptoms from which the authors determined whether the family member was HIV positive hardly reliable data as symptoms cannot be naturalized under uniform cultural understandings. They show that those who died (9.6% between 1991-1994) had on average one year more schooling than those who didn't, although for women, level of education did not prove to be significant, which they do not point out. Mortality was drawn for age, occupation, and gender as well. Farmers were seen to be less likely to be infected, but the authors do not state that this may be due to the fact that they are largely land-based and lack the same kind of significant movement as other occupations, like transport and petty trade. What is telling here are the statistics for women. Merchants had the highest infection rate, followed by white-collar women, and farmers were last. Given the economy of casual sex and the disempowerment of women, and levels of movement, these statistics are not surprising, and the authors make no reference to these links.

Even though socio-economic status is positively correlated in this study with HIV infection, and is indeed the main argument of the study, the authors never account for income variables with the virus. Moreover, education and
occupation are naturalized into an income status. Here, education is considered significant because it is assumed that the higher the education, the more likely one is to be exposed to prevention measures, such as condom use. Even if one is well educated, this should not necessarily correlate with high income, considering the soaring levels of unemployment on the continent as, for instance, Nigerians with PhDs may only be able to secure work as security guards. The purchasing of condoms, thus, is a luxury.

What is deeply alarming about the assumption that only those with disposable income are in a higher risk position to contract HIV is that those with whom they have sexual relations are never accounted for. Men with disposable income may find steady, multiple, or intermittent girlfriends who attend university, work in the market, they may be sex workers, or they may be simply looking for a job. These couples may be in love, they may be simply having a casual affair. The women involved often do not have a disposable income. Therefore the analysis that HIV infection correlates with socio-economic status is extremely misleading. Instead, these studies need to analyze the cultural economy of casual sex and the disempowerment of women. Here, there is a need for a socio-economic accounting not just for those with disposable income, but the relationship between those who have extended cash flows and the poverty of women who are drawn into economically viable sexual liaisons. Indeed, the projected figures and young women are six times more likely to contract HIV needs to be situated in this context and not continually ignored.
Filmer's study (1998), which was also cited and emphasized by the UNAIDS study, states that Botswana, a country that is considered one of Africa's most prosperous nations has one of the highest infection rates (34%) among a population of 1.5 million, thereby claiming that poverty as a precursor to HIV can be deceptive. But what he does not state is that nearly half the population lives below the poverty line. Countries like Botswana and South Africa have relatively good health care infrastructures, adequate HIV testing centers, and the accessibility to health care is much higher than most African nations, meaning that they also have more sophisticated means to account statistically for HIV and other medicalized bodies. In Nigeria, there are very few testing centers and very little access to health care. Calculating HIV infection only relies upon very few markers, the most common being the compulsory testing of women for pre-natal care in hospitals and these are women who can afford clinical care. At least 70-80% of the population cannot even enter clinics and therefore the vast majority of the impoverished classes do not know their sero-status and nor is it statistically possible to account for them.

On his last public appearance before his death in early June 2003, the late Professor Olikoye Ransome-Kuti, architect of Nigeria's public health care system, stated that he was quite certain that Nigeria's infection rate was much higher than the estimated 3.5 million (2001 statistic) and asserted that it was between at least eight to ten million. Others speculated on this figure and I had my own suspicions while in the field that the numbers ran around this estimate, as the numerous health care workers that I spoke to told me that testing for pre-natal
women returned on average a 25% HIV infection rate. Military doctors told me that ECOMAG (West African peace keeping) soldiers returning from service in Liberia and Sierra Leone come into the infirmary with 100% of them being infected at any given time. An HIV-positive medical doctor:

in some of our hospitals in Nigeria, the prevalence rate is definitely more than what the government is saying. Some are reporting as high as 7 or 8 %, and this is from their own studies. Some studies were carried out some time ago where about 65 health-care workers were screened and nearly 40 of them turned out to be HIV-positive. Like I said earlier on, it is no doubt that many more people than has been reported in the country are infected. Nobody is going for test. Who’s getting tested? How many centers do we have for testing in Nigeria to start with? As a matter of fact, I do not know how they got their studies. They say they’re from studies of pregnant women who were attending antenatal clinics. That may be valuable to some extent but it does not represent the entire population of the society. That’s just it.

While the government at the state level (and not the federal) generates statistics on HIV dispersion, it does so haphazardly and apprehensively. The reason for apprehension is its own internalization of stigma and discrimination where many states do not want to be seen as carrying a high load of HIV positive people. As a result, there have been a number of AIDS activists who have accused states of fudging their own statistics. For example, I heard rumors from AIDS activists who insisted that some states fake their numbers on national HIV statistical returns. Furthermore, it was reported to me that government officials from Benue state, located in the Middle Belt, which has the highest infection rate in the country was quite disturbed by this fact, which led some members of the state government to claim that the numbers were false. Therefore, there is a demand on the part of AIDS activists to actually calculate HIV bodies. Here it is not imagined that the state will use HIV statistics to carry out disciplinary action
as Foucault might suggest, but rather it is imagined that such statistics will hold
the state accountable to actually do something pro-active about the AIDS
epidemic, including the regulation of cure claims. This is a biopower from below
because AIDS activists are invoking a prior accounting scheme and they have a
capillary investment in it.

Moreover, calculations of HIV rates are naturalized without attending to
methodological variance and obstacles. Perhaps more interesting is the way that
rumor can transcend official facts. Even the politics of stigma and
discrimination can go beyond the HIV-body and the community, impacting
official statistics. My argument here is that Filmer's study and many others like
his naturalize statistics that are gathered under severe methodological obstacles.
Perhaps these methodological constraints need to be taken as the primary object
of study in order to de-essentialize the officialness of statistics, which Filmer
and others use as marker, to dispel the myths of poverty.

The potential for rearticulating these research practices may lead to
questions that no one seems to be currently asking: Why is so much money, time,
and the recruitment of consultants worldwide spent on generating documents that
produce research on risk factors, the risky body, dispelling myths of poverty,
cultural and religious beliefs about HIV, and who is most likely to die? In
contrast, there are very few consultancies or focus put toward examining
assumptions of Western and individualistic ideas of disease epidemiology. Also,
there is no measure on the relationship between disease variance and the status of
drug and health care regimes. What could happen to an individualistic model under the severe stress of massive capital flight?

*Government Response: Configuring Perceptions of Political Will and Human Rights*

HIV/AIDS represents a conflict of obligations that the state has toward both the regulatory contract and PLWHA. On the one hand this conflict represents the demands of multilateral organizations that insist on adhering to payment of external debt, enforcement of global trade provisions that I discuss in the next chapter, and the creation of biopolitical regimes that are more powerfully directed by the development industry. On the other hand, there exist the demands of PLWHA for the state to accommodate their interests such as medical care and attentiveness to human rights violations, which in some but not all ways are in contrast to the interest of the multilateral organizations. This conflict of obligations further reinforces the absence of an AIDS medical paradigm as the regulatory contract, and indeed occasionally dipping into the state treasury procures little capital to revamp the medical infrastructure. However, the multilateral politics that shape state capacity to respond to HIV/AIDS are not often part of PLWHA discourses on accountability and action. Rather, they are shaped by the role of the state in post-colonial legacies and configurations. But perhaps more importantly, and as will be seen below, activists and PLWHA who do not circulate in the powerhouse of AIDS policy-making will almost always assert that the state does not care to make any interventions into the AIDS epidemic.
I found this perception of the state as the sole actor responsible for addressing AIDS (and indeed other issues considered to be reaching mass crisis) to be a very curious one, mostly because Nigerian discourses of globalization's impact on the country are predominant, and are marked by a long and sometimes violent history of oil politics, IMF, and of an economy that went from booming to being one of the poorest in the world. But as I trudged through an ethnography of the state and its relationship to HIV/AIDS, I found that the state is not viewed as a monumental entity necessarily contrasted with the international politics of multilaterals. Indeed Bayart's (1993) assertion that the post-colonial African state is comprised of both internal and external activities and politics is not lost upon AIDS activists. For it is the continuing legacy of colonialism that reveals for them why government does not respond to the AIDS crisis. In particular, activists who have had much contact with PLWHA throughout the country told me that government must identify with PLWHA in order to bring the epidemic under control. A lack identification, or the government treating HIV/AIDS as if it is their problem is most often articulated as the lack of political will and the promise of democracy dividends.

An AIDS activist:

There's a great divide between those in power and those being ruled. Now the process that has been occurring in the past is that we "elect people" who are equipped either by coup or by process of election people who go into the shoes of the colonial masters. Now, to Nigerians, right, the rule by constitution is still foreign to us, because it is a rulership that came out as a result of foreign dominance of our society. These were laws that were put in place for us to adapt ourselves to. It wasn't a law that evolved from our culture. Now if we are able to establish a relationship amongst
ourselves whereby our constitution is reflective of our society, our ways of doing things, it wouldn’t be very difficult to conform, because then we don’t have to read this constitution to understand what we’re supposed to do. Rather it will be reflected in the constitution what we are expected to do. So that rights could now become respected. And elected officers would now go into offices with the ideology that they’re still representing people. The way we look that our issues, our issues represent them as masters. Master-subject relationship is what is occurring.

Political will to implement AIDS policy and programming, democracy dividends and an articulation of the rights of people to reap the benefits of such implementations are further inhibited by those working in government structures.

I found that in numerous discussions government officials would often refer to government as not understanding the complexity of any given problem, as if government is an omnipresent, yet intangible and elusive entity a view that reflects civil service organization in which accountability is often hard to trace.

A human rights activist:

When people [working for government] identify government as a major problem, it shows that the laws that should enforce certain things are not there. There’s no one there to enforce them we identify the colonial masters who had the problem because we have not seen ourselves, entirely as Nigerians, as contributing. We still see that divide, that dichotomy between those in power and those being ruled. So it is easy to now identify them as the problem. Do you see where the new colonialism presents itself? So what we’re doing now is that we’re still recycling those structures of colonialism. When somebody in government is complaining about government--what is he? Who is the government? That means that the tools are still in place.

I speculate that there are several reasons for holding the state solely responsible for addressing the AIDS epidemic. These are temporal in nature, and also marked by a cultural discourse of democracy/suffering. First, the perceived
failure of the state since the first military takeover in 1964 has generated a longstanding engagement on the Nigerian state. This became more pronounced when IMF structural adjustment was instituted in Nigeria in 1986, the public outcry and subsequent groundswell opposing the decision, was directed toward the government leadership, because certain austerity measures (such as devaluation of the naira) were put in place that were unacceptable to the majority of the population. The administration previous to Babangida, under General Buhari, did not accept such measures, which in many ways represented public opinion, and therefore by 1986 public outcry was directed to the Nigerian political leadership and not necessarily the IMF. In 2002, Nigeria completed its trade policy, which focuses on an extensive privatization plan, market liberalization, and more emphasis on an export economy. It is also in the process of complying with the World Trade Organization agreement to which it is a signatory. As these initiatives could be considered an extension of IMF austerity measures, they have been greeted with mixed feelings. For instance, the discourse of suffering/democracy among the public is so powerful that many view privatization as the only recourse to repair the economy and infrastructure. Daily encounters with government at all levels has led to the nearly unanimous view that the state is incapable of repairing even the most basic services such as telecommunications and electric power, which break down almost daily in every household. How government comes to decisions about trade, or even the terms of those decisions are not always transparent. With the additional problem of poverty, access to internet and international debates on the political implications
of global trade are further limited. Moreover, may are less consumed with international politics and more so with issues of survival, increasing levels of crime, and the transitory politics of democracy, all of which the state is held ultimately responsible.

Second, as argued throughout this chapter, the very collapse of medical infrastructure and difficulties in accessing treatment have left the status of HIV as a curse or taboo, rather than an infection, leading to rampant human rights violations. AIDS NGOs, support groups and PLWHA are primarily focused on and consumed by human rights violations for which the state becomes the object of both redress and cooperation, demonstrating the non-monolithic status of the state. For instance, when NACA was first creating its bureaucratic organization, and certainly receiving a great deal of funding from the World Bank and others, a battle ensued between it and the Federal Ministry of Health (FMH). The FMH contended that because HIV was a health issue, NACA activities belonged under its jurisdiction. (But many activists and certainly government workers claimed the FMH wanted to secure AIDS policy because it would have access to more money.) For AIDS activists it had become primarily a social issue. I witnessed a confrontation between an AIDS activist, and the minister of health. The activist went down a list of human rights violations that are encountered by PLWHA in hospitals and clinics, accused the FMH of not appropriately responding to the medical needs of PLWHA, and concluded by claiming that the best course of action was to keep NACA under the presidency. Therefore, alliances with the state are very complex one parastatal may be seen as the best possible means of
positive intervention in the epidemic, while another branch of government may be seen as a potential disaster.

Yet others say that the establishment of NACA was a move to demonstrate political will:

it's political in the sense that the government has made a statement that it is responding. They were responding in the wrong direction. (Though, some people may differ with my opinion, and it's welcome.) Why? Because nothing was being done and now something is being done. But the idea is that nothing is being done because apparently NACA isn't going to work with the Ministry of Health. All you're doing is getting a group of people, who I would term consultants, to draw up a structure and empower them with funds to run the ministry from outside. That is what it is. Brilliant. Everybody involved is equally taxed to do the job but, come on, you can do the same thing, with the same structures, less finance.

The state and local government levels encounter much of the same complexity. For example, an activist, Bede, with whom I spent a great deal of time, was traveling from Lagos, where he was based, to the East in Imo state, where he was from, coordinating rural activities. A nearby LGA doctor in Imo contacted Bede and told him that he was overwhelmed with patients coming in for HIV treatment. The doctor had complained that the state had promised to release funds for HIV/AIDS activities for over a year and nothing was showing up. He had nothing to offer these PLWHA except compassion, which wasn't enough. As I was leaving the field, Bede was helping him organize all his patients to go to the state capital to perform a sit-in. In another incident involving LGAs, and perhaps in contrast to the latter incident, I went along with some activists from an NGO to a meeting in Badagry to speak to the LGA chairman and the chief medical doctor. The members of the LGA met the local government chairman a week prior who told them that AIDS does not exist. The LGA chairman ditched the meeting but
the medical doctor was around. The NGO members asked the doctor what was being done about HIV/AIDS in the community. He told them that they were welcome to start something, but they said all they could provide was technical assistance to programs that they wish to start. There was not much interest expressed in the proposal.

Two AIDS activists:

Why hasn’t the government responded to the issue of HIV/AIDS? Because it hasn’t felt the impact. It’s a situation of well it’s not our problem, it’s their problem; what do they really want drugs or cake? The masters are now saying the servants are infected. I had to travel through nine states [in 1999 with other researchers] through five zones in the country. We were documenting the violations of people living with HIV/AIDS. In other states, apart from Lagos, nothing was actually being done. When I say nothing, I am talking about nothing. There were some NGOs, which were handicapped, that were actually doing the only things being done. The government had no form of activity for HIV/AIDS at that point in time. Now, much was said about this attitude of the government. It [the problem of HIV/AIDS] was produced such that none of the government officials were infected, and as a result of that, nobody cared.

The [present] government seems to be trying actually, but the past ones were filled with arrogance. They were all liars and pretenders. Many of them are [HIV] positive and they still continue to sleep. The past military-many of them are positive in Nigeria and we [an AIDS NGO] have their names. Yes, now. I would not lie about it. Yet they will continue to say that there is no HIV in Nigeria, or something close to that, just because they don’t want to take the responsibility to take care of the issue in the society. They prefer to steal the money to be spent on that [their own treatment].

The lack of political will is connected to public discourses on democracy and democracy dividends. PLWhA use the same language of political will and democracy, utilized by most Nigerians, to describe and construct discourses of AIDS care expectations that are generated by encounters with the state. If the regulatory contract does not construct AIDS as a medical problem to ensure the
cohesion of capital flows, the state's own occlusion of a medical paradigm is driven by a post-colonial politics that has lead to a dysfunctional health care industry. For, instance, the place where PLWHA most often encounter their first wave of abuse, stigma or discrimination is in government hospitals. I have heard numerous stories from PLWHA who have been tested for HIV without their consent; been turned away or segregated from the rest of the hospital population if found to be positive; were never told that they tested positive, but such results were reported to family, employers or children's schools, as a result which PLWHA lost their jobs, housing and were shunned by family. Therefore, NGOs cooperation with the state emerges usually when it impacts government officials or individual medical workers (and not necessarily agencies or branches of government) who possess a sensitive awareness that they have direct contact with PLWHA.

The divide between rulership and those being ruled produces the notion of identification government not identifying with PLWHA and Nigerians not identifying with themselves. This generates an effect of not knowing and as one activist indicated to me, it doesn't effect anybody where it is of no concern it is their problem. If it comes home, that is important. The very erasure of the biological nature of HIV reinforces this divide between rulership and those being ruled in which ignorance of AIDS becomes not an epistemological but an ideological construct.
Dr. Wole Daini was a human rights activist, and a trouble maker, dating back to primary school and medical school at the College of Medicine at the University of Ibadan. He was nearing the end of his degree in 2000, at which time, UI announced it was going to triple the fees because the university could no longer pay its electricity and phone bills. With this news, students began to protest the fee hikes and Wole shortly became involved. He told me that he would get up at 6am every morning and walk through the dorms, banging a pot to wake other students up in order to start the day’s protest activities. The students found out that in fact these bills were being paid by the state. He and other students met with campus administrators and presented a list of 67 reasons why they should not pay the fees, and told the administrators that if they could come up with one reason why the students should pay fees they would forget the other 67. The administration could not come up with another reason and later that afternoon the ringleaders of this student group, including Wole, it was announced, were expelled from school, and had one hour to leave campus or face arrest. He went immediately to Lagos where he hired a colleague who was a human rights lawyer to represent him because he decided to sue seven different campus administrators and professors, an act unheard of at this time. This went into court three times. The first time these officials showed up with eight lawyers. Wole’s lawyer did not show for the first hearing, so Wole was forced to defend himself. He told me that the defendants delivered a forty-minute opening argument. Wole gave a twelve-minute opening argument which was met by twenty-four objections and the judge overruled all of them. He won the case and was back in school within days.
However, to this day, he has still not received his medical certificate, despite orders from the court. One day, I saw Wole after he completed an AIDS advocacy workshop and he received a certificate of participation. He thanked the organizers profusely because it was the first time he was in a learning environment where he wasn’t considered a truant.

Wole’s parents found out that he was positive while he was being interviewed on national radio; and they were not surprised he was responding to it an activist context. While he did not face alienation or ostracization from his family, as many PLWHA often do, his parents got increasingly uncomfortable with the fact that he, along with his HIV positive partner, Bisi, were making national headlines, culminating with a July 2001 three-page-expose of the two of them in The Guardian, Nigeria’s leading newspaper. One Sunday night while he was at his parent’s home, they told him that they feared he was ruining the family name. He responded by going to court the next day and changed his name from Wole Daini to Wole Liberty.

One of the first government responses of the Obasanjo regime to AIDS, just prior to the consolidation of NGO networks and the allocation of new money, was to provide rapid relief through the promotion of condoms an overwhelming task with limited resources. At the time, a very weak policy on HIV/AIDS (1997) was in place that did point to human rights violations against PLWHA, but none that provided any legal back-up. Moreover, although health policies in Nigeria construct access to health care as a fundamental human right, neither policies nor
laws are rarely implemented. Therefore, activists have commented that the first thing that they feel that government should do is actually implement policies on HIV/AIDS. Two AIDS activists:

It's so sad that HIV, not just in Nigeria, is associated with social issues. And in gleaming those issues you require policies and laws in place to checkmate those ideologies that are wrong. Those are the reactions of a government that it [HIV/AIDS] has touched. But it doesn't touch the government. There's so much denial in the system of governance. There's so much denial to the realities of HIV AIDS It is so appalling to hear the government debating the amount of money that will be spent on drugs. The fund is not an issue here, the strategy is the issue. That is where we're missing it. We have identified funding as a total package and that is not true. There's so little or so much that money can do. But it cannot be counted what political will can achieve.

HIV/AIDS in our society, by virtue of the fact that so much wrong information has gone out about [it], is now more of the human rights issue. And you cannot effectively address the issue of HIV/AIDS infection without considering the entire picture of the violations that people living with HIV/AIDS, considering the fact that HIV AIDS is not something that is visible to the face. You can't see someone and say yes this person is infected.

However, in the same way that state-NGO alliances are precarious and unpredictable, I found that what constitutes human rights violations is not wholly agreed upon. In fact human rights organizations in Nigeria that were actively responding to the brutality of the Abacha era do not know what to do with themselves, a description often made by some AIDS activists. One AIDS activist told me that they have not transitioned from critics of the military to problems in the current form of governance. More importantly, in focusing on the construct of civil rights, Nigerian human rights organizations have not been able to recognize the emergent rights discourses that are being put forward by AIDS activists, which is the language of the right to life. The right to life extends the notion
of civil rights utilized during the pro-democracy movement in the 1990s. This meant that PLWHA's human rights required protection not just from the state, but from the medical establishment, neighbors, family members, employers, and landlords. The discourse of the right to health additionally construed positive rights, such as health entitlements, which are bound up with a democracy dividend welfarist vision. As one activist told me: I don't know what right to life we're talking about when there is no drugs, and no free access to health care, people cannot even eat well, people do not have housing--everything that constitutes the right to life is missing. An AIDS project manager for the UN comments on the discursive gap between civil rights and the right to life:

Well, in this country, if you take human rights for a non HIV-positive person--even that person does not have basic human rights. Do all the people in this country have the right to food, to water, to all of that? Do they get that? So nobody's rights are being met in this country. The value of rights itself is not there, it is not recognized. Then the other thing, which is something I see that we cannot ignore at all, is this concept of the practice of slavery, servitude. People have for generations and generations, an obedience to a master. And that culture is there--whatever the master decides is which you have to be patient with and happy with. The master is beating people, it's alright, you'll get beaten. So security and rights to dignity are being violated as it has been done for ages. And it is damaging in that an average person does not even recognize his or her own rights... So they do not recognize human rights at all, let alone the rights of positive people.

Even if the right to life is consistently articulated, it is not consistently practiced among AIDS activists. I have witnessed numerous forms of severe verbal abuse and threats of dismissal by senior NGO workers to their lower-level workers for things such as not opening the door fast enough and not watering the plants correctly. I spoke to an AIDS activist about this to which he flippantly commented, human rights activists are the worst human rights abusers.
The following case perhaps exemplifies the lack of consensus on what constitutes human rights violations and related, conflicting policies of the state. On July 14, 2001, Georgiana Ahamefule entered the Ikeja High Court with her lawyer, Felix Morka, to challenge, among other issues, the termination of her employment in 1995 as an auxiliary nurse at the Imperial Medical Centre, on the grounds that she is HIV-positive status. Ahamefule was accompanied by members from several AIDS activist and service organizations, including Morka's own human rights NGO, the Social and Economic Rights Center (SERAC). To the shock and surprise of all parties involved, Ahamefule was denied access to the courtroom due to her sero-status. The presiding justice, Caroline Olufawo, insisted that national or international experts come to Nigeria to give testimony on whether or not an HIV-positive person can safely enter a courtroom and not infect those who are HIV-negative. Ahamefule petitioned the appeal court in Lagos to challenge the ruling, asserting that the restriction of her access to the courtroom is unconstitutional and is in violation of her right to a fair hearing, as well as her right to be free of discrimination. More importantly, she is seeking a declaration that she is in fact a person, entitled to citizenship, defined by the 1999 Constitution and entitled to her human rights, regardless of her HIV-positive status.

An excerpt from the court transcript is worth quoting at length (Ahanihu, 2001):

Morka: My Lord, we have a summons for direction before the court. The summons is dated July 31, 2000. The defendants have been served and we are asking the court for a date of hearing. The defendants have a motion for
extension-time to file their statement of defense. They are not in court, but we shall not be asking for it to be struck out because of the peculiar nature of the case of which time is of the essence.

Judge: About this case. Don't you think that the better thing to do is to approach her former employers for financial assistance? They can pay some money to her.

Morka: It is because they have not responded to our letters and appeals that we have come to court. Moreover, this case raises fundamental issues of the rights of the plaintiff and perhaps, millions of others like her, some of whom may be in this courtroom.

Judge: This HIV/AIDS thing is something else. The other time I went to a clinic and learned there was a member of staff who is HIV-positive, I quickly told them not to let him near me. The defendants have to protect themselves and their patients from AIDS.

Morka: That is the misconception people have about AIDS. HIV/AIDS is not contagious; it is not as if a person with HIV/AIDS comes into this courtroom every person is going to get infected. There are proven scientific modes of transmission. We are saying that the plaintiff in her capacity as an auxiliary nurse with limited contact with patients was not in a position to jeopardize the health of the hospital staff and patients.

Judge: But I understand that in Uganda or Kenya or so, they put them in a village and surrounded them with soldiers, so that they could die without escaping to infect other people.
Morka: My lord, those countries you just mentioned have laws which are more developed and protective of the right of people living with HIV/AIDS than what we have in Nigeria, and that is what we are calling upon the court to do; develop this area of Nigerian law. Moreover, the incident you mentioned may have been in connection with the Ebola virus, which is contagious. And in any case, they were confined to arrest the spread of the virus and for them to receive medical attention, not to die.

Judge: (to the Bar) Anybody wishes to say anything?

Amicus: My lord, I think the case promises to be very interesting. This area of the law is vague. I wish I knew the date, so I can be in court to witness the proceedings.

Judge: Is the plaintiff married?

Morka: Yes, and they have a child.

Judge: The husband better be tested to see if he has AIDS.

Morka: He is negative and the child she had after she tested positive tested negative. My lord, we are also saying that the disease is not associated with promiscuity contrary to popular belief.

Judge: The matter is adjourned to February 5, 2001. But please do not bring your client to this court. Let her stay away.

On February 5, 2001, the day of the second hearing, Prof S.A. Adesanya, a Senior Advocate of Nigeria (SAN), appeared for the defendants and opened the proceedings as soon as the case was called up.
Adesanya: My lord, we have an application to file our defense and deem it duly filed.

Morka: We have an application for accelerated hearing. The defendants have been served.

Adesanya: We do not oppose the application.

Judge: Move your application, Mr. Morka. (Morka moves the application).

Adesanya: We have some reservations. We want to be guided that if the plaintiff is put in the witness box, both the judge and the lawyers will be safe and not get infected.

Judge: That is a good observation. It is a very good one. Yes, Mr. Morka, what assurance do we have that if she is brought to court that lawyers and litigants are safe?

Adesanya: and your lordship s safety too.

Judge: Yes, after all, life has no duplicate.

Morka: We are giving the court the greatest assurance that if she is in this courtroom, nobody will get infected by mere casual contact. My lord, HIV is contacted through having unprotected sex, contaminated blood, sharing (of) needles and sharp objects. A person is not likely to contact HIV by sharing toilet bowls, cutleries, etc. These are scientifically proven.

Judge: Are you a doctor?

Morka: No, I am a lawyer, but I took time to enlighten myself.
Adesanya: My lord, we require expert medical evidence to assure us that we will not be at risk. In South Africa, lots of doctors have lost their lives from attending to AIDS patients. We strongly require expert evidence. We would need to cross-examine the expert witness.

Judge: Mr Morka, can you produce an expert opinion?

Morka: Should it be by affidavit evidence or does the expert need to be in court?

Adesanya: We will not be satisfied by affidavit evidence. Affidavit evidence will not do. The doctor has to be brought to be cross-examined.

Morka: When do you require the expert witness?

Adesanya: It has to be before the trial.

Judge: I cannot grant this application until I have the medical evidence.

Morka: If the court requires expert witness as a pre-condition for granting this application, then we shall produce it.

Judge: It is my opinion that the view of the learned counsel for the defendants should be respected in view of the fact that life has no duplicate and must be guarded jealously. It is hereby ordered that an expert opinion be heard on the subject matter either from an expert in Nigeria or from any other part of the world where research has been fully carried out.

Georgiana Ahamefule began her employment at the Imperial Medical Centre in 1991. In 1995, she became pregnant and developed boils on her skin and reported her health problem to the chief medical director, Dr. Alex Molokwu.
After medical examination, Molokwu carried out diagnostic tests, but according to Ahamefule, he never disclosed which tests were being carried out or their outcome. Rather, Dr. Molokwu requested by letter (dated Oct 12, 1995) that she go on a two-week leave, and referred her to the Lagos State University Teaching Hospital (LUTH) with a note in a sealed envelope addressed to Dr. Okany. After Okany read the note, Ahamefule was asked to return to the hospital with her husband. When she returned with her husband the following day, both their blood samples were obtained, allegedly without any disclosure as to the nature of the tests to be carried out. Ahamefule and her husband were later informed that she tested HIV positive while her husband tested negative. Shortly after this visit, Ahamefule returned to her place of employment and asked Molokwu why he did not tell her or discuss these initial findings with her before sending her to LUTH. She states that at the time the doctor became extremely hostile with her and ordered her out of his office. As she left, Ahamefule was asked to collect a letter from his secretary. The letter, dated October 23, 1995, stated that her five years of committed service to the clinic was abruptly terminated on the grounds of her HIV-positive status. Despite repeated appeals, the decision was not reversed, and moreover, her appeal for adequate severance pay was also denied. Instead Molokwu gave her a letter of recommendation to enable her secure employment elsewhere. According to Ahamefule, the emotional and psychological trauma triggered by the actions of her employer contributed in considerable degree to the sudden loss of her pregnancy. She stated that the hospital further humiliated her when it declined to provide her services following her miscarriage.
The suit filed by Ahamefule claimed that the termination of her employment on the grounds of her HIV-positive status constitutes unlawful discrimination, being in violation of articles 2, 18(3) and 28 of the African Charter of Human and People's Rights (Ratification and Enforcement) Act, Laws of the Federation of Nigeria; that the defendants' action in subjecting her to an HIV test without her informed consent constitutes unlawful negligence; that the defendant's action in denying her medical care on the grounds of her HIV-positive status constitutes a flagrant violation of the right to health guaranteed under Article 16 of the African Charter on Human and People's Rights Act Cap. 10 Laws of the Federation of Nigeria and Article 12 of the international Convenant on Economic, Social and Cultural Rights (ratified by Nigeria 1993).

The defendants asserted that Ahamefule's claims were frivolous, vexations and an abuse of court process, and should be dismissed with cost (Guardian p25). They also claimed that when Ahamefule had her second pregnancy in 1995, it had become the rule and modus in Imperial Medical Centre that every employee must go through a medical HIV test which is undoubtedly contagious, and this had become necessary in order to protect not only the staff, but members of the public at large, including patients in the hospitals. The defense also claimed that Molokwu advised her to undergo tests to screen for HIV, syphilis and other sexually transmitted infections, which she consented to at no cost to herself. The defendants claim that they were statutorily bound to ensure that the hospital was safe, that members of the public are safe, protected from contagious or infectious diseases (Guardian, p25).
In less than a month after Ahamefule’s initial hearing, Justice Carolina Olufawo dropped the case because of the subsequent uproar in all the national newspapers over her behavior in the courtroom. She also cited the Guardian in contempt of court for falsely printing proceedings from the court, even though the Guardian printed the court transcript, considered a factual document. The case is pending in front of the appeal court.

I spent a great deal of time with Georgiana, but her lawyer instructed her that she was not to talk to anyone about her case. But two AIDS activists comment:

I think because in Nigeria, inasmuch as we’re trying to constitute a legal system--what the final picture of the law is--as I don’t think it has finally evolved, we’re still trying to get ourselves--our minds--disabused from what colonial dominance is. Except when we come out of those shackles, whereby we see ourselves as humans rather than subjects, in a particular section or instrument, we have a problem defining what law is. And Georgiana’s case is no different from any other case on the streets. It is socially greeted because some people choose to make it that way. But outside of that, a lot of people suffer like that, and nobody cares.

In terms of Georgiana’s case, if you understand that the courtroom is a place where you get recourse for what ever abuses are metted out to you and you’re not allowed to get judgment on it. Why? Probably because the judge is not aware. But beyond the judge, the courtroom, how can somebody actually come out and fight the government? Because the court room represents the government. And if the government cannot stand up for its citizens, you know, it isn’t that the government can’t claim ignorance on an issue that it has widely publicized. But if the government claims ignorance on that perspective, it shows how wrongly placed we are. But if assuming for any reason that the government says, we don’t know, well, it is most unfortunate. But HIV/AIDS has only brought to light the fact that our constitution, or rather our means of governance or rule is really, really shaky.
The fact that HIV/AIDS is an underdeveloped area of law in Nigeria not only reflects nascent awareness of the epidemic, as has been the case in every country when AIDS first came to light, but also the perception that government response to HIV/AIDS is weak or lacks political will. There are several issues to point out: First, the very solicitation of scientific expertise, deemed appropriate by the court, is what AIDS activists read as very shaky governance. Here is where AIDS activists may view the ignorance of the court on biological issues as illegitimate and indeed ideologically constructed, because according the them, the court should reflect government awareness on matters of HIV/AIDS. HIV/AIDS has revealed the idea of shaky governance to be the end result of the dynamic between the state and the regulatory contract that work together to erase an AIDS medical paradigm. Taboos, cures, identification between people and government, and divides between rulership and those being ruled stand in disconnection with the biological nature of HIV. Second, the current divide between a societal understanding of civil rights, generated under military rule, and the newly and (un)apprehended discourse of the right to life, appropriated from Western discourses, leaves little leeway to develop this aspect of law. This divide reflects the inability to build consensus, legally or otherwise, on what exactly counts as rights violations.

Nigerian courts are not the only space in which violation of rights lacks consensus, for there are perhaps even greater conflicts about rights on the international level, not in terms of individual rights, but in terms of national autonomy. One of the greatest forums for assessing the constitution of rights is
within the World Trade Organization, as the G-8 and the rest of the world continue to dispute to what extent a nation can make decisions about its state of national health care. In Chapter Three, I analyze how provisions in trade-related intellectual property law have promulgated global fights and local divisions on access to treatment for HIV/AIDS.
Chapter Three

The TRIPs Agreement and Nigerian Compliance: An Ethnography

KP: Who negotiated and signed the TRIPs Agreement on behalf of Nigeria?

Lawyer: It is not certain—the exact names, but the way things work out in Nigeria and the way things worked out for that particular agreement is that Nigeria has a desk officer in Switzerland. They attended meetings and negotiated on behalf of Nigeria. Now, unlike most developing economies, there was no input from the private sector.

KP: Does that mean there was no input from the public at large either?

Lawyer: Correct.

KP: How will TRIPs benefit Nigeria?

Lawyer: For the extent that we remain in the community of nations [my emphasis] and for us to remain business partners with the rest of the world, we must comply with the TRIPs Agreement. If we are not happy with it, we need to renegotiate or call for renegotiations. If we don't comply, there could be trade sanctions. To that extent, we will benefit, if we comply.

KP: In what way?

Lawyer: Because we will continue to be seen as a country that is friendly to the rest of the world; that protects investment. Now we need more than any other time in Nigeria's history, foreign investment. And without the backing of the World Bank saying that, oh, yes, these people have complied with this and that, nobody wants to trade [with Nigeria]. If we don't comply with TRIPs, most countries, most corporations will not be sure that we won't go back to a military government. So we need to demonstrate that we can do business with the rest of the world.

Introduction

What does it mean to be member of a community of nations for an African country such as Nigeria? Since the World Trade Organization (WTO)
came into official being in 1994, the idea of an international trading community has been fraught by disputes over trade rules, where the majority of members in developing countries have claimed unfair trading practices. One of the most disputed issues under the Trade Related Intellectual Property (TRIPs) Agreement, a treaty of the WTO, are patent rules that direct drug capital flows and access to drugs for infectious diseases, especially AIDS. Through TRIPs, a direct relationship between intellectual property law and global trade has been constructed for the first time. TRIPs gives twenty-year patent protection to companies that manufacture proprietary drugs, meaning that they have exclusive manufacturing, pricing and distribution rights for the duration of the patent. The existing patent protection requires mandatory patenting of pharmaceuticals for all signatories of TRIPs. This represents a cultural uniformity of legal concepts, as several nations prior to TRIPs legally forbade the patenting of pharmaceuticals because they are deemed as life-saving and therefore belong in the public domain.\(^{15}\) The patent life of a pharmaceutical product is now twenty years and use rights extend to manufacturing, selling, distribution, and pricing practices. These new rules have caught worldwide attention with subsequent global access to drugs campaigns because the financial interests of pharmaceutical companies conflict with public health concerns of civil society and national governments. Hence, the monopoly control on pharmaceuticals creates extreme limitation on access to drugs, as TRIPs is designed to wipe out the generic industry, which many developing countries rely upon for drug access. Despite the problems posed by monopoly corporate control of drugs, the TRIPS Agreement provides for what
are known as public health safeguards (or legal loopholes that helps to ensure greater access to drugs) that a state's national law could choose to incorporate. But this loophole remains an extreme point of contention among the developed negotiating countries, which want to secure the circulation of proprietary drugs.

Nigeria became a TRIPs signatory on January 1, 1995, and was scheduled to comply by January 2000. But it has yet to comply because it still must overhaul its intellectual property law. The Nigerian Patent and Designs Act, a national law, does not match TRIPs requirements and is currently under review.

TRIPs is nearly global in scope and all signatories must adhere to global harmonization of the law. Although hailed by its proponents that TRIPs provides equal options to any individual or company in the world to protect its products, there are several issues that get missed in this assessment. First, most companies in the world who manufacture generic products do not have access to global patent data-bases, which require thorough searches in order to determine that a potential product is new. Second, the same companies, or individual inventors for that matter, do not have the capital to simply apply for a patent and certainly not the capital needed to search out and dispute patent infringement. In fact, the big pharmaceutical companies allocate more money toward the technical and legal end of drug manufacturing than most generic companies are even worth.

TRIPs matches and extends existing development policies as well as global financial institutions conditions on foreign aid, in that it represents a paradigm that favors foreign investment and privatization of the state. That is, TRIPs constructs private capital rights over and above public rights. In this sense,
TRIPs coheres a conflict of obligations that the state has toward the community of nations (market liberalization, intellectual property protection, state privatization) and its own citizenry (procuring health care, education, security). But unlike the wide and massive discontent among Nigerians directed against IMF structural adjustment and state privatization in the late 1980s, which spawned a national movement for democracy, complying with trade regimes, and particularly TRIPs, is being warmly welcomed among elite lawyers, government, and policy makers, who are capitalizing on the sheer absence of debate in the country. How can this be so?

I wondered why hardly anyone knew, why there was no debate. I wondered why there was virtually no (exceptional) analysis that often typifies the Nigerian media. For this was not a question of People Living with HIV/AIDS (PLWHA) getting treatment, it was also about accessing the simplest of medicines such as antibiotics. But while complying with the TRIPs Agreement is a relatively subdued, invisible, and nearly non-transparent affair, a parallel national debate was taking place on the government's privatization plan under its trade policy initiated first under the military regime of Sani Abacha and continues to evolve under the Obasanjo civilian cabinet. Those who may have been against IMF adjustment in 1986, but were for privatization of the public sector in 1999 declared that the government does not have the capacity to run its own institutions evident of daily power outages, and collapsed health, education, and telecommunication institutions. It was thought that anything from the outside would be better than this. If the government cannot meet its democracy dividend
obligations, than privatization could not be worse. In fact, privatization has been imagined as liberatory even though it creates stronger and more consolidated ties between national elites and global financial institutions.

In carrying out an ethnography of Nigeria coming into compliance with the TRIPs Agreement, the task at hand was to use the space of TRIPs, where disparate cultural understandings of international and national law could be seen as competing for the power to make territorial claims over governance. I realized that an ethnography of compliance had to happen at higher institutional levels. I also knew that this would be only a partial perspective, as even those working in the highest levels of government do not have access to transparent practices, mirroring civil service structures for which the right hand does not apprehend the maneuvering of the left. But what I wasn’t prepared for was the fact that neither government and elites invested in compliance, nor the public, especially AIDS activists, did not have access to the global debates on trade related intellectual property. Such debates have consumed the attention of social movements and defiant governments attempting to secure generic drugs such as Thailand, India, and Brazil among others, who either faced trade sanctions or were under trade sanction threat. And thus, Nigerian public and private sectors did not have an analysis for their own national context. So my objectives needed to begin elsewhere, needed to ask how to conduct an ethnography of not knowing, and ask why such question was worth pursuing. The debate taking place over privatization was my way in. It caught my attention because it was, at first glance, quite confusing, because similar policies of liberalization were contrary to
public opinion just thirteen years earlier. I had to ask a lot of questions and think about many things: the cultural and physical embodiment of slow and painful economic decline; widespread assertions (of my interlocutors) that government wants and takes everything for itself, including power, money and hope; a conspiratorial speculation (my own) of the ability of nations who are pushing for TRIPs-plus compliance to brilliantly calculate the final arrival of sheer desperation that will answer yes to anything.

But even so, how does one finally come to not knowing and what relationship does this have to governance? Not knowing about a fundamental shift in the future trajectory of governance is facilitated by structural and cultural arrangements. It exists in a field of affects for which outcomes are partially known, perhaps through disconnection, and maneuvered in a narrow field of vision. Not knowing about the debates around the globe and not knowing about the impending transformation of what seems to reside putatively in the realm of the legally obscure reflected the very thing that Nigeria had endured and become. A Nigerian lawyer comments on not knowing in Nigerian government circles:

Most departments have their own mandates streamlined and there's very little room for interaction and interchanges between them. So it is only recently that they tried to interact, in which they have entered into ministerial committees in order to consider activities that impact on the activities of the other ministries. So even where you see that some mandates overlap, each department tries to create its own turf within that framework. For example, the Ministry of Environment will pick up a certain aspect of genetic resources related to biosafety, and the Ministry of Science and Technology will take up its own frame related to technology development and ignore biosafety. So this is steep in policy contradictions. So because of that, they create the minimum level of interaction. They hardly know what the other person or other department is doing which
would greatly impact on them in the course of trying to protect their own turf. They’re only interested in protecting themselves.

K: what is the point of protecting their own turf?

It is probably human nature [laughs], but it’s something that has evolved over time because of the structure of the government and politics involved in fighting for resources, departments are interested in sustaining their own relevance and activities so they’re trying to get as much resources as possible.

In the broader picture, all that was known was this: telephones do not work in the ministries; computers and internet access are non-existent in government/policy making offices, making it impossible to access the politics of trade and intellectual property; the desk officer in Switzerland did not report back to the relevant ministries, which to this day do not link commerce to public health and therefore do not share institutional communication; the patent office has no compiled databases if you have filled out the two-page form properly, you get your patent, a practice hardly competitive of forces in Europe and the US; Nigeria is on the wrong side of digital technology; billions of dollars can be made in the commercialization of folklore, music, and genetic resources, all of which slips out of Nigeria and Africa’s grasp; globalization for some, compressed space and time, something needed to compete in the global patent race, and in Nigeria, time and space are painfully elaborated, making the benefits of globalization a common phrase among policy-makers difficult to reap; and TRIPs compliance is the answer to bringing Nigeria into its rightful place in the world. Like privatization, multilateral trade related intellectual property, for those who
organized conferences and agendas, was the magic bullet, and it was this imaginary that left no time or space for not knowing.

Like culture, governance in Nigeria has multiple meanings and dynamics in which the configuration of the state materializes simultaneously through its international obligations and local transformations. Therefore, understanding Nigeria's compliance with TRIPs/WTO and the subsequent implications for accessing drugs and combating AIDS, can tell us something about democratic state formation (in an decade of a supposed upswelling of democracies) as it is constituted in multiple sites that cannot always be called local, national, global. That is, governance, as it is practiced and implemented, is formed in response to each site and level in multiple spaces. By analyzing the contentions over treatment access in Nigeria's ongoing steps toward TRIPs/WTO compliance, my purpose here is to think about a post-practice (and perhaps post-Bordesian) moment where structural adjustment effects inform and motivate strategy.

The global battles over TRIPs and drug access are well-known at this point, making international headlines and incorporating what was once obscure concepts in patent law into social movement slogans; it is not my intention to elaborate on them. But I want to draw attention to the fact that nearly all the literature on the subject constructs a dichotomy between two main players caught in a struggle of power between wealthy pharmaceutical corporations versus poor people world-wide who face little treatment options. I find this picture to be only a small part of a greater story. There are numerous strategies at work that involve national
actors and institutions where there exist a far more complicated set of discourses and practices that lie outside of this dichotomy, something that global AIDS and anti-globalization activism often misses. In thinking about the unaffordability and unavailabilty of drugs, I examine how TRIPs is not necessarily an overarching and unmoving structure for drug access, but rather how it enables the very technologies of negotiation, power, and sovereignty.

The chapter first lays out briefly the history of the TRIPs Agreement, Nigeria's relationship to it, and conflicts in patent law. Second, I discuss three different series of meetings and conferences between October 2000-August 2001 that took place among a) a national coalition of NGOs seeking to secure drug access and their eventual relationship with global AIDS activists, and b) national and regional symposiums on coming into compliance with the WTO, organized by the US Department of Commerce, with primary funding provided by the US international development agency, USAID. I examine how the actors separately operate and focus on the increasing conflicts articulated when all actors arrived in the same venue to discuss the making of the new law.

Brief Background on TRIPs

Current global trade rules have changed and evolved significantly since the fifty-year era of the General Agreement on Tariffs and Trade (GATT), a Bretton Woods institution that morphed into the current day WTO. The GATT was originally designed and run by an old boys network of diplomats whose aim was to create congenial trading relations among empires after World War II.
The era of decolonization disrupted this congeniality as former colonies, now independent states, were quickly acceding to existing global agreements (Rhagavan, 1991). The Kennedy Round of GATT during the 1960s was a significant turning point, as postcolonial states encountered remarkable debates on what counts as fair trading practices in especially agriculture (Rhagavan, 1991). It became clear that the GATT was meant to accommodate empires, which controlled the trade of export products and raw materials in and out of the colonies. With decolonization, empires supposedly no longer had control over such resources and newly independent states expected or at least demanded equal treatment under the same trading rules. As tension increased between former empires and former colonies, the GATT became a forum in which the disciplining of the newly independent states via global trade rules served as a device for the new and not so new formation of international relations.17

The governing body of GATT created a dispute mechanism, which was comprised of rotating members from three member states. If ever trade disputes arose, they would be discussed and negotiated in the GATT dispute mechanism until a consensus was reached among all parties. The dispute mechanism has evolved into a court of law in which legal action, such as trade sanctions, usually encouraged or acted upon unilaterally by the US, can be administered. This includes the notorious Special 301, which under US trade law requires the US Trade Representative to identify countries that do not provide adequate intellectual property protection or that deny market access to US private manufacturers in ways that are deemed unfair by the US. Any country not living
up to enforcement mechanisms are put on a priority Special 301 list, which means that they face the threat of trade sanctions if changes are not made that address US concerns.

The GATT constructed a loose intellectual property system that provided the basis for technology transfer, copying, etc, which permitted industrialized countries such as Japan and Germany to catch up and achieve technological equity with other technological nations (Ringo, 1994). Now TRIPs is actually hindering technology transfer and technological advancement, which has raised questions among developing countries on the true intentions of the developed world, where the rights of sellers and manufacturers are skewed over and above economic development. Therefore, TRIPs can be seen as the coveting of knowledge into legal realms of secrecy, creating barriers to technological access.

The US first pushed the installation of unilateral measures via TRIPs because it viewed the GATT as inadequately enforcing IP rules throughout the world. The problems around piracy and counterfeiting were growing in the 1980s and perceived to be out of control by US corporations, whose manufacturing bases were in decline. Establishing a new dispute mechanism that could adequately replace the old system was imagined as the way to stop counterfeit activity. An ethnographic approach to counterfeiting shows that a dispute mechanism arbitrated in Geneva provides a enormous disconnect on the ground with those engaged in pirating, as employment opportunities are extremely limited, and a culture of consuming counterfeit goods are widespread. Developing countries originally opposed TRIPs on especially these grounds
where there was no financial incentive (among police, courts, consumers, etc) to curb the activity of counterfeiting within their countries.

Moreover, TRIPs represents a significant shift from safeguarding public interests to now protecting private interests. As such, governments are literally ceding sovereignty to international regimes so that they can develop the rules to govern new and significant levels of international integration (Ringo, 1994). As alluded to in the opening epigraph, the configuration of a community of nations, one which is understood through the notion of compliance and friendly to the liberalization of markets and investment climates, is born out of this political history of the GATT, and the WTO marks its more modern moment (Ringo, 1994).

At the Uruguay Round of GATT, held in the early 1990s, which was the venue that negotiated the TRIPs Agreement, African representatives came relatively unprepared to address the new trade related IP changes on the agenda. Specifically, African delegates lacked experience on the complexity of IP law and international trade issues (UNECA, 1996). Johnson Ekpere (no date) and Bankole Sodipo (1997) have written extensively on cultural understandings of IP law as outlined by TRIPs. TRIPs represents an single author paradigm, which evolved out of Lockean notions of property, a cultural understanding that is completely alien to many African cultural contexts. One Nigerian lawyer explains:

The patent system or the contemporary orthodox intellectual property regime emphasizes individual rights. On the other hand, the knowledge systems that exist traditionally in Africa involve a communal ownership of knowledge as well as some kind of obligation to share the knowledge
inasmuch as there are some restrictions or conditions on them. In this case, knowledge and ownership can be shared freely in society. Even where the knowledge is located with one individual, say for a traditional healer, he holds it in custody for the entire community and that knowledge is constituted by virtue of his membership of that community. So it does not give him any personal or private rights to own that knowledge. Also TRIPs is very categorical about recording and writing. Unless there is a totally new system of intellectual property rights that is outside the world patent system, then they [African states] would have to create a totally separate class of knowledge detection, where such criteria could be used to describe the knowledge. Because affectively traditional knowledge is mostly transmitted orally because there’s really no written system.

There was very little coordination among African delegates at the Uruguay Round. The private and public sectors were not consulted before this round, as the delegates may not have fully understood the implications of the proposed IP law. Additionally, an analysis of how TRIPs would impact already weakened African industrial sectors was not made at the time of the negotiations. At the Uruguay Round, many African countries, including Nigeria made commitments beyond their institutional capacity in fulfilling the requirements of the TRIPs Agreement. Moreover, there was little awareness on the part of the industrialized nations that even if TRIPs provisions are legally put in place within the established deadlines, developing countries do not have the resources to actually implement such measures. A lawyer comments on the problems of implementing the new patent law:

The government will only move as it is pushed. Today in the US, the government is being lobbied to change its policy on the amount of money it collects from the USPTO [US Patent and Trade Office]. Years back it collected everything, I mean maybe about 80-90%. The Nigerian government has priorities. We have to let it understand that this does not make sense, that this is a fraud. I pay you N4,000 to apply for a trademark
and I cannot get it unless you advertise it and you don’t give money to the trademark office to advertise it, so this too is a fraud. So we have written the register of trademark, indicating that we are going to sue you for failure to publish the journal. But doing that whether as a law firm or the rest of my colleagues, the registrar is not going to like that. You also need funding. For instance, look at farmers, if you want to talk about farmer’s rights. How many farmers can go to a meeting or conference to push for these issues? Nobody. How many artists or composers can do that? With a fund, some will be able to do that. So funding is number one.

The First Intellectual Property Law Conference: IPLAN and USDOC

In December 2000, a conference on intellectual property (IP) law called Administration of Intellectual Property in Nigeria: A Stakeholders Conference was held in Abuja, the capital of Nigeria. On the agenda were two major tasks: the first was to elucidate the current status of IP administration in the country and the second was to brainstorm and make suggestions on overhauling Nigeria’s IP law in order to come into compliance with TRIPs. Two institutions organized this conference the Intellectual Property Law Association of Nigeria (IPLAN) and the Commercial Law Development Program (CLDP), a U.S. Department of Commerce (USDOC) initiative. IPLAN is a Nigerian association of over fifty law firms and companies, which are either owners of intellectual property and/or are interested in the development of a regulatory framework. Currently, Nigeria’s IP laws are out of date and the administration of such laws barely function. IPLAN’s work is based upon the conviction that IP rights can encourage local technical growth and foreign investment and works to lobby government for future changes. Although, in speaking with several lawyers in this group, I found that many see the development of IP law as a way to gain new and wealthy
clients. One lawyer even said to me, they [IPLAN members] are in it for the money.

The US Department of Commerce’s CLDP is funded mostly by the international development institution, United States Agency for International Development (USAID). CLDP’s mission is to support economic and political reforms around the globe. Beginning in 2000, CLDP was awarded $1.2 million by USAID to start a technical assistance program that aimed at improving oversight of publicly financed projects, rework its regulatory functions, and rewrite its patent law. Aside from updating Nigeria’s patent law to meet its obligations to the World Trade Organization, CLDP also claimed interest in curbing the sale of counterfeit goods, including pharmaceuticals, which are highly pirated and counterfeited in Nigeria (discussed in chapter four). The team from CLDP was comprised of employees of the USDOC and the US Patent and Trademark Office some of them with accompanying eyebrow raising biosketches. 18

A Nigerian lawyer familiar with developed country trade agreement tactics comments on US interests:

First and foremost, the U.S. efforts are not altruistic. They aren’t charitable. It is out right self-interest because it will benefit them and benefit their industries. The industries that are at the forefront, intellectual property protection is actually key to their development telecommunications, biotechnology, and pharmaceuticals. So those three areas specifically are totally dependent upon high intellectual property protection to sustain leadership and control of those industries. So it is in their own interests to make sure that there’s a global system of the intellectual property.

This meeting was first in a series of three (the second largely including all of the West African states ECOWAS; and the third was an actual working
meeting set to redraft the Nigerian IP law.) The most remarkable theme throughout all was that the institutionalization of intellectual property law, in a manner that favors the interests of foreign companies, specifically, foreign direct investment, is directly connected to national economic growth. Summing up this sentiment, Professor Adekunde, speaking on behalf of the late attorney general, Chief Bola Ige, stated:

We must provide the basis for leveling up with the industrial countries. There are moral and economic rights at stake. We must ensure the rights of the public to have access to inventions Internet technology and knowledge databases are all crucial for a digital technical society. It can be improved here. Digital technology will enhance global trade. We cannot afford to be on the wrong side of digital technology Genetic resources and internet technology increased in commercial value ($3.2 billion) last year. Traditional knowledge is attracting widespread attention and folklore is taking on a new economic and global significance

He concluded by saying,

Having regards therefore to the importance which intellectual property is expected to play in our national development I want to task your conference to discuss and agree on a blue print which will focus on the operation of a strong and robust intellectual property system which will enable the country to take its proper place in the world I urge our American friends to come out and support the development of our intellectual property administration...

Here the attorney general's comments that launched the conference imagine the global intellectual property system to be a new paradigm for economic development. Consistently echoing this sentiment, the US representatives presented statistical data that correlated a relationship between economic growth and good IP laws and regulatory regimes. Attorney, Justin Hughes, of the USDOC:
One of the key ways in which IP protection is critical to economic growth is as a *precondition for financial and technological investment* (his emphasis) In 1998, we did a regression analysis of patents granted and gross domestic product. That analysis showed a statistically significant relationship between the two. In short, moving up the economic ladder is clearly correlated with exercising intellectual property rights. There is good reason to think that the causal relationship goes in both directions: that increasing wealth makes a country increasingly concerned about its intellectual property and increasing attention to its intellectual potential makes a country more wealthy.

However, there was never an analysis of how good and harmonized laws and regulatory environments magically instantiate increased economic growth. This could be for a number of reasons. The first is that the vocabulary and meanings of economic growth are differently articulated among these actors. The US representatives do strongly believe that foreign direct investment has trickle down effects what is good for the liberalization of markets and barriers to investment is ultimately good for the host country. That is, it is perceived that more jobs, and more economic stability come to such environments, often only measured statistically in gross domestic product and the balance of international payments, not in national infrastructures, poverty indexes, and national budgets. Nigerians may see economic growth measured and defined in entirely different ways. Statistical production and knowledge derived from it, is not usually relied upon, or intuitively viewed as fact or fiction. For example, the temperature in Celsius is never circulated as common public knowledge one day may simply be very hot than the next. No one ever considers the population of his or her village or city; and truly the population of Nigeria is estimated to be between 110-125 million, but no one really knows for sure. Poverty indexes for Nigeria,
derived from UN statistics, easily inform those accustomed to the common parlance of statistical operators that is, many of us are overwhelmed when we hear that over 70 million Nigerians live on less than a dollar a day. But in Nigeria, these figures are not encountered as such, but rather they are socially and corporeally experienced. As an example, there are thousands of men and women selling anything and everything in public and other spaces, including wares and miracle cures on buses, or renting debit cards for the public telephone system. Indeed, I did almost all my shopping in traffic jams while living in Lagos where the informal economic sector is prolific. What gets generated are different kinds of meaning and engagements of economic growth, in which informal sector growth is calculated in marginalized ways that steers attention away from the lack of employment or growth in the formal sector. The sheer immeasurability of these economic and social informal sectors are overwhelmingly tangible (as opposed to any direct feel of GDP or foreign direct investment for that matter) as one either traverses through them or actually experience them in a day-to-day manner.

The second reason for the lack of explanation for how intellectual property law will spur on economic growth has to do with the Nigeria lawyers and policy makers themselves. Many of them are quite keen on leaving this a fuzzy area, as most view foreign direct investment as a way of generating new commercial clients, and wealthy ones at that. Representing the environment as ripe for proper enforcement was precisely what many lawyers and government officials may have wanted to portray to the US. That is, accommodating foreign direct
investment is the priority here. One lawyer reflects on Nigerian government strategies:

Well, as far as the government is concerned they’re only looking at it from their own perspective—global trade, investment, you know this paradigm. And that is very wrong. Because of the impact of TRIPs in other sectors such as environment, health, agriculture, you know, you name it, there’s a need for a coordinated approach that would involve a broader and holistic view so that you can look at it in terms of what the ultimate effect is in all sectors, and be able to balance that out, that is, the so-called trade objectives.

Another lawyer tells me about his own investment in new IP laws:

As a person on this issue I wear more of my commercial cap. If I have somebody that I am representing I will push. If I don’t have anybody I will keep quiet. Because if I wear my academic cap, and say what position best be adopted, will I benefit from that position? I’ve done enough pushing for things and not benefiting.

This unexplained fantasy of instant commercial growth was interrupted by Professor Johnson Ekpere, who served on the OAU’s Scientific and Technical division for ten years where he researched, advocated and designed a model law (a *sui generis* paradigm allowed for in TRIPs) meant to offset the potential economic and ecological consequences of the TRIPs Agreement. In referring to agriculture patents and how they generate the consolidation of an international private seed market, he concluded his talk by saying “not only will you starve to death, you won’t have the money to import the seeds.” This was news to many in the room and one of the conference administrators attempted to diffuse the implication of his talk by saying “for those who understand what Prof just said, you can ask any questions. Many approached him for corridor talk afterwards.”
One of the most interesting presentations that consolidated the stage for future conference relations was made by the Nigerian musical performer, Charly Boy.

Our copyright is our pension in old age, our copyright is our only means of livelihood, remove that and you have removed from us the dignity of labor and the right to life. So tell me why I should not work around with an attitude. You see, the society expects so much from me, they see my counterparts in other countries and wonder what we are doing wrong when we work just as hard, in most cases harder. As new technologies make the infringement of copyright more prevalent, and the subject becomes a more prominent trade barrier, the huge losses due to piracy will provide serious economic and political retaliatory actions from affected countries. What then is my country Nigeria doing to protect me?

Charly Boy outlined the systematic infringement of copyright by Nigerian media and the recording industry, and particularly attacked the state network (also a parastatal), the Nigerian Television Authority, which uses artists work without permission or compensation. He was one of the founders of the Concerned Performing Musicians of Nigeria, which is an organization comprised of entertainers and writers committed to addressing the issue of copyright. Many artists have taken their cases to court, at times with success, and other times, media outlets have not lived up to court orders. Attention to this matter first became visible when the gospel singer Onyeka Owenu staged a week-long hunger strike in front of NTA over copyright infringement.

Essentially, Charly Boy, along with many other artists were calling for a rewriting of the IP law that would award individual rather than collective rights because in practice, he asserted that the Nigerian recording industry does not share intellectual property proceeds collectively. But perhaps more importantly is the issue of piracy, both within Nigeria and abroad (especially during the
NAPSTER phenomena). While Charly Boy addressed problems of piracy conducted by media outlets, and by extension, internationally via NAPSTER, and other internet technologies, there was no mention of the underground pirated music industry in Nigeria, of which products are sold in massive quantities throughout urban traffic jams, right alongside counterfeit drugs. This issue turned out to be a critical erasure, as fighting media outlets in court only scratches the surface of the problems of IP enforcement. But it was an erasure that enabled an alliance with US representatives who wanted exactly what the Nigerian artists were asking for: the most stringent intellectual property protection possible. The US then proceeded to build relationships with the artists,\textsuperscript{19} and emphasized copyright at public meetings while, over time, it evaded the issue of patents, crucial to generic drug access. Ultimately, the US slipped in drafts of a patent bill meant only for few to see. The US also expressed concern over sparse infrastructure and technological depletion, which financed and said yes or no to the very construction of conference agendas that aimed to meet Nigeria's TRIPs/WTO compliance. These expressed concerns gave the appearance of a genuine concern to assist Nigeria in rebuilding its infrastructure, while erasing US agendas and interests.

Questions of enforcement are perhaps the most perplexing. Why exactly is the US so financially and politically invested in enforcing IP protection within developing countries when in fact Nigeria does not have the means to carry out these legal obligations? Illegal manufacturing and distribution of CDs and drugs are not even viewed as such to the general public in Nigeria. Purchasing these
products is seen as the only affordable ways to access recreation and medical care, respectively. As such, the police are not equipped or trained to identify IP infringement. Moreover, they are not motivated to carry out such work as they are far more consumed with financial survival, where if paid regularly, an average police officer makes the equivalent of about $70 per month. Therefore, they are more often engaged with what Achille Mbembe calls private indirect government (2000) where supplementing income comes from extorting money from motorists and others. The court system is much more sympathetic and aware, but even cases upholding infringement claims often do not see the rewards of settlement, as those convicted simply decide not to pay. The call from the US to enforce intellectual property is deeply contradictory. On the one hand, enforcement, that is, the protection of (often) foreign private capital is expected of nation-states who are signatories to the TRIPs Agreement; and on the other hand, there are simultaneous demands to downsize the post-colonial state as conditions of foreign aid, which thus completely hinder the state’s capacity to carry out enforcement measures. Like debt repayment, these provisions must be viewed as a potential form of capital flight. This is, the expectation is to protect IP rights with the use of national resources that consistently escape investment in social welfare.

*Problems with the Law*

The current patent law in Nigeria is based on an early twentieth century British system. The Patented and Design Act of 1990, patents are not at all clearly
defined in terms of what counts as a new and innovative invention. In terms of registration, the law only requires that an inventor comply with documentation (that is, the only requirement is that forms are filled out properly). A lawyer:

We don't have substantive examination in the Nigerian Patent Office. All they do is make sure that the forms are correctly filled and they grant a patent. So you can get a patent for almost anything in Nigeria today, even if it is expired. I mean it could fall into public domain in some other place and they may not scrutinize it. The reason for this is that there is no infrastructure in place: we need pharmacists, researchers, and so forth to do the examination.

Under current TRIPs rules, an inventor must show that an invention is new, involves an innovative step and has commercial use. But in Nigeria, there is no examination process as there are no databases or other resources such as pharmacists or researchers to scrutinize the novelty of a patent. This additionally hinders research and development, as there is no library for patent research in Nigeria. The problem with infrastructure was clearly the greatest concern among conference attendees. As it is an overwhelming problem, attention over the global political and economic implications (and how to develop an IP law that could offset these problems) were not even discussed.

Patent infringement under TRIPs is extremely difficult to determine. Nigerian law requires that a patent application must be filed where the holder is a resident and expects that holder to seek out infringers. While the US, musicians, and pharmacists all want to see enforcement of IP law, they want strict legal procedures against infringement for different reasons. The US and the musicians are seeking protection of their own products. While this may seem like a compatible alliance, the musicians have far fewer resources than US corporations
to register their copyrighted products (required by TRIPs for extra-national protection) and to litigate against infringers in and outside of Nigeria. Pharmacists, however, are far more concerned about the issue of counterfeit drugs in circulation that cause drug resistance and severe health effects. Yet, one of the best ways to secure access to generic drugs in Nigeria for opportunistic infections and HIV are through a TRIPs loophole called parallel importation. Parallel importation is related to what is known as exhaustion of intellectual property rights. Theoretically, in patent law, once a patent holder releases a product on the market, s/he no longer has any monopoly control over that product. In other words, his/her intellectual property rights end (or are exhausted) once a product hits any market. This is significant because many global pharmaceutical companies set different pricing standards for the same products being marketed in different countries. Nearly without exception, the prices of the same product, made by the same company, differ significantly across borders. For example, in Nigeria, prices for some drugs for opportunistic infections are higher than in Spain due to a pharmaceutical industry practice that sets prices according to what country elites can afford. Parallel importation legally allows for a country to shop around for the lowest price on the same product wherever it may be distributed in the world, so long as the parameters (listed as national, regional, and global rights exhaustion) are revised and stated in a country’s IP law.

Parallel importation would be the best option to guarantee lower prices for access to drugs, yet the Nigerian Patent and Designs Act does not allow for any kind of parallel importation. Even if parallel importation were seriously
incorporated into the existing law, there remain several problems due to sentiment on parallel imports, as well as Nigeria's own state policy on parallel imports. The first issue of sentiment lies mostly with pharmacists and other medical workers who dislike the idea of parallel importation due to increased levels of smuggling of fake and substandard drugs, which is an enormous problem in Nigeria (Peterson and Obileye, 2002). Many fear that the already existing grey drug market will only grow worse with the millions of HIV positive people seeking lower cost drugs that may be fake or substandard and which could lead to severe problems of drug resistance. Moreover, many argue that increased parallel importation has lead to a decline in local manufacturing because it is essentially cheaper to import than manufacture due to high multi-taxes imposed on the local industry. Therefore, reconciling legal room for parallel imports with counterfeit drug flows remains almost impossible with the lack of infrastructure in place to secure drug safety.

The second issue on policy has to do with the National Agency for Food, Drugs Administration and Control (NAFDAC Nigeria's drug regulatory agency) registration regulations, which do not allow for parallel importation because the provisions only permit for a national exhaustion of rights. This means that there is limited circulation of products that are covered by IPR in one country to only those put on the market by or with the consent of the patent owner in the same country (that is to say, shopping around is only limited within Nigeria). The Drugs and Related Products Decree states that a drug product must be registered with NAFDAC. For registration, NAFDAC requires power of
attorney from the pharmaceutical company in registration procedures, a provision meant to originally curtail counterfeit imports. Because the pharmaceutical companies are fighting parallel importation due to profit margin impediment, it is unlikely that a company would register its same manufactured product found elsewhere on the world market for a cheaper price. Therefore, both national pharmacy and regulatory laws greatly restrict parallel importation.

In a policy report (Peterson and Obileye, 2001), my co-author and I found that in several ministries some workers and indeed lawyers did not even know about (global) parallel importation as a patent law concept. A pharmacist comments on why this is so:

It is because of the nature of business in Nigeria. What people do is come into Nigeria, get a local subsidiary in which they are given exclusive rights and power of autonomy to get products from America, for example. Your product usually only comes from one place. Britain was our colonial masters and so we got into this habit of never buying, say from Japan. We would consider it fake. So this means that people have never been privileged to explore parallel importation because of a business culture that buys from one place. This is done because it is seen as better and we literally call it more original. They feel that from Britain or America is the primary source where quality products are manufactured.

Moreover, there is little understanding of the TRIPS Agreement among government workers in terms of its relationship to health. The notion of health is not intuitively linked to trade regimes and practices, and with the chronic problem of ministries not sharing information or networking.

Other TRIPs loopholes, or public health safeguards include provisions for compulsory licensing and Bolar exceptions. Compulsory licensing allows for a government official, usually a minister, to declare that in a public health state of emergency (such as high rates of HIV infections), a patented article (e.g. drug)
can be declared for public need. At this point, the government official can then license the manufacturing of said drug to a Nigerian company without the permission of the patent holder. Under the TRIPS Agreement, there are new requirements for compulsory licensing which includes obtaining permission of the patent holder if possible, prior negotiations of price reduction, ending a compulsory license once emergency needs have been met, etc. A Bolar exception provides for a (usually generic) company to conduct research on an existing drug that is under patent. This allows for the generic company to conduct what is known as reverse engineering, which can create a generic copy and run it through clinical trials so that as soon as the patented drug version goes off patent, the generic company can have it ready for market. This is an important stipulation because drug development research can take many years. Instead of waiting for the drug to go off patent to begin research, which could actually prolong the life of the patented drug, it allows for the immediate availability of a generic drug version (Peterson and Obileye, 2002).

However, compulsory licensing and Bolar exceptions, which are touted as significant TRIPs options have very little use in Nigeria due to the fact that the local pharmaceutical industry has severely declined since 1990. Nigeria does not manufacture any raw materials for drug production and must import under the new domestic trade policy that has increased domestic import taxes while eliminating those for foreign companies manufacturing export products. With this stipulation and the extraordinary currency devaluation, local manufacturers
on the whole cannot significantly produce and when they do, they often cannot meet criteria for good manufacturing practices needed for quality drugs.

A pharmacist comments:

Parallel importation is the most important [for Nigeria]. The government will not issue a compulsory license because it is too political. Nigeria's production base is far too small for this and government cannot afford to put money into manufacturing. Right now they are diminishing every aspect of the economy because of external and internal debt. There was a government manufacturing base with all the equipment and everything necessary to produce drugs, but it is not producing a thing at the moment. What the government wants to do is leave everything to the private sector to develop on its own and this includes drugs.

A lawyer adds:

Parallel imports may be good for some countries, it may not be good for Nigeria because at the end of the day it is like saying that we did not want the US to make money, but why shouldn’t it be that Nigeria is making the money?

At the 2001 WTO ministerial meetings held in Doha, Qatar, it was agreed by all signatories that access to drugs would not be hindered by international trade rules. There have been points of controversy in the past, mainly raised by the US, which questioned the legality of compulsory licensing and parallel imports. The Doha WTO Declaration states that each member state has the right to: 1) grant compulsory licenses and have the freedom to determine the grounds upon which such licenses are granted, 2) determine what constitutes a national health emergency, and 3) establish its own regime for the exhaustion of IPR without challenge (subject to national treatment provisions of Articles 3 and 4 of the Agreement). This meeting took place just two months after the September 11th attacks. At the time, the US was attempting to override the patent on Bayer's Cipro to secure as emergency medication for the anthrax attacks (which Canada
successfully achieved). This was not lost on developing countries, which claimed that it was unreasonable for a rich country to challenge patents after a handful of anthrax cases while its policy is to discourage poor countries from overriding patents to address the AIDS epidemic (Agovino, 2002). But since the Doha negotiations, the US and the EU have entered into new negotiations insisting that only certain diseases can be counted under TRIPs health care safeguard rules. No discussion has been reached by negotiating countries as of yet.

Nothing more than stalemates are continually encountered at global trading forums, where Nigerian Geneva negotiators have more recently been rather adamant about the inclusion of public health safeguards. Yet, while the global debate rages on, Nigerian ministries are quietly complying under unfavorable circumstances within US led meetings and behind ministry’s doors in the spirit of congeniality and cooperation. This represents an increasingly common strategy utilized by the US, whereby a) it capitalizes on the lack of communication between ministries, and between ministries and Nigeria’s Geneva representatives, and b) bilateral and regional (trade or otherwise) agreements become the alternative avenue and means for compliance when global negotiations continually fail. Yet, the difference between Nigeria’s position at global negotiations versus local implementation, represents the state’s conflicting desire to be more squarely inserted into the global economy.

*M decins Sans Fronti res (MSF) and the Treatment Access Campaign*

The global humanitarian organization, M decins Sans Fronti res (MSF, Doctors Without Borders), started a global access to drugs campaign after it won
the Nobel Peace Prize in 1999. This campaign has been fraught as it has caused MSF to rethink its own definitions of humanitarianism. MSF began as an organization that provided emergency medical relief inside war conflicts zones, with the strong understanding that it would have a non-interference policy with governments and local organizations. However, the different European arms of MSF have steadily extended their networks into non-conflict or non-war zones where they run health programs for local populations for whom health care is otherwise unavailable.

MSF's operations in Nigeria further demonstrates the organization's unclear ideas of humanitarianism as Nigeria is not at war but experiences serious bouts of civil unrest. But, Nigeria has lived through severe meningitis outbreaks over the last ten years where over 100,000 people have come down with the infection. Outside of MSF, little treatment options have been available and the organization served as the primary institutional intervention into the epidemic. Indeed, when members of MSF discussed these conflicting ideas of humanitarianism, I asked what then is the justification for MSF in Nigeria. I was told that perhaps it was an issue of population sheer numbers with limited access to health care.

While I was in Nigeria, MSF was in the initial stages of starting a new access campaign, in line with its global campaign operations, and it ended without much success shortly after I left the field. MSF encountered a great deal of problems in getting the access campaign off the ground due to two primary reasons. The first is that their own hands-off policy made them initially unclear
about how to manage and interact with local NGOs. The non-interference policy actually kept them from understanding the dynamics of local NGOs the players, the real experts on the ground, and generally how the system and strategies of AIDS NGOs work. The second reason has to do with the NGOs themselves. Because MSF was organizing primarily around TRIPs and not any other drug access issue pertinent to Nigeria, many NGOs showed up to meetings not necessarily interested in, or had any knowledge of TRIPs impact on drug access. Others clearly just wanted close affiliation with an international NGO for personal or professional reasons. When these local NGOs found that a lot of work needed to be done, including research, they never showed up again. This could be due to several reasons: NGOs are already consumed with a great deal of work and many could have been put off by what was perceived as MSF’s lack of leadership. Some of the AIDS NGOs did maintain some consistent showing at the meetings, but no true working relationship with MSF actually materialized outside of these meetings. Often when NGOs have meetings and invite others to attend, it is understood that transport fare and lunch will be provided. MSF always provided lunch, but never transport fare, which limited participation. MSF was completely unaware of this culture of the NGO institution and never made plans to actually assist other NGOs.

By February 2001, *This Day* newspaper published an article on a new trade policy bill that was on the floor of the House Assembly. It was followed by an op-ed piece by the chairman of the House Commerce Committee, Rep Abdullahi, who outlined why Nigeria should reject WTO provisions. This spurred
a bit of a panic within MSF because up until this time, it was completely unknown that the government seemed to be moving into action. An emergency MSF access coalition meeting was convened and many people attended, including two of the handful of WTO legal experts in the country. At the time, the MSF-Nigeria leadership was lacking institutional stability. For over a year, MSF had a high turnover rate of its ex-pat staff and neither domestic nor international NGOs and international agencies really understood what MSF was doing or what it was up to. And with each turnover, there was little briefing on local context or status of TRIPs and treatment access. When a couple of international legal experts both Nigerian and based in Lagos showed up to this meeting, I got the distinct impression that some of the ex-pat staff were surprised to see the sophisticated level of analysis. Indeed, the national staff was there to work for the ex-pats and not always considered experts in their field or Nigeria.

At this meeting the Nigerian TRIPs experts outlined the problems.

Expert 1:

The US is pushing very hard to create an environment for companies that want the strongest intellectual property protection possible interests that are solely driving the current developments. Those in power do not understand the implications. They only see these new developments in terms of getting foreign investment and don't see the impact on social welfare. They are willing to bend over backwards to foreign investors.

Expert 2:

The draft trade policy was developed by the Minister of Commerce and was circulated for comments. This is the new patent legislation. The government does not know about this. There was an editorial that shows that people who are in the system are sympathetic to alleviating the impact of TRIPs and we should seek them out. We don't have adequate knowledge in country. They're different concepts of essential commodities. There is a need to create a package that is easy to understand
and easy to sell We have virtually no legal experts on patents in this country.

At the time, there was no true understanding of what was going on at the federal level. No one knew if this trade issue in the House was a bill or a policy that was going to be decided upon. No one knew the Ministry of Commerce's agenda or where all the relevant documents could be found. Again, I found myself in the midst of an ethnographic not-knowing that eventually brought me into contact with an unknowing state. The meeting ended with strategies of acquiring information. I volunteered to meet with the *This Day* reporter who wrote the article on the trade policy. After several calls and a visit to the *This Day* office, I found that the journalist was based in Abuja. We agreed to meet that same week. He could not give me any further information on the bill/policy, but I was taken aback when he said that the chairman of the commerce committee wanted to meet with me. So I went to the gates of the National Assembly to look for Rep Abdullahi. When I arrived, the guards told me that I needed a letter of invitation to pass through. I told one of them, But, sir, I need to see Rep Abdullahi, and was simply allowed to enter. I found his office and waited for hours. Eventually, I left a note under his door with my cell phone number and left. I proceeded to keep trying to look for the bill/policy or any information while I waited and hoped that the chairman would call me. I encountered journalists, policy-makers and lawyers. At the time, some AIDS activists that I knew were attending an advocacy workshop in Abuja. I stayed with one of them in her hotel room. One night during my week-long stay, my friend told me that I needed to meet a lawyer she knew who she thought could help get some information. A quintessential big man,
he entered our room and told me more about his connections with government, his familiarity with government officials (how he womanizes with them) and less about anything else. I never heard from Abdullahi and never heard much more about the trade policy/bill. Nothing ever came of it.

Documents and policy-makers are some of the clearest indexes of state practices. But going in search of such objects shows the difficulty in ascertaining the very contours of the state. I was dwindling in and out of all of its public and private layers, unable to filter out what precisely needed to be zoomed in on, something not unfamiliar to the majority of Nigerians. This omnipresent encounter with the state is the flipside of the violent encounters experienced by PLWHA in medical institutions, where shadows and violence are intertwined and expressed simultaneously.

In the end, trying to track down what might be considered authentic documents and people foreshadowed what was to eventually come as the intangibility and lack of transparency are also characteristic practices of the USDOC that fit in neatly with the non-transparent entities and practices of the Nigerian state.

ECOWAS intellectual property meeting

By April 2001, the US had returned to convene a West African regional (ECOWAS) meeting on TRIPs compliance. This meeting was advertised in the national newspaper, The Guardian, and among many items on the agenda was a panel called, Problems with Parallel Importation. I found this curious because defining the problem of parallel importation from an USDOC and Nigerian
perspective would yield entirely different ideas. But when I arrived at the meeting, I was surprised to see that the panel was taken off the agenda completely. Instead, throughout the entire conference attention was drawn to copyright and trademark rules because both these issues, as pointed out earlier, give the impression of true alliance and concerns over national and regional technological development. Patents were neatly avoided as they point to issues of skewed power and problems around national sovereignty. In fact, some presentations made by the US contingent focused almost exclusively on legal issues outlined in TRIPs pertaining to internet and genetics technology. I remember sitting in these sessions in a remarkable state of disbelief. For, how many lawyers and policy-makers in the room, especially from places like Burkina Faso and Mali, actually had clients who would be concerned about cybersquatting and single nucleotide polymorphisms (SNPs, which are DNA sequence variations that occur when a single nucleotide in the genome sequence is altered)? I tried to remain open to this, knowing full well that such technologies should never be imagined as off an African technological map. But when it came time for question and answer, the legal questions that were more germane to current technological contexts and unfair trade elucidated the priority for national development concerns. During question and answer periods, comments from the floor addressed these concerns:

Burkina Faso representative:

Voluntary licenses do not work at all. We need compulsory licensing because we know that the holder will not give it up voluntarily. Medical structures to manage the health system effectively are also needed.
Nigerian woman:

Because the [local] manufacturing industry is in decline there’s no use for government to issue a compulsory license.

Nigerian man:

Compulsory licensing is hard to achieve. We need to include parallel importation in the patent law.

The following exchange deserves attention:

Question/statement (Nigerian scientist):

Why don’t African countries comply with TRIPs? Well, we can see the problem with trade sanctions against South Africa, Thailand, Brazil, especially on the issue of parallel importation.

Answer (USDOC):

First, TRIPs was negotiated. No one was forced to sign the agreement. Second, South Africa could have given compulsory licenses, but did not take the measures to do so under Article 7 [of TRIPs]. In terms of parallel imports, Article 6, and exhaustion of rights: TRIPs agreed that exhaustion would not be affected. So South Africa can make a law to allow parallel imports that would not affect TRIPs, but their own national medical law is the actual problem. There are no cases at the World Trade Organization with South Africa. It is simply that pharmaceutical companies are suing South Africa in the high court of Pretoria. In terms of essential medicines, it was found that five out of 23 essential medicines were under patent. The problem is not with patents, but with tariffs and customs.

The scientist above was pointing out instances of trade sanctions or threats of trade sanctions against countries that are attempting to access generic drugs either by parallel importation or by compulsory licensing. Thailand, for example, faced US trade sanctions after it attempted to make a generic copy of the drug, fluconazole, which is part of the anti-HIV combination, manufactured by Bristol-Myers Squibb. This drug was originally designed by the National Institute of Health, a US government agency, and the patent was turned over to the company
for sole manufacturing rights. The cost of the drug for monthly use in Thailand was greater than the average Thai wage and therefore the Thai government began local production, as the patent was not licensed in the country. The US threatened increased tariffs on Thailand’s jewelry and wood exports (which constituted 25% of Thailand’s total exports) if the country did not return to exclusively marketing patented products. Under US pressure, Thailand adopted a law banning parallel imports and ended its fluconazole program. This threat came at a time when the Thai economy was in the throes of the widespread Southeast Asian financial crisis. Thai physicians and patients were particularly outraged when they discovered that fluconazole was invented by the US government and is licensed on an exclusive basis to Bristol-Myers Squibb. Moreover, Thailand adopted a bill that severely restricts the use of compulsory licenses. Under the urging of US trade officials, Thailand implemented a law that is much more restrictive than the rules set out in the TRIPS agreement. The idea that TRIPs provides for public health loopholes as stated by the USDOC representative is simply an echo of what is stated in the document. The case of Thailand shows that a conflict between what is allowed in TRIPs and the legal duties of the US Trade Representative to search out those countries who defy US interests is really at issue here.

The response by the USDOC obviously evaded this issue and pointed out what the Nigerian scientist was not exactly right about: South Africa’s own medical law. The pharmaceutical industry indeed brought legal action against this law, which was eventually dropped due to world-wide outcries and pressure. Perhaps more important though is the idea that no one country was actually forced
to sign on to TRIPs. The notion of force has to be qualified, as minimally all countries knew that not signing TRIPs would marginalize them outside of global markets. Moreover, the idea that there was a lack of force implies that there is an even field at the negotiating table for which all parties are equal players and have adequate infrastructures and expertise to carry out enforcement. But even the history of GATT negotiations since the 1960s, as well as the case of Thailand, reveals a very particular materialization of power, leading to conflicts between desires for national sovereignty and global market integration.

At this ECOWAS meeting, there was a remarkable difference in the tone and I got the distinct impression that this was no longer a jointly shared organizational project by both the USDOC and IPLAN. Several lawyers who are members of IPLAN told me in the corridor that the US had basically taken over the agenda entirely. One person in particular seemed remarkably perplexed and perhaps a little disturbed by these turn of events, as it was viewed that IPLAN and USDOC were on the same side. At a lunch break, I decided to sit with the USDOC and talk about their work with them. They were all very pleasant and to my surprise disclosed to me a number of details about their work. It was the first time that I found out that the USDOC was conducting meetings like this throughout the world, especially in newly democratic states such as in Eastern and Central Europe. I was also told that the majority of their funding (about $1.2 million for Nigeria) comes from USAID. This information absolutely silenced me for a moment because while USAID has been known to fund nefarious projects in the past, it also allocates a great deal of foreign aid to HIV/AIDS
development in Nigeria. This money usually gets distributed to local NGOs, which are looking for ways to get inexpensive medical treatment to members and clients. To many AIDS NGOs, this may have the appearance of a USAID policy contradiction, which supports AIDS activism yet also works to severely curtail drug access. But there may not in fact be a contradiction, as USAID funding for prevention and education campaigns are located in the realm of individual empowerment and responsibility, drawing attention away from the legal structures that generate obstacles to pharmaceutical flows. This point of information would later lead to a final bitter dispute between the US and AIDS activists in Nigeria.

The Beginning of the End of the MSF Treatment Access Coalition

By May and June 2001, MSF got final clarification from its Amsterdam office on how to proceed with the access campaign. Two meetings took place whereby MSF made it clear to the group of NGOs that for some time they themselves were not clear on their own role. It stated that now was the time for the group to take over coordinating activities, with MSF providing technical and legal support, and financial assistance for workshops and education. However, promises of technical support to NGOs were reneged in the past. MSF was asked by several NGOs to give a presentation at the OAU Heads of State pre-summit on HIV/AIDS just a few months prior. MSF decided not to participate because it would be too political due to the fact that a march at the end of the pre-summit meeting was scheduled, one that turned out to be jovial and non-confrontational. Little did MSF realize that NGO practices are often regulated by their funders. Indeed the Ford Foundation, UNICEF, and the Policy Project were all in
attendance. Moreover, MSF did not contact anyone to say that they were not showing up which essentially angered many AIDS NGO members and broke any promise of future relationships.

At the coalition meeting, MSF emphasized that the problem of drug access belongs to Nigerians and because MSF is comprised of ex-pats it could not lead the direction of the group. MSF also stated that it could contact international companies, which could provide generic drugs at affordable prices. As usual, there were new faces at the meeting and the group had never cohered in a way that could make the coalition function to pressure government for TRIPs health care safeguards. Everyone in the room understood MSF’s position and discussions then revolved around strategies, such as making action plans clear to the members themselves. One person restated what was almost always said at these meetings:

We need to get the position of other stakeholders so that we know what to do. Organizations in Nigeria such as CISCGHAN [an AIDS coalition] should be involved. In terms of the experience from around the world, what you find is that is human rights groups and people living with HIV/AIDS are the ones mainly involved. But human-rights groups are not very well-informed in Nigeria. I have been talking to human rights groups about advocating for HIV/AIDS. To form a coalition we need more human rights and people living with HIV/AIDS groups. We need to define what we need to do. We need to identify the problems the basic reasons why people do not get drugs. Then it will be easier for us to tackle the problems.

As people volunteered to take on different tasks, one person in attendance suggested that a coordinator be appointed and another suggested that MSF take on the secretarial work, to which MSF restated its hands-off position. The discussion then launched into a very interesting direction that MSF was not expecting. The
issue at hand was how to institutionalize the coalition. Suggestions were made to register it as an NGO, hire office staff, recruit a board of trustees, and apply for funding. MSF insisted that the coalition was a coalition and not an NGO. The perceived need to set up an NGO comes from both the existing relationships between NGOs and the development industry that have to meet standard funding rules set by the state. But it is also characteristic of Nigerian NGOs seeking status-building relationships with international agencies, which blends into already established ideas of status and hierarchies. At one point, one person asked, how exactly does a coalition function? The genuine confusion over how a coalition operates without an NGO structure reflects ideas of AIDS volunteerism in Nigeria, where some form of remuneration is expected for one's time. Taking time out of one's daily work routine, even if that work is related to drug access, was not entirely conceptualized by the some of the Nigerians attending the meeting. Following this discussion was more talk about problems that typify drug access in Nigeria. The appearance was that MSF was expected to do the work. Now with MSF out of the organizational picture, the meeting space resorted back into the frame of just talk.

It was decided that a steering committee and a coordinator would be selected. MSF has been very accustomed to providing expertise and technical assistance to access campaigns in other parts of the world, where treatment coalitions have been led by HIV positive people. In this meeting, a pharmacy expert on treatment was nominated by a representative of the local manufacturing industry. As far as a couple younger AIDS activists were concerned, he had no
place there, but reticent to actually oppose his nomination as it would be a sign of disrespect. The same man who made the nomination also wanted to be on the steering committee even though it was his first time attending the coalition meetings. MSF vehemently opposed this because he was representing the local pharmaceutical industry, (and perhaps self-interest) and not the public interest. But in Nigeria, a culture of self-interest takes on a life of its own, not the least of which is restricted to local private capital interests. If compulsory licensing were to be a reality, then local manufacturing was perceived as needed to be on board. Most people in the room supported his presence on the steering committee because they viewed themselves to have more in common with the local industry (with desires for it to be revamped) than with the global companies, and he remained on the steering committee. MSF’s opposition to the industry presence on the steering committee may have contradicted earlier statements made about its hands-off position. Later, after this five-hour long meeting, one of the MSF staff said to me, people really don’t have a clear understanding of civil society here. I responded by asking him, and how is it that NGOs can be constituted as civil society with the business relationships that they have with development and humanitarian organizations?

This was one of the last MSF coalition meetings. It never moved into any action for reasons that pertain to the organizational cultures of MSF and Nigerian NGOs. However, a new campaign, called the Treatment Action Movement has since been instituted, with some members who came to some of the MSF coalition meetings. It is housed in an NGO structure that largely functions just like any
other NGO. Perhaps ironically, part of the Treatment Action Campaign’s funding has trickled down from the coffers of USAID.

*Devising a new intellectual property bill*

In November 2002, I sent an email to a lawyer in Nigeria asking him about the status of the IP bill. I had already returned from the field a year previously and was trying to follow the TRIPs compliance progress. He wrote back and said that the Americans were coming back in two weeks to sit down and devise a draft to be eventually submitted to the National Assembly. He had seen a draft and as far as he was concerned, things did not look good for treatment access. I thought that the ethical thing to do was to alert the AIDS NGOs that subscribe to a national listserv about the potential consequences, especially since the government has just initiated a free antiretroviral program for 20,000 people living with HIV/AIDS. All the drugs for this program are generic and come from companies in India; and with an IP bill that outlaws generic purchasing, the program could immediately become illegal.

The day after I sent this mail, I received several mails from Nigeria, especially from the Treatment Action Movement, who wanted clarification and also wanted to spring into action; and two mails from ACT UP and Consumer Project on Technology (CPTech). In no time, Oxfam and MSF Europe came into the dialogue. For the next two weeks, these organizations and NGOs in Nigeria began coordinating to prepare for the meeting. CPTech’s lawyers worked with Nigerian lawyers. ACT UP and MSF Europe put pressure on the World
Intellectual Property Organization and attempted to contact the USDGC who refused to respond or meet. In Nigeria, members of AIDS NGOs understood the implications but did not understand the details of the law. I put them in touch with an IP expert in Lagos and they all met immediately for an impromptu workshop.

I found myself in the middle of putting people in the US and Europe in touch with those in Nigeria, and some already knew each other through prior international conferences. This was not the usual participant observation that I was used to; perhaps it was more of an evocation, as the events that were set in motion were actually generated by me in the first place. But the most fascinating aspect of the frenzied email exchanges and phone calls were the different paradigms of knowledge that international and Nigerian actors brought into this space of urgency. Each employed their own understandings around treatment access priorities. For the international actors it was all about TRIPs and the history of US intervention on health care safeguards, for which they often carried out rather high profile battles at international trading forums against countries who represent the interests of transnational pharmaceutical companies. For many of the Nigerian actors, problems of treatment access was confined to lack of political will on the part of government, and it was at first surprising for some of them to see that the US might have a devious agenda on the table. This was perhaps due to the fact that some of them receive funding from US institutions, but also due to a fantasy-like image that most Nigerians have about the US. International treatment access NGOs often evade naming problems of political leadership and medical infrastructure as serious obstacles to drug access for at
least two reasons. The first is that it may be perceived as being in line with the pharmaceutical industry, which names infrastructure and political leadership as reasons why drugs should not be distributed to Africa and other parts of the post-colonial world. The second has to do with constructing the dichotomy of all-powerful global companies against weak individuals and nation-states, for which the post-colony especially is reified into a monolithic structure within which power relations are represented, perhaps not intentionally, as homogenous. Both international and Nigerian NGOs are partially right about their own contextual assessments. But in the course of these email dialogues, and the disconnect of knowledge paradigms employed to advocate for action, it was clear that all actors involved imagined post-colonial relations as comprising a clear divide between the national and international.

For example, it was soon found out by the Nigerian NGOs that the issue of transparency was not simply limited to the Nigerian government. In the past, the USDOC/IPLAN meetings were open to the public and included media publicity. This time, the meeting was closed and organized on an invitation-only basis. Included on the list of invitees were the Nigerian musicians who attended the previous workshops, private practice lawyers, and the Minister of Commerce, among others. The Minister of Health was not informed nor invited and the AIDS NGOs were initially refused access. Because of the ways in which Nigerian AIDS NGOs have been empowered by international funding and connections, which enabled closer relationships to a government that portrayed itself as caring about AIDS, the NGOs used their own connections to demand entrance to the
meetings. I asked an international NGO worker, whose organization receives USAID funding to get some more details on what the USDOC was up to. He contacted numerous higher-ups in USAID who all claimed that they never heard of the USDOC's trade capacity building project and its work in Nigeria or elsewhere. Either the very existence of the program was completely denied, or as in Nigerian civil service structures, the right hand does not know what the left is doing. I told CPTech about these denial and after the meetings, it obtained government documents through the Freedom of Information Act, which substantiated all the information that USDOC provided me at the West African meetings.

One of the biggest issues during these email exchanges was trying to get a hold the draft of the new IP bill to be negotiated and eventually implemented. While MSF Nigeria was attempting to coordinate the access campaign, staff members met with government officials to talk about including health care safeguards in the new patent law. As far as MSF was concerned, there appeared to be guarantees that such measures would be included. Within a few days, the draft of the law surfaced, but no one knew for sure just how many drafts were in actual circulation or if the negotiated draft or another secret draft would actually be sent to the National Assembly. This draft was examined by lawyers in Lagos, Paris, and Washington DC. It was discovered that it was not one of the drafts written by Nigeria policy-makers, but an entirely different draft largely devised and written by the US. It contained what are commonly referred to as TRIPs-plus provisions that would wipe out existing compulsory licensing laws (which
are quite liberal, although never used in Nigeria) and no measures for parallel imports were included. The Nigerian NGO members took their crash-course TRIPs training, made their way into the meeting, advocated for and won the needed health care provisions.

To this day, the draft IP bill has not reached the National Assembly and it is not clear which ministry it may be sitting in for final clearance. As can be seen, many local actors are competing for power and see TRIPs compliance as opportunities and hindrances. But these conflicts point to questions of the legitimacy of the nation, elites vying for foreign investment clients, the drawing of unexpected alliances, and the culture and obstacles of civil service which can quickly dislodge re-imagining the flow of pharmaceutical pathways as a rights paradigm in TRIPs negotiations.

I now turn to a discussion on medical and drug infrastructures and show how clinical subjectivities, medical expertise, and new patient group formations constitute larger questions of citizenship.
Chapter Four

Therapeutic Economies and African Biosociality

In Lagos state, medicines for tuberculosis are supposed to be free. When I go into the hospitals to get medication, I am often told that the drugs are not there. One time, after being told to go home, someone [a medical worker] came up to me and offered to sell me TB medication for a good price. You know I got sacked from my job because I am HIV positive and there was nothing fair about pricing medicines that are supposed to be free.

--Woman who is now TB free after seeking treatment from a health NGO

They want their cake and eat it too

--Nigerian representative of a global pharmaceutical company based in Lagos referring to the demand by AIDS activists for treatment access

People [in Africa] do not know what watches and clocks are. They do not use Western means for telling time, they use the sun. These (ARV) drugs have to be administered during a certain sequence of time during the day. And when you say, 'Take it at 10:00,' people will say, 'What do you mean by 10:00?'

--Andrew Natsios, Head of USAID, testimony against the use of ARV for PLWHA in Africa, at the International Relations Committee of the House of Representatives on USAID's Fight on AIDS, June 7, 2000

Introduction

The massive Nigerian HIV/AIDS pandemic, with over four million people infected, has generated heightened concern over the quality and accessibility of drugs. The new civilian government installed in 1999 has been stepping up efforts to combat the virus in the country, with efforts to revitalize medical services and infrastructure as well as insure prevention and education campaigns directed mostly by non-governmental organizations (NGOs). However, there is very little attention being paid by both government and NGOs to actual drug policy, drug circulation, the quality of drugs, and their rational use in the country. This chapter
maps out what Vinh-Kim Nguyen (forthcoming) calls a therapeutic economy, which he describes as the totality of therapeutic options in a given location, as well as the rationale underlying the patterns of resort by which these therapies are accessed. The notion of therapeutic economy emphasize(s) the link between therapies and wider economic and social relations (Nguyen, forthcoming). The available therapeutics in Nigeria include counterfeit medicine, expensive and out of reach proprietary drugs, traditional medicine, faith healing, and HIV cure claims. The chapter focuses on the problems of pharmaceutical access and distribution, while noting that the other options emerge to fill a desperate treatment vacuum (although in chapter five, I discuss cure claims at length). That is, the many people who cannot afford drugs often resort to numerous other treatment options. In each case, patients invest varying beliefs of drug efficacy beliefs that are contextualized by options and infrastructure.

The production and circulation of drugs in Nigeria is beset by numerous problems. Currently, 49% of all drugs on the market in Nigeria are considered counterfeit or substandard. These drugs are available in tens of thousands of illegal drug markets throughout the country. Rational use is severely curtailed because consulting physicians or pharmacists is unaffordable or infeasible due to their limited availability in most of the country. Thirty percent of registered pharmacies in the country are concentrated in the city of Lagos and many states within the federation have less than five pharmacies (meant to serve millions of people) with virtually no pharmacies existing in the rural areas. Hospital pharmacies face chronic drug shortages and cannot provide for even basic
medicines for endemic diseases and parasites; and hospital workers often keep their own stashes of drugs and sell under the table to patients as a supplemental income. This practice and others have contributed to increasing drug resistance to especially diseases that should be highly monitored such as tuberculosis and malaria. An additional problem is that the Nigerian pharmaceutical industry has declined by 50% over the last fifteen years. Today, only 20% of all drugs on the market are manufactured in Nigeria while 80% are imported. Regulatory bodies are underfunded and understaffed, leaving a lack of monitoring on both imports and locally manufactured drugs. The lack of funding has severely curtailed government and university research efforts on diseases such as tuberculosis (TB), malaria, and HIV. This is particularly relevant because the majority of TB and malaria strains are resistant to most therapy; and there are many sub-strains of HIV endemic to West Africa for which very little or no research has been conducted issues of great concern to research scientists in Nigeria.

Medical infrastructure and drug distribution have declined and become chaotic in the last twenty years for at least three reasons. First, after the civil war and the oil boom of the early 1970s, there was massive hospital and health care expansion and the government was slow to react. Steeped in post-war reconstruction efforts, government could not immediately reconstitute or expand the regulatory organs to forestall the growing chaos of drug distribution as many people seeking business opportunities entered (often illegally) pharmaceutical practice. At the same time, past military dictatorships siphoned off large public funds, which further worsened any efforts to revitalize health care systems and
drug distribution efforts. Second, structural adjustment policies under the International Monetary Fund (IMF) in 1986 contributed to increasing medical and drug distribution decline. The IMF insisted that the Nigerian state cut back spending on public services, including health care and drug revolving funds, both of which continue to be inadequately financed. At the time, the structural adjustment policy also devalued the currency, which cut earning power in half within the first month of IMF implementation. This impeded the IMF's stated goal of total cost recovery in the health care sector, and health care and drugs quickly became unaffordable to over 70% of the population. As a result, Nigeria now has an enormous debt repayment of $2 billion per year. The national health care budget stands at a mere $200 million. On top of this ten-fold difference, half of Nigeria's oil wealth goes to multinational corporations, and currently oil makes up nearly 100% of the country's GDP, marking a significant form of capital flight and lack of resources available for health care and drugs. Third, countries such as the US are becoming more insistent on postcolonial states such as Nigeria to combat counterfeit pirating including drug products. But at the same time, the US insists upon continued state privatization as foreign aid stipulations, which severely curtails the state's ability to actually regulate and monitor drugs. This represents a potential significant transfer of scarce funds that go into enforcing anti-pirating measures that may contribute to eliminating the means to secure generic drugs the only drug products truly accessible to any postcolonial state. Therefore, with all of these factors Nigeria currently is severely limited in financing its own drug regulatory systems. Yet, despite these problems, many
pharmacists have held numerous national symposiums that have generated much media attention over the chaotic nature of drug distribution, illegal drug markets, drug misuse, and the danger of counterfeit consumption. In the process, pharmacists have called for increased regulatory budgets and oversight as well as education for police, legislative and court authorities.

Given this environment that poses few treatment options, the chapter first describes the structural conditions of this therapeutic economy by briefly mapping out global pricing and distribution strategies, and related, Nigerian drug distribution patterns. Additionally, it focuses on how patients seeking therapy negotiate and apprehend knowledge of drugs, structured by their therapeutic options and through which therapeutic subjectivities are shaped. It concludes with a discussion on Rabinow’s concept of biosociality (1992), which argues that the function of market structures and trade related intellectual property law are important factors shaping the evolution of technology and therapeutic subjectivity. That is, for Nigerians, economies of scale and political control are precisely what drives the circulation of technologies, whereby biosociality is articulated in Nigeria and indeed many parts of Africa, via the absence of available drugs, rather that the absence of non-existent drugs. Furthermore, I argue that a different kind of biopolitical regime is at work in the African postcolony where the contours of the state are organized and directed by its relationship to international financial and development institutions. As a result, different and conflicting forms of risk and surveillance interact to produce biosocial relations. As will be shown, the dynamics of global and Nigerian drug
circulation, and global policy networks that organize debt, trade and market viability, provide the very material basis for African biosociality.

**Global Drug Pricing Strategies in brief availability of HIV and OI drugs in Nigeria**

The greatest controversy generating questions of treatment access has to do with the cost of drugs throughout the world. Drug development is not only characterized by a need to fill a therapeutic gap (although this is not always the case), it is also characterized by both commercial and scientific viability. The proprietary pharmaceutical industry estimates that the cost of developing a drug is between $300-$500 million. As a so-called block buster drug can command as much as $4-6 billion per year, delays in bringing a drug to market can cost a company about $1 million per day, according to pharmaceutical industry assessments. Therefore, (in the United States, the minimum estimated market that a big pharmaceutical company is likely to be interested in for it to undertake the development of a drug, is in the vicinity of $250 million a year (Sunder Rajan, 2002: 101). This means that drugs that command a lesser profit may not in fact be worth considering for development.

With these industry assessments, pharmaceutical companies claim that high drug prices are necessary to fund research and development. However, there have been a number of contentions over the actual cost of bringing a drug to market. The Pharmaceutical Research and Manufacturers of America (PhRMA), an industry lobby group, estimates that private industry finances 43% of drug development (other studies by Oxfam report 20%). HAI-Europe (1999a) reports that US drug companies spent US$1.2 billion on direct-to-consumer advertising in
1998 and Atueyi (1999) reports that 15-20% is spent on promotion and advertising. Besides research and development, long time-to-approval by the FDA is another justification for high prices cited by industry. However, anti-retrovirals have the shortest time-to-approval of any class of drugs: a mean of 44.6 months, half the industry average of 87.4 months (Per z-Casas, et. al., 2000a).

These drug cost estimates often erase the fact that the public sector shares a great burden of work in drug development. Indeed, most drug discoveries are made in the public sector (over 60% by some estimates) with many scientific and technological transfers being made from the public to private industry. That is, once government research is completed, patents are turned over to the private industry for manufacturing and marketing. The cost of clinical trials for these drugs is further reduced by heavy government sponsorship: the US government funded more than a third of patients enrolled in US trials for 14 different AIDS drugs (Per z-Casas, et. al., 2000a). Furthermore, the $300-$500 million figure is highly disputed. It was arrived at through an industry commissioned study carried out at Tufts University (DiMasi, 1991), which put the figure at $231 million. DiMasi looked at the number of new drugs approved by the FDA and divided it into research and development budgets that were discounted for the length of time taken to bring a drug to market. Since then, this figure has been adjusted for inflation and the time taken for the development of new drugs (Sunder Rajan, 2002: 134). However, most of development costs come in pre-clinical research, much of which takes place in government funded settings (Sunder Rajan, 2002: 134). Moreover, many of the newly developing drugs are not necessarily meeting
a lack of therapy in the market place, but rather, they are clinical drugs that are attempting to build upon already existing medication or coming off patent (Sunder Rajan, 2002: 135). Sunder Rajan examines DiMasi’s updated report that now puts the cost of drug development at $800 million, which includes opportunity costs that represent the money companies could have made if they (were a investment bank and) had invested in financial markets, rather than in research and development. James Love (1997; 2001, cited from Sunder Rajan, 2002) of the Consumer Project on Technology reexamined these figures and asserted that they rely only on unaudited industry data. Additionally, there is no cited source of pre-clinical trial data to base the figures and a drastic difference in estimates on clinical trial cost between DiMasi’s industry estimates and Love’s IRS data ($65.5 million and $7 million respectively). The fact that much of the research was conducted in public labs and the unconvincing logic of opportunity costs shows that this figure, which has been naturalized as fact by the industry, is quite doubtful.

Despite the various claims of cost, anti-retrovirals have earned significant revenue for the pharmaceutical industry. US prescription drugs sell at the highest prices in the world. Between 1997 and 1999, Glaxo Wellcome’s sales for AZT, 3TC, and Combivir totaled more than US$3.8 billion. Bristol-Myers Squibb sold more than US$2 billion worth of d4T and ddI over the same period (Per z-Casas, et. al., 2000a). In 2002, prescription drugs earned companies $192.2 billion in the US alone, and the industry is growing at an estimate of at least 12% per year in US markets.
The pharmaceutical industry claims that high prices (and certainly intellectual property protection) are needed for new drug innovation. Yet, the global landscape of drugs suggests that there is an overabundance of drugs in especially the US, where pharmaceuticals are available for diseases that do not even exist. For example, the drug Sarafem, manufactured by Eli Lily was created for a new disease similar to premenstrual syndrome, what is now called premenstrual dysphoric disorder (PMDD). Sarafem is actually Prozac and when it was about to go off patent Eli Lily designated a new set of PMS symptoms similar to those for Prozac and even reconstituted the drug color to be pink for its female consumers. Joseph Dumit refers to pharmaceutical abundance and the targeting of new disease populations as surplus health, indexing a particular kind of therapeutic society in the making. Yet, as drugs are available for non-existent illness, proliferating in the developing world is surplus disease where existent and available therapeutics cannot be found or access, and neither are markets, regulatory or medical institutions and expertise that oversee and regulate their delivery. Even for those in Nigeria and Africa who participate in free anti-retroviral programs, the drug regimens themselves are rather cumbersome, as they are designed for life-long adherence. The fact that many struggle to eat regularly a prerequisite of this sort of drug intake demonstrates that the idea of innovation as put forth by the pharmaceutical industry needs to be qualified. Indeed, upgrading existing drugs for non-existent diseases is a dubious assessment of the present-future innovative practices of the industry. Yet, while
this is so, the incredible effects of surplus disease require innovation and certainly a rethinking of what exactly counts as such.

The presence or absence of generic competition in the market is a key determinant to pricing levels, as competition brings down prices dramatically. Even though the generics industry commands great profits, it does play an important social role in accessing drugs by governments with low GDP. It also poses a significant role for the poor as most people in developing countries do not benefit from state health coverage or insurance schemes. If someone in the family is ill, medicine is paid by families who may often sell scarce assets or go without food in the process. The pharmaceutical industry relies upon the TRIPS Agreement (discussed in the previous chapter) to create the necessary conditions for ensuring the continued existence of a robust and wealthy pharmaceutical industry. One important way to ensure this will be to undermine the capacity of generic companies to quickly bring cheap drugs to market (Tickell, 2001). It is in the interest of proprietary companies to wipe out generic competitors because as soon as cheaper drug versions enter the market, prices begin to tumble until the lowest possible price is achieved. If the prices fall in developing countries before rich markets, then the industry runs the risk of demands for price cuts in industrialized countries before the necessary return has been recouped (Tickell, 2001). I would assert that the TRIPS Agreement is designed to wipe out when generic companies whose research cultures involve reverse engineering techniques that is largely frowned upon the by proprietary industry because this enables generics to copy existing drugs. But these companies research
practices may come to an end when generic companies must switch over to a novel research based paradigm in 2005, required by TRIPs. It is left to be seen just how this will impact those who rely on generic products, as Nigeria, for example sources all of it ARV drugs for its free government program (for 15,000 people) from generic companies in India. If this supply dries up under TRIPs provisions, there may be serious risks for drug resistance not only posed to those taking the drugs, but also for those in the general population who may contract resistant HIV strains.

An example of how prices can rapidly tumble with the presence of generics can be seen with fluconazole in Thailand, which is not patented there. Before fluconazole was produced as a generic in 1998, Pfizer sold it for US$7 per 200 mg capsule. Three Thai companies began production and Pfizer dropped its price to US$3.6, even though generic companies were charging much less (Biolab was charging US$0.6). After initially responding to generic competition, Pfizer increased its price in Thailand back up to US$6.2 in March 2000, while Biolab’s price decreased to US$0.3 (20.7 times cheaper than Pfizer’s price). Multinational companies have had to contend with similar competition from Cipla in India. Glaxo Wellcome’s lamivudine (3TC) 150 mg tablet costs 78% less in India than in the US. Brazil generically manufactures a great deal of its anti-retroviral drug supply, which is sold at a fraction of the global prices. A generic form of zidovudine is 14 times cheaper in Brazil than in the US (Per z-Casas, et. al., 2000a). Yet, comparing prices between countries is inherently difficult because of the problem of comparing official exchange rates and real currency values;
differences in pharmaceutical distribution channels (private versus public sector, retail versus wholesale); different strengths and pharmaceutical dosages; price fluctuations over time. As well, companies often price the same drugs in different countries at very different prices, which usually reflects prices that country elites can afford.

A recent objective of the UNAIDS created internationally coordinated programs, particularly the Accelerated Access Initiative, that work with global pharmaceutical companies in bringing down the cost of drugs. In the past, it has been shown that vaccine and contraceptive procurement has been successful when international organizations, national governments and pharmaceutical companies work together to meet priority health concerns (oral contraceptive prices are 130-240 times cheaper in poor countries than in the US). The current UNAIDS initiative has been negotiated in nine African countries — Burundi, Cameroon, Cote d Ivoire, Gabon, Mali, Morocco, Rwanda, Senegal and Uganda — which have reached agreements with four research-based pharmaceutical companies to provide anti-retrovirals at significantly reduced prices. In addition, five pharmaceutical companies (Boehringer Ingelheim, Bristol Myers Squibb, GlaxoSmithKline, Hoffman LaRoche and Merck) and the World Health Organization (WHO), World Bank, UNICEF, UNFPA and UNAIDS, under the Accelerated Access Initiative, are exploring ways of speeding up access to HIV/AIDS treatment in developing countries via price reduction negotiations. For example, Bristol-Myers says that as part of its new proposal, it will sell Zerit and Videx for a combined price of $1 a day, or $365 a year. However, these two
drugs must still be combined with a third to complete the AIDS regimen. Merck’s new reduced price for its drug, Crixivan, is $600 a year, and its new price for Stocrin is $500 a year. Adding either of those drugs to Bristol-Myers’s two medicines will bring the annual price of a three-drug regimen in Africa to about $865 to $965 per year. These are indeed significant price reductions, but given that the average yearly salary in Nigeria is US$624, these prices remain far beyond the economic reach of most in Nigeria.

The Access Initiative utilizes public relations firms to bilaterally negotiate the reduction of high and out-of-reach drug prices in Africa. In exchange, stringent—intellectual property laws are conceptualized, proposed, and often implemented for African states in a manner that favor and protect multinational pharmaceutical companies' business practices in Africa. While these negotiations are being hailed as the best and only option to access treatment, other issues are crucially erased. First, the implication is that there is simply a lack of HIV drugs in circulation, when in fact there are virtually no drugs available in most rural and even urban areas in Nigeria and Africa. The lack of available drugs represents a resource, structural, and financial crisis, which cannot be solved by merely reducing the prices of proprietary HIV drugs. Such measures erase other problematic issues with AIDS policies (discussed in chapter two). Second, even after prices are reduced for HIV proprietary drugs, generic brands remain much lower in cost. Third, the UN and the pharmaceutical industry are not inclined to bring attention to the lower cost of generics because the price negotiations are contingent on intellectual property protection that aims to outlaw importing
generics in negotiating nation-states a strategy that keeps only proprietary drugs in circulation.

The major global companies located in Nigeria are Roche, Swissfar, Glaxo, and Pfizer. During the 1970s they all had manufacturing premises, but now they serve largely as distributive outlets. Most product lines are actually fast moving as a pharmacist states that:

the companies want to defend their products and an importer doesn't want competition, so people will defend their marketing rights. This means that they will be against parallel importation and will be concerned about access. If there is a broad range of products circulating on the market, they are not bothered by a concern that people cannot access drugs. People in general don't understand the access issue. It is something that has not yet taken root in Nigeria. A lot of people do not understand the implication of what they need to fight for, and they don't know what they should ask for. But this is changing because this AIDS thing has got some people worried about access to drugs.

Perhaps making these costs even higher is Nigeria's current trade policy that favors an export economy, in which any piece of land can be declared an export processing zone, generating very high tax breaks for export manufacturing. Nigeria's local pharmaceutical manufacturing industry has declined so severely that it must import 100% of raw materials for drug manufacturing. Through the justification of export trade logic, it was imagined that taxes on raw material would encourage local manufacturing of raw materials. But instead it has generated the near collapse of the industry. The executive secretary of the Nigerian Pharmaceutical Group, Kunle Okelola, noted that the following create substantially higher drug costs (Ikoro, 2001): shipping and handling usually is about 20-30% of drug price; additional costs for shipping to health facilities
(inland transportation cost); taxes paid on imported drugs are 25%; imported raw materials are 5%; there should be no value added tax (VAT) on pharmaceuticals but some are still made to pay 5%, a cost which is now in process of being eliminated; and price mark-up by manufacturers, importers, suppliers, retailers to ensure profits for all. A UN policy maker gives this prediction:

I think that in privatization government hands over everything to the private sector and that is for profit-making. And there, the people you cannot afford to buy the drugs, they will not get it. It will just be for the rich people. Even then it should be supported by a very good social security system, so that everybody has access. Now even those who are rich can't buy it. They cannot buy it because they're not on the market. But in that case, it will at least will be on the market.

Considering global pricing strategies, initiatives to bring the cost of drugs down and state privatization, I turn to a survey that was conducted by MSF in April-June 2000 in Lagos, Nigeria on behalf of the Coalition of Civil Society Groups on Access to Essential Medicines, comprised of 21 NGOs (MSF Nigeria/COCSGAEM, 2001). The survey was done in order to provide information on the availability and affordability of some of the anti-retroviral and OIs medicines in the Lagos area, which represents a great bulk of Nigeria's drug market. Public and private hospitals, community pharmacies and drug companies were visited. Overall, MSF reported that there was very little stock in general in all the facilities that were visited. Those drugs that are expensive are deliberately not kept in stock because of low demand and are purchased only upon request. Patients are often sent directly to the pharmaceutical companies in order to purchase drugs. Only three anti-retroviral drugs were found in four out of fourteen health structures. In the market, although there were many sellers, there
was only one place where ARVs were available. Prices are obviously unaffordable for the majority of the Nigerians (minimum salary per month in Nigeria: 6,500 Naira= $52). Table 1 gives an average price for each item and notes that there is significant mark-up in private pharmacies, hospitals and the market. (Important note: generics ARV drugs were not available at the time of this survey).

**TABLE 1. Average price for selected drugs in Nigeria**

<table>
<thead>
<tr>
<th>DRUGS</th>
<th>PRIVATE PHARMACY</th>
<th>PRIVATE HOSPITAL</th>
<th>PHARMACEUTICAL COMPANY</th>
<th>MARKET</th>
</tr>
</thead>
<tbody>
<tr>
<td>AZT 100mg tab (Glaxo except Apotex)</td>
<td>4.82</td>
<td>1.46-2</td>
<td>0.86-0.24-1.19</td>
<td></td>
</tr>
<tr>
<td>AZT syrup 114:04 (Glaxo)</td>
<td>70</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lamivudine 150mg tab (Glaxo)</td>
<td>3.65</td>
<td>1.32</td>
<td>0.3</td>
<td>75</td>
</tr>
<tr>
<td>Nelfinavir 250mg (Roche)</td>
<td>2.9</td>
<td></td>
<td>1.63</td>
<td></td>
</tr>
<tr>
<td>Saquinavir 200mg (Roche)</td>
<td>0.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>stavudine 40 mg (BMS)</td>
<td></td>
<td>1.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>zidovudine 300mg (Lamivudine 150mg (Glaxo))</td>
<td>0.94</td>
<td></td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>zaltegravine 0.75 mg (Roche)</td>
<td>2.5</td>
<td></td>
<td>1.48</td>
<td></td>
</tr>
</tbody>
</table>

*Source: MSF/COCOSGAEM, 2001*

Note: the prices indicated in the column Pharmaceutical companies are the institutional prices sold at hospitals and pharmacies. The first three items (AZT tablet, AZT syrup and lamivudine) were available in private pharmacies which imports them from the USA, the rest was purchased directly in Nigeria through subsidiaries.

Table 2 lists cost of OI treatment in Nigeria. In the MSF survey, the OI medicines were more available than ARVs. They were also easier to find in the governmental structures, as well as in the pharmacies. Table 3 shows drugs
needed for additional OIs that were, on investigation, found to be generally not available and not affordable.

**Table 2: Cost of OI treatment in Nigeria**

<table>
<thead>
<tr>
<th>Drug</th>
<th>minimum price</th>
<th>treatment period</th>
<th>dosage</th>
<th>treatment cost ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>co-amoxiclav 375mg tab</td>
<td>0.29 g-0.97</td>
<td>7-14 days</td>
<td>1/4ds</td>
<td>12.18g-24.36g</td>
</tr>
<tr>
<td>ceftriaxone 1g inj</td>
<td>1.134 g-25.35</td>
<td>7 days</td>
<td>1g/day</td>
<td>82.88g</td>
</tr>
<tr>
<td>ceftriaxone 250 mg inj</td>
<td>4.61g-8.42</td>
<td>7 days</td>
<td>1g/day</td>
<td>331.52g</td>
</tr>
<tr>
<td>azithromycin 250mg tab</td>
<td>2.2-7.6</td>
<td>6 weeks</td>
<td>1 gmi</td>
<td>66-220</td>
</tr>
<tr>
<td>ciprofloxacin 250mg tab</td>
<td>0.21g-1.6</td>
<td>7-14 days</td>
<td>2bd</td>
<td>448.8-886.6</td>
</tr>
<tr>
<td>ciprofloxacin 200mg/100ml inj</td>
<td>3.32 g</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-trimoxazole 480 mg tab</td>
<td>0.1g-0.23</td>
<td>14-21 days</td>
<td>2 bd of 3</td>
<td>24.64g-83.16g</td>
</tr>
<tr>
<td>rifampicin 200 mg tab</td>
<td>0.05g-0.13g</td>
<td>6 months</td>
<td>2/day</td>
<td>45.46-8.88</td>
</tr>
<tr>
<td>pyrazinamide 500 mg tab</td>
<td>0.09g-0.14</td>
<td>2 months</td>
<td>4/day</td>
<td>21.6-33.6</td>
</tr>
<tr>
<td>albenzaole 200 mg</td>
<td>0.35-0.66</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>fluconazole 50 mg tab</td>
<td>3.58-4.09</td>
<td>7 days</td>
<td>1 od</td>
<td>257.6-28.83</td>
</tr>
<tr>
<td>fluconazole 100 mg tab</td>
<td>2.87-4.47</td>
<td>7 days</td>
<td>1 od</td>
<td>401.8-87.38</td>
</tr>
<tr>
<td>ketoconazole 200 mg tab</td>
<td>0.56-0.75</td>
<td>14 days</td>
<td>1 p/d</td>
<td>7.34-105.3</td>
</tr>
<tr>
<td>acyclovir 200 mg tab</td>
<td>0.21g-1.6</td>
<td>5-10 days</td>
<td>1 tab</td>
<td>447.9-886.6</td>
</tr>
<tr>
<td>metronidazole 200 mg tab</td>
<td>0.02-0.03</td>
<td>7 days</td>
<td>2 tabs</td>
<td>0.84-1.62</td>
</tr>
</tbody>
</table>

*Source: MSF/COCSGAEM, 2001*

Note: g=generic

**TABLE 3. Status of other drugs for OIs sold in Lagos that are useful for treating opportunistic infections**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Drug</th>
<th>Status</th>
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<tr>
<td>Cytomegalovirus (CMV)</td>
<td>Ganciclovir IV, Cidofovir IV, Foscarnet IV</td>
<td>Not available, Not affordable</td>
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<tr>
<td></td>
<td>Extensive Herpes</td>
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</tr>
<tr>
<td>-----------</td>
<td>------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>MAC</td>
<td>Ribavirin</td>
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<tr>
<td>PCP</td>
<td>Pentamidine</td>
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</tr>
<tr>
<td></td>
<td>Trimethoprim-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sulfamethoxazole IV</td>
<td></td>
</tr>
</tbody>
</table>

*Source: MSF/COCOSGAE, 2001*

Note: These drugs are for serious indications and are still under patent. No generics are available except for drugs treating PCP.

On the availability of drugs, a medical doctor told me:

People should have access to drugs. Drugs must be available where they need them, and drugs must be accessible, the drugs must be affordable, the drugs must be acceptable. These things are lacking with regards to drugs in Nigeria. They’re lacking. The drugs are not there. I was this thinking this morning myself that how many doctors have seen antiretrovirals in Nigeria? Throughout my stay at UCH [as a medical student at the University College Hospital at University of Ibadan] it is supposed to be the best, hospital in this country I did not see a single ARV. And I was seeing patients every day. You can imagine what that means. So where’s the access?

**Drug distribution**

Many global AIDS activists located in Europe and North America are very much invested in securing access to drugs for poor people throughout the world. One of the many avenues that they take are fighting for legal provisions in the TRIPs Agreement that increases access to generic drug access. At the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) held in New York City in July 2001, which I did not attend, but was reported back to me by many Nigerian AIDS activists upon their return to Lagos, I was told about conflicts that emerged between African AIDS activists and Western AIDS activists. On the one hand, Western AIDS activists were concerned about international trade rules and high drug prices that hinder access to drugs in the
developing world. On the other hand, African activists were more concerned about political accountability of their nation's leaders linked to problems of infrastructure that impede quality medical care and medicines. These are not necessarily incongruent concerns, but activists outside of Africa are hesitant to acknowledge these concerns because they are often the very same issues, particularly lack of infrastructure, used by the pharmaceutical industry to justify low or absent distribution and out of reach costs. AIDS activists in the US and Europe generate a wealth of information, exchanged over list-serves and webpages. It is quite astounding how well they track even the most minute drug price fluctuations across nation-state boundaries. However, it is nearly impossible to find information circulating in these internet spaces on just how HIV and related drugs are distributed. One can read about price reduction victories in African countries, but one would never know that the availability of such drugs may only extend to a few urban hospitals, pharmacies, and NGOs. So, as there is a paucity of drugs in Nigeria and Africa, there is also a paucity of information on the problems of in-country drug distribution, and is probably one of the most important reasons that activists and policy makers who organize globally around AIDS issues, 1) strike entirely different agendas in their policy and activist work, and 2) generate biosocial formations are necessarily distinct across borders.

In thinking about problems of infrastructure in Nigeria, both Western and Nigerian AIDS activists have not delineated the structural conditions of drug distribution that include counterfeit and substandard drugs, drug shortages, illegal drug markets, self-medication cultures, lack of pharmacies, problematic
prescribing practices, and failed government sponsored drug revolving funds, which are all discussed below. As such, the political agency of various actors are also rarely discussed, particularly those who are off the anti-globalization activist maps, such as Nigerian pharmacists, policy makers, business people (legitimate) or otherwise, and infrastructures who/which play specific and, sometimes, contradictory roles in drug delivery.

Therefore, my ethnographic terrain is not about tracing the social life of a drug, as Marcus and Fischer have suggested as a methodological practice (1986) that might suggest that many actors are constructing one universally understood object here. But rather, tracing what Sunder Rajan calls a drug’s imaginary life, which suggests that drug-as-object has different political meanings and trajectories (45). Therefore, it is an ethnography that attempts to open up the imagined didactic exchanges between producers and consumers of drugs in order to filter out the deeply chaotic nature of drug circulation in Nigeria and indeed chaos was always the word used whenever I asked about drug distribution.

The original drug dispensation program was based on a colonial administrative system where drugs were transported to central stores and dispensed by government pharmacists. Following the Biafran Civil War and the oil boom of the 1970s, there was massive hospital and health care expansion. The colonial system of drug dispensation could not meet the needs of an expanding health care system and the government was slow to react. Moreover, there were post-war businessmen who were looking for commercial opportunities and entered into pharmaceutical practice. This is the point upon which the circulation
of substandard and fake drugs became a concern in Nigeria. Government, steeped in post-war reconstruction efforts, could not immediately reconstitute or expand the regulatory structures to forestall the growing chaos of drug distribution. (Editorial/EKO Pharmacist, 2000). Currently, laws pertaining to drug distribution are rarely enforced (as there exist no budgets to do so) which is perhaps the main reason why distribution is chaotic, and illegal distributive outlets persist.

The import license era during military rule was uncontrollable, as non-professional pharmacists could freely import drugs and sell them at huge profits. Together, military and civilian counterparts took over drug markets. Additionally, overseas manufacturers found the 70 million-person market as lucrative and started to pack and distribute imported drugs in Nigeria. Companies such as Pfizer, Abbott, Glaxo, Wellcome, and Roche came to Nigeria and started to manufacture drugs. (Editorial/EKO Pharmacist 2000). Not until 1990 was the National Drug Policy executed which gave rise to the National Agency for Drug Administration and Control (NAFDAC), Nigeria’s equivalent to the US Federal Drug Administration (FDA). In my time meeting with regulatory officials, they have pointed to the explicitness of decrees that outline the multi-sectoral government officials who are responsible for organizing the means to carry out decrees. When I asked a Pharmaceutical Council of Nigeria (PCN, which regulates pharmacy premises and pharmacists) official what happens at the meetings, he responded (with a smile) that perhaps they do not meet at all. Each time I visited a high official at NAFDAC, I always arrived after NEPA took light, that is after electricity was shut off by the power company in that part of
town (a daily occurrence whose timing is unpredictable), walked eight flights of stairs, and hung out in a dim room with workers who were restricted from performing duties with no electricity a simple infrastructure requirement that helps to enable regulatory practices.

Equally important is that pharmacists have lost control and there are few enforcement efforts to curb illegal activity. The private sector distributive outlets are currently concentrated in urban areas while the rural areas are neglected. Problems of parallel importation of counterfeit drugs and drug dumping have led to questions of safety, efficacy and quality of drugs available and accessible in Nigeria. Drugs can be purchased from nearly any outlet including manufacturers, wholesalers and retailers. Both over-the-counter and controlled drugs are available in open markets, pharmacies, patent vendors, hospitals, etc. In other words, drugs that are available are very easy to find and very difficult to control. However, many of the drugs available especially from illegal outlets are fake and/or substandard. Therefore, the end user has trouble accessing quality drugs at the right time, for the right price, in the right quantity and quality, and from the right people (Anyika, 1999).

Drug Shortages

Several fundamental problems have emerged with chaotic distribution in Nigeria. One is that there is a chronic out-of-stock syndrome, in which drugs that are needed by the populace are continually unavailable. Drug shortages are considered as the a) physical absence of prescribed drugs as a result of primary
non-availability and b) inability of the patient to go home with the prescribed drugs even when such drugs may be available in the hospital. Chukumerije (1982) reported that drug shortages in hospitals are fairly rampant. One reason for the shortages includes inadequate budgeting for drugs, where salaries command the bulk of hospital budgets with little left over for supplies and equipment. Also reported were prescribing drugs for which substitutes were available, prescriptions based on patients' wants, prescribing for self or relations, and prescriptions of brand products. Furthermore, there are flaws in pharmacy practice, in which pharmacists access drugs through the wrong purchasing system and order too many bulk supplies which lead to easy drug expiration. Drugs have also been found to be stored under the wrong conditions and there additionally exists a lack of hospital formularies leading to problems of pilfering. Sometimes payment is not made regularly to contractors, which hinders supplies (Chukumerije, 1982).

It should be noted that there are several government-run free drug programs and there are many reports that indicate problems with drug shortages and lack of access in these programs.25 I spoke to several PLWHA with TB co-infection who told me that sometimes when they go to retrieve TB drugs from the free programs there are none available to them. Some even reported that medical workers had private stashes of drugs that they offered to sell under the table, usually at high prices. I spoke with several people patronizing free programs who experienced this and none of them knew how hospital workers got the drugs in the first place. One woman told me that drugs
are not easy to get. It's not easy. Like I was going to the teaching hospital on my own. I have been going there since January [2001]. And since May [2001 it is July 2001 at the time of the interview] they are not getting supplies. It is difficult because according to what I had [tuberculosis], it is no good when somebody starts a line of drugs and then suddenly stops. That is what makes it difficult. Some people can start getting it now, but as time goes on, they cannot get supplied. So this is a discussion of great concern among patients who are using these drugs.

It must be kept in mind that among many other factors, the failure of free treatment programs largely fails because of inadequate drug distribution, which contribute to high levels of drug resistance. I spoke with a worker at the Lagos State HIV/AIDS Control who told me that when they go to the hospitals and ask if TB medication is there, they are always told that everything is in stock. I told her that many PLWHA that I spoke to gave me a quite a different story. She replied negatively when I inquired as to whether she ever asked to see the drugs that were in stock. Drug shortages can be disastrous for HIV and TB infections that are difficult to monitor and can develop fast resistance if drugs are not available and properly administered.

For many PLWHA, access to drugs can most easily be attained through clinical drug trials. NAFDAC requires that any new marketed drug entering the country must first undergo an FDA Phase III clinical trial equivalent in order to be properly registered. The global companies usually go to teaching hospitals where drug trials are set up and administered. I spoke with many PLWHA who participated in some of these trials. Most of them experienced several problems, including being forced to pay up to $300 per month, a policy unheard of in the US, where clinical trial participants are usually compensated for being a clinical
trial subject. Additionally, none of the people I spoke to received any type of informed consent. They all responded negatively when I asked if they signed anything or received information on the purpose of the trials, or the way the drugs are supposed to work. One woman even told me that she was not told how often she was supposed to take the drugs. Very shortly after she was put on the trial for prevention of mother to child HIV transmission, she went to Durban, South Africa for the 2000 International AIDS conference and it was at the company's booth where she found information on dosage and side effects. Another woman told me that she was given expired drugs to which the chief doctor at the Nigerian Institute for Medical Research intervened on her behalf and was eventually given proper unexpired drugs. But such delays in her treatment poses risks to drug resistance.

**Substandard and counterfeit drugs**

A second problem that has emerged is the number of substandard and counterfeit drugs circulating in Nigeria that enter the country, as well as high numbers of stolen and smuggled goods. Substandard non-counterfeit drugs (both imported and locally manufactured) are abundant. A substandard product is one that contains excessive microbial contamination or has too much or too little active ingredients contributing to drug effectiveness. The Nigerian and other pharmaceutical industries sometimes produce products with contamination in excess of established limits, which is often due to inappropriate or contaminated water supplies, raw materials, and storage (Ogbeche, 1998). Pharmaceutical products such as oral and topical preparations are generally not required to be sterile. However, it is desirable that they contain low levels of microbial
contamination. High levels of microbial contamination may result in spoilage and degradation of the products and/or may constitute a health hazard to the user. A study carried out by Onawunmi (1999) showed gross contamination of the samples tested with pathogenic organisms such as \textit{E.coli} and Salmonella. The presence of these contaminants is attributed to the contaminated water and raw materials used and non-adherence to good manufacturing practices (GMP). Notably, a report by the Netherlands Leprosy Relief and Royal Tropical Institute, showed that most of all the TB drugs analyzed in Nigeria did not pass the quality assurance test and suggested that this is a major contributor to the development of multi-drug resistance TB (van der Grinten, 2000).

In April 2001, \textit{The Lancet} reported that out of 581 drug samples available in Nigerian pharmacies, and selected on the basis of their inclusion of the World Health Organization's Essential Drug List, \textit{nearly half} (48\%) did not comply with set pharmacopoeial limits (RB Taylor, et. al., 2001), pointing to both substandard and counterfeit drugs in circulation. Counterfeit medicine is a pharmaceutical product that is deliberately and fraudulently mislabeled with respect to identity and/or source. Such drugs may include products with correct ingredients, with the wrong ingredients, without active ingredients, with insufficient quantity of active ingredients or with fake packaging. There is inadequate and little consistent information about the scale of worldwide pharmaceutical counterfeiting. According to public and confidential reports received by the WHO between 1982 and 1997, counterfeit pharmaceuticals were found in at least 28 countries, although many cases were not confirmed or validated. In 25\% of 751 cases,
counterfeit drugs were reported to come from the following places in the following percentages: 25% from industrialized countries, 65% from developing countries, and 10% from unspecified sources (WHO, 1997).

Counterfeiting in Nigeria came into existence before 1974 when the Food & Drug decree no 35 of 1974 was promulgated. Due to national and world economic recessions, drug products were placed on import license. With the devaluation of the currency, the expendable income of the average Nigerian became low. One of the problems was that drugs became unaffordable to most Nigerians and the high demand of drugs, due largely to their inappropriate use, still persisted. This created a vacuum that lead to the rise of illegal importing of fake drugs, which came in cheaper than the genuine drugs imported by qualified or knowledgeable importers. When government became aware that the existing decree could not adequately address the situation, the Counterfeit and Fake Drugs Decree no.17 of 1989 was promulgated. This established the Federal Task Force (an arm of NAFDAC) in 1989. However, these decrees are rarely enforced, as the police have little training on these issues and indeed little interest as their own low salaries may suggest that they have an interest in sustaining cheaper drugs (and as an aside, the urgency to extort motorists at road blocks), even though they might be counterfeit.

Counterfeits are a major cause of treatment failure and the development of resistance. Counterfeits also increase morbidity and mortality, while decreasing productivity and further worsening the economic burden and poverty of the masses (Brown, 1999). PGM-MAN (2001) reported the following statistics:
49.6% of counterfeit drugs can be traced to open drug markets; patent medicine dealers distribute 32.8% of counterfeit drugs; 58.8% of physicians in Lagos purchase from open drug market dealers as their vendors of choice; 10.8% of cases of consumption of counterfeit drugs lead to adverse drug reactions and fatality.

The Director General of the Agency NAFDAC, Dr. Dora Akunluyi, stressed the alarming growing rate of Nigerians dying of hypertension, heart failure and stroke linked to fake and adulterated drugs in the country. PSH (2000) reported that nearly half of all counterfeit drug intake leads to resistance to drug therapy as well as worsening symptoms. Nearly thirty per cent of all physicians reported that their patients experienced life threatening encounters with fake drugs and 10% had encounters resulting in death. And nearly 35% had adverse drug reactions and the development of complications. An AIDS activist:

Something very, very traumatic is happening in our society where substandard drugs have gotten in. So if you're talking of (laughs) access to essential drugs (laughs) or access to drugs that have full potency-- what kind of drugs are you actually accessing (laughs)? So what are you actually backing when you say access to drugs? I want to deal with issues that are fundamental because assuming that we now say we get access to drugs, we now say, OK, all government should do is to subsidize all drugs where pharmacists are empowered in every local government--those are ways to handle it. They now say that government should establish local government pharmacies--the 777 local government areas--each one has one, drugs to be subsidized and it will be of good quality.

A UN worker on drug access:

OK if we talk about rights, every positive person has the right to have access to drugs. The drugs and not registered in the country yet. And the government has gone ahead and made a deal in bringing the drugs. So what will happen to the drugs? Same as what is happening to the oil it will be sold outside the country And why it is being done is because somebody is making money. So it will be the same thing--the private sector is coming in, somebody else will be making money and this whole circus will go on.
Illegal drug markets and self-medication cultures

Two of the major distribution mechanisms for substandards and fakes are open drug markets and the growing number of patent medicine shops (intended for over-the-counter drugs, but many sell controlled products) that are not well regulated at all. In fact, Ezeanya (2000) reported that illegal drug markets, where the majority of fakes are bought and sold, are greatly financed and have the protection of unions. According to Ovbiagele (2000), patent medicine shops outnumber pharmacies. One of the criteria for granting patent medicine licenses is that patent medicine shops must be in an area where community pharmacies are not available (especially in the rural areas) and where controlled drugs are not available, yet such licenses are granted without consideration of location. A 1998 survey by the School of Pharmacy, College of Medicines, Idi Araba, Lagos showed that the volume of fake drugs coming from the open drug markets, has risen from 33% in 1988 to 49.6% in 2001 (PSN, 2001).

According to PSN President Alhaji Mohammed Budah there are over 40,000 illegal premises in Lagos and just as many are spread throughout the nation. I have walked through the Lagos markets and both controlled and uncontrolled substances can be found. Almost all drugs are sitting in the hot sun and are subject to deterioration. In such settings there are usually no ideal conditions to store and keep drugs, which erodes biochemical content and decreases efficacy of already existing spurious drugs. In some cases this leads to adverse side effects and death (Fashesin, 1998). Many people seeking drugs with whom I spoke preferred to buy their drugs in the markets because the costs are
lower and this form of self-medication also saves money because going to a
doctor for treatment and care can generate additional costs. One pharmacist,
Tubosun, who can readily identify real drugs from fakes, knows many of the
sellers. Tubosun can walk through the markets and watch sellers listen to potential
customers who give a list of symptoms in which the sellers proceed to find the
miracle in his stash. At the same time, the sellers will quietly whisper to
Tubosun, which drugs on display are fakes and that he should avoid them. Drug
availability even extends to roadside hawkers who sell medications of all sorts in
traffic jams and along busy and commercial roads. Sellers are even found on
public transport. While taking a bus to Nsukka, several traveling drug salesmen
on board would take turns wooing the crowd by offering candy and not very
funny jokes about gender relations and then launch into the efficacy of their
wares. It was amazing to watch the crowd on the bus evolve from boredom and
annoyance into enthusiasm and consumer passion, including myself. Everything
including pain pills, acne busters, and aloe vera was offered for sale. I even
bought some imported Indian Neem toothpaste, which I quite enjoyed.

Pharmacies, prescribing practices, and self-medication

Other major challenges for those who are in compliance with PCN (as
opposed to those running illegal outlets) include transportation, non-availability of
funds, no electricity for storage regulation, and unreliable telecommunications.
These obstacles lead to a lack of desire to dispense drugs particularly in rural
areas, due to the fact that such constraints cannot meet PCN stipulations for drug
storage and administration. Table 4 show the total number of pharmacies and
pharmacists distributed throughout the country by state. Table 5 shows the percent of pharmacies and pharmacists concentrated in the rural areas. Derived from PCN s list of registered pharmacists and pharmacy premises, the criteria used in determining what counts as urban, as opposed to rural, were whether modern infrastructure facilities, as well as larger scale commercial activities, are in place. For many states, particularly in the north, this means that a great deal of urban communities is concentrated in state capitals. It should be noted that 30% of all pharmacy premises in the country are located in the city of Lagos (yet Lagos has the highest number of illegal premises and the highest number of PPMVL which are supposed to be in the rural areas). Moreover, the statistics below demonstrate that every single state in Nigeria inadequately serves the rural areas, meant to serve upwards of millions, in which there are less than five pharmacies in the rural areas of every state; and for some states, many urban areas are grossly underserved.

**TABLE 4. Percentage of urban pharmacy premises in Nigeria with total number of pharmacies for each state**

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<thead>
<tr>
<th>STATE</th>
<th>%URBAN</th>
<th># PHARM</th>
<th>STATE</th>
<th>%URBAN</th>
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**TABLE 5. Total number of registered pharmacists in Nigeria by state**

**SOURCE: statistics derived from PCN list of registered pharmacies, 2000**

Even in the urban areas where pharmacies are accessible, dispensing drugs among pharmacists is highly mystified for many patients. The names and dosages of drugs prescribed to patients are rarely labeled (O. Taylor, 1998), which is common practice and the policy of many hospitals and pharmacies. Moreover, O. Taylor (1998) also reports that doses, duration of use, storage conditions and side effects are not well communicated to patients; and Ohaju-Obodo (1998) reports common over prescribing practices.
One time I went to Owerri with my friend Stella who is a well-known feisty health and human rights activist. We went to see her family in a nearby village, and when we arrived we found that her mother-in-law was ill. The next day we took her to the hospital in town where she waited most of the day for her to see a doctor (not at all unlike the public hospitals in the U.S.). After she finished up we walked with her to the hospital pharmacy where she picked up her prescribed medication. There was a sign posted next to the pharmacy window in both English and Igbo that encouraged any questions about the drugs they were receiving. I pointed this out to Stella as we had had several discussions about dispensing practices in the country. Stella's mother-in-law received her drugs in a plastic bag, which, marked in pen, stated how many pills she should take per day. The name and dosage of the drug was not listed. Stella went back to the pharmacy and asked them to label it correctly. I was leaning against the car, which was parked right in front of the pharmacy. Members of Stella's family were also there and we were waiting for these last details to get sorted out before we went back to the village, while we listened, appropriately perhaps, to Fela Kuti sing 'Coffin for Head of State' over the car stereo. And then suddenly all hell broke loose. I don't know how it ended up in the street as quickly as it did, but Stella was screaming at what appeared to be at least two hospital administrators on their non-labeling policy, with a couple dozen patients who had gathered around to hear it out. They calmly told Stella that too many patients self-medicate and that is the reason why they cannot label prescriptions, to which Stella countered, and what happens when your patients have adverse side effects or
allergic reactions to prescribed drugs? How will any medical worker ever know what was prescribed when the patient has no idea? And what if the patient dies? Then what? To these questions, there was no response.

Indeed the fear of self-medication of controlled products is the most common justification pharmacists give for non-labeling. But conversations I had with many pharmacists indicate that something else is at work, which is perhaps the desire to keep knowledge of drugs circulating only among pharmacists and medical workers. Many articulated what seemed like a mantra of self-medication. Very few wanted to even explore the notion of assisting a very large self-medicating population. The profession of pharmacy, long held in esteem has been increasingly denigrated due to the inhospitable climate of drug distribution and difficulties in competing against illegitimate businesses. Non-labeling acts as a reconfiguration of expertise where making certain knowledge secret gives a sense of authority back to a profession that no longer commands legitimacy or status. That is, letting information and knowledge slip out makes one no longer feel like a professional pharmacist. One of the newsletters of the Pharmacists Counsel of Nigeria stated at the 1999 annual meetings that it was decided that a new prefix Pharm would precede, Mr. and Mrs. prefixes. Together, the mystification of drug knowledge and new titles seem to establish a sense of control over professional loss.

An AIDS activist:

They [pharmacists] don’t assist people in taking drugs. They do not tell people what the side effects are. What are positive people doing right now? Self-medicating. So the country is not yet ready to procure the drugs. Wait until the next thing that will happen, and that is private-sector
jumping in. Everybody will bring in drugs, so this country will be overloaded with drugs than what we might see is a nightmare that we have not seen in any other country yet.

But clearly these practices combined with current drug distribution channels have generated different kinds of knowledge of drug products. As pharmacists largely do not believe in assisting the self-medicating population, patients usually obtain their knowledge of drugs from illegal market sellers. More from field notes here.

Self-medication and non-adherence to dosage regimen abound in all regions and societal strata in Nigeria. A survey by Bright and Taylor (1999) showed that irrespective of socio-economic stratum, self-medication is very high, recording 75% as the lowest figure. It concluded that if pharmacists refuse to assist the self-medicating population then morbidity, mortality, iatrogenicity and other adverse effects will be on the increase. Additionally, the extent of self-medication in the Nigerian society was measured in the Lagos area in 1997. Demographic characteristics of the respondents showed that males and middle-aged people indulge in this practice due to effectiveness, saved time, and medical relief. Most would not want to see a doctor first while a significant number engage in self-medication without any professional advice. Table 6 shows the demographic characteristics of self-medication.

<table>
<thead>
<tr>
<th>Demographics/reasons for self-medicating</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>65.21</td>
</tr>
<tr>
<td>Females</td>
<td>34.79</td>
</tr>
<tr>
<td>15-25 years</td>
<td>57.90</td>
</tr>
<tr>
<td>26-40 years</td>
<td>48.10</td>
</tr>
<tr>
<td></td>
<td>Percentage</td>
</tr>
<tr>
<td>----------------</td>
<td>------------</td>
</tr>
<tr>
<td>41 and above</td>
<td>13.71</td>
</tr>
<tr>
<td>Cheapness</td>
<td>22.56</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>11.35</td>
</tr>
<tr>
<td>Sure relief or Cure</td>
<td>55.23</td>
</tr>
<tr>
<td>Time saving</td>
<td>66.19</td>
</tr>
<tr>
<td>Respondents with clear knowledge of pharmacists</td>
<td>88.79</td>
</tr>
<tr>
<td>Respondents who would request for pharmacist intervention</td>
<td>32.49</td>
</tr>
<tr>
<td>Respondents who would see doctors first if ill</td>
<td>9.0</td>
</tr>
<tr>
<td>Respondents who feel they do not need a pharmacist</td>
<td>36.11</td>
</tr>
</tbody>
</table>

Source: Bright and Taylor (1999)

Self-medication and the irrational use of drugs has lead to antimicrobial resistance, which can lead to severe difficulties in treating illnesses and may prolong disease progression and epidemics. Irrational drug use has turned into a serious public health concern with economic, social and political implications that are global in scope and cross all environmental and ethnic boundaries (Williams, 2000; Holloway 2000). Infectious diseases account for 45% of deaths in low-income countries and 90% of these deaths are due to six killer diseases, namely, acute respiratory infections (mainly pneumonia), diarrhea diseases, HIV/AIDS, TB, malaria and measles. Antimicrobial resistance is increasingly found in at least four of these diseases. Importantly, chloroquine for malaria is no longer effective in 81 of the 92 countries where malaria is a public health issue and over 20% of new TB cases are now multidrug-resistant (mostly due to non-observance of Directly Observed Treatment DOT and poor dispensing practices).

Tuberculosis has seen an increase in resistance of new strains called multidrug-resistant tuberculosis (MDRTB). Nigeria has the sixth largest TB infection rate in the world (Sheru, 2000). According to the Netherlands Leprosy Relief (van der Grinten, 2000) the only reliable high quality drugs available for TB are distributed through NGOs. (Importantly, fake TB drugs have been linked to poor
management and distribution [Oke, 2001]). Idigbe et al. (1996) found that among 28 chronic TB cases, the majority of patients did not sustain their treatment and many had mixed infections. In the case of TB, the emerging resistance means that medication that once cost $20 for initial treatments, must now be replaced with drugs a hundred times more expensive to fight resistant strains. To make matters worse, resistance is already emerging to anti-HIV drugs. There are reports of resistance to all currently marketed anti-retrovirals.

**Drug Revolving Funds**

Accessing drugs through government hospitals is usually conducted through drug revolving funds. These funds were originally created through a petroleum trust fund, where institutions are given seed money to purchase drugs, sell them at accessible prices and save the revenue to buy revol ving drug stocks. However, since this trust fund was eliminated in 1998, only states with political will keep them going in both state and local government hospitals. Private hospitals and sometimes community pharmacies manage their drug supplies independent of drug revolving funds. Lagos University Teaching Hospital (LUTH), for example, bases its drug selection on the essential drug list and then sources its drug supplies from government donations (secured by competitive bidding open tenders, local purchase orders or direct purchase, whereby multinational companies are usually favored), donations from pharmaceutical companies, World Bank projects, and non-governmental organizations (Anyika et. al., 1998). Anyika et. al. (1998) states that the cost recovery of drug revolving funds can be delayed up to 1-2 years. Eniojukan et. al. (1997a) reported that out
of 50 hospitals surveyed, only 60% operated a drug revolving fund in 1995 and that pharmacy departments were lacking in specialized clinical services. Additionally, none offered patient education clinics, drug use evaluations, pharmaco-economic evaluations, and little patient and drug therapy monitoring, such as patient review charts or patient medication profiles. Eniojukan et al. (1997a) concluded that these gaps were due to an absence of well-defined departmental objective and aims; lack of well-defined standards and guidelines for pharmaceutical practice; and lack of vision of what pharmaceutical practices and services should provide. Moreover, community pharmacists are placed at primary health care levels. Eniojukan et al. (1997b) found that community pharmacists are not well integrated into the primary health care programs and most community pharmacists surveyed (90%) believed that government has no defined role in primary health care programs for pharmacists. The WHO recommends that pharmacists should be involved in training community workers responsible for the management of pharmaceutical services at local levels. While community pharmacists are perhaps well suited for this role, they are completely left out of this function (Eniojukan et al., 1997b; Tayor 2001). Given this environment of chaotic drug distribution, I turn to a discussion on what I am calling African biosociality that contextualizes the materiality of this therapeutic economy within a specific biopolitical regime.

African biosociality

Michel Foucault's concept of biopower (1978) articulates how modernity has put knowledge about life into the realm of explicit calculation. The discourses
and practices of biopower have revolved around the politics of the body in order to bring about regulatory mechanisms that specifically refer to strategies that organize knowledge, control and welfare. Paul Rabinow (1992) rearticulated biopower, as biosociality, through his research on the now finished Human Genome Initiative. The Initiative was built upon not only the object to be known human DNA but also known in such a way that it can be changed.

(Pl number missing-2). He states (i)n the future, the new genetics will cease to be a biological metaphor for modern society and will become instead a circulation network of identity terms and restriction loci around which and through which a truly new type of autoproduction will emerge. (7) In short, patient groups will ally themselves around gene specific loci in which older practices and discourses of medicalization, race, gender, etc., will not necessarily disappear, but their meanings will change. In other words, it is the evolution of technologies that will organize medical and therapeutic subjectivity.

Indeed patient groups have formed in the US and Europe. They raise funding for research, ally themselves with pharmaceutical companies, pose questions about ethics, and lobby government. But these specific biosocial practices, intertwined with technological advancement, must be able to command high and steady funding toward the realization of new therapies. And it is the financing of such projects, the ordering of research agendas (geared toward potential blockbuster drugs), and the reconfiguration of possibilities for the biotechnology industry that poses hope for new therapies, and indeed these patient groups.
Rabinow's analysis of technology as built into biosociality is extremely insightful, but what remains rather under-theorized, although alluded to, is the role of intellectual property (IP) law and markets biosociality's modes of abstraction as equal determinants in biosocial practices and formations especially in the postcolony. In terms of market distribution and market rationality, even when patient advocacy groups in the US approach pharmaceutical companies to conduct new therapeutic research for genetically linked diseases, the companies must consider the potential profit that such a drug can ultimately command. If a patient group represents a relatively small disease population, then it may not be worth the company's attention to invest hundreds of millions of dollars and 10-15 years of research to develop a drug, even if the patient advocacy group sources funding to contribute to research. Therefore, some biosocial practices of patient advocacy groups are in fact determined in large measure by the private industry's estimation of market success. As many patient groups are advocating for what will become proprietary drugs, the role of IP law for these products is different than access to generic products. That is, proprietary drug development is geared toward these patient groups as potential consumers, matching the pharmaceutical industry's desire for stringent IP law. Generic drugs have an altogether different kind of movement within IP law, where the proprietary drug industry pushes, via IP law, for what might be called a biological marginalization or eradication that is, the desire to wipe out the industry and its products. And in this marginalization, a distinctly different form of patient subjectivity emerges.
While biosociality, as Rabinow articulates it, can be imagined for people living with HIV/AIDS (PLWHA) in the US or Europe, understanding the formation of HIV positive support groups, for example, in Nigeria or elsewhere in Africa, certainly cannot be derived from the workings and precipitations of the Human Genome Initiative alone. Nigerian HIV support and care models materialize almost only in the context of the global distribution of drug commodities. That is, AIDS care and support models in Nigeria form for the distinct reason that there is an absence of proprietary drug markets as well as treatment and care for PLWHA. Very much unlike a patient group in the West, a Nigerian HIV support groups (not a patient group as there is little potential therapy to be accessed) discussions are about the lack of existing available drugs and treatment, the impact of poverty, being sacked from one’s job, absorbing the loss of one’s community and family due to alienation, looking for free drugs while struggling to eat regularly. For so many participants in these groups, it is the virtual absence of drugs and medical care that fuels the mystification of AIDS and the enormity of stigma and discrimination that they experience.

African biosociality therefore operates within a biopolitical regime whose framework is different than a how Foucault imagined it for the French state. The African state, operating under the tutelage of international financial institutions, is left to manage the struggle over the means to control coercion where as Mbembe (2000) argues, the features of warfare and civil society coexist in a single dynamic (74). That is, under what Mbembe (2000) calls a fractionated sovereignty, unfulfilled promises of state restructuring and reintegration of
African states into world markets has lead to disruption of postcolonial models of governance. As a result the state is faced with social protest as well failed attempts to end dissent by force. Membre writes:

all it [the state] has left is control of the forces of coercion, in a context marked by material devastation, disorganization of credit and production circuits, and an abrupt collapse of notions of public good, general utility, and law and order. The upshot is an increase in resources and labor devoted to war, a rise in the number of disputes settled by violence, a growth of banditry, and numerous forms of privatization of lawful violence (74).

Struggling over the means to control coercion is a far different sort of biopolitical engagement that the postcolonial state faces as opposed to North American or European states. Expanding on Robert Castel’s *La Gestion des Risques* to reconfigure Foucault’s older face-to-face models of surveillance for populations at risk, Rabinow states that

(w)e are partially moving away from the older face-to-face surveillance of individuals and groups known to be dangerous or ill (for disciplinary of therapeutic purposes), toward projecting risk factors that deconstruct and reconstruct the individual or group subject The target is not a person but a population at risk. As an AIDS-advocacy group in France put it: It is not who one is but what one does that puts one at risk. (8).

I would suggest that the African post-colonial state is not even preoccupied with older forms of surveillance models or projecting risk factors, as the means or interest for surveillance over populations at risk does not exist. On the one hand, both Foucault’s and Rabinow’s biopolitical regime assumes a clean delineation of roles among the state, civil society, and the private sectors (although none of these entities are ever entirely monolithic and bounded), and through which ideas of risk and surveillance manifest. On the other hand, Membre’s notion of the struggle over the means to control coercion articulates a
politics of the body (not by the state alone) through which attempts to manage violence is not invested in populations at risk, but rather risky populations contending a fractured state and access to wealth, power, and security. However, while the state is invested in the means to control coercion, it is the international development industry and NGOs that are invested in new categories of risk that are deployed in awareness and prevention campaigns that target perceived high risk social groups. Therefore, conflicting notions of surveillance and risk emerge and operate simultaneously in the same space. As a result, the HIV body is managed simultaneously through extreme forms of violence experienced in government agencies and the public, as well as by the development industry and NGOs, which are disciplining risky behavior.

A few examples of the disinterested and disabled fractured state that are not preoccupied with new categories of risk demonstrate this. In Nigeria, the population is not agreed upon (estimates always run between 100-120 million) and the state has, for the most part, not been able to carry out surveillance studies that quantitatively mark disease outbreaks. During a severe meningitis outbreak in the state of Kano in 2000, a Nigerian doctor told me that he went to a hospital to check on a non-related issue and found numerous meningitis cases coming in daily. Medecins Sans Frontieres was inundated for most of the year with meningitis cases and vaccinations, yet the state of Kano itself denied the very existence of a meningitis epidemic (I talk more extensively about a previous outbreak that apparently never went away in chapter five). At another time, when I was driving out to the eastern part of the country for a traditional wedding with
some friends from Lagos, we passed an area where hundreds of people living with leprosy were lined up for miles on the highway median extending their hands in the hopes that the drivers will drop money or food as they sped by. My companions in the car told me that the government stopped subsidizing the leprosy institution a few miles away and people were forced out. When I asked workers at the Federal Leprosy Control Agency about the institution, the lepers, and why the funding stopped, they laughed and told me that those people line up there everyday, and there is a truck that drops them off and picks them up. In other words, the lepers were running a scam operation and the notion of state surveillance was a moot issue.

The lack of state surveillance of populations at risk has actually inspired what might be called a biopower from below. While the government at the state level (and not the federal) generates statistics on HIV dispersion, it does so haphazardly and apprehensively. The reason for apprehension is its own internalization of stigma and discrimination where many states do not want to be seen as carrying a high load of HIV positive people. As a result, there have been a number of AIDS activists who have accused states of fudging their own statistics. One of the projects that the state has taken on is the sentinel reports on HIV/AIDS in the country (1991, 1996, 1999, 2001). These statistics show wide variance where, for example, Benue state reported 18.6% infection rate in 1999 and then in 2001 it reported 13.5% (National AIDS/STD Control Programme/FMOH, 1999, 2001). There is no explanation provided for the apparent decline in HIV infection. Moreover, these statistics are clearly marked by a flawed methodology in which
all statistics are derived from women who seek pre-natal care in hospitals, which amounts to about 20% of the population. (About 80% of the population does not have access to orthodox medical care and usually seek the help of traditional healers.) HIV testing is mandatory for pre-natal hospital care and although this is the best data that the government can use to determine prevalence rates, AIDS activists assert that mandatory testing constitutes a rights violation. But the problem is that there are few testing facilities even in the urban areas and most AIDS workers and activists, and health practitioners assert that even if testing facilities existed in large numbers, it would be hard to get people to come for testing when no therapies exist. As so many people say, I would rather not know. Therefore, there is a demand on the part of AIDS activists to actually calculate HIV bodies. Here it is not imagined that the state will use HIV statistics to carry out disciplinary action as Foucault might suggest, but rather it is imagined that such statistics will hold the state accountable to actually do something proactive about the AIDS epidemic. This is a biopower from below because AIDS activists are invoking a prior accounting scheme and they have a capillary investment in it.

Furthermore, the notion of risk needs to be situated within larger economic and social structures. I spent some time in one of the most impoverished communities in Lagos where youth were organized by a local NGO, Health Matters, to learn about HIV risk, as well as gain skills such as barbering, pedicure/manicures, and peer counseling. This community is actually located on top of Lagos Bay between the mainland and the island of Lagos. There are one-
room homes that extend over long connecting bridges that are made out of cross-
sectioned hardwoods and extend for perhaps a half-mile if not further over the
water. The work done by Health Matters in this community is not just carried out
in the form of weekend workshops where information is distributed and everyone
goes home at the end of the day, but full time working in the community where
peer and family dynamics are intimately known. These were youth who had far
more information about HIV/AIDS than anyone else in the general population,
and had an extraordinary concept of HIV related risk and risk factors. Yet for
some youth, following acceptable low-risk behavior was rarely practiced. They
often told counselors and myself about the many stresses at home, mainly
poverty, which exacerbated stresses between peers. Sex is perhaps the most
inexpensive form of recreation as well as a site of peer pressure for such youth.
Moreover, condoms are not affordable for most in this community and therefore,
risky behavior can be commonplace. Indeed, risks are weighed not by the future
of potential health problems associated with HIV, but rather by the immediacy of
survival where one (especially youth and women) may engage in risky behavior
such as sex work in order to meet immediate concerns of procuring food and other
forms of security. Therefore, the youths own education about both the
medicalization of risk and their very bodies as a mode of risky transport for HIV
must be theorized in the context of social and economic forces at work.

Biosociality constitutes social practices that first, have to do with the
existence of drug availability, markets, and the law, that are built into new social
formations; second, the biopolitical regimes through which surveillance is
imagined constructed and deployed; and third, project risk factors, which are not simply located in medicalization or technology, but poverty and marginalization. African biosociality, therefore, must be understood as located in a market-legal-technology frame in which its biopolitical regime is characterized not by a mediation of the (weak African) state alone, but by a network of state, civil society, and international exchanges and connections.

Perhaps just as important, an African biosociality extends Rabinow’s assertion that meanings are changing around medicalization, the making and remaking of the body and illness, and race and gender. These changes are all apparent for Africans living with HIV/AIDS. But additionally, African patient groups are organizing themselves around new understandings, meanings, and analysis of capitalism and North-South relations (Paul Farmer, [1999] and Jim Kim, et al., [1999] are exemplary here), whereby patients seeking drugs in Nigeria’s therapeutic economy actually experience the corporeal feel of surveillance and management by forces both internal and external to the state.

I now turn to a more in-depth look at the proliferation of HIV/AIDS cure claims in Nigeria. Cure claims are just one aspect of therapeutic options that have shaped (inter)subjectivities. But cure claims also have evoked conflicting ideas of democracy in national public debates over the veracity of such claims, as well as spurred nationalist sentiments on the prospect of a potential Nigerian HIV cure.
Chapter Five

Democracy and Biological Nationalism: HIV/AIDS Cure Claims and Clinical Trials in Nigeria

Introduction

In 2000, the National Institute of Pharmaceutical Research and Development (NIPRD), based in the federal capital, Abuja, Nigeria, conducted a clinical trial on several new AIDS medicines. The trial involved 120 human patients with HIV and lasted nearly six months. The medicines tested were all developed in Nigeria, but the conditions that made such a trial possible and the reasons for its existence are the unusual part of this story. Through a number of very public events that this chapter describes, the clinical trial emerged out of bitter debates over the issue of HIV/AIDS cure claims. In an environment where over 70% of the population cannot afford standard medical care and current AIDS policies are not reaching the majority, numerous cure claimants\textsuperscript{29} have emerged on the scene making promises of miracle cures for HIV/AIDS.\textsuperscript{30} Many people living with HIV/AIDS (PLWHA) have flocked to cure claimants' doors, often selling off all of their assets to secure the hope that they or a loved one will be saved from AIDS.

Cure claims have grown out of, and in some ways, have become an organic replacement for, a dilapidated national medical infrastructure, where the majority cannot afford access to treatment and medical care. Medical infrastructure continues to decline since particularly the implementation of
International Monetary Fund (or IMF) structural adjustment policies that devalued the currency, switched to an export economy, and effectively privatized health care. In addition to unaffordable drugs, tens of thousands of illegal drug markets, and millions of counterfeit drugs circulating in Nigeria, cure claims are part of a complex therapeutic economy where different forms of clinical knowledge interact with competing claims of expertise. This chapter situates cure claims and clinical trials in a broader framework of access to drugs for HIV/AIDS that considers how AIDS policy networks and competing forms of therapeutic and drug regimes are a product of continued neo-liberal economic agendas slated for African countries by international donors, creditors, and national elites.

This chapter begins by describing public controversies generated around the most famous cure claimant in Nigeria, Dr. Jeremiah Abalaka. As Abalaka rose to prominence, disputes between AIDS activists and cure claimants made national headlines beginning in early 2000, and were sustained for well over a year. AIDS activists asserted that cure claimants were fraudulent, committed human rights violations, and were getting rich off of HIV positive people. Cure claimants insisted on the efficacy of their cures and their right to practice medicine. In my fieldwork, I met with many people living with HIV/AIDS who embodied a variety of different experiences, reception, and subjectivities around such cures. And it is important to point out that the truth of cure claims is not necessarily at issue here, but rather at stake are the conditions that structure how cure claims can emerge and be apprehended as true or false.
Both AIDS activists and cure claimants employed conflicting ideas of democracy in support of their arguments, a point which will be further elaborated upon later in the chapter. The public contributions to these debates were grounded in post-colonial nationalist sentiments. That is to say, at the center of these debates is the promise and potential of a Nigerian science versus the failure of a Western science to generate any real results for an AIDS cure. As the public generally supported claimants' assertions that a cure for HIV was discovered, it also demanded that proof of such cures be produced not necessarily for itself but for the international community. This led to the second issue that I will discuss: a government-mandated clinical trial, as mentioned earlier, for which PLWHA were to serve as the final authoritative answer to a long-embattled question on cure claims.

These debates among the public, AIDS activists, and cure claimants reflect a particular political moment in Nigerian history that is attempting to recuperate from thirty years of military rule, the Biafran civil war, and IMF structural adjustment. As such, disputes over cure claims and clinical trials represent cogent questions about Nigeria's own sense of self, its reshaping under civilian rule, and its place and role in the global economy, questions that share both the desires for political and economic redemption, and, to a lesser extent, being on the right side of neoliberalism. Discussed at length in the previous chapter, this term is commonly referred to in Nigeria as being on the right side of globalization discursively used to refer to the potential to rise above the global
maldistribution of resources, which are corporeally felt, experienced, and discussed at length in the realm of the everyday.  

My aim here is to reconsider the realms of clinical knowledge and expertise as a way to pose new ethnographic questions about a democracy that does not reflect its liberal form, but rather an imagined yet unfulfilled social contract; and additionally, to pose questions about a nationalism that is not necessarily liberatory, but rather biologically marked and grounded especially in post-IMF redemption. This chapter is ultimately concerned with how scientific and medical knowledge is directly implicated in and produced by democratic practices and institutions manifesting themselves in Nigeria. Let me now turn to Dr. Jeremiah Abalaka’s claim to fame.

*Dr. Jeremiah Abalaka’s HIV/AIDS Vaccine*

In late 1999, chief medical doctor Jeremiah Abalaka of the Medicrest Hospital, in Gwagwalada, a sattelite town of Abuja, announced that he discovered a preventative and curative vaccine for HIV/AIDS. Dr. Abalaka came to prominence after he made a deal with military elites to begin treating HIV positive soldiers. There is a high rate of HIV infection in among Nigerian troops, especially those returning from peacekeeping missions in Liberia and Sierra Leone. For some doctors working in the military, there was dissention. Before he started treating the soldiers, Abalaka was asked to present his findings to military doctors. One doctor informed me that in this meeting Abalaka unsuitably answered the numerous questions posed by the military medical personnel. The
major point of contention was that Abalaka would not disclose the method he uses for blood treatments that he injects into his patients. At the end of this meeting with Abalaka, some doctors did not want him to work with the military without further empirical evidence. Yet the military establishment allowed him to proceed initially with the treatment of thirty soldiers.

To this day, Abalaka keeps the details of his methods secret, which has sparked the greatest debate among the public. He stated that he would not release his methods because he fears that a multinational corporation from the West would steal his product, and that the Nigerian government could very well charge him for economic treason (Ukwuoma, 2000). He also has stated that it would be unpatriotic to reveal the scientific details of his cure, but that he would do so when he has Nigerian President Obasanjo’s support. In a move to silence his critics, medical disclosure often was substituted for Abalaka’s assertion that he had injected himself with HIV and would do so again on national television to show that his vaccine worked. For some, such assertions were the basis of proof, yet for others, it was viewed as a ploy to seduce more HIV positive patients. For, a single dose costs of Abalaka’s vaccine costs about US$200, the near equivalent of what most in Nigeria earn in a year; and after taking up to four or five doses, it is claimed that an infected patient will be completely cured of HIV.

The controversy surrounding medical secrets and disclosure is generated by several important structural constraints. Secrets and disclosure cannot be read as simple confusion over the constitution of scientific validation and
standardization. Rather, they must be contextualized in the divestment of medical research budgets as part of the devastating effects of military rule and IMF structural adjustment. A formerly widespread medical research culture was also lost in this context, and along with it, the increasing importance of the role of intellectual property in global drug development. Currently, trade related intellectual property rules are the primary protectionist measure for the proprietary drug companies; and these rules largely direct the global production and distribution of pharmaceuticals. Following Hernando de Soto (2000), on the one hand, establishing IP regimes becomes a rallying point of neoliberal and even liberal intellectuals, and on the other hand, becomes the reason for lack of treatment. Whether or not this was a convenient excuse for Abalaka not to disclose his methods, it highlights a global technological divide in which intellectual property rules that construct secrecy blend into environments where other forms of secrecy reside. This includes hiding one's HIV status due to stigma and discrimination, which is generated by the absence of drug accessibility. These factors produce other unforeseen issues such as the further muddling of secrecy and disclosure in local scientific research practices where strong intellectual property protection and capital for drug development are not available.

Almost immediately, the military reported favorable results, declaring that all the soldiers who received Abalaka's vaccine had recovered from HIV. Senior medical personnel at the government Specialist Hospital Gwagwalakda confirmed that HIV positive patients had tested negative after undergoing the therapy
(Hayatu, 2000). The Chief Staff Air Vice-Marshall Isaac Alfa told reporters in early 2000 that Abalaka treated these soldiers returning from peacekeeping missions outside of the country and they had been cured. Additionally, Abalaka asserted that between January and May 2000 he had cured more than two dozen other patients who underwent sero-conversion with five weekly shots. At the time, he had 750 patients lined up for treatment, asserting that 85% had shown remarkable improvement. Other medical doctors claimed to use Abalaka’s treatment and declared similar findings. Outside observers such as the National Institute for Pharmaceutical and Research Development (NIPRD) and the Nigerian National Academy of Sciences reported mixed results from submitted samples. In June 2000, Dr. Charles Wambebe of the National Institute of Pharmaceutical Research and Development (NIPRD) submitted an initial report to the National Assembly on several cure claimants in the country. It stated that after conducting clinical tests on two patients, the results showed that the viral load was significantly reduced after two doses of the vaccine. The NIPRD letter recommended further studies on Abalaka’s vaccines at the Centre for Disease Control and Prevention (CDC) in Atlanta. However, the report called upon the Nigerian National Food and Drug Administration and Control (NAFDAC) to prosecute Abalaka for allegedly making false advertisements.

The Nigerian National Academy of Sciences presented their own findings in June 2000. Academy president, Professor Anya O. Anya, stated that the treatment had not been subjected to immunological evaluations and should not have been sold. Anya claimed, the samples submitted by Abalaka [to the
academy] for assessment were insufficient to be really significant. We were shown the laboratory in the hospital where the vaccines are prepared. The room is scantily equipped for its purpose. It was untidy and not well organized (Namibian, 2000). Anya also stated that the samples appeared to be impure and could cause hypersensitivity reactions or transmit infectious agents such as hepatitis C. With different levels of government giving either support or criticism, Abalaka accused the government of writing the Nigerian Medical and Dental Council to strike out his name from its register even though he viewed Wambebe's comments as favorable praise. He also insisted that the presidency sent patients to him through the back door, but would not allow him to claim credit in the open.

Shortly after treatment began, many soldiers came down with hepatitis and renal failure, which the military never disclosed, but which I found in my own research. One soldier who was part of the initial group of thirty, and is now an AIDS activist, told me in 2001 that half of that group is now dead and the others are still positive. In very little time, several HIV positive soldiers became AIDS activists and started working alongside other AIDS activists who had extensive human rights backgrounds. This is significant because soldiers and human rights activists, who were at odds over military dictatorship in the 1990s, were literally working in the same offices for the first time since the end of military rule in 1998. Together, these actors launched an offensive against military and medical institutions that supported Abalaka and other cure claimants. As they were empowered by Western money and AIDS intervention models, they appeared on
television, in the newspapers, and at national AIDS symposiums often going head-to-head with cure claimants, accusing them of fraudulent activities.

An example of how cure claim disputes became public is shown in the following, rather dramatic event. On June 8, 2000, Abalaka presented a paper at the West African regional conference on HIV/AIDS in Abuja, funded and organized by the Foundation for Democracy, a Washington based organization. His paper presentation entitled Vaccine Development and Vaccine Trial Preparedness in the West African sub-region, did not, once again, include disclosure of his methods or details of his research findings, which according the national daily, The Vanguard, ended nearly in physical combat. At one point, Mohammed Farouk, a former soldier who was sent to Abalaka by the military, claimed that Abalaka was misleading the public. Abalaka demanded an apology, which Farouk refused and more outbursts enveloped the conference room. Abalaka back-tracked a bit and stated: I cannot give an assurance of guarantee that my treatment will cure any particular case of HIV infection just as myself or any other human being cannot give an assurance or guarantee that any other treatment will cure any other disease, meaning that it was impossible to guarantee 100% efficacy of any medical therapy, implying that Farouk's treatment may have been the one that did not work in this instance. The then director of the federal National Action Committee on AIDS (NACA) asked Abalaka about the efficacy of his own treatment to which he reportedly replied that his vaccines were only effective on non-AIDS patients. This is perhaps the
only forum where he made such a statement. In others, he continually insisted on the discovery of a cure.

Throughout the course of these disputes, both cure claimants and AIDS activists employed conflicting meanings of democracy to support their arguments. The very establishment of civilian rule has generated numerous public debates around what is commonly called democracy dividends, which refers to the fulfillment of an imagined social contract (such as rights to food, health, and housing, etc.) that became largely bankrupt after so many years of military rule, and unattainable after IMF structural adjustment. Additionally, within this broader context, democracy is often used interchangeably with civilian rule in a way that assumes freedoms one is entitled to, previously unattainable under military rule. Therefore, on the one hand, cure claimants used the idea of a newly democratic Nigeria to assert that they could freely practice and treat PLWHA. Indeed, Abalaka was quoted in a national newspaper claiming that scientific and medical protocols should never come between a doctor and patient. On the other hand, AIDS activists took up democratic ideals of civil rights, utilized by the pro-democracy movement in the 1990s (which meant freedom from detention, harm, etc). However, AIDS activists extended the notion of civil rights to include the right to life. This meant that their human rights required protection not just from the state, but from cure claimants, the medical establishment, neighbors, family members, employers, and landlords. Similar to democracy dividends, the discourse of the right to health construed further positive rights, such as health entitlements. What is most compelling about these contesting ideas of democratic
politics is that AIDS activists conjured the more liberal version of a social welfare state, while cure claimants more often evoked the radical principles of neoliberalism where the state is subordinate to private capital interests.\textsuperscript{35}

These conflicting evocations of democracy may encounter problems with the so-called good governance agendas of international donors and creditors, described so well by Rita Abrahamsen (2000).\textsuperscript{36} Such institutions place neoliberal democracy conditions on foreign aid, including AIDS funding. Essentially, this means that in order to receive foreign aid, a nation-state must ideally meet criteria such as free and fair elections, privatization through continued state downsizing, and the liberalization of markets for foreign investment. In the context of these trends, appeals to democracy in debates over cure claims amounts to asking the state for a larger and stronger role in describing and regulating the use and misuse of available drugs. Therefore, cure claim debates represent the desire for the state to expand, while international donors are requiring a neo-liberal opposite.

I have spoken to several PLWHA who have told me that they ended up with no positive results after seeking treatment and that their families were left in near destitution. My cell phone number was passed around and I received several calls from HIV positive people or family members calling on behalf of those who were dying. Several people disclosed to me that they did seek treatment from cure claimants without any results.

AIDS activists and those who visited cure claimants reacted differently when I asked what the reasons were for seeking treatment. For those who visited
cure claimants, usually they discovered their HIV status in medical clinics where they were often tested without their knowledge. In nearly all cases, they were not permitted in hospitals or they were left to die in a quarantined ward, where family members, or perhaps no one, would care for them. If treatment was available, even for opportunistic infections, it was largely unaffordable. Sometimes medical doctors would disclose status to landlords, school teachers and other family members and PLWHA and their families would subsequently be evicted from their homes and children expelled from school.

These practices of uncaring medical practitioners working in hospitals and clinics are tied to doctors own reconfigured ideas of expertise. Like pharmacists, discussed in the previous chapter, medical doctors have also felt a loss of prestige and identity. While they still command societal status as professionals, as opposed to pharmacists, they work in environments where equipment is sparse and with hospital staff who are not regularly paid and are not necessarily motivated to work. Doctors have also lost ground to cure claimants and traditional healers, which the majority of the population visits for their primary medical care. Expertise is then inculcated in this sense of loss, where doctors objectify and re-objectify themselves in contrast to people who are sick and deviant. That is, a sense of professional loss is channeled into an idea of medical expertise, which is equated with medical purity and medical invincibility. As an example, one day I had the opportunity to talk to three military doctors who told me that conducting compulsory or secret HIV testing is within perfectly acceptable medical parameters (AIDS activists consider this practice a human
rights violation). I asked why this is so and the response from all of them was that they needed to protect themselves. I then commented that because they are working with patients all day long and do not use universal precautions (masks and gloves) they are perhaps at more risk than those who engage in unprotected sex. I then asked them how a patient can be sure that he or she will be protected from doctors if no universal precautions were taken? There was some silence after this question, but one of them still insisted on the need to protect himself. If protection was really the issue here, I further asked why would a hospital with little resources, pay more for a compulsory HIV test rather than for relatively inexpensive disposable gloves and masks? And why would a hospital seem to care more about knowing the HIV status of its patients and not the status or protection of its medical workers? These questions flattened out the conversation, but the most interesting part of this dialogue was that, for the doctors, it was completely unimaginable that a medical worker could be infected with HIV. Interviews with other medical workers, who are now AIDS activists and working outside of medical institutions, conferred this notion of medical purity and invincibility and the reified objective positionality of the doctor as a cultural artifact of medical institutions. This medical culture blends into the prevailing environment of stigma where HIV is rarely mentioned as a problem or concern for its workers. Nurses have told me about handling blood with their bare hands while having virtually no knowledge of HIV transmission. One dentist disclosed to me that he and his staff were the only caring workers (due to self-education) in his hospital toward HIV positive people and therefore would receive patients who
were not seeking dental care but rather seeking out someone to talk to about being HIV positive. The lack of sensitivity toward HIV positive patients is therefore a combination of factors that include symbolically configuring expertise under conditions of professional loss. This in turn, produces an understanding of an objectified purity that interacts with existing stigma to produce clinical institutional cultures that foreclose discussions and knowledge of HIV in the workplace. Within such medical institutional conditions, cure claimants offered not only treatment, but compassion, when none was to be found in clinics and hospitals. And because they claimed to have a cure, a culture of medical practices emerged that differed greatly from orthodox medical care. Cure claimants represented the only ally for PLWHA under desperate circumstances and within a structural framework whose options include expensive or counterfeit medicines and little medical consultancy.

AIDS activists usually believed that people who sought out cure claimants were ignorant and did not have the proper information. Additionally, AIDS activists more often asserted that cure claimants should not be allowed to practice. In AIDS NGO offices there were often disputes among activists, mostly against the proliferation and advertisement of cure claims. Most of those arguing the loudest against cure claims were either military personnel, or well versed in Western human rights discourse, or had medical training. Although one AIDS activist told me that cure claims was the outcome of democracy dividends where freedom of speech and private capital interests are imagined as comprising democracy, typical comments among activists are as follows:
I have still not met anyone who was cured but stigma is still so great that even if there are those who are cured, they are not coming out.

We have to stop Abalaka and his lies. Paul Ojay is another one.

Abalaka is just collaborating to commit murder. He has the support of important people in government. He has no scientific reasons for all this.

Complaining to a journalist on the representation of cure claims in the media:

Yinka’s (a young HIV positive woman) picture was on the cover of The Guardian but there was no story, yet Abalaka’s picture was on the front page of The Punch for five days in a row. Media coverage of AIDS cure does not take into account the number of people being exploited by people like Abalaka. They need to report on cases of violation and exploitation.

The idea that cure claimants should not practice was understandable, yet problematic. This discourse emerges in the same space that cure claims are a part of. That is, cure claims are not viewed by activists as perhaps the most prolific research culture in Nigeria where none otherwise is nurtured with the proper funds and regulation, but rather they are viewed more in the space of a Nigeria 419, the term and legal code commonly used to describe fraudulent activities. But perhaps they should be seen as at times occupying both spaces, or one or the other. As many activists often view any sort of non-orthodox medicine as invalid, there is still no discursive space among activists in which to argue for a scenario where research can be financed and encouraged while protecting PLWHA.

A Nigerian government representative who spoke at the OAU Heads of State Summit in Abuja in June 2001 does articulate room for this space, but she viewed it with a vision of not just accessing, but commanding global traditional medicine markets:
The modern health care delivery system must be included for AIDS work. We cannot divorce it from cultural and social contexts. Traditional medicine must be seen as part and parcel to HIV/AIDS. The government private-sector funding is inadequate, and traditional medicine fills a gap. Africa is endowed with medicinal plants, yet they are not accorded global medical standards and Africa itself has no standardization. The answers to our problems could be lying somewhere within this vanishing knowledge. We need assessments of botanical possibilities and cultivation. Traditional healers are not aware of the expanding market for botanical medicine; and how this market could in fact deplete resources and encourage training. With the failure to do this the gap will remain. In terms of cure claims they must be scientifically evaluated and we must have collaboration with traditional healers. Traditional healers are constantly at risk for HIV infection. There’s no money for their training and research and development comprises less than 0.1% of the national budget. This could be seen as generating jobs for healers because at present traditional and alternative medicine markets comprise a $1 billion industry a year at this point.

While commendable, desires for commanding global markets fail to take into account the simultaneous European and North American insistence to downsize and privatize the state. That is, while there is a call by local actors for Africa's increased participation in the global economy, state structures such as clinical and medical research and regulatory bodies decline under privatization schemes. This leaves no room for the state to meet international drug standardization and therefore, little opportunity to get local drugs to global markets.

Notwithstanding its own desires and outside pressures, within less than a year after the treatment of soldiers began, the government imposed a ban on Abalaka’s vaccine and all other cure claimants. The federal government offered that the vaccine and other cure claims needed scientific validation, and proceeded to organize an expert committee to test all known AIDS cure claims. Moreover, the government claimed that it did not want to be seen in the international community as promoting charlatans, as the World Bank, USAID, and unnamed
global pharmaceutical companies publicly claimed interest in the government's findings.

The government ban created a massive outcry within the general public. Abalaka himself went as far to say that the Minister of Health illegally manufactured the ban without the consent of the Presidency, in a move to destabilize the government. One national newspaper polled people at random to ask whether Abalaka should be banned and an overwhelming majority said no. Many claimed that if Abalaka were a white man, he surely would get the attention he deserved. There seemed to be an explicit public belief that the Nigerian government did not think that Nigerians were capable of such scientific feats of discovery.

Let me briefly cite two sources that summarize both the media and my own encounters with public sentiment, articulated in nationalist terms, on Abalaka and cure claims.

From the national newspaper *Today*, reporter Aliyu Hayatu (2000):

Much as we may wish to believe Abalaka, however, we are intimidated to a contrary posture by considerations, which have more to do with inferiority complex than the compelling objectivity of logic and reason. The disease, AIDS, the world has been told, is incurable. The best brains in the white man's land of Europe and America had tried to produce an AIDS cure without success. How then can an Abalaka, a Blackman whose brain we had been conditioned, through relentless propaganda, to believe he was inferior to that of a Whitman (sic), achieve what the whites of America and Europe have failed to achieve. Besides, whereas in relative terms, the Whiteman of Europe and America has money and facilities in fantabulous terms, Abalaka has only the bush and a decapitated naira [the currency] to contend with How then could Abalaka, with all these mighty, mighty disadvantages, upstage the well-placed and well-endowed Whitman (sic) of America and Europe by producing an AIDS cure ahead of them. How dare a specimen of humanity from the Dark Continent of Africa, accomplish something which the mighty, mighty whites of Europe
and America had tried and tried and tried, and are still trying, without success. Yes, how can Africa, the supposed land of disease, squalor and backwardness, register and achieve what Europe and America, the so-called territory of civilization, enlightenment and science, fail to produce.\textsuperscript{38}

From an Igala (Abalaka s ethnic group) diasporic listserve member:

This Abalaka issue has been on for quite some time. I know of very enlightened distinguished Nigerians who can swear by his vaccine. Instead of our leaders trying to encourage this man, they want to put his name in disrepute, because as an enlightened person, he doesn't want to allow his glory to be stolen. Is it when they blacklist him or he dies that we will realize his worth. While I am not advocating that he has the cure for HIV or AIDS, I do not think the approach being adopted by the people at the helm of affairs is right. This man is potential revenue for our country, even more than Oil, he is a potential second term for the President; why are we determined to kill this potential? Let the president himself lead the inquiry into the efficacy of his drug. I know if he were in the United States, by now he would be a national monument. If the West doesn't want us to progress, why do we continue assisting them to achieve that evil dream?

The nationalist discourse is clear and troubling. At once there is sarcastic mocking of Western superiority and the belief in the gifts of remuneration one is to find in the US. But underlying these sentiments are cultural articulations of the status of a post-colonial Nigeria. Here lie the desires for redemption, after military rule brought international sanctions on Nigeria and the IMF propelled this oil-rich country into extreme poverty. Moreover, the nationalism here is biologically marked and contextualized in an ambivalent national identity discussed in the introduction.

The only room for articulating nationalist sentiments lies in a space that connects Nigerians to the state and its integrated international politics and circuits. It is within this space of unclear meaning that the only possibility for expressing nationalist sentiments is based not on a cultural unity but rather a public
redemption that seeks to fulfill a social contract that the state and to a lesser extent, the IMF and international agencies are viewed to have betrayed. The organizational crux of this feel of belonging and redemption is a biological nationalism for which HIV its presence and its absence serve as the index upon which the public could reconfigure what it means to be Nigerian.

HIV was deployed in a manner similar to how discourses of an imagined cultural unity are often apprehended, where some cultural myths are reified as more valuable than others in outlining the cultural truth of a nation. Specifically, while the nationalist discourse embodied an imaginary of Nigeria’s redemption, it also allowed room for the discourse of HIV as curse, rather than infection, to proliferate. It was not grounded in any outcry over the four million infected, or for any regard to the real problems faced by PLWHA. Rather, the nationalism itself was grounded in ideas of a Nigerian medical science that would rely upon indigenous sources to find an efficacious drug for HIV. It was hoped that an AIDS cure could reclaim Nigeria’s international image as well as commanding new and significant means for the country’s GDP. That is, an HIV cure, and not the HIV body is what enabled a cultural dream of redemption in this nationalist discourse.

Moreover, this redemption provided by an indigenous HIV cure invokes the idea of how to be on the right side of globalization, both in image and economics. Therefore, although a parallel is being drawn to cultural nationalism, a biological nationalism unravels the state as a stand-alone totality. Cure claim efficacy and being on the right side of globalization are intrinsically linked, not
just through a discourse of nationalism. But indeed through both global drug
distribution patterns and international financial policies that enable cure claims to
proliferate through a produced dilapidated medical infrastructure.

Shortly after the government ban, Abalaka sued the federal government.
With the help of a famous human rights attorney, Gani Fawehinmi, he asserted in
court that the ban violated his fundamental human rights (Ukwuoma, 2000).
Reportedly, over 100 of Abalaka’s patients stormed the National Assembly to
demand the lifting of the ban. At this point, there was some talk of putting forth a
National Assembly vote, to which one professor of virology stated: the issue at
hand does not lend itself to pro-Abalaka or anti-Abalaka. Scientific truths are not
open to voting (David-West, 2000). The court eventually overturned the
government ban, upholding the argument that indeed Abalaka’s rights were
violated. However, the federal government’s investigation committee ordered
that the use of the vaccine be declared illegal. Significantly, one outcome of this
committee established a layout of what qualifies as sound science, as well as
created a clinical trial protocol that matched international standards. How the state
intends to meet such standards of clinical reliability with existing scarce research
monies is yet to be seen.

The differing interpretations of democratic politics are indeed shaped by
medical policies, medical infrastructure and the circulation of drugs. In this sense,
these are competing attempts to actually define the contours of democracy.
However, demands for regulation and the adjudication of cure claims put the state
in the position of defining its own role in protecting patients from themselves and
from victimization. It also highlights the question of state autonomy in decision-making as the state faces the conflict of continually being not only beholden to international polices that engender massive forms of capital flight and neo-liberal obligations, but increasingly beholden as well to a society that aggressively attempts to hold the civilian state accountable for its anti-corruption and democracy dividends promises. Let me turn to a discussion about a government-mandated clinical trial in order to examine the possibilities for state action and self-definition.

Clinical Trials

As a result of the public outcry and controversies generated over cure claims, the House of Representatives Committee on Health held a public hearing in 2000. The Committee ordered a clinical trial to be orchestrated by the National Institute for Pharmaceutical and Research Development (NIPRD) to test the efficacy of the purported claims. NIPRD, located in Abuja, is the only institute with an industrial and aromatic plant extraction factory in Africa used for medicinal plant research. Most raw materials are retrieved from traditional healers who are hired as consultants. NIPRD is committed to protecting the herbs, patenting the discoveries locally, and sharing the proceeds with local healers and healer associations. Additionally, NIPRD has pharmacology and toxicology, human biology, AIDS, and biotechnology and genetic engineering departments. The quality of drugs in the open market can be ascertained and drug standardization done.
The clinical trial did not involve initial toxicology studies or animal models designs, and instead went straight into human trials to ascertain the efficacy of the preparations made by twelve different claimants. The contents of the claimants' medicines were not disclosed to NIPRD. Nine different centers were chosen throughout the country and 120 PLWHA were selected. The method was not blinded and there were no placebo control groups. PLWHA were recruited through existing HIV support groups and by cure claimants. Many of the people who participated in the trial claimed that they did not understand the nature of the trial and some asserted human rights violations.

While the trial was initiated just before I left the field, I talked to several PLWHA who were enrolled. One person informed me that she was attending an HIV-positive monthly support group meeting when one of the leaders, Hassan (a pseudonym), of another AIDS NGO came into the room. He announced that there was going to be a clinical trial for HIV drugs and that if anyone wanted to participate they should sign the forms, which everyone in the room proceeded to do. When this group gathered before one of the cure claimants to begin the trial, he became profoundly angry at them and asserted that Hassan, a long time anti-cure claim activist, was trying to set him up and ruin his reputation, and continued to verbally abuse those who were instructed to show up. Everyone was shocked and became suspicious of the entire process. Hassan had enormous political influence and power. Some of the international AIDS donors often consulted him before deciding to fund a new AIDS NGO, effectively allowing him to control the funding landscape. Moreover, Hassan was seen as the intermediary between
people enrolled in the trial and NIPRD, which some AIDS activists found problematic due to his lack of medical expertise. In any case, the demand for proof on the part of the public, and not AIDS activists, who already were convinced that no cure had been found, effectively put AIDS activists into the same working space with cure claimants for the first time since their disputes began. Both sides were entirely uneasy about this new working relationship. But moreover, PLWHA enrolled in the trial felt just as uneasy and angry with the activist leadership who placed them in a tense situation.

About six months after the trial ended, the Center for the Right to Health, an NGO based in Lagos, carried out research on purported human rights violations as well as trial subject, trial coordinator and cure claimant views of the trial procedures. Both my own and the Centre for the Right to Health’s interviews with trial participants found that in some centers, trial subjects signed informed consent forms, but many if not all did not receive copies of these forms. Most claimed that they did not understand what the trial was about. Some AIDS activists blamed NIPRD, while cure claimants blamed representative NGOs for lack of understanding. Many trial subjects believed that a cure would come from the trial and this was their primary motivating factor for participating. There were additional complaints of unethical practices carried out during the trial. Some trial subjects reported unbearable pain and other side effects. Most did not receive care for pain and some were hospitalized at their own expense. Compensation widely varied each time the trial subjects showed up for experimental treatment. I spoke with several who complained of dizziness, rashes,
and fainting, and even witnessed and assisted one woman who fainted after a treatment. Some of the following experiences represent continued tension between AIDS activists and cure claimants while others represent a lack of clarity or consensus of the purpose of the trial.

I was hospitalized for up to seven good weeks at the Military hospital as a result of side effects to the drugs I was given by the doctor [meaning claimant]. I spent close to N100,000 [about $1000] for my treatment without anyone coming to my assistance [self-paid]. Indeed I suffered for taking part in the trial. I was given injection by the doctor, which he called kasabumbum. It turned my eyes and I became very dizzy. I almost died. (CRH, 13)

I was hospitalized for days as a result of the drug I was given by the doctor [meaning claimant]. When I was eventually discharged I went to him in annoyance to complain to him about the problems I was having with his drugs. To my surprise he merely said that nothing could be done and that if six out of ten PLWHA sent to him by government died and four survived the trial then he would be praised for doing a good job. (CRH, 16)

When I went to the doctor [claimant] and my body was reacting to his drugs I complained to him. He just told me not to worry, that after about three days I would get better. Of course I did not get better I went back to him and he told me that what I was experiencing was a fight between two elephants his drugs and HIV virus while my body was the grass. He said that where two elephants meet, the grass must surely suffer. When I further complained to him that I was not improving he was furious with me and called me names saying that I was trying to spoil his good name. He further said that I am one of this enemies who have been employed to destroy his good works. I was totally confused. Don't I have a right to complain about my body? (CRH, 16)

The doctor referred to by all of the above trial subjects responded:

If someone had side effects, honestly I will not let that person go like that okay, I am saying this from my own side. I am not saying that I did that as in prescribing for a patient in this case but what I am saying is that if it happened that I had anybody who had any complaint I would have to help such person the best way I can. (CRH, 16)
Yet, while some trial subjects complained about the conduct of the claimants, one of the claimants himself complained that NIPRD never showed up to monitor the progress of the patients as apparently outlined in the trial protocol. As one stated:

They have never bothered to come and see any of these people [trial subjects] or even told them anything. They are not animals but human beings. I think they deserve some respect. It is unethical. You should have known that the drugs [meaning cure claims] were not working so that you can provide alternative drugs. Since October 2001 till now NIPRD has forgotten that about 120 patients all over Nigeria were used in the trial, they have not given them any [alternative] drugs, neither have they provided for their children. This is unethical to me. It is sheer wickedness. (CRH, 17)

At the same time, one of the NIPRD administrators based in Lagos had an entirely different idea on the issue of monitoring. He asserted that NIPRD did not want to get involved nor pre-empt what the claimants were doing. Some representatives, perhaps not all, from NIPRD felt that their only duty was to recruit participants for the trial after confirming that they were HIV positive, and at the end to know whether any of the drugs were efficacious. One NIPRD administrator countered, however, by asserting:

We should usually follow the normal procedures recognized world-wide. Any drugs for clinical trial should first get the approval of the regulatory body like NAFDAC and also the ethics review board of each teaching university [hospital], where the study is to take place, should endorse the trial. Then the products should be left in the hands of experts. There should be nothing like dealing directly with claimants of the drug. There must be independent investigators made of experts. There are people who know what to do. The different stages of a clinical trial should be strictly followed. We should not be in a hurry to come up with a product for human consumption. (CRH, 19)
One of the military doctors, Dr. Pat Matemilola, who was at the original Abalaka meeting and is now the coordinator of the National Network for People Living with HIV/AIDS commented on the safety of the trial:

Virtually all of them that took part in the trial were unable to complete the trial. The reason for this was due to severe reactions, which they experienced to injection they were given. A person takes an injection and the next thing he just falls like collapsing or even collapsed and slept for so many days without being able to do anything. And nobody knows the contents of the injection. So when they came to me and said they were given injection, I asked, What injection? What we were told was that you were going to be given herbal medicine. So, we were all confused. We don’t really know what was being administered to them. Most of the participants dropped out of the trial. (CRH, 14)

Professor Akinsete, former executive director of the National Action Committee on AIDS (NACA), housed in the office of the presidency, commented on the public understandings of the cure claims and clinical trials:

This is what happens when there is a misunderstanding of what a clinical trial is all about. It is unethical to think that drugs could just be injected into people. People complain that we, medically trained people, do not accept the claims of cure that is why we are prejudiced against the claimants. But this is not so. That was the reason why I said it was important to have the trial conducted in about three or four centers as well as put people in charge to be able to organize and guard the interest and safety of the patients, which is most important. You cannot start injecting drugs into people without first ensuring their safety. (CRH, 14)

Long before the trial took place, I spoke to research scientists at various public institutions who at the beginning of my stay appeared to have strong beliefs that Abalaka’s vaccine had much potential for efficacy and could induce sero-conversion. But toward the end of my stay, as cure claim disputes mounted, and it appeared that Abalaka would not disclose the details of the vaccine, there
was increasing doubt, not necessarily articulated as such, but rather the insistence that a lack of peer review was at stake. Additionally, some research scientists may have had an investment in the efficacy of the drug. The reason for this is that, as stated earlier, NIPRD brings together high-tech research with traditional medicine, and has marketed successful drug products in the past. The success of Abalaka would further promulgate NIPRD’s methods beyond Nigeria and into the international community.

Just before NIPRD carried out the trial, a huge controversy involving the pharmaceutical giant, Pfizer, was making national headlines and thousands of people protested in the streets. Pfizer carried out a haphazard clinical trial for a meningitis drug in the northern city of Kano, where it was asserted that Pfizer violated international clinical trial protocols. Several children died and many were left disabled. As the Pfizer controversy was fresh in people’s minds, it is quite curious that there was a lack of apparent regard for PLWHA during the cure claim trial. The lack of monitoring undermines the trial as it was partly a face-saving strategy to an international community that was keeping close watch, and renders nationalistic impulse for an indigenous cure impotent.

I left the field before the trial ended and before follow-up interviews were conducted by the Center for the Right to Health (CRH). But in reading the CRH report, I was struck by the fact that although the trial was critiqued (no centralized location, no independent experts, etc.) there was no mention of trial design itself. All of the activists, especially those in more powerful positions, never explained why they did not or could not have access to trial protocol and procedures; nor
how or if they demanded equal participation in the procedures. Not even high-level policy makers appeared to effectively intervene when they knew of the severe side effects and the terse treatment the trial subjects experienced.

As far as patients were concerned, safety was not at all an issue. As NIPRD reportedly never showed up to some of the sites, there were concerns among AIDS activists that because NIPRD, as the government body, did not carry out clinical trials as charged, it would enable claimants to hijack the process. In other words, if the state was not implementing its own policy of intervening in the trials, claimants could continue to advertise the veracity of their claims. For many AIDS activists, the clinical trials were meant to expose cure claimants, once and for all, as charlatans. For trial subjects, especially those who did not receive adequate informed consent, the clinical trials were viewed as finally getting treatment where none could otherwise be found.41 While cure claimants, trial subjects, AIDS NGO leadership and NIPRD all traded blame, it was unclear why there were no demands for transparency at the beginning and end of the process. In fact, many high-level policy-makers and AIDS activists do not even know the whereabouts of the final report. Therefore, the trial may have ultimately been a stage on which all actors involved could finally play out their own agendas and claims of expertise. In other words, this was very much a performance of a clinical trial, that is, trial as rhetoric, but one that had real consequences on living bodies and suffering.42

Conclusion
Cure claims are part of a therapeutic economy whose political contours are shaped by intellectual property regimes, global drug distribution, and state privatization. This chapter has attempted to ethnographically not only to describe the conditions that produce medical and clinical knowledge and subjectivities, but to show the very construction of the African post-colonial state though which knowledge and subjectivities are created. As argued by Mbembe, Bayart, and Abrahamsen, the national and the international in Africa are completely interwoven in a way that makes it difficult to disentangle the two. Supporting this argument, an ethnographic view of cure claim debates reveals: conflicting ideas of democracy that seek state expansion (social welfare) to regulate drugs while international donors and creditors make demands for a minimalist state (neoliberal); a biological nationalism that asks for both the revival of Nigeria’s image before the international community while at the same time desires post-IMF economic redemption; and ideas of commanding global traditional medicine markets while the state downsizes and loses its capacity for regulation.

As a result of past and current polices that synthesize the state, the only therapeutic resources available on the ground are counterfeit drugs, which amount to about 49% of all drugs in circulation; proprietary drugs but at a high cost and where anti-retroviral medication is almost non-existent; tens of thousands of illegal drugs markets; traditional medicine, which the majority of people may even often safely patronize; and cure claims. Together all these factors make up a totality of a therapeutic economy where there exist competing clinical knowledge and expertise, where available therapeutics are apprehended by PLWHA whose
subjectivities are thus inculcated by design. Military personnel, for example who become AIDS activists especially after receiving treatment from a cure claimant may embody several different kinds of subjectivities over time, beginning with the belief that they will be cured to being influenced by Western representations of drug efficacy. Those seeking treatment from cure claimants are motivated by the widespread discourse of HIV as curse that keeps them underground. Cure claimants proliferate because they represent confidentiality, compassion, and answers, none of which is at all available in clinics and hospitals. The idea of a curse only becomes possible in the absence of drug availability and medical care and there are no medical or discursive structures (with the exception of NGOs) that can construct HIV as an infection. Therefore, cure claims and those seeking treatment from claimants cannot be read as simple charlatans or as ignorant. Instead, emergent medical subjectivities are apprehended via the available forms of expertise and knowledge production.

The widespread construction of curse, most evident in medical institutions, has also generated many layers of secrecy. As stated earlier, we can see how the issue of medical secrecy gets constructed through several institutional frameworks. In the absence of a strong intellectual property law and its enforcement in Nigeria, secrecy always prevails over medical disclosure. This blends into an environment where stigma and discrimination experienced by those with HIV/AIDS is not simply a cultural dynamic, but rather is generated by the lack of available treatment. In the Abalaka case, neither the media nor government thought to investigate any subsequent deaths. And due to stigma and
discrimination, AIDS patients did not come out publicly to declare that any of the cure claims were not working for them. This further consolidated the nationalistic drive to reify an HIV cure over and above any discourse of the HIV body. As the discourse of democracy (dividends) and suffering (discussed in the introduction) widely circulate within Nigeria, it may be curious at first to note that the suffering HIV body was not incorporated into existing public discussions and paradigms. But as suffering may be a weary, yet fully practiced articulation for many, the different political and economic networks of secrecy cohered to produce a magic hope of redemption.

AIDS, cure claims, and clinical trials therefore cannot be approached as single issues. They are structurally and historically shaped, producing distinct experiences and subjectivities that make up a biological citizenry. Adriana Petryna (2002) has described biological citizenship as different from traditional notions of citizenship, in which the state can no longer guarantee biological survival as a prerequisite for political participation. Here the biological can be viewed as a primary category to analyze political and economic networks, in which the fusion of national and international forces structure AIDS policies, rights and therapeutic economies. Indeed, it is the very category of citizenship, as opposed to Rabinow's assertion of gender and race reconfigurations that mark the status of the state in a post-colonial era, the circulation of technologies, and the availability of treatment and health care. The biological and questions of
citizenship and subjectivity reveal the imagination and failure of Nigeria's imagined social contract and hope for the delivery of a new democracy.
1 Interviewed June 2001.
2 It should be noted that there are very few anonymous testing centers in Nigeria and that the majority of the population—about 70-80%—seeks traditional health care services as their primary health care. Therefore, populations selected for HIV demographic surveys are those who have at least some or limited hospital and clinic access, which neglects a larger portion of the more impoverished social classes.
3 London Club (commercial creditors) is owed US$ 2 billion in Brady bonds; multilateral creditors, World Bank and African Development Bank are owed US$ 2.7 billion; non-Paris club bilateral partners are owed US$ 121 million and promissory note holders are owed US$ 1.2 billion.
4 Jeffrey Sachs (2001:3) emphasis is worth quoting: My point is that if you’ve tried and tried and tried the simple postponement route, and the debt burden keeps growing, you need to recognize that you’re not doing the right thing—you need cancellation rather than postponement. I am hopeful that after fifteen years of this experience, the international community will figure this out. Actually, I think they have figured it out, they are simply not willing to recognize this publicly.
5 The idea is to free up funds for countries to spend on education and health care. The Jubilee 2000 and Jubilee South organizations/movement have commented that these reforms have not significantly reduced debt repayments and in some cases, many countries in financially worse situations.
6 General Gowan, the head of state who defeated Biafra (which seceded from Nigeria in 1966) in 1970, reneged on his promise to return Nigeria to civilian rule and announced an indefinite continuation of military rule under his regime. He was overthrown by General Murtala Mohammed in 1975 (Edozie, 2002).
7 Gaining the most international attention during this period were the executions of the Ogoni Nine over land and oil disputes in the Niger Delta region. Also, Canada and the UK’s development agency DFID pulled operations at this time. Japan, the Netherlands, and some UN agencies did remain, but their work significantly declined during this period.
8 While I was in the field, the Oputa Panel, a truth commission (although it was unclear if it was a truth and reconciliation or truth and justice commission) was set up to address human rights abuses since 1966, when the Nigerian military first took power. One of the cases before this panel was on the death of Abiola. As the Oputa Panel was televisied, I saw the testimony of Abiola’s prison guard whose main duty was to sample food and water before it was given to Abiola. On the day of the meeting with the Americans, Abiola’s guard was asked to leave the room and not sample the tea that Abiola was given while in this meeting, leading Nigerians to raise suspicions once again that Abiola’s death was not due to ‘natural causes’ as his autopsy states.
9 The first two features Kankwenda describes are: 1) the suppliers at the level of transnational and big development business institutions sell their products and services by financing the buyer or by advancing him money. Whether grant or loan the seller always does good business, directly or indirectly, as an individual or as a system; 2) The development merchants do not wear the garb of businessmen, but come dressed as guru, marabout or prophet of development. They come as do-gooders, and humanists preaching the way of salvation, the way out of crisis, and even the way of development, and they finance those who follow their preaching and prescriptions.
10 In bringing new African nations into the global economy, African governments relied upon the former colonial powers to fill the gap on developing Africa. Just after World War II, modernization theory was employed as the initial paradigm for development, which evoked a clear representation of Western values that was limited in practice because it was believed to be an autonomous process independent of politics, culture, and institutions. Modernization theory asserts that a universal teleological state of backwardness, particularly characterized by low economic growth, can be eventually reversed. It is assumed that becoming modern is a process that happens in stages and is moreover, spatially diffused. Here, it is postulated that developed countries in the West were the measure of evolutionary modernity that developing countries should emulate to become fully modern. That is, developing countries can capitalize on becoming modern by following the (macro-economic) examples of the evolved nation states. The most forceful
reaction to modernization theory was dependency theory, which was initially developed to theorize the impact of neo/colonialism in the periphery in Latin America. However, translated into an African context, many political scientists, and to a lesser extent, anthropologists, treated Africa as a functionalist notion of the world system, and created an external spatial and temporal dimension between the so-called inner and external dynamics of Africa. The modernization paradigm also dehistoricized development, thus overlooking the complexity of the state apparatus and institutional frameworks that encompass both traditional and modern legal characteristics, and ignored the subtle and sometimes blatant differences between informal and formal uses and administration of power. And culturally, modernization as development was in contrast with local ideas of development. This has led to assertions, particularly by Samir Amin, that the state in Africa has no real autonomy. The idea that imperialism dominates and takes over the agency of African nations ignores or does not account for complex anthropological observations of the state or the dynamic qualities of associational networks, community and grass root politics and movements that express differing forms of autonomy.

One of the starkest examples of these differences emerged in 1980 when the OAU met and issued the Lagos Plan of Action for the Implementation of the Monrovia Strategy for the Economic Development of Africa. It was the most comprehensive statement for a vision of African development. It emerged out of the perceived failure of external development and macro-economic projects and was guided by principles of self-sustainability and self-sustaining development. The political economics of the Lagos Plan entailed altering Africa’s position in the international division of labor, changing patterns of production that would alter primary production as a singular economic viability for the stimulation of manufactured goods that would rely upon Africa’s own raw materials, management, finance and technology and less on imported goods (Ake, 1996). The World Bank and IMF countered this proposal with Accelerated Development in Sub-Saharan Africa: An Agenda for Action in 1991. The emphasis in this report was on a crisis in agriculture and internal problems in Africa. Pragmatically, it focused on bringing about more free market forces in which trade and exchange rate policies, reform of input supply and marketing services for agricultural products, and more effective uses of the public sector. After five years of debate, the Lagos Plan was deemed unfavorable to the multi-lateral organizations and the Lagos Plan lost steam with the new structural adjustment packages accepted by numerous African states in the mid-1980s (Ake, 1996).

Here I am referring particularly to the New African Partnership for Development (NEPAD), which is one of the first real policy manifestations of the discursive opposition drawn between foreign aid and foreign investment. While the Bretton Woods institutions have recently admitted (the World Bank more so than the IMF) that macro-economic approaches, especially structural adjustment programs, have failed to alleviate poverty, the strategies to address such failures are rapidly turning to foreign direct investment (FDI). NEPAD is being hailed as the newest development paradigm for the African continent, representing a more cohesive alignment between African elites, corporate forces and multilateral institutions. It not only represents primary direct investment with the hinting hope of excluding foreign direct aid altogether, but also represents a cooptation of the language of imperialism and nationalism that reconfigures the force and historicity of these terms. Indeed the document claims its legitimacy from the so-called African Renaissance. The promoters are the African heads of state from Nigeria, South Africa, Senegal, and Algeria. However, very few NGOs or the public had even heard of the plan, and for those who have, more often information came from their northern colleagues. Yash Tandon (2002) has described NEPAD as two separate documents. It is as if the two parts of the document - the first diagnostic part, and the second prescriptive one - are written by two separate groups of people working independently from one another. There is very little either logical or ontological link between the two parts. While the diagnostic section is partly reflective of a generally radical epistemology, the prescriptive part is almost entirely from the text-book neo-liberal orthodoxy (Tandon, 2002:1). For example, one of the claims in the document states that debt has reached a stalemate while at the same time articulating the need for more aid to finance the project. Moreover, the notion of partnership is never defined partnerships with whom? The document acknowledges legacies such as colonialism, the cold war, and the divisions in the international
economic system. It also acknowledges Africa's inherited "weak capitalist class" and "weak accumulation process" leading to patronage and corruption" (para 25) and therefore Africa's peripheral and marginalized role in the global political economy. Economic empowerment and self-reliance are thus key to redirecting the development process in Africa.

NEPAD concludes that Africa needs to undertake massive new investments. But in the entire document there are no articulated ways in which money is going to rapidly come into Africa. Here is where NEPAD envisions that investment partnerships with industrialized states will come to the rescue, an imaginary that opposes other kinds of foreign aid indeed the target amount of public aid in the 1970s exceeds that of the first years of the 21st century. Partnerships between north and south, in development discourse and certainly for AIDS work, have been gaining fast ground over the last decade. But this perhaps the most forceful articulation that defines partnerships as the opening of new markets leading to ideas that this will bring Africa to rapid economic growth and the end of international economic marginalization.

One of the conditions for capital investment initiatives is the building of social and political stability, that is, democracy, specifically good governance. The leadership of NEPAD will decide upon good governance, although it is unclear who comprises this leadership or how they came to hold such power. But how and who gets to define good governance? Currently the US, and indeed much of the world, views the Obasanjo administration in Nigeria as characteristic of good governance, mostly due to the fact that Nigeria has updated its trade policy to fit the needs of foreign investors, relatively good relations on oil issues (despite the civil unrest that contends this relationship), and very favorable military cooperation. On the other hand, most Nigerians would disagree with the idea that Nigeria is packed with good governance. These are sentiments based on the inability to secure basic needs and the ongoing encounters with corruption. The potential serious consequences of these democracy conditions are that a machinery is now in place to ensure that nothing is done to prejudice the inflow of FDI. For Nigeria, how will foreign capital function any differently than it has in the past? A sponsor of NEPAD, Nigeria is deemed both resource rich (oil) and resource poor (it has no money) because that money is either tossed like cake to debt repayment or soaked back into the hands of the elite. Therefore, NEPAD deems this a resource gap that simply asserts that African nations have no capacity for savings, without considering the high percentage of these funds that are paid out externally. NEPAD strongly articulates that the benefits of globalization can be reaped by the most marginalized. But there is no sense of how FDI will create an even playing field between rich and poor and powerful and weak players and there seems to be no concern that the opening up of markets will perhaps only strengthen those elites who support the initiative the most. From a Nigerian perspective of good governance, filling in resource gaps may not in fact change the politics of oil money flow in the country, nor will it bring about incentive to actually encourage life-style change, which is what the battle against corruption in the country is all about. Hence, Yash Tandon's astute assessment: the ruling elite's case for wanting an inflow of capital becomes all the more suspect if it is in control of both the state and the major sources of export revenues, such as oil or minerals. If, furthermore, the ruling elite is in alliance with foreign corporations, or foreign banks, wanting profitable investments in these countries, then it is difficult to escape the conclusion that the whole thing is a massive fraud (Tandon, 2002).

During fieldwork, most of my daily time was spent with two AIDS NGOs in Lagos, although I did drop in and hang out in a number of other AIDS NGOs in Lagos, Ibadan, and Abuja on a less frequent basis. I managed to be in contact with other members of AIDS NGOs around the country through workshops, meetings, and conference venues where I had the opportunity to speak to them at length, but unable to actually conduct participant observation in their home locales.

UNICEF has been especially cognizant of the fact that many teenagers of poor families are left to economically fend for themselves, while they live in households who cannot meet their all their needs.

These countries include Australia, Finland, New Zealand, Norway, Brazil, India, Mexico, Korea, Taiwan, Argentina, Egypt, Ghana and Thailand. A patent is relatively undefined in Nigeria. What counts as traditional intellectual property has now evolved into new definitions of
novelty and innovative steps that match the development of technology and a market environment that reflects strategic and competitive assets in contemporary globalization (Ringo, 1994).

16 Although, the World Intellectual Property Organization (WIPO) is designed to provide this kind of technical assistance, it does not always meet this crucial function. As one lawyer in Kenya joked to me about WIPO fact-finding missions, he asked, is it fact or fiction?

17 The significance of decolonization and the accession of postcolonial states to GATT in the 1960s and 1970s, is a point that is missed by a number of scholars on the history of GATT. It seems to me that there is a great deal to learn about this transition from colonization to independence.

18 For example, Keith Marsh came to CLDP out of the Pentagon, and is described as an established musician who joined the military in 1997. He worked as a non-commissioned officer in different parts of the world as information security officer, was responsible for administrative and logistical support to several geographically separated individuals most of whom were in the Philippines, Japan and Thailand. After the fall east, it was back to Europe and assignment Great Britain. Most of his duties with the Royal Air Force United Kingdom were of a sensitive nature, and while there was temporarily deployed (sic) to Saudi Arabia in support of Desert Storm . It is unclear what purpose the self-representation, indeed proclamation, of an adventurous US spy would serve here. Certainly CLDP’s own representation of wanting to help Nigeria could easily be called into question among Nigerians, some who historically hold suspicions of US intelligence practices in Africa and elsewhere.

19 This relationship between the US and Nigerian musicians actually began in 2000 when the USDOC first came to Nigeria to assess the TRIPs compliance.

20 Although the rather unreported and violent conflict in Benue state as well as the Delta states may be an exception, and certainly Nigeria’s peacekeeping missions in Liberia and Sierra Leone cannot count as such.

21 MSF shut down its meningitis operation in 2002, which was based in Kano after the state government repeatedly denied the existence of the epidemic and eventually restricted MSF from state hospital access.

22 A new campaign has since begun, spearheaded by a coalition of NGOs called the Treatment Action Movement.


24 The classes of drugs most important to PLWHA are: anti-infective agents to treat or prevent OIs; anti-cancer drugs to treat malignancies such as Kaposi sarcoma and lymphoma; palliative drugs to relieve pain and discomfort, both physical and mental; ARVs to limit the damage that HIV does to the immune system by reducing viral load. As HIV/AIDS is recent medical problem, many drugs created especially to treat HIV infection and its related diseases are proprietary and therefore expensive. However, many generic brands are becoming more and more available on the global market, which is bringing down the price of drugs. Therefore, determining which drugs are important for HIV and HIV-related treatment depends upon price and availability, as well as patent law issues. Based upon extensive field research, MSF (2000a) estimates that the priority medicines should be considered for resource poor settings are drugs for the prevention of opportunistic infections; palliative drugs, such as analgesics and anti-diarrheals; anti-retrovirals can act as a preventative of opportunistic infections and help to extend and improve the quality of life by reducing viral load; and anti-retrovirals to prevent mother-to-child transmission (such as AZT, NVP) and to use as post-exposure prophylaxis (P rez-Casas, et al. 2000a).

There are three main types of ARV drugs: nucleoside analogue reverse transcriptase inhibitors (NRTIs), protease inhibitors (PIs), and non-nucleoside reverse transcriptase inhibitors (NNRTIs). NRTIs target an HIV protein called reverse transcriptase. These were the first type of drugs available to treat HIV. Today, two NRTIs often form the backbone of any anti-HIV drug combination. Common dual combinations of NRTIs that are used as part of combination therapy are: d4T & ddI, AZT and 3TC, d4T and 3TC, AZT and ddI. Combinations that are avoided are: AZT & d4T, d4T & dDC, ddI and dDC. Protease inhibitors were the second class of antiretroviral drugs to be available. They are usually used in combination with two NNRTIs. Often in capsule
form, these pills can be heat sensitive and daily doses can include anything from four to sixteen pills. PIs are not usually recommended as the first line of anti-retroviral treatment in resource poor settings. An NNRTI is often taken with two NRTIs as an alternative to a PI. A daily dose may involve one to four pills. NNRTIs are increasingly viewed as a preferred first line treatment particularly for people in developing countries.

25 Some of these programs include: National Immunization Programme for children, Lagos State free malaria programme, Lagos state free eye treatment programme, Lagos state free health care services for pregnant women. Lagos state free emergency treatment in the case of accidents (MoH, 2001), and some NGOs and international organizations fund and provide TB treatment in about 16 states.

26 Additional drug markets are spread over the nation at Idumota in Lagos, Ariria in Aba, Head Bridge in Onitsha, and Kano market. Others are at Obete in Enugu, Gamboru in Maiduguri, Gombe, Kaduna and Owerri. (PSN, 2001). In August 1999, a survey conducted in Lagos State revealed that there were about 20,000 illegal drugs premises scattered in the 20 local government areas of the state (PSN, 2001). Another survey conducted in June 2001 for the Pharmaceutical Society of Nigeria showed that the number of illegal premises in the state increased from 19,708 to 48,376 because of the inactivity of the regulatory authority, NAFDAC (PSN, 2001).

27 I especially thank Olutubosun Obileye for sharing the burden on work in determining the these figures.

28 I thank Chloe Silverman for pointing this out to me.

29 This is a term coined first by AIDS activists and eventually utilized by multiple actors, including policy makers. There seems to be little objection in using this term by claimants themselves.

30 Many of these are faith healers, especially Pentecostal Christians, including the well-known Lagos-based Prophet TB Joshua of the Synagogue church. Most are traditional healers, others are scientists and doctors, and there are also average people who stumble across homemade or other cures. I am not creating a divide between scientific research and illegitimate (i.e. traditional healers) cure claims. One reason is that traditional healers a term used in Nigeria have successfully treated illnesses since before the arrival of Western medicine and currently are considered some of the best experts on botanical/medicinal knowledge. The University of Jos pharmacognosy department hires traditional healers as consultants and the World Health Organization recently endorsed this sort of joint research (WHO, 2002). The National Institute for Pharmaceutical Research and Development, based in Abuja, is the only agency with an industrial and aromatic plant extraction factory in Africa used for medicinal plant research and they too hire traditional healers as consultants. My point is that I do not want to differentiate between Western-trained research and indigenous knowledge, nor do I want to collapse them. At this point, standardized (and foreign) pharmaceuticals command the greatest legitimacy among AIDS activists, while cure claimants are demonized whether they are Western-trained or indigenous healers.

31 Here the clinical trial, as in the US and Europe, becomes the gold standard of proof for any pharmaceutical cure claim.

32 However, I changed the term here to reflect the specific economic policy designs currently underway in Nigeria.

33 More broadly, I am interested in rethinking the role that medical anthropology and science and technology studies have to offer these issues. Medical anthropology has been traditionally interested in cultural perceptions of health, illness, risk, and behavior. Science and technology studies has been primarily concerned with the relationship between technological objects and society. Both subdisciplines do not necessarily address how and why these concerns have become manifest under technological inequities, maldistribution of resources, and severe material stress within both the metropole and the postcolony. Expanding upon these traditional concerns in the subdisciplines, I want to think about medical pluralism as a complex negotiation involving democracy, nationalist imaginaries, and neoliberal economics.
Abalaka has claimed that he does not add herbs or chemicals to the vaccine, but he describes the vaccine as having a yellow color and it takes him more than two hours to work on each sample of blood to obtain the final product (Phillips, 2000). Barnaby Phillips. Although it should be stated that cure claimants occupy a more ambiguous position. While Abalaka, for example, declared that government should not interfere with medical practice, he also called upon government structures to support his efforts, which I read as a call for a form of pseudo-regulation.

The term good governance was first coined by the World Bank in 1989. Large development institutions (such as OECD, USAID, DFID, etc) proceeded to make it their primary criteria for foreign aid. Good governance was used to assert that the reason that IMF structural adjustment did not work was because African nation-states did not properly implement them. That is, they needed proper governance structures to make neo-liberal policies work. This discourse is a literal about-face on the part of Western donors which during the Cold War believed that urbanization, education provisions, and other social transformations in the African post-colony would create new demands for the distribution of welfare and political participation. Within a Cold War climate, such fears were seen as detrimental because of the potential for mass organization and loss of containment, so valued in the fight against communism. The dilemma was how to create economic progress without creating destabilization pressures intrinsic to the modernization process (Abrahamsen, 2000:27). Good governance in the 1990s follows this logic where a minimalist yet good governing state is ideal. Governments continuing toward regressive policies, even those created by foreign aid donors during the Cold War (Kenya, Liberia, Sudan, Somalia and Zaire are examples), were to now change in a new environment where the former Soviet Union was no longer funding its client states, the capitalist countries agenda for containment had ended, and foreign aid was severely reduced. Abrahamsen argues that the good governance agenda can be thus viewed as a discursive transformation that, while claiming to liberate the poor, enables the West to continue its undisputed hegemony on the African continent under changed conditions of the new world order (44).

The Expert Committee on the Verification of Claims of Cure in Nigeria

Aliyu Hayatu, The Abalaka Phenomenon, Today Newspaper, April 23, 2000

It should be noted that fraudulent activities, poverty, armed robberies, corruption, etc., and a particular Nigerian humor that intersects all of the latter also mark a discourse of both belonging and redemption.

The Pfizer case deserves a longer discussion. In September 2001, thirty Nigerian families filed suit against the pharmaceutical company, which accused Pfizer of inadequately warning Nigerian families about the risks of its experimental meningitis drug, Trovan, during a clinical trial. In April 1996, there was a meningitis outbreak in the northern city of Kano where more than 100,000 people came down with infection. It was announced over local radio that treatment could be obtained at the Infectious Diseases Hospital, where hundreds of meningitis sufferers gathered around two separated foreign medical camps that established themselves on the ground: the international humanitarian organization, Medics Sans Frontieres (MSF Doctors without Borders) and the now-largest pharmaceutical company in the world (commanding $11billion/year), Pfizer, Inc. MSF, already based in Nigeria, arrived first and was providing free treatment at the hospital with the antibiotic chloramphenicol, a standard of care for treatment of bacterial meningitis. Pfizer found out about the meningitis outbreak via the internet and moved swiftly to produce a clinical trial protocol in just under six weeks (normally it takes about a year). Chartering a jet, the company spent nearly $10 million to carry out the emergency trial. The company had selected 200 children to test its clinical drug and set out to accomplish two objectives in the trial. The first was to test to see if Trovan would be useful for meningitis, as it already had enrolled thousands of patients around the world its biggest testing program ever for a broad range of infections: sinusitis, bronchitis, gonorrhea, pneumonia. The second objective was to improve upon the standard injection by administering the oral form, Trovan. Half of the children were given trovafloxacin and the other half given cefotaxime, known to treat some forms of meningitis. Among these children, eleven died (five with trovafloxacin and six with cefotaxime), and many others were left with meningitis related symptoms such as deafness,
blindness, seizures, and an inability to walk or talk. As both MSF and Pfizer teams were working basically within the same compound, it was not clear to patients or patient's parents that there were two teams, one running a humanitarian operation, the other conducting a clinical trial. The entire surrounding area transformed into an emergency room and the ensuing chaos did not allow room for any sort of discernment, especially since informed consent procedures were purportedly not followed.

While US children who were test subjects previously received intravenous therapy, children in Nigeria received an oral form of Trovan, which had never been tested on children. The Washington Post reported that children who did not respond to therapy did not receive the standard chloramphenicol, which has led to claims of negligence. Moreover, the Pfizer clinical trial design made the spinal tap optional to see how the medication was progressing, which is usually a standard of care within 48 hours of initial treatment. Within three weeks of setting up camp, Pfizer disappeared on their chartered DC-9, never returning to track long-term effects of the Trovan.

Pfizer claimed that the trial was carried out according to international standards. The Nigerian government arranged for the company's accommodation, while apparently silencing criticism, according to court documents. The FDA approved exporting the clinical oral tablet form the same day it was requested. Moreover, the company claims that the trial design was cleared through the hospital's clinical ethics committee. However, two doctors on staff said that there was no ethics committee in existence at the time of the trial and that no approval was given to carry it out. As it turns out, the approval document was created and backdated after the trial was concluded. One doctor on Pfizer's staff, Dr. Juan Walterspiel, was highly critical of the study design and warned management that the methods were unsafe and unethical before and after the study was conducted, which led to his dismissal. Additionally, Pfizer did not get written informed consent, but asserts that patients were adequately informed that the treatment they received was experimental. The FDA never objected to the lack of consent forms for drug approval. It was not until after thousands of Nigerians took to the streets in protest and a two-part expose in the Washington Post that both the FDA and Nigerian authorities launched belated inquiries. In rebutting accusations, Pfizer argued on its website that given the impoverished conditions, patients ought to have deemed themselves lucky to get the cutting-edge medical care and upgraded local facilities that Pfizer's trial offered.

By December 1996, Pfizer had tested oral and intravenous Trovan on 13,000 people in 27 different countries. Late that month, the company applied to the Federal Drug Administration (FDA) for the approval of Trovan. Six months after the filed application, FDA inspectors examined documents from Nigeria and found nearly four dozen discrepancies. One document listed a child's white blood cell count as 68, while another listed 680 for the same child. Other records showed that some lab tests were conducted in Kano, while others showed they were actually done at one of Pfizer's labs in Connecticut. Pfizer claimed that such discrepancies did not compromise the validity of the trial or its conclusions. In the midst of this, the FDA never discussed why it did not approve the marketing of Trovan for children, as they are considered corporate secrets. Pfizer withdrew its request to use the drug against epidemic meningitis after the FDA indicated that it would not approve for such cases based upon several concerns including the failure to conduct adequate follow-up exams. The FDA approved Trovan as a marketed product for the use against fourteen adult illnesses on Dec 19, 1997.

Pfizer sponsored a February 1998 launch meeting in Orlando. More than 1,800 sales people rhythmically chanted Tro-van, Tro-van, Tro- van, recounted in a company magazine. ... Soon the drug was one of the most prescribed antibiotic brands in the United States. Pfizer reported that sales reached $160 million in the first year of marketing and sales (Wall Street analysts predicted up to $1 billion per year Drug Companies tests in poor countries raise ethical questions) and that roughly 2.5 million adults had taken it by mid-1999. Within sixteen months on the market, there had been 140 reports of liver problems in Trovan patients. At least 14 suffered liver failure and six died. Pfizer claimed that no serious liver problems had surfaced in its experiments, including the Nigeria tests. The FDA then advised that Trovan be restricted for use in patients with serious diseases whose need was great enough to outweigh the risks of liver damage. European regulators suspended the sales of Trovan altogether.
After Pfizer failed to show up in a Nigerian court where the lawsuit was originally filed, it was later filed with the US District Court of the Southern District of New York in Manhattan. The US court originally dismissed the case, ruling that US courts were not the appropriate place for the case (rather Nigerian courts were). However, the US Court of Appeals for the Second Circuit revived the case and remanded it back to the district court in late 2003. Proceedings have not yet begun.

41 Throughout the world, this is the usual scenario for those who cannot afford access to treatment where easy access to clinical trials represent the only access to general health care.
42 I want to thank Chloe Silverman for making this point to me.
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