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A ‘Critically Applied’ Approach to PrEP: Introduction

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This series has two aims. The first is to deepen anthropological engagement with a novel biomedical technology to prevent HIV. The second is to help bridge the divide between ‘critical’ and ‘applied’ approaches in our discipline. Over the following months we will publish a series of articles that work toward these joint goals. To introduce this series I begin with a brief background note about the biomedical prevention of HIV then offer a conceptual framework to understand what a ‘critically applied’ approach might be.

The biomedical prevention of HIV

In 2012, the U.S. Food and Drug Administration (FDA) approved the commercial use of an antiretroviral drug to prevent HIV through a method known as HIV pre-exposure prophylaxis or “PrEP.” This drug is marketed by Gilead Sciences and sold under the brand name Truvada. In 2016, the European Medicines Association (EMA) also approved use of Truvada for PrEP, and shortly thereafter the World Health Organization (WHO) issued recommendations to implement PrEP around the world through the distribution of this single brand name drug as well as its generic equivalents (tenofovir disoproxil fumarate [TDF] and emtracitabine [FTC]). Currently, the cost of PrEP in several high-income countries is mostly covered by public and private insurance plans as well as a co-pay card from Gilead, though people in many states still face challenges to access. Meanwhile, in middle- and low-income countries, PrEP implementation is being supported by global health organizations, including the Bill & Melinda Gates Foundation and the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). While the precise impact of PrEP on health outcomes is hard to determine, current estimates indicate there are approximately 390,000 people in PrEP programs: the United States has the highest number of PrEP enrollees (192,000-197,000) and Kenya has the second highest (53,000-54,000) (AVAC 2019).

As Truvada moves across continents and into local formularies, our understanding of HIV prevention is being destabilized. For the past forty years, under the guidance of the Centers for Disease Control and Prevention (CDC) and the WHO, public health departments have focused

primarily on preventing HIV by promoting abstinence, behavior change, and condoms (ABCs). However the biomedical paradigm is shifting global strategies to address this disease (Nguyen 2011). For some, the introduction of PrEP inspired new reason for hope. Many people were reassured that with this new technology we might be able to slow HIV incidence, as part of a larger effort to treat our way out of this epidemic. Moreover, for people whose intimate lives have been shaped by HIV, PrEP opened new opportunities for intimacy, including by easing concerns about relationships across HIV-status and quelling anxieties about the risk of acquiring a virus during sex. As one PrEP advocate I met put it, the approval of the drug meant we could have "sex free of fear!" (Whitacre 2018). But PrEP also introduced new concerns, including about the safety and efficacy of taking an antiretroviral drug to prevent HIV. Some gawked at the high cost of the single brand name product available for use and expressed concerns that PrEP might influence "risky behavior" – "if people start taking this drug, will they stop using condoms? Will they have 'unsafe' sex?" These hopes and concerns have consistently animated conversations about the implementation of PrEP in diverse geographies and a similar set of concerns will likely shape the development of the next generation of PrEP technologies.

While tracing these many debates about the ongoing implementation of this novel biomedical technology, in this series we are primarily concerned with how to think about and engage with PrEP, as anthropologists trained in critical social theory and committed to applied approaches for improving health outcomes. Writing from research universities as well as departments of public health in Geneva, London, Memphis, Oslo and San Francisco we are working to better understand the place of this technology in our contemporary world, wherein just over half of people living with HIV have access to treatment [21.7 of 36.9 million], 1 million people [670,000–1.3 million] die of AIDS-related illnesses each year meanwhile nearly 2 million [1.4 million–2.4 million] more acquire the virus (UNAIDS 2018). We are heartened by recent progress to expand access, and concerned that the Trump administration just halted PEPFAR support in several high-burden countries (amfAR 2019). We share a common concern that geopolitics and pharmaceutical profit are being prioritized over human life. We are also aware that the sexualities of entire sub-populations have been characterized by the risk of acquiring HIV and are cautious that PrEP (like statins) may be redefining what we mean by 'health' through abstracted measures of risk (Dumit 2010). However we also see how a biomedical solution may be an important tool to 'treat our way out of this epidemic' and heal 'risky' sexualities. Looking across this global landscape in which hope, risk, pleasure and desire are recombining in new ways, we believe it is our task to hold in mind the many opportunities and challenges that PrEP presents, and explore the tensions they reveal. From this standpoint, we might be able to 'think PrEP' and

engage with it.

A ‘critically applied’ approach

Recognizing how much work it takes to comprehend the potential of this single technology, we think PrEP is an interesting case for a broader conversation about how anthropologists engage with biomedicine today. On one level, we believe PrEP is a good case for understanding our role in the ongoing response to epidemics as well as the development and use of biomedical technologies. On another, we find that PrEP provides an opportunity to better understand the direction we want to lead the field, as scholars committed to ‘critical’ and ‘applied’ approaches in medical anthropology. So just as we aim to deepen anthropological engagement with a novel biomedical technology to prevent HIV, we also want to help bridge the divide between ‘critical’ and ‘applied’ approaches in our discipline.

As a way of digging up the divide and highlighting its place in the field, I turn to the writing of Nancy Scheper-Hughes. And following her example, I begin with a joke:

A doctor and three medical anthropologists – Hans Baer, Michael Taussig, and Arthur Kleinman – are standing by a river. Suddenly, they hear the final cries of a drowning man. The doctor jumps into the river and, after battling against the swift current, hauls in and tries to resuscitate the dead man. After a short while another body floats by and the same attempt is made to save it. Another and another comes down the stream. Finally it occurs to Hans Baer to head up stream in order to investigate the contradictions in the capitalist mode of production that are responsible for the mass fatalities. Meanwhile Taussig goes off, very much on his own, bushwalking in search of the cryptic message in the bottle that at least one dying man or woman would have had the foresight to send out. Dr. Kleinman, however, stays behind at the river bank in order to help facilitate the doctor-patient relationship (Scheper Hughes 1990).

In 1990 Nancy Scheper-Hughes begins an article with this somewhat satirical scene and she uses it to open a discussion about ‘critical’ and ‘applied’ approaches in medical anthropology. In particular, she highlights how those who are said to be critical, namely Baer and Taussig, are shown to move away from medicine, while he who is said to be ‘applied’ is granted space alongside the doctor. Indeed, Dr. Kleinman is the only one granted the privilege of being recognized in the ‘clinical’ encounter and thus seen to be ‘applied.’ Scheper-Hughes expresses concern that such a conception of the applied (in the joke, and the discipline), which focuses on the clinic and the doctor-patient relation, reduces many of the central ambitions of medical anthropology. She also

expresses frustration that critical conversations do not seem to have a place within the clinic. Here, she finds herself caught between wanting to matter inside the clinic, and wanting to show that what really matters is outside of it.

Working from this admittedly contradictory position, Scheper-Hughes contends we need a **'critically** applied' approach, and she offers three propositions. First, we should reduce "the parameters of medical efficacy" and thus slow the momentum of "medicalization" (Illich 1975). Second, we should identify alternatives to biomedicine, including other ways of understanding the body, health, and healing to cultivate "medical pluralism." Third, we should "radicalize medicine" – that is, harness its power, inhabit its knowledges and practices, and orient the entire social institution toward equitable ends. Now it is worth emphasizing that much has changed since the time Scheper-Hughes authored this piece. Michel Foucault hadn't been recited *ad nauseum*. Judith Butler hadn't popularized performativity. HIV hadn't grown into a global epidemic. Paul Farmer hadn't named structural violence. Ontology was just a twinkle in the eye of 19th century philosophy. Indeed, our field has advanced in many important ways in recent years. Yet Scheper-Hughes' words still provide a vital guide because we are still grappling with the divide between "critical" and "applied."

This series aims to help bridge the gap. This will be evident in the papers you will read. While they are empirically focused on the recent emergence of a biomedical technology to prevent HIV – something I can tell you personally that Scheper-Hughes definitely didn't see coming – they are also theoretically invested in advancing anthropological engagement with the central concepts she describes: "medicalization," "medical pluralism," and "radical medicine." Indeed, there was plenty Scheper-Hughes did foresee and several paths toward praxis we have journeyed down. And here we are decades down the path wondering which directions we might go. As you read the contributions to this series, we invite you to look down the path with us – to help us refine and expand the anthropological imagination – to conceive what a "critically applied" medical anthropology might be today.

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