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Anachronic: Viral Socialities and Project Time among HIV Support Groups in Barbados

From 2005 to 2015, up to five support groups for people living with HIV (PLHIV) operated in Barbados. However, by early 2020, all but one had disappeared. What caused the demise of these groups and why? What does this demise tell us about the HIV response in Barbados, and more particularly, everyday life for PLHIV? More generally, what does it tell us about “viral socialities” (ties formed between groups of people as they confront the lived effects of infection and discrimination attributable to HIV) and the effects of “project time” (a time frame delimited through the priorities of global HIV/AIDS agencies) on these socialities? Through ethnographic and archival research methods, this article reveals how multiple, unstable project times create and transform viral socialities of Barbadian PLHIV with anachronic effects for some—i.e., a sense of alienation or being “out of time” in relation to the priorities of the global HIV response. [HIV/AIDS, support groups, Barbados, temporality, public health]

Returning to Barbados in January 2020, a year after completing fieldwork investigating how Barbadian people living with HIV (PLHIV) were navigating everyday life during a time of fading interest in and funding for the HIV response, I phoned Reverend Anton and his wife, Reverend Janelle, to see how they were doing. Rev. Anton and Rev. Janelle, along with Ms. Alleyne, a social worker from the Ministry of Health, coordinated “Moving Forward Together” (MFT),¹ the only active support group for PLHIV in Barbados at the time of my fieldwork, which met approximately once a month in a room in a Ministry of Health building in Bridgetown, the capital of Barbados. During our phone call, Rev. Anton said there was much to talk about, but he wanted to see me in person to relay the news, so we should meet in the bandshell of Queen’s Park in the city center. I was curious to find out what the group had been doing over the past year, but now I was even more curious as to why Rev. Anton wanted us to meet in a park and not the regular Ministry of Health meeting room.

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A few days later, we met and sat down on a bench inside the bandshell, with heavy rainfall on the roof making it difficult to hear each other. Rev. Anton then told me that Ms. Alleyne had passed away a few months ago, and that the Ministry of Health building where the group usually met was currently undergoing renovations, so the support group no longer had a social worker or a meeting place. The Ministry had not yet provided a replacement staff worker, nor had they provided an alternative meeting place, so the support group was now meeting occasionally in churches or in parks like this one. Rev. Anton and Rev. Janelle were now shouldering all responsibilities without any external financial support, rendering the ongoing existence of the group precarious, but they were committed to keep meeting, as they believed the group served an important purpose for members.

Since the early 1990s, organizations and support groups for people living with HIV have existed in Barbados, and for about 10 years (approximately 2005–2015) there were between two and five groups of various sizes and interests operating simultaneously. However, by the late 20-teens, MFT was the only support group exclusively devoted to PLHIV in active service, and now it was in a precarious position with no paid staff, funding, or home base. What happened? How and why had a relatively robust sector of civil society organizations (CSOs), devoted to the health and welfare of a population defined through a viral infection (PLHIV), declined and all but disappeared over a relatively short time span? Was it simply a matter of funding sources drying up? Were Barbadian PLHIV healthier and able to maintain “normal” lives so there was no longer a need for such groups? Or were there other reasons for their demise? What does this demise tell us about the HIV response in Barbados, and more particularly, every-day life for PLHIV in Barbados? More generally, what does this “biopolitical drama” (Heckert 2018; see also Marsland 2012; Marten 2020; Reed 2018) tell us about global health temporalities and their impact on what Robert Lorway calls “viral socialities ... the affective, intimate ties that form between groups of people as they confront the lived effects of denigration, deprivation, and injustices” attributable to an HIV positive (HIV+) status (2021: 217; see also Mazanderani 2012)?² Put slightly differently, how might an examination of the rise and fall of Barbadian PLHIV support groups over the decades-long HIV pandemic reveal the effects of multiple “project times,” time frames delineated by donors and government agencies (Benton et al. 2017), on the viral socialities of PLHIV? How might these effects force a reckoning with grand narratives of the past, present, and future of the HIV/AIDS pandemic found in mainstream discourses on HIV/AIDS?

In addressing these questions, this article applies a forensic lens to the management of the HIV response in Barbados and the global organization of the HIV/AIDS response more generally. Forensic anthropology, a subfield of physical anthropology, involves applying skeletal analysis and techniques in archeology to solving criminal cases. Forensic anthropologists gather information from human remains and their recovery context to determine who died, how they died, and how long ago they died (National Museum of Natural History N.d.). In this article, I deploy standard ethnographic and archival research methods (conducting interviews, joining informal conversations, participating in PLHIV support group meetings, and analyzing past and present government and international aid agencies’ reports) to gather various pieces of information (the remains) about past Barbadian PLHIV support

groups and CSOs to determine how and why most of these groups and organizations died. Piecing together these remains—comments from leaders, staff, and/or members of past and present PLHIV support groups, CSOs, and government ministries, observations of ongoing daily activities of PLHIV and support groups like MFT, and data from reports produced by various local, regional, and global authorities tasked with funding and managing the HIV response in Barbados—allows me to reconstruct the broader historical context in which these support groups started, developed, and declined—i.e., the changing social, political, and economic landscape over the *longue durée* of the local and global HIV response. Through this forensic lens, I draw attention to not only the localized effects of transformations of global health interventions of a four decade plus pandemic, but also to what I call the anachronic effects of multiple project times, or hegemonic global health temporalities, on viral socialities: I analyze the ways in which global HIV interventions (and their attendant funding structures) and narratives of past, present, and future HIV treatment and prevention policies and protocols have changed over time, producing shifts in formations and intensities of PLHIV subjectivities and social relationships, with uneven effects for differentially named and positioned PLHIV populations. Multiple project times and their attendant shifts in naming, prioritizing, and funding particular categories of PLHIV have resulted in some groups of PLHIV finding themselves out of time or anachronic in relation to dominant narratives of the present and future of HIV/AIDS management.

This forensic lens applied to the rise and fall of local PLHIV CSOs and support groups, producing an argument about shifting viral socialities and the anachronic effects of multiple project times and hegemonic narratives of HIV/AIDS on some PLHIV, contributes to the growing literature examining the centrality and impact of temporal orders (Benton et al. 2017) or regimes (Dziuban and Sekuler 2021) in the global HIV response. Numerous researchers have drawn attention to the temporal effects of the end of AIDS narrative, a now widely circulated message of projected optimism communicated by numerous health organizations on national and global scales (see, e.g., UNAIDS 2021). The end of AIDS narrative incorporates a linear chronology of progress from HIV as a death sentence to a manageable, chronic disease in its historical rendering of the pandemic, along with a prophetic future end date in which AIDS “disappears,” primarily due to biomedical technologies and interventions. This narrative arc produces new pressures on and valuations of current models of treatment and prevention, with differing effects for differentially located PLHIV as it shifts attention away from treatment and support of PLHIV and intensifies the focus on biomedical interventions to eradicate the virus in specific at-risk or key populations (Kenworthy et al. 2018; see also Benton 2021; Benton et al. 2017; Dziuban and Sekuler 2021; Marten 2020; Sangaramoorthy 2018).

Researchers have also drawn attention to the temporal effects of the global roll-out of ART, which transformed the dominant classification of HIV/AIDS from terminal to chronic, giving rise to what has been called “the age of treatment” (Moyer 2015), and new forms of management of PLHIV. Nguyen (2010) coined the term “therapeutic citizenship” to describe the network of local, national, and global state and NGOs involved in the definition and maintenance of healthy populations as moral and ethical projects, which develop techniques to monitor, manage, and assess bodies (see also Nguyen et al. [2011] and Whyte’s [2014] discussion of

“clientship”). Benton et al. (2017) make the important additional observation that formations of therapeutic citizenship, such as “positive living” rubrics for PLHIV, incorporate biomedical temporal frameworks that define and mediate notions of difference, health, and self in different sociocultural contexts. They also note that in many Global South and marginalized Global North communities, initiatives for the management of HIV as a chronic health condition operate within a time frame delineated by donors and government agencies (see also Manderson and Smith-Morris 2010; Sangaramoorthy 2018). These bounded time frames can be understood as “project time,” which is embedded in and productive of other time frames/lines that impact PLHIV lives such as “adherence time” (clinical treatment and public health protocols focused on synchronizing patients’ lives around ARTs), and “punctuated time” (standardized life narratives that require a break with the past and embrace clinical adherence time frames and positive living moral orders).

Recent research, including Whyte (2017), Sangaramoorthy (2018), Marten (2020), and Dziuban and Sekuler (2021), further engages with the analytical significance and material effects of “multiple, intersecting, and at times antagonistic temporal regimes ... that can coexist and interact in a field of analysis, introducing antagonistic, stabilizing or crosscutting temporal orientations that shape understandings of the past, perceptions of the present and visions of the future” (Dziuban and Sekuler 2021: 6–7), which can significantly impact differentially positioned PLHIV. Much of this literature focuses on defining and/or comparing competing temporal regimes in the age of treatment and either emphasizes the disciplinary, biopolitical effects of these regimes in terms of self-care and self-management or provides perspectives that directly focus on the technologies and uses of time under these regimes (Benton et al. 2017: 457). However, less attention has been paid to the ways in which multiple or cumulative temporal regimes contribute to the production, transformation, or erasure of viral socialities over the *longue durée* of the HIV/AIDS pandemic. With a forensic lens applied to the rise and fall of Barbadian PLHIV support groups, I attempt to demonstrate how the shifting narratives, infrastructures, and funding priorities of multiple project times over the *longue durée* of HIV/AIDS pandemic (re)organize viral socialities in Barbados, resulting in some PLHIV feeling anachronic (displaced and out of time) in relation to the hegemonic narratives and logics of contemporary HIV management and governance. Put slightly differently, I argue that viral socialities are unstable and subject to broader political, economic, and technological forces of project time(s) that rearrange, reshuffle, amplify, or undo them, with differing effects for differentially positioned PLHIV. However, I will also argue that the remains of dead PLHIV support groups, found in these laments of loss, may be generative sites of new viral subjectivities, socialities, and activisms.

In the remainder of this article, I will provide a brief overview of the historical context of HIV in Barbados, focusing on the organization and funding of the HIV response in the 1990s and first decade of the 2000s, and the establishment and growth of local CSOs dedicated to supporting PLHIV. I will then focus on the latter half of the 20-teens, over the course of which global HIV funding for various projects dried up or shifted in focus, and most PLHIV CSOs and their support groups declined in membership and activities and/or were replaced by a different set of CSOs whose purview included, but was not exclusively dedicated toward, the needs and interests of PLHIV. Finally, I will briefly discuss the present day (2019–20), primarily

focusing on PLHIV reflections on the current state of the HIV response in Barbados. All sections include memories, opinions, and critiques of members and leaders of the PLHIV support groups that operated and/or disappeared during this period to illustrate the impact of longue-durée transformations of project times on viral socialities and complicate the grand progress narratives of HIV/AIDS.

The Barbadian HIV Response from Crisis Times to the “Age of Treatment” (1984–2015)

HIV cases in Barbados were first reported in 1984, with infection rates increasing until the early 2000s, plateauing in the mid-2000s, and declining since the 2010s (mortality rates have declined much more significantly than infection rates) (Barbados Ministry of Health 2012; Barrow and Barrow 2015; UNAIDS N.d.). Until the mid-1990s, the government’s approach to HIV was piecemeal, with no coordinated, systematic response to the rising infection rates. Jackie, a now-retired social worker who used to work at the Queen Elizabeth Hospital (the primary hospital located in Bridgetown, Barbados), remembered how, in the early to mid-1990s, “there were lots of people coming to the clinic ... who were very, very, young ... (and) you had a lot of people doing work around saving souls and all kind of stuff.” Seeing the social isolation and suffering of these patients, Jackie dedicated herself to providing palliative care for hospitalized PLHIV. In 1995, the Ministry of Health established The Elroy Philips Centre, a hostel and hospice for PLHIV, and Jackie was transferred there as the domiciliary care coordinator; she also helped start and coordinate an HIV food bank. Slowly, she was able to train other social workers to assist a growing PLHIV population and their complex needs.

In 2001, the National Commission on HIV/AIDS, which eventually became the National HIV/AIDS Commission (NHAC), was established in the prime minister’s office. Its mandate was to implement a broad program to limit the further spread of the epidemic into the general population. A World Bank report, highlighting the high rates of infection and serious potential consequences of “HIV as one of the major threats to (Barbados’s) overall success as it endangered the country’s human capital” (Marquez 2004; World Bank 2015a, 2015b), contributed to the development of an Adaptable Program Loan designed to help the Caribbean region fight the epidemic. In June 2001, the Barbados HIV/AIDS Prevention and Control project became the first program approved under the US\$155 million Multi-Country HIV/AIDS Prevention and Control Project for the Caribbean, and Barbados became the first country to receive World Bank funding for a multi-sectoral HIV/AIDS Prevention and Control Project that included the scaling-up of ART.

The World Bank project was primarily implemented through NHAC, and built working partnerships with government ministries, trade union representatives, business leaders, CSOs, and people living with HIV/AIDS. This large injection of funding meant that NHAC became a central node through which a robust HIV response was organized. The World Bank project also identified the importance of social and material supports for PLHIV and provided significant financial support for PLHIV CSOs and support groups. A 2003 report notes the participation of a variety of organizations ranging from labor unions to regional health organizations, men’s groups, medical health professionals, business associations, and at least one PLHIV support

group, and contains a glowing review from a U.S. Agency for International Development (USAID) staff member: “I was a bit wowed by the degree to which Barbados has truly institutionalized a multi-sector approach to addressing HIV/AIDS. You are not only a role model for the Caribbean, truly and honestly Barbados is a global role model” (Marquez 2004).

These early reports and evaluations emphasized and rewarded the importance of a ‘multi-sector’ or pan-societal response to rising HIV infections, in which responsibility and care were articulated as social obligations requiring the participation of all segments of Barbadian society. The World Bank loan also had the potential to make a difference in the lives of all PLHIV. Due in part to the loan, the Barbados government was able to commit to universal and free provision of ART for all PLHIV, open a dedicated HIV care and support out-patient facility (Ladymeade Reference Unit), and provide funds for CSOs dedicated to establishing PLHIV support groups.³ However, Jackie, the social worker, noted that during this period of rapid expansion and intensification of the HIV response, there was significant tension between NHAC and the Ministry of Health (her employer). The World Bank funds were primarily managed through NHAC, who, according to Jackie, were “promoting themselves” and creating a “big media campaign” but didn’t consult Ministry of Health workers like her who were “out on the street ... doing the work.” In her work at the Elroy Philips Centre, Jackie witnessed a steady stream of PLHIV who continued to deal with homelessness, unemployment, and social isolation due to fear and discrimination from their families, communities, and workplaces.

Jackie was part of the first wave of HIV workers and activists who advocated for PLHIV and contributed toward the establishment of sites such as the Elroy Philips Centre, where PLHIV could not only find material and emotional support but also spend time in a space free from the judgment and discrimination they faced in their daily lives. Spaces like the Elroy Philips Centre were likely key nodes in the genesis of viral socialities, as PLHIV and their allies spent time with each other, sharing experiences and strategizing how best to address the multiple challenges of living with HIV. Jackie’s memories also highlight some early dissonance between official narratives of HIV governance and management, such as those made by the USAID employee above, and the narratives of health workers involved with PLHIV on the street, who witnessed ongoing suffering and marginalization of many PLHIV.

Civil society organizations dedicated toward supporting PLHIV formed in the early days of the pandemic but multiplied under the World Bank loan. One of the first on record was Support, Assist and Educate (SAE), started in March 1993, “to mobilize persons infected or affected by HIV/AIDS, thus involving them in addressing their psychological, social, health and spiritual need.”⁴ Michael, one of the first leaders of SAE, remembered how much of a difference the group made to its members: The early days of the pandemic were full of fear and rejection, but he felt that regularly meeting and sharing with other PLHIV helped him a great deal. Over the next two decades, SAE became increasingly connected to and reliant on NHAC, which provided funds for SAE’s activities. Additional HIV/AIDS CSOs formed in the 1990s and early 2000s included the AIDS Society of Barbados (ASOB), and United Gays and Lesbians Against Aids (UGLAAB), resulting in a multiplication and intensification of viral social networks. Similar to SAE, these organizations received some

of their funding and material support (such as office space) from the World Bank loan (via NHAC) and/or the Ministry of Health.

In 2008, the World Bank authorized a second HIV/AIDS project for Barbados from 2008 to 2013 (extended to 2014) with the commitment of a US \$35 million loan to support programs that encouraged adoption of safe behaviors and increased access to prevention, treatment, and social care, particularly for high-risk populations including youth and men who have sex with men (MSM) (World Bank 2015a, N.d.). During this period, additional funds from other global HIV/AIDS agencies arrived in Barbados: The Global Fund (an international agency partnership designed to accelerate the end of AIDS, tuberculosis, and malaria as epidemics) provided funds to support HIV programs across the Caribbean region (The Global Fund 2007) and from 2011 to 2019, PEPFAR (The U.S. government's international HIV/AIDS agency) invested over \$6 million in Barbados to build a laboratory, institutionalize STI/HIV surveillance systems, strengthen relationships between civil society organizations, and tailor health services for members of key populations acutely affected by HIV "to ensure the most at-risk populations got tested for HIV early so that they could immediately undergo life-saving treatment" (Tagliatala 2020).

In the summaries of this second round of globally funded HIV projects in Barbados (from approximately 2008 to 2019), we see a shift in emphasis from supporting a generalized HIV response in all areas (knowledge, treatment, prevention) across all sectors of Barbadian society to prioritizing access to treatment (increasing the numbers of PLHIV on ART),⁵ and a shift in treatment priorities from all PLHIV toward more targeted programming for key or at-risk populations, primarily identified as LGBTQ, MSM, and/or sex workers. New CSOs dedicated to supporting these at risk populations, including "Movement Against Discrimination Action Coalition" (MOVADAC), "Community Education Empowerment and Development" (CEED), and "Equals," arose during this second round of funding. However, support groups *not* defined primarily in terms of at-risk populations also emerged during this period, including "Helping Each Other" (HEO), which focused primarily on women living with HIV/AIDS, and "Moving Forward Together" (MFT—the group mentioned at the beginning of this article), dedicated to supporting all PLHIV and their carers. Thus, in this second project time, we see a proliferation of global HIV health organizations with more targeted treatment plans (and attendant funding for these plans) coming into existence alongside the previous, more broadly focused project time of the first World Bank loan, resulting in further proliferation of CSOs and support groups for both PLHIV in general as well as more targeted key or at-risk populations. In the next section, I explain how the prioritization of targeted populations, combined with the contraction in global HIV response funding, contributed to major shifts and schisms in PLHIV socialities.

Contraction (2015–2020)

Most support group members, leaders, and government workers who I interviewed noted that the end of the World Bank loan in 2014–2015, followed by termination of PEPFAR funds in 2019, signaled a major change in the Barbadian HIV landscape: As a former member of UGLAAB put it "Once the World Bank Loan stopped, that was

the end of it ... there used to be a line item (in the government's budget) for every Ministry to have HIV/AIDS programs/education, but now that's gone." Reverend Janelle made a similar comment, noting that since the (World Bank) funding ended, "it's (HIV/AIDS) gone off the map," and that there were now hardly any public discussions about HIV. A former facilitator of one of the support groups said that the end of PEPFAR funding would have far-reaching effects for everyone, from the Ministry of Health to CSOs like Equals and CEED, while another facilitator of an HIV education program stated: "There's no more HIV dollars in the Caribbean, so we have to find creative ways to send out messages."

The shifting priorities and funding of global HIV/AIDS agencies' projects over a span of almost 20 years produced multiple challenges for PLHIV CSOs and support groups. Interviews with former and current group leaders and members, and staff from NHAC and the Ministry of Health, revealed frictions that pervaded many, if not all these organizations. Some of these frictions were clearly generated from the funding reductions that took place in the latter 20-teens, but they also spoke to long-term, interrelated infrastructural and organizational frictions created by the changing project priorities of global HIV/AIDS agencies. These long-term frictions included: (1) increasingly niche-driven funding opportunities defined through key and at-risk populations leading to the proliferation of and competition between support groups; (2) inconsistent infrastructural support and leadership, including a lack of clarity from funding agencies about the goals and objectives for PLHIV support groups to continue receiving funds, which often led to reliance on (3) charismatic leaders or "founder's syndrome,"⁶ which created problems in group management over time. Issues (2) and (3) often combined to produce (4) accusations that group leaders and/or members were involved in these organizations primarily for self-interest and/or material gain.

Excerpts from conversations and interviews help illustrate how these frictions, produced through shifting project times over the *longue durée* of the pandemic, contributed to the fracturing of some established PLHIV socialities and the development of new ones. Patricia, a former leader of HEO, the group dedicated primarily to helping women living with HIV, believed that her group was sidelined by NHAC and the Ministry of Health because the second World Bank loan and PEPFAR funds were primarily targeted toward at-risk populations like MSM, youth, and/or sex workers. She felt that this prioritization of HIV funding for specific categories of PLHIV (or people at higher risk of HIV infection) created and fostered divisions between PLHIV rather than bringing them together: "You have people running groups (that) just come together in the group because they're of this one situation ... so then we get all sorts of 'isms' and they have people in groups (like) the homosexual, the heterosexual, the people with other issues and people that are schizophrenic." Patricia found that as a result of global HIV organizations' recent prioritization of at-risk populations, her group never received much attention or support from the Barbadian government and/or their funding agencies: "I went to about 4 multi-disciplinary trainings ... but you know ... we didn't have support of organizations, the strengths of organizations to keep (it) together. ... (It is) the Commission, (who is) responsible for the whole item." Eventually, she became tired of, "pushing myself up there and not getting (anything)," so after years of driving around the island to help people and "using my own gas (i.e., paying for all expenses related to working

for the group) ... my body said ok, let's stop." Nobody else stepped in to run the group after that, which, to Patricia, meant that for HIV+ heterosexual women in Barbados, "Nobody cares but themselves."

Patricia's explanation for (and frustration over) the lack of recognition and support for her PLHIV support group convey astute observations on the effects of shifting project times and their effects on viral socialities. She observed how the presence of multiple global HIV/AIDS agencies and their funding priorities in the 2010s contributed to the parsing of the HIV population into groups defined primarily through the category of at-risk. This resulted in new or intensified social formations, CSOs, or support groups, but only some of them received funding according to these new project priorities. While this differentiation of the PLHIV population, based on epidemiological data-tracking, likely reflected accurate infection trends, it also introduced or heightened social differences between PLHIV, differences that had not been emphasized in earlier phases of the pandemic project funding. Patricia's description of "all kinds of 'isms'" was an astute observation of the simultaneously productive and divisive effects of biosocial tinkering over shifting project times.

Similar and different frictions unfolded at SAE, the oldest PLHIV support organization in Barbados. SAE had a long-standing relationship with NHAC (the primary distributor of World Bank funds). Michael, who had been a member of SAE since the mid-1990s and was also a former president of the organization, thought that it suffered from bad management within and outside the organization, and called it a "spoiled child":

If you give and give without trying to make the child understand that there is a source ... the child will never appreciate the fact that this is something to be cherished and cared for. ... They will just (say) "Oooh, this is an old one! I want a new one!" And that's what was happening. They (NHAC) had the money so they just gave and gave and gave. And these people saw, (and thought to themselves) "I don't have to do anything in return! I got a whole house! I got my mother's place rebuilt from scratch!"

Michael's example of funds being used to build houses did not refer to explicit grafting, but rather the ways in which funds were provided to groups like SAE without much accountability, and how some group leaders and members were primarily interested in using their HIV status for personal and/or material gains. In so doing, Michael felt they had become dependent on free perks, such as government funds for subsidized housing and/or home repairs. Michael's experiences led him to think that some group leaders and members were just "in it for me" rather than actual training, helping, and and/or educating people. Like Patricia, Michael increasingly felt that he was being exploited, in that he put a great deal of time and effort into managing SAE, but was not compensated fairly: "Mind you, they never spent a cent on (me) ... Michael built everything from Michael." According to him, issues of poor management, insufficient training, and selfish motives were not just limited to PLHIV support groups in Barbados but were endemic to the regional (Caribbean) HIV response.

Michael's comments about some support group leaders and members' self-interest in material gain resonate with Adia Benton's discussion of how an HIV

positive status in Sierra Leone entitled some HIV positive people to make claims and benefit from a health care system that defines HIV as exceptional and privileges foreign donor priorities and agendas (Benton 2012: 311; see also Moyer and Hardon 2014). For Michael, these perceptions generated feelings of alienation and resentment and led to his eventual withdrawal from SAE. Here we see an example of the diminution of viral sociability over time, generated in part through Michael's long-term participation in PLHIV support groups and witnessing changes in members' motives, interests, and relationships as funding sources multiplied and became increasingly embedded in the bureaucratic structures of global HIV/AIDS agencies. However, Michael and Patricia's shared sense of altruism and feelings of increased exploitation and alienation can also be viewed as evidence of new viral subjectivities produced through the shifting templates of project times. As PLHIV support groups transformed from voluntary associations to organizations with salaried or remunerated membership and leadership, and became embedded in and dependent on funding provided through various government departments and/or global HIV/AIDS organizations, motives and interests in group membership shifted, producing (inadvertently) more bureaucratic, materialistic, and/or monetary orientations, which, in turn, produced new subjective orientations for some long-term PLHIV like Michael and Patricia whose early membership in these groups was based on different motivations and goals that pre-dated the influx of international aid.⁷

The Present (2019–20)

Most of my interlocutors who had past or present involvement in the Barbadian HIV response agreed that the contraction of funding by global HIV/AIDS organizations in the mid-20-teens produced and/or increased frictions within and between many PLHIV CSOs and support groups (although, as noted above, it could be argued that the proliferation of funding from multiple global organizations was just as much a factor contributing toward these frictions), leading to the demise of most support groups by the end of the 20-teens. Nevertheless, most (but not all) PLHIV I interviewed still believed there was an ongoing need for PLHIV support groups in Barbados: Patricia, who had recently held a temporary job reviewing HIV patient files at the Ladymeade Reference Unit, said there was still a surprisingly large percentage of PLHIV who are not accessing their ART medications regularly.⁸ Patricia thought this low uptake of ART medications might be due to the fact that some PLHIV do not want to visit the Ladymeade Reference Unit as they are fearful that most people know it is the place where HIV+ people go for testing and medication, and if they are seen entering the facility, then it could result in their HIV status being involuntarily disclosed, or they did not trust Ladymeade staff, who might “talk and gossip” about them. Rodney, a former SAE group leader, thought that “things are getting better” in Barbados, but, like Patricia, he believed there is still widespread stigma against PLHIV, and that there is an ongoing need for “psycho-social support.” Jackie was less optimistic than Rodney, as she thought PLHIV still faced discrimination in Barbados: “I don't think (a mind shift) has happened yet ... people are still fearful that even though someone is at undetectable levels they could still infect other people.” Most interviewees agreed there was enough evidence of ongoing issues like fear of disclosure, discrimination, and stigmatization to justify the need

for counseling, outreach, and peer-based support and education, services that could best be provided through PLHIV support groups.

Patricia noted some additional ongoing challenges for certain groups of PLHIV: She said that there are persons in her gender and age group (women over 60) who are dealing with social isolation and financial hardships such that they “are not able to maintain their health (or) can’t supplement their diet and hardly get anything to eat.” The combination of financial and emotional stress for some PLHIV could lead to tragic results: During a group check-in at one MFT meeting, two older members discussed how they had attempted suicide in response to their status being involuntarily disclosed either through gossip (someone saw them entering the Ladymeade Reference Unit and spread the word throughout their community) or betrayal of confidence (a trusted family member told neighbors). Another younger MFT member said she was having a hard time making ends meet while running her small goods stall at the Bridgetown bus terminal—she was planning to expand her offerings by preparing small snacks and meals, but she was worried that if people found out she was HIV+ then they wouldn’t want to purchase her food.

Despite the general agreement that many PLHIV continue to face financial, psychological, and social challenges in their everyday lives, and that various forms of support for PLHIV are justified in present day Barbados, by the time I started fieldwork for this research project (January 2019), the only active (i.e., holding regular meetings) group explicitly for PLHIV was Moving Forward Together (MFT), facilitated by Reverends Janelle and Anton, and Ms. Alleyne, the social worker with the Ministry of Health. Other groups like SAE, HEO, MOVADAC, and UGLAAB had either shut down or were currently dormant. Some organizations such as CEED and Equals were very active, but either provided programs and services for targeted segments of PLHIV (i.e., LGBTQ) or did not provide services addressing specific PLHIV issues.

The Warp and Woof of Project Times and Viral Socialities

PLHIV CSO leaders and support group members I interviewed spoke of struggles over inconsistent and/or declining funds, poor leadership, self-interest, and/or poor infrastructural support, leading to increased frictions within and between these groups that contributed to their demise. While all this is no doubt true, in this article I am trying to put forward a different interpretation of the rise and fall of Barbadian PLHIV CSOs and support groups that draws attention to the ways in which shifting agendas of international HIV/AIDS agencies over the *longue durée* of the pandemic have contributed to the creation, transformation and diminution—the thickening and thinning—of viral socialities.⁹

The advent and increasing global availability of ART since the late 1990s, generated in part through the activism of PLHIV networks and organizations in various locations, resulted in profound changes to the overall health of many (but by no means all) PLHIV, and transformed the status of the virus from terminal to chronic in many parts of the world. More recently, ART has been acknowledged as a key component in HIV prevention strategies, with the knowledge that PLHIV on ART can achieve an undetectable viral load and therefore are not at risk of transmitting the virus, transforming PLHIV from passive recipients of treatment

protocols to key participants in prevention strategies. Thus, PLHIV activism and greater participation in HIV response initiatives (locally, nationally, and globally) have been increasingly incorporated into plans and budgets of inter/national HIV responses (Marsland 2018: 478–79) since the 1990s, best illustrated through the now common presence of GIPA/MIPA (greater involvement of people with HIV/AIDS; meaningful involvement of people with HIV/AIDS) principles in many HIV/AIDS agencies' project plans and reports. As GIPA/MIPA principles were incorporated into HIV/AIDS funding protocols, an HIV+ status increasingly became a qualification for getting salaried work, stipends, or allowances in organizations where PLHIV had been volunteers before, so an HIV+ status could now accrue moral and economic value (Whyte 2014: 65, 186–87; see also Benton 2015, Biruk 2019, and Carruth 2018). Similar to Biruk and Trapence's discussion of engaging LGBTI persons in an LGBTI-rights NGO in Malawi, the gradual incorporation of PLHIV support groups and CSOs into the projects and budgets of global HIV interventions transformed PLHIV subjectivities and relationships, support groups' organizational cultures, and relations with local health systems (Biruk and Trapence 2018: 346; Reed 2018).

As GIPA/MIPA principles were increasingly incorporated into well-funded and deeply bureaucratic global HIV-response projects and budgets over the aughts (2000–2010), epidemiological research demonstrated that particular regions and/or social groups were prone to disproportionately high, HIV infection rates and/or had poor access to and/or uptake of ART. Rising interest from global HIV/AIDS agencies in the epidemiological significance of key, vulnerable, or at-risk populations such as MSM/LGBT, sex workers, and/or specified minorities in particular regions, resulted in shifts in global HIV/AIDS project objectives as they increasingly focused on these specific regions and/or populations (Biruk 2020: 487, Heckert 2018: 139). At the same time, the 2008 global financial crisis precipitated donor funding shortfalls, forcing global health policymakers to adjust, reduce, and/or refocus their HIV response strategies, which in many cases, translated to the reduction of psychosocial and palliative care and funding for services designed to increase access to care and adherence to ARTs (Marten 2020: 197). By the mid-teens, global health agencies began to circulate end of AIDS discourses accompanied by achievable targets such as the “90/90/90” campaign,¹⁰ which impacted local HIV/AIDS responses (Marten 2020: 200–201), resulting in new project priorities and pressures (Benton 2021).

These shifts and transformations in biomedical knowledge about and biotechnologies related to HIV have therefore produced shifts and transformations in the objectives and funding of global and local HIV projects, resulting in multiple project times over the 40-plus years of the pandemic. Through a forensic analysis of agency reports and conversations with Barbadian PLHIV and others involved in the Barbadian HIV response over many decades, we can see how viral socialities were formed in the early days of the pandemic through shared experiences of suffering and discrimination, a desire to help PLHIV and change social attitudes toward HIV/AIDS. However, the arrival of global health agency-funded projects altered the ways in which PLHIV thought about themselves, their relationships to each other, and their relationships to the health infrastructures designed to support them. The sizable World Bank loan in the early aughts was designed as a broad multi-sectoral pro-

gram, and included a range of social and material supports for PLHIV, resulting in the growth and expansion of existing PLHIV CSOs and support groups. But it also initiated changes in PLHIV subjectivities and relationships within and between these organizations, with some members being remunerated (paid stipends or salaries as staff), as the organizations became increasingly embedded in the bureaucratic infrastructures (and their attendant measurements, evaluations and languages) of state and global agencies. A second round of World Bank funding, along with new funding from PEPFAR and the Global AIDS Fund in the mid-aughts and early teens, focused more on tailoring services toward members of key populations, resulting in greater support for some CSOs and support groups and not others such as HEO (primarily established for HIV+ women). This second project time created or intensified new social identifications and divisions among and between Barbadian PLHIV. Therefore, multiple project times, with their shifting funding priorities and inconsistent infrastructural support, introduced and/or intensified multiple PLHIV subject formations (such as the heterosexual vs. LGBTQ PLHIV, or altruistic volunteer vs. the salaried employee) that contributed to greater frictions within and between PLHIV CSOs and support groups, contributing (in part) to feelings of displacement, alienation, and loss among some PLHIV who participated in these groups, and the demise of most groups by the late 20-teens.

Conclusion

This article applied a forensic lens to the HIV response in Barbados over approximately four decades, focusing on the remains of PLHIV CSOs and support groups that emerged and declined during this timeframe, revealing the *longue-durée* effects of multiple project times on viral socialities. That is, it revealed how changes in objectives and funding priorities of international HIV/AIDS organizations over time contribute to the creation, transformation, and undoing of subjectivities, social relationships, and activisms of Barbadian PLHIV. The emergence and expansion of Barbadian PLHIV CSOs and support groups, followed by frictions within and between these groups, and their gradual demise over a relatively short period of time, points to the potential and limits of social ties generated through a shared viral infection: The growth and proliferation of PLHIV support groups in Barbados from the 1990s to the mid-2000s demonstrates how significant social ties may form between groups of people as they confront the lived effects of infection, medication, discrimination, and/or injustice attributable to HIV. However, these ties are not natural nor are they immutable; rather, viral socialities are unstable and subject to broader political, economic, scientific, and technological forces of multiple project times, which may strengthen, undermine, or rearrange them.

In Barbados, where a stable but minimal health care system operates, and ART is now accessible to and affordable for most PLHIV, key drivers of viral sociality have been intensified, transformed, and/or diminished through multiple project times generated by and through international HIV/AIDS organizations and state agencies, but personal and social challenges (experiences of stigma and discrimination) alongside economic challenges (unemployment, unstable income) continue for many PLHIV. This is due to the fact that when funding priorities and organizational infrastructures of international health agency projects are externally imposed and changeable,

inconsistent, or withdrawn over time, they produce new and shifting intensifications and diminutions of PLHIV socialities and subjectivities, which may help some while neglecting others. In other words, the vagaries and vicissitudes of multiple project times over the *longue durée* of the HIV/AIDS pandemic produce shifting formations of attention and neglect for differentially positioned PLHIV, so that some (such as MSM or sex workers) become the focus of attention and funding at a particular moment, while others (such as older, heterosexual women), slip off the radar, despite ongoing challenges.

Reflecting on the demise of PLHIV CSOs and support groups, some Barbadian PLHIV like Patricia and Michael convey feelings of frustration, alienation, and loss. In this article, I have argued that these reflections are the metaphorical remains of former CSOs and support groups and these feelings are the anachronic effects of shifting, unstable viral socialities produced through multiple project times. These anachronic effects reveal a form of banal neglect of some PLHIV produced through a failure to establish long-term, permanent interventions that would strengthen local health infrastructures and their ability to consistently treat and care for all PLHIV and those who support them. At the same time, these anachronic effects may also be generative sites for future social activism and movement as PLHIVs and their allies reflect on loss and figure out ways to address new challenges.

Notes

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1. Names of all interviewees and civil service organizations and PLHIV support groups affiliated with interviewees have been changed to ensure anonymity and confidentiality of group members and research participants.

2. I consider “viral socialities” to be a subcategory of biosociality, “the notion that people with shared biological conditions come together to form social networks” (Bradley 2021: 544). Viral socialities draw attention to specific social relations produced through the lived effects of HIV infection.

3. The information in this paragraph is drawn from a World Bank report titled, “The Barbados HIV/AIDS Prevention and Control Program,” for a prior research project (Murray 2012). The link is no longer active. For a similar summary, see Headley and Siplon (2006).

4. This quote is from a Ministry of Health website. I am not including the website address to protect the anonymity of the organization and members who were interviewed for this article.

5. See, for example, the “Treat All” Campaign organized by the Barbados Ministry of Health, PEPFAR, and Pan-Caribbean Partnership Against AIDS (PANCAP N.d.).

6. Founder's Syndrome is "the influential powers and privileges that the founder exercises or that others attribute to the founder" (Block and Rosenberg in Diaz and Rees 2020).

7. Biruk makes a similar point in their analysis of how the MSM category in LGBTI rights work in Malawi is a bureaucratic technology and a "slippery site of value production" that is constitutive of identities (2020). See also Whyte's discussion of "therapeutic clientship" (2014) and Biruk and Trapence 2018.

8. Patricia's observations are borne out by recent statistical data: According to UNAIDS, of the approximately 2,700 people currently living with HIV in Barbados in 2019, 90% knew their status, 52% knew their status were currently on ART, and 46% had suppressed viral loads, indicating the fact that Barbados had fallen significantly short of the UNAIDS 90/90/90 targets for 2020 (UNAIDS N.d.). It should be noted that these statistics are not consistent: A 2020 PEPFAR report lists Barbados having reached 89-58-89 of the UNAIDS 90-90-90 targets (Tagliatala 2020).

9. It is important to remember that these global HIV/AIDS agendas are not based on the capricious whims of a bureaucratic cadre, but rather they are the result of rigorous, ongoing scientific research informed by epidemiological trends, new biomedical discoveries, and pharmaceutical innovations. However, these are primarily biomedical benchmarks that change as biomedical knowledge about viral infection, prevention, and treatment evolve. Ethnographic studies of PLHIV worlds repeatedly critique biomedical essentialism and foreground the social, economic, and/or political dimensions of biomedical interventions, their attendant infrastructures, and their disciplinary effects on PLHIV (Murray 2021; Mykhalovskiy and Namaste 2019).

10. Ninety percent of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90% of all people receiving antiretroviral therapy will have viral suppression (UNAIDS 2017).

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