ANTIRETROVIRAL THERAPY IN WALVIS BAY, NAMIBIA

by

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Abstract

Highly Active Antiretroviral therapy (HAART) is a successful means of treating infection with the Human Immunodeficiency Virus (HIV). Namibia was among the first countries in sub-Saharan Africa to achieve universal access to HAART for HIV-positive citizens through the public sector. In this thesis, I explore treatment outcomes in Walvis Bay, a busy port city at Namibia’s coast. I find that gender is the most important factor shaping HAART, with women reporting for testing and treatment in greater numbers than men, sooner in the course of their illness, and enjoying lower mortality after treatment initiation. There are no compelling biological explanations for this distribution; I postulate a series of socio-cultural and political-ecological factors driving outcomes in Walvis Bay. In particular, changing gender roles and different points of entry into care are important at the individual level. I describe a ‘toxic masculinity’ that, however fragile, actively interferes with testing, treatment, and health-seeking behavior. Female identity, conversely, emerges as altogether more stable and more suited to the clinical and social demands of HAART. More broadly, actions are shaped by large-scale processes of urbanization and globalization, and especially the effects these have on labour, subsistence, and culture change. I conclude by suggesting modifications to the rollout program that may help to distribute the benefits of HAART more equitably through the treatment population. This research has important implications for other countries in sub-Saharan Africa as they gradually move toward universal access to HAART. More generally, it may presage future challenges of globalization and infectious disease.
Acknowledgements

In the fall of 1929, Hemingway wrote a letter to F Scott Fitzgerald in which he reflected on the nature of writing. “The good parts of a book,” he explained, “may be only something a writer is lucky enough to overhear or it may be the wreck of his whole damn life – and one is as good as the other.” As an anthropologist I suppose I have had great luck in choosing my friends, and the fortune to overhear countless wonderful things – and sometimes to wring them from people to their undoubted frustration. There is also plenty of wreckage in these pages; if one is indeed as good as the other I trust my readers won’t mind, though the clichéd but damnably durable caveat applies: the best things here I overheard, but the wreckage is my own.

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Appendix 1: Applying Lessons Learned
Once again I have rubbed shoulders with a truth without fully comprehending it.

-Antoine de Sainte-Exupéry, *Wind, Sand and Stars*

**THIS THESIS IS ABOUT** HIV treatment in Walvis Bay, Namibia. Namibia has made singular progress in rolling out treatment for HIV and, as I was preparing my PhD work in 2008, had achieved one of the highest levels of treatment access in the developing world. Logistical issues like supply-chain management had once been considered the greatest barriers to treatment in Africa; with these problems now largely overcome, I began to wonder what sorts of challenges might lie ahead for a ‘mature’ rollout program. In particular, I wanted to know whether patients from all walks of life were accessing treatment equally, and whether some patients had better outcomes than others: now that medication was available, in other words, was it working? I went to Namibia in the spring of 2008 intending to spend about 18 months living in Walvis Bay examining this problem.

I went to Walvis Bay with the assumption that men would fare better on HIV treatment than women. Namibia is a young country with a very progressive constitution – one which
exclusively uses gender-neutral terminology throughout, and explicitly bars discrimination on the basis of gender\(^1\). However, this model document still has not displaced a long history of patriarchy. Many pre-colonial Namibian tribal societies were decidedly egalitarian; European powers rewrote that social order by importing gender norms from abroad (Becker et al 2000). This is perhaps most visible today in the women of the Herero tribe who, before Colonial contact, wore simple leather skirts and head-dresses. Today, Herero 'traditional dress' for women involves a floor-length Victorian gown, complete with billowing petticoats, full sleeves and high neck. It is a running joke in the capital, Windhoek, to roll one's eyes about having to share the back seat of a crowded taxi with a Herero woman. Some tribes successfully resisted the imposition of Euro-Christian culture: the Himba (Rizzo 2012) and the San are two frequently-cited examples. Practically speaking, however, Namibia has been and remains a decidedly patriarchal country: women only gained equal recognition as persons under family law in 1996\(^2\), and rape within marriage was outlawed in 2000 (Hubbard 2007). This law was enacted against a background of great resistance and ongoing tacit approval of marital rape by many politicians and traditional authorities (Hamata 2001).

Men, in short, remain politically and economically dominant in Namibia. Women still generally have fewer opportunities than men, and struggle for their share of employment and education; further, women are disproportionately exposed to violence (structural and physical), and more susceptible than men to HIV infection for reasons both biological and cultural (Dunkle et al 2004). Women are also much more likely than men to assume subordinate roles in sex

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\(^1\) The constitution also bans discrimination based on HIV status, though in practice this too has been slow to change (Figueira 2001).

\(^2\) The Married Persons Equality Act 1 of 1996 created new legal status for married women, supplanting the existing (Roman-Dutch based) law under which wives were legally equivalent to minors and gave husbands the rights over the property of both spouses.
work or ‘sugar daddy’ relationships, both of which increase their exposure to HIV and may limit their access to good medical care and social support. In 2003, I traveled to Namibia to conduct undergraduate research on the country’s nascent program for preventing mother-to-child transmission of HIV (PMTCT). I discovered that women enrolled in the trial had virtually no support from their male partners – how would this lack of support affect a national rollout? Lastly, epidemiological data published while I prepared to conduct my fieldwork suggested that in both the rich world (Berg et al 2004; Nicastri et al 2005) and in some developing countries (Fonseca et al 2007) female HAART patients had higher mortality than males. Given the weight of this evidence and the received wisdom of advocates and activists in the field of HIV, I thought it a reasonable assumption that men would benefit most from the rollout of treatment.

What I found in Namibia was the opposite. Despite all that is stacked against them, women turn out for HIV treatment in higher numbers than men, and much sooner in the course of their illness. They adhere better to their treatment and ultimately survive longer. Despite the prevalent rhetoric that women are the oppressed majority in the HIV pandemic, it became quickly apparent that, at least as far as treatment is concerned, in Namibia it was men who were at a disadvantage. Men were less likely to access treatment, and when they finally did, were often at so advanced a state of physical deterioration that they were beyond hope. Figuring out why this should be the case is the project of my thesis.

Ultimately, I have tried to answer this question through a sort of critical political ecology of HIV treatment in Walvis Bay. I mean ecology here in the sense of a study of the relationships between organisms (especially humans and viruses) and their environment. Walvis Bay’s environment is a unique one, and the political-economic and socio-cultural forces shaping
actions in that environment are complex and powerful. To some extent, this project includes an ethnography of gender in Walvis Bay. This focuses more on men than women not because of any antifeminist bias, but rather because women’s own narratives of their treatment – and those of their caregivers – were generally straightforward. Men’s narratives, on the other hand, seemed decidedly more problematic, and their outcomes worse. In the end, an exploration of what it means to be a man or a woman on treatment demands a discussion of what it means to be a man or woman in general. I also conclude that the meanings of gender are in this case also very closely tied to a specific context – HIV in Walvis Bay in the early 21st century.

* * *

In the end, I spent just over 2 years in Namibia, mostly living in Walvis Bay’s poor black township of Kuisebmond. I spent most days at the local community center, or at the HIV clinic. This was not my first trip; after my undergraduate research in 2003, I made further research trips in 2006 and 2007. Almost immediately upon investigating the basics of HIV in sub-Saharan Africa, the scale and complexity of the problem becomes overwhelming. Richard Dowden, longtime head of the Africa desk for The Independent and The Economist, once remarked (2008) that he had almost never felt so hopeless in all his travels on the continent as he did when researching a story on HIV in a decimated South African village:

...the journalistic questions that would normally flow in such an encounter die in my throat. I leave them some money and walk away. For the second time in my life in Africa I want to keep walking, lose my notebook, tell my editor there is no story. The other occasion was the Rwandan genocide.
During my first visit in 2003, I felt similarly overwhelmed. All manner of problems seemed tied up with HIV in an endlessly self-catalyzing reaction: unemployment begat poverty, which hampered education, which begat crime, violence, and substance abuse, crumbling infrastructure, political inertia . . . it was hard to avoid feeling that nothing could stem the steadily swelling tide of death and decay. I was reminded of David Foster Wallace’s (1997) description of a trip he once took on a cruise ship:

and the ocean itself . . . turns out to be basically one enormous engine of decay. We saw some real horrors in port, local boats that looked dipped in a mixture of acid and shit, scabbed with rust and goo, ravaged by what they float in. Not so the megalines’ ships. It’s not an accident that they’re all so white and clean, for they’re clearly meant to represent the Calvinist triumph of capital and industry over the primal decay-action of the sea. The Nadir seemed to have a whole battalion of wiry little Third World guys who went around the ship scanning for decay to overcome. Writer Frank Conroy . . . talks about how ‘It became a private challenge for me to try to find a piece of dull bright-work, a chipped rail, a stain on the deck, a slack cable . . . eventually, toward the end of the trip, I found a capstan with a half dollar-sized patch of rust on the side facing the sea. My delight in this tiny flaw was interrupted by the arrival, even as I stood there, of a crewman with a roller and a bucket of paint. . . (Wallace, 1997)

So it seemed, at first, with the people on the front lines of the fight against HIV in sub-Saharan Africa. A colleague working for Doctors Without Borders in Cape Town once remarked that, since the majority of all admissions at his teaching hospital in the city were HIV-related, “primary health care is HIV care here.” This was truly a disease ecology: surrounded by a viral engine of relentless decay, ministering to an ever-growing number of patients who were “ravaged by what they float in,” the fight against HIV seemed doomed to be eventually overwhelmed. It seemed no doctor, nurse, or community worker could ever stem the tide. Rust never sleeps: one day the paint would run dry, the corrosion would begin inexorably to spread, and the ocean’s victory would be complete.
As it turns out, this has not been the case: since my first visit to Namibia, tremendous strides have been made in the fight against HIV. The incidence of HIV in Namibia has slowed, and overall HIV prevalence has plateaued and begun to drop. Antiretroviral drugs have reached almost all eligible patients, and HIV clinics have gained a sense of momentum and progress against the disease that is a stark contrast to the desperation that marked early efforts. The problems that I describe in this thesis are small ones in what is overall an effective response; my informants universally reported that the HIV treatment campaign was doing well. In Namibia, the tide has turned. Further, as my research progressed it became apparent that these patterns were true elsewhere: by 2011, HIV had plateaued or decreased in all regions of the world save Eastern Europe (UNAIDS 2011).

HIV treatment in Namibia, therefore, is in the main a successful program ready for refining, and not a disaster in need of a drastic overhaul. It is a mature and stable program that lends itself well to longitudinal ethnographic work, rather than a short-term clinical intervention. This is a dramatic change from much previous scholarship on HIV: for years the field has existed in what Vinh-Kim Nguyen (2010) calls a “state of emergency” – a perpetual crisis mode in which there seemed to be little room for slow deliberation or critical reflection, a space in which novelty dominated and few interventions lasted long enough to bear out long-term research.

The fact that in many cases this state of emergency is easing is good news for patients. However, it also presents challenges for researchers. The body of knowledge around gender and antiretroviral therapy has grown massively since I first went to the field, making it difficult to resist the urge for never-ending follow-up and to finally draw some sort of definitive conclusion. Every time that the clinic updated its database or a colleague published compelling
new findings I recalled once more Graham Greene’s (2006:48) warning in *Journey Without Maps* that “the thesis was an end, but the collection of material for the thesis had no end. The thesis was as evasive as the castle in Kafka’s religious parable.”

* * *

I use a variety of approaches to explore the central question of HIV treatment outcomes in Walvis Bay. In the first Chapter, I begin with an overview of the city itself – its politics, its demographics, its history – and explain why they are crucial for understanding HIV treatment there. Because Walvis Bay is such a dynamic and globalized port, I also argue that the example of Walvis Bay may in fact hold important lessons for other, similar, African cities. In Chapter 2, I continue with an overview of HIV and antiretroviral therapy in Namibia, including a discussion of how HIV has spread in the country and how the rollout of treatment has progressed. In Chapter 3, I outline my research agenda and methods, including a discussion of ethical concerns. Chapter 4 is dedicated to a survey of my key informant interviews – these were a set of discussions with HIV professionals (including nurses, doctors and counselors) living in Walvis Bay. In Chapter 5, I apply the insights of these professionals to a statistical examination of the clinical data in Walvis Bay, with comparative data from around the globe. The final section of this thesis presents an ethnography of life on antiretroviral drugs, with examples drawn from in-depth interviews and a period of participant-observation in the Walvis Bay HAART clinic and the daily lives of individual patients. In Chapter 11, I conclude with a consideration of the results and their implications.
Note on Terminology

Throughout this thesis, I use racial descriptions that may be unfamiliar (and indeed jarring) to some readers. Other authors in the region have grappled with this same issue, and come up with various solutions. I follow Henry Trotter, whose *Sugar Girls and Seamen* (2008) uses the local racial terminology and begins with the note, “while these terms cause consternation and debate in some circles, they are taken for granted by most citizens . . . so I use the term ‘black’ to refer to African . . . people; ‘white’ refers to people of (largely) European descent, such as Afrikaners; and ‘coloured’ describes ‘mixed-race’ people.” Trotter is writing in and about South Africa – especially Cape Town and Durban – but as with many such things the linguistic and racial worlds of South Africa and Namibia are contiguous; the same terminology is used in exactly the same way in Namibia and is by far the most locally relevant. Therefore, throughout this thesis I follow the above use of local racial terminology.

Walvis Bay is a highly heterogeneous community where multilingualism is the rule rather than the exception: Namibia’s national language is English, and in Walvis Bay several different European and African tribal languages are represented. Unfortunately, these various tribal languages are not all closely related nor mutually intelligible, and the (significant) effort to learn one would not offer facility in the others. I therefore took the decision to learn Afrikaans; though it was supplanted as the national language at Independence in 1990, it remains many peoples’ first or second language. Further, most Namibians who cannot speak Afrikaans can speak English, meaning that I could be sure of fluency in at least one of the *linguas franca* in most situations.

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3 Categorizing the differences between (and within) Namibia’s tribal language groups is very complex (See Maho 1998, but also Lusakalulu 2007), but they are perhaps most easily grouped into Bantu and Khoisan (or Khoekhoe).
My daily conversations were conducted in several languages: English and Afrikaans were most commonly used among white, black and coloured Namibians in and out of the township, although for political reasons I sometimes made a point in the township of speaking in English rather than Afrikaans. The latter is still associated with the forces of apartheid strongly enough that it was probably beneficial to establish myself as an English-speaking foreigner rather than a local Afrikaaner.

Because the University of Namibia only built the country’s first medical school in 2010, most doctors and many nurses I met in Namibia were immigrants: several of Walvis Bay’s medical professionals were francophone Congolese; they were sometimes more comfortable speaking French with me than English. Many officials in the coastal fishing industry are from Spain, and I had occasion to speak with them in Spanish as well (though most also spoke English). The city’s many Zimbabwean medical professionals invariably spoke English.

It was the norm in Walvis Bay to mix several languages in a single conversation – even in a single sentence. People regularly borrowed exclamations, greetings, or even whole phrases from all of Namibia’s languages, and frequently asked me to teach them words from languages I spoke. They re-appropriated the slang – and sometimes the racial epithets – of various languages and often inverted them for their own use, or redirected them with caustic effect. This makes for a broad and very expressive verbal palette, but also presents a challenge for the ethnographer who hopes to learn the local language as a means of gaining deeper access into the community; this challenge will likely only grow in the future. Throughout this thesis I revisit variations on this theme: the rapid and unpredictable urbanization of Africa will continue to pose problems not only for ethnographers but planners, epidemiologists, economists, and virtually anyone else trying to pin down such a quickly moving target.
I use the term ‘gender’ throughout this thesis in some specific and some flexible ways. In academic usage, the terminological dyad of ‘sex’ versus ‘gender,’ first proposed by John Money, still dominates (Money and Ehrhardt 1972; Muehlenhard and Peterson 2011). Whereas ‘sex’ is now generally considered a biomedical/anatomical term referring variously to external genitalia or chromosomal arrangements (and usually described as ‘male’ or ‘female’), ‘gender’ commonly refers to the result of a contingent and dynamic set of social roles that are expected of – and produce – certain types of social actors. These are more often glossed as ‘masculine’ and ‘feminine.’

However, in HIV research, the word ‘sex’ is often confusing: it is sometimes used as a verb (ie., ‘intercourse’), particularly where discussing modes of transmission – ‘risky sex,’ ‘sex work,’ ‘transactional sex,’ and so on. Further, many biomedical and epidemiological studies use ‘gender’ rather than ‘sex’ as a variable in statistical analyses when the latter would, strictly speaking, be more accurate. In this thesis, I use the term ‘gender,’ albeit advisedly. In statistical analyses, I simply used the information on patient ‘sex’ (which was always a 2-way, “M/F” variable) that was available in the clinic’s database or in the secondary data. In my own interviews, patients self-identified. Although I discuss the biological outcomes of a straightforward pharmaceutical process, I maintain that the key drivers of differential outcomes among the patients I met were not their different physiology but rather their socio-cultural and political-economic relationships. The webs which – to paraphrase Geertz – suspended men and women while they spun. In other words their gender, not their sex, seemed most salient.

* * *
It may not be giving away the ending of my project here to admit that, Like Sainte-Exupéry, I ultimately felt that I rubbed shoulders with many truths in Namibia without ever, perhaps, fully comprehending them. In the pages that follow, I explain what I learned about HIV treatment in Walvis Bay, and the broad lessons that can be learned from this close study. I also begin to point up the limits if not of the anthropological endeavor generally, at least of myself as an ethnographer in particular. Many of my findings were unintuitive, and in some cases they may bear important instructions for the future. In some cases, though, what I found simply left me puzzled. Any anthropological investigation of health must necessarily involve a dizzying breadth and depth of analysis, but HIV carries with it a unique emotional burden. The weight of human misery wrought by the virus itself is matched by the ways in which human communities respond to it. I rubbed shoulders with a great deal of shame and stigma, of hope and faith, and of seemingly endless resiliency and wanton self-destruction; I am not sure I will ever fully comprehend them.
Walvis Bay is a lonely place to live, and an even lonelier place to die.

-Maggie Orford

Walvis Bay, Namibia, is a city uniquely hostile to human habitation. The Benguela current, a ribbon of cold Antarctic water extremely rich in organic material, runs up the Atlantic seaboard in a region long ago named the Skeleton Coast; when this cold water meets the dry desert air it produces dense fog. As a result, the city is invariably obscured by cold, damp clouds or bathed in blinding sunlight that glints off the pale, quartz-based sand with painful glare. The salty fog corrodes virtually every man-made structure with remarkable alacrity. Even in these days of satellite navigation, the waters around Walvis Bay abound with quickly decaying shipwrecks.

The town’s highway sign reads “Your Oasis of Opportunity,” though there is no actual oasis there¹. Immediately inland from the cold waters of the South Atlantic lie the massive sand dunes of the oldest desert in the world, the Namib. The Namib generally receives 15

¹ The official motto on the coat of arms, In Utrumque Paratus (“Prepared for Either Alternative”) seems equally ambiguous.
millimeters of rain per year, though in Walvis Bay itself the last ten years have averaged 2.2 millimeters (Billawer and Ekobo 2002). The local flora – mostly salty scrub and hardy succulents – have adapted to draw their moisture from the salty substrate or from the comparatively abundant fog. Serious water shortages are relatively common: in March 2008 we were without tap water for three weeks. Parks and lawns in the city’s wealthy neighborhoods have to be watered with ‘purified effluent;’ essentially recycled wastewater, it gives off a trademark smell as it mists into the air or bakes in the sun.

The local winds seem antagonistic. South winds bring the sulphurous smell of organic decay from the salt marshes, and north winds, depending on their angle, variously bring the faintly ammoniac smells of an expansive guano platform off the coast, or the overpoweringly acrid stench of several fish processing operations that line the industrial beachfront. West winds come off the ocean with fog and inversion patterns that prevent rain, while the dreaded east wind comes scouring across the desert bringing soaring temperatures, sandstorms, and sometimes locusts.

For many years, sailors regarded the Skeleton Coast with fearful awe. Although the waters in the area teemed with marine life (Walvis Bay is an Anglicization of the similar Afrikaans, old Dutch, and German names for ‘whale bay’) that along with rich guano deposits attracted European and American seafarers, the coast was also a morass of hazards that dashed wayward boats at an astounding rate. As recently as 1942, when the MV Dunedin Star, a merchant mariner from England, ran aground north of the city, a total of five other boats, two airplanes and a convoy of eleven trucks needed to be dispatched to help her passengers and crew. It was one month later, after one of the rescue boats, one of the airplanes, and several
trucks had themselves been wrecked, grounded or sunk, that the remaining trucks laboriously arrived overland (Dawson 2006).

The noon hour is sounded daily neither by church bells nor canon but by an air raid siren. Occasionally, massive pockets of hydrogen sulphide created by decaying organic matter on the floor of the lagoon build to a critical mass and erupt, killing marine life in droves and putting seafood on many tables for days, but also playing havoc on the local aquaculture industry (Weeks et al 2014). These eruptions also render the water and air so caustic that ships’ hulls and copper piping in the harbor are quickly damaged (de Klerk 2010). Sandstorms regularly foul the train tracks enough to derail engines, and blow pale drifts across the highway that is the city’s only connection to the rest of the country.

Even a quick glance at a map (see Plate One below), however, reveals why settlers braved these dangers and colonial forces battled over Walvis Bay, and why its rapidly growing population is the second largest in the country. It is the only significant natural harbor in Namibia, and the largest between Luanda, Angola and Cape Town, South Africa; it is a crucial chink in the otherwise almost impenetrable armor of the Skeleton Coast, the only toehold in what Portuguese explorers called ‘As Areias do Inferno’ (the sands of hell). For modern freighters, the journey from points north to Walvis Bay is three days faster than the journey to Cape Town, and offers access to the member states of Southern African Customs Union\(^2\), the oldest customs union in the world. In short, the city’s strategic merits have long outweighed its aesthetic ones.

\(^2\) As of 2013, SADC had fifteen member states: Angola, Botswana, Congo (Kinshasa), Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia and Zimbabwe. Madagascar’s membership was suspended following the coup of 2009.
Plate One: Map of Southern Africa including Namibia (Google, 2015a).

Urbanization, Globalization, and Change

The same was true when I decided to conduct my fieldwork in Walvis Bay. Despite the harsh conditions, it is a compelling site for anthropological research. It is an important site, first, because so little work has been conducted there. It is the second-largest city in Namibia, a country that has made rapid progress in the provision of antiretroviral treatment for HIV. It is a city whose story needs to be told. Second, and perhaps as important, is that Walvis Bay is in
many respects representative of important and growing changes in the African city. The continent’s rapid rate of urbanization has been the subject of a growing body of research and commentary, and Walvis Bay’s high levels of socio-cultural and political-economic heterogeneity, its highly dynamic, migratory population and its connections with the global village make it a microcosm of new African urbanity. In this respect, Walvis Bay has at least as much in common with Mombasa, Durban, or Lagos\(^3\) as it does with the small communities of rural Namibia: the problems it faces today may well be the problems of tomorrow for Africa’s new urban centers. It is also, therefore, a story about cities that needs to be told. Lastly, the city is an epidemiological powder keg – something I describe at greater length in Chapter 2.

Like many other parts of the world, sub-Saharan Africa is urbanizing quickly. Walvis Bay is the hub of Namibia’s mining, fishing and shipping industries, and supports thriving business for marine engineering, contracting, stevedoring, canning, and other services. Its status as a bustling port opens the city to a constant stream of visitors: whereas much of Namibia is regionally homogenous and divided by tribe, a walk down Walvis Bay’s main streets passes Portuguese posters in front of the Russian library, Malaysian sailors browsing Chinese shops, and the shadows of massive Singaporean oil rigs being repaired by South African engineers in the harbor en route to Nigeria. All of Namibia’s tribes are represented in the city, as are Coloured and English-, German- and Afrikaans-speaking white Namibians; the diaspora is represented by significant populations of South Africans, Angolans, and Francophone west- and central-Africans.

\(^3\) By 2013, Walvis Bay was allied closely with Maputo, Mozambique, in successfully and actively expanding their port operations while traditionally powerful ports like Cape Town and Saldanha Bay languished (Moses 2013).
This diversity has become the natural background of the city. During an early visit to the townships with a local, I noticed I was being stared at frequently. I asked my friend what people imagined when they saw me. “They probably think you’re Russian or Spanish. No . . . you don’t look Spanish. So, Russian.” I was surprised to be identified with these two seemingly random nationalities. I later learned that, because of fishing concessions that the Soviets earned in exchange for military assistance during the liberation struggle and the Spanish earned in exchange for post-independence development assistance, sailors of these two nationalities were generally the only whites who walked through the townships. “Until,” I was told, “the sex workers moved closer to the harbour.”

The city is also a major magnet for in-country migrants, who come primarily from rural areas looking for work. Walvis Bay is properly thought of as a city of migrants: in 2002, roughly 1/3 of the population reported having arrived within the last ten years, and fully 70% of current inhabitants were born elsewhere (Billawer and Ekobo 2002). The population is predominantly male, and the demographic pyramid biased greatly toward working age: in 2001 more than 2/3 of the population were between the ages of 20 and 59 (ibid.), a marked contrast with Namibia as a whole (and many other developing countries) where youth predominate. In the 2001 census, men made up 58% of Walvis Bay’s population; in other words, a population gender ratio (usually expressed as number of males per hundred females) of 116:100, compared with 98:100 for Namibia’s population as a whole.

The city’s unique demographics are the result of a variety of interacting forces. Many of the jobs available in Walvis Bay are in labour-intensive, male-dominated fields like mining and fishing. Women tend to leave Walvis Bay when they are pregnant in order to deliver their

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4 I revisit these statistics in greater depth in Chapter 5.
children in their home villages; newborn children are often then left in rural areas to be cared for by extended family after their mothers return to the city. The elderly also tend to leave Walvis Bay once they can no longer work. Places in local primary and secondary schools are increasingly hard to find (Hartman 2010), putting pressure on school-aged children to leave Walvis Bay as well. The population demographics are also skewed by the abiding faith many Namibians have in the ability of the new urban economy to provide while rural lifeways disappear; people (especially working-aged males) arrive in search of employment, and leave for rural areas for harvests on regular season cycles. Walvis Bay emerges in some respects as an ephemeral place, a city where people stay but do not live.

Because of these high levels of migration, many languages are spoken in Walvis Bay. Until 1990, Afrikaans was the official National language; it was replaced thereafter by English. In Walvis Bay’s white and Coloured populations, Afrikaans remains the home language of at least two-thirds of residents. English and German are the most common second languages, and nearly all of Namibia’s tribal languages are represented. In the black townships, 68% of residents cite one or another dialect of Oshiwaambo (the Bantu-based language of northern Namibia’s dominant Awaambo tribe) as their home language (Billower and Ekobo 2002), though Damara/Nama and Herero are significantly represented. Practically, though, conversations in Walvis Bay are as mixed as the population. Most people are polylingual and communicate in a rough-and-ready pidgin of English, Afrikaans, and a variety of African languages. My diary from 3 May 2010 records the ways in which I was greeted while walking the half-mile through the township from my house to the shop:

1) “Hey, Boeretjie!” (An Afrikaans diminutive of the derogatory ‘boer’)

2) “Hallo, Shirumbu!” (the Oshiwabmo word for ‘white person’)

3) “Hello, Buenos días!” (A Spanish greeting from an Angolan trader who, as my friend suggested, must have assumed I was Spanish)

Most important for my research, perhaps, are the interactions between this dynamic population and the city’s mixed economy. In Walvis Bay, major international companies (Maersk, Rio Tinto, Areva and DeBeers, among others) operate alongside petty trading, township markets, and a substantial underground economy, drawing a huge range of labour from international experts to unskilled seasonal migrants. Although unemployment in Walvis Bay was estimated in January 2010 to be roughly 30%, this is still well below the national average of 51.2%. As a result of its deep and direct connections to the international market economy, however, the city is also very directly susceptible to market phenomena both local and seemingly distant. In the late 1970s and early 1980s, for instance, a fisheries crisis caused an exodus that cut the population by one third (Billawer and Ekojo 2002). While I lived there, the city was trying to position its port as a shipping hub for minerals mined in the Katanga region of the Democratic Republic of Congo trucked to boats bound for Finland for refining, along with Zambian copper, Namibian uranium, and container traffic from the Atlantic and Indian oceans (van den Bosch, 2010). This dizzying web of international links could promise great wealth and great risk.

When I began looking for a flat in Walvis Bay, I had a telling visit with a real estate agent. When I suggested I was looking for a place for one, possibly semi-furnished, she laughed. “No offense,” she replied, “but I just had someone come in looking for 40 furnished one-bedroom units. And offering to pay cash.” The regular arrival of the Brazilian navy for exercises, frequent influxes of professionals and labourers, and abundant speculating are a huge boon to the real
estate and service industries (Klukowski 2010), but annual moratoria on various coastal fish
stocks ripple through everyone from fishing companies and canneries to fuel salesmen, taxi
drivers and women selling lunches by the shore. Fluctuations in the international markets
(particularly commodities and currencies), therefore, will continue to affect the city directly –
and probably increasingly so in future.

This level of connectedness with the global economy – enhanced in Walvis Bay’s case by
the climate’s virtual preclusion of any agricultural self-sufficiency – is an important part of what
makes Walvis Bay compelling, and in all likelihood a major driver of infectious disease. Mobility
is tied to HIV prevalence in ways that are only beginning to be explored, but at this point it
seems safe to suggest that an increased participation in the global market will also increase the
city’s exposure to HIV, tuberculosis, and emergent infectious diseases like SARS and novel
strains of influenza.

Nor is this interconnectedness limited to flows of global capital: Walvis Bay has no ‘soil,’
per se, only sand. Growing plants on a scale more ambitious than front-yard or soccer-pitch
 crab grass is difficult and requires huge amounts of irrigation, soil, and fertilizer. Water,
though, is at a serious premium – the city does not have a self-sufficient source of potable
 water but instead pipes water in from fragile inland aquifers in the (ephemeral) Kuiseb river.
Virtually all food is imported, including a great deal of sea food – most Walvis Bay catches are
sold for export – so the city, however powerful an economic engine, is also kept viable by very
real lifelines across the region, country and world.

One result of this socio-cultural and political-economic heterogeneity is that Walvis Bay
is a lively, dynamic, and conflicted place, the sort of new African city described in The Economist
as “painfully hard, shiny . . . sometimes like bubonic swellings about to burst, yet at the same
time post-modern, vital—cities of gold, of new ideas” (Baobab, 2010). As global connections intensify, more and more African cities will begin to look as hard, shiny and vital as Walvis Bay.

Another result is that Walvis Bay is actually a very lonely place to live. The constant comings and goings of migrants makes it difficult to develop a sense of rootedness and social connection. In this respect it is atypical of the fieldsites of traditional anthropology, and poses a unique set of research problems. I lived in a newer area of Kuisebmond, in a development adjacent to the cemetery and the fish canneries. When explaining to friends who lived in older parts of Kuisebmond that I frequently encountered racism in my neighborhood, they explained that my area was full of ‘new arrivals.’ They laughed them off as simple country folk who’d never interacted with whites much before. On the other hand, long-term inhabitants of Kuisebmond were nastily dubbed Ombwiti by their rural counterparts. A Herero word, ombwiti means something like ‘over-ripe,’ or ‘rotten,’ in reference to a fruit that has stayed too long on the vine.

This tension between ‘rural’ and ‘urban,’ between ‘naïve’ and ‘rotten,’ offers little scope for middle ground. Many saw Walvis Bay as a place to pump for money and then leave, quickly, and this showed in the community. Even well-established community organizations were marked by high turnover, careerism, and a near-universal willingness to leave town at short notice. In the townships, people often assumed that I was lost, crazy, or a criminal – why else would I be in the townships? Downtown, I was a tourist, a sailor, a German, or something

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5 I discuss my research methods in Chapter 3.

6 The use here of Herero (home language of less than 10% of the Namibian population) is telling. An Awaambo informant explained to me that during the apartheid era, many Awaambo men who came from the north as migrant workers took ‘local wives’ (a process well documented in, for instance, mining communities in South Africa). These local wives were primarily Herero-speaking women from closer to Walvis Bay, and a sort of Awaambo-Herero creole spoken at home began to find its way into wider use.
shady, but above all I was an unfamiliar face in the small and tightly-knit group of born-and-raised Walvis Bayers, another of the thousands of transient figures passing through the city. Through the course of my fieldwork, this aspect of life in Walvis Bay (and migrant cities like it) emerged as important not just for selfish reasons, but as a crucial aspect of the social determinants of health for HIV patients.

**History**

The discussion of Walvis Bay’s unique geopolitics is well served by a detour through Namibian and southern African history, in which Walvis Bay has always played an exceptional role. The archaeological record in the area currently dates to the late Pleistocene, and Namibia is home to some of the oldest rock art in the world; the Apollo 11 cave has yielded a series of paintings dated to 25-27000 years BP. Archaeological evidence suggests that the Walvis Bay area was inhabited by semi-nomadic pastoralists from at least 4000 years BP; the area appears to have been much more lush during this period (Wallace and Kinahan 2011). As the local climate began to grow more arid, the inhabitants probably began to more actively exploit marine resources; the many shell middens that dot the landscape south of present-day Walvis Bay suggest that the sea provided well. Adaptations in tools, pottery and production dated to around the 1000 years bp indicate that it was during this period that the Nara melon, which still thrives in the desert, became a significant part of the local diet.

I visited some of the middens amongst the shifting sand dunes just a short distance outside town. In addition to well-preserved human remains – including a few full skeletons – there was an abundance of pottery, beads, and tools. Nearby, the fossilized mud holds the footprints of the remarkable menagerie that inhabited the area when it had a more tropical
climate: elephants, several ungulates (including a now-extinct relative of the African buffalo), and well-preserved sets of human footprints. Projects to protect and catalogue these sites are an urgent matter: once exposed by shifting dunes, they are usually destroyed by the harsh environment in less than one year.

As Europeans, and especially the Portuguese, began exploring south-eastern routes to Asia, Walvis Bay became well-known to sailors. It was these European visitors who named the local inhabitants the Topnaars, probably a phonetic approximation (in old Dutch) of ≠Aonin, Nama for “people living on the edge” (Billawer and Ekobo 2002). They are still referred to as Topnaars today, and small Topnaar communities continue to eke out a semi-pastoral life in the sands around Walvis Bay.

The Portuguese were the first Europeans to step ashore in 1486, with Diogo Cão erecting a stone cross at a seal colony 150 kilometers north of Walvis Bay now known as Cape Cross; Bartholomeu Diaz landed near Walvis Bay one year later (Fleming 2004). In 1786, the British sailed the Namibian coast in search of a good port and a suitable site for a major penal colony; finding Namibia too harsh, they sailed on and decided instead on Australia (Goldblatt 1971). In 1793, Dutch settlers from the Cape colony sailed north and took Walvis Bay for Holland; they ceded the port to the British in 1814. The south of Namibia, meanwhile, was subject to increasing (though still small and infrequent) overland incursions across the Orange river by Dutch and English explorers out of the Cape (Dierks 1999).

With the colonial scramble for Africa nearing its height, Germany took possession of most of the territory of present-day Namibia at the 1884 Conference of Berlin. They named the territory Deutsche Sud-West Afrika, but it did not include the enclave of Walvis Bay. At the same conference, Britain had formally declared Walvis Bay (and an inland enclave measuring 10
miles square around the city) to be included in their Cape Colony. Walvis Bay increasingly became a key strategic and logistical point in southern Africa. Colonials and locals alike began jockeying for control over imports, taxes, and resources, and Walvis Bay increasingly found itself the center of a growing international network: the harbor was used to resupply Napoleon's garrison while he was exiled in St Helena (Wilken and Fox, 1978). Jonker Afrikaaner, chief of the coastal Nama/Damara tribes, monopolized the road from Walvis Bay to the capital, Windhoek, from the mid-19th century, and resisted Colonial encroachment on the scarce coastal resources that sustained traditional pastoralism. He also used this position to dominate and tax neighboring tribes (Wallace and Kinahan 2011).

The period of German rule is a dark chapter in Namibia’s history, and a shameful chapter in the history of humankind. Olusoga and Erichsen (2010) describe how the Germans’ massive seizures of land, use of concentration camps, and ultimately perpetuation of genocide under the guise of racial and psychological pseudoscience eerily presaged the Holocaust.

Germany’s colonial policy known as *Herrentum* (roughly translated to something like ‘autocracy’ or ‘mastership’) essentially involved a straightforward extraction of resources from the interior, and labour from the populous north, without even the patina of religious, educational, infrastructural or ‘hygienic’ development – however cynically motivated or ultimately destructive – pursued by other colonial powers in Africa. Tötemeyer (1987) describes the German approach as “characterized by the idea that a ‘stupid’ local inhabitant would make a humbler and more useful worker than an educated one.” (42) Naturally, Germany’s colonial expansion gave rise to local resistance, particularly from the Herero on whose lands the Germans made the greatest incursions. The Kaiser’s response was one of
history’s most horrific genocides. The description by Adam Hochshild (1999), the authoritative historian of the Belgian genocide in the Congo, is worth quoting at length:

The exclusive focus of the reform movement on Leopold’s Congo seems even more illogical if you reckon mass murder by the percentage of the population killed. By these standards, the toll was even worse among the Hereros in German South West Africa, today’s Namibia. The killing there was masked by no smokescreen of talk about philanthropy. It was genocide, pure and simple, starkly announced in advance.

After losing much of their land to the Germans, the Hereros rebelled in 1904. In response, Germany sent in a heavily armed force under Lieutenant Lothar von Trotha, who issued an extermination order:

‘Within the German boundaries every Herero, whether found with or without a rifle, with or without cattle, shall be shot . . . Signed: The Great General of the Mighty Kaiser, von Trotha.’

In case everything was not clear, an addendum specified: 'No male prisoners will be taken.'

Of an estimated eighty thousand Hereros who lived in the territory in 1903, fewer than twenty thousand landless refugees remained in 1906. The others had been driven into the desert to die of thirst (the Germans had poisoned the waterholes), were shot, or – to economize on bullets – bayonetted or clubbed to death with rifle stocks. (281-282)

Ultimately 80% of the world’s Hereros, and half of the world’s Namas, were killed (Meredith 2005). Karla Poewe (1984), conducting ethnographic research decades later, described Herero society as still rent by deep psychological pathologies. After their defeat in World War I, Germany lost control of Deutsche Sud-West Africa to South Africa, who renamed it “South West Africa.” They ran the country under a military regime from 1915-1921, and a civil administration thereafter. Walvis Bay however, remained a possession of Cape Province, and therefore sovereign British Territory. South Africa ignored this British claim on Walvis Bay and subsumed it under their South West African rule. The League of Nations denied South Africa’s request for annexation of South West Africa, but instead granted them a ‘mandate’ over the territory. The “vague wording” of this mandate set the stage for further trouble in
Namibia, which would last almost the rest of the century (Totemeyer 1987): South Africa became the most frequent defendant before the United Nations (Wainhouse 1964).

South Africa’s control over South West Africa was almost immediately questioned and criticized, but South Africa managed to ignore diplomatic challenges and even legal challenges through the League of Nations and later the United Nations. Simultaneously, South Africa’s domestic political climate was changing, and in 1948, Malan and Verwoerd formally instituted apartheid. Apartheid policies also shaped South West Africa powerfully, with Group Areas Act laws delineating Walvis Bay’s neighborhoods, and black Namibians left disadvantaged in most areas of public life. Lowenstein (1962) reported in the early 1960s that the country had only three secondary schools for the black population; ten blacks had undergraduate degrees. Of the several groups that, perhaps inevitably, arose in protest of South African rule, the most dominant and effective was the mainly Awaambo South-West African People’s Party (SWAPO). In 1966, the United Nations recognized SWAPO as official representatives of the Namibian people, and ordered South Africa out of Namibian territory. When South Africa refused, battle lines were drawn and a decades-long war between SWAPO and South Africa erupted (Thornberry 2004).

Throughout, Walvis Bay maintained its central importance. South Africa relied heavily on the port as a base for attacks in Angola⁷, as a means of bypassing trade embargoes on its own ports, and as a bottleneck from which to strangle shipping traffic to the rest of southern Africa. This was facilitated in 1977 by South Africa’s tactical decision to re-transfer

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⁷ Communist Angola was a safe haven for (Soviet-sponsored) SWAPO rebels, and home to Namibian refugee camps during much of the war of the Independence.
administration of Walvis Bay to the Cape Province, thereby distancing the city from the South African federal government and giving it still more leverage as a ‘trading chip.’

SWAPO turned for assistance to left-wing movements around the world, seeking refuge in Angola, Rhodesia and Mozambique, and military support from the Cubans and Soviets. For South Africa, therefore, the fight against SWAPO was to some extent a cold-war proxy battle against Communism and they accordingly received covert support from the United States and Britain (Lake 1976; Norval 1987), and a remarkably complex fight for control of Namibia's significant reserves of strategic minerals, especially uranium (Johnston 1981). It was also, for South Africa, a fight on multiple fronts against several other African liberation movements simultaneously, while choked by trade embargoes and saddled with a growing reputation as a global pariah. As colonial powers fell like dominoes across Africa, Namibia’s independence must increasingly have seemed like an inevitability; it was not until 1990, however, that Namibia gained independence: one of the very last African nations to do so. Walvis Bay, ever the exception, was retained after independence as a South African territory until 1994 when, with Nelson Mandela’s election, the city (and the nearby Penguin Islands) was finally returned to Namibia.

Today, this historical legacy still shapes Walvis Bay. While conducting my research, I lived in Kuisebmond, the township built in the 1960s and designated ‘black only’ by the South African regime (Moorsom 1984). The stamp of apartheid-era town planning remained on the place (see Plate 2 below), 15 years after the South Africans gave up control of Walvis Bay, and

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8 South Africa achieved (black) majority rule under Nelson Mandela in 1994, though the country itself had been a ‘union’ since 1910 and independent from Britain since 1934. The Sarhawi Republic in west Africa is a disputed exile republic which could arguably still be considered a Spanish colony.
20 years after the rest of the country became independent. Kuisebmond lies north-east of town, adjacent to the local Navy base and a long line of smoking, stinking fish canneries whose smell often blankets the township for hours at a time. Though no longer legally separated by Group Areas policies, immovable boundaries still effectively delineate racial neighborhoods. Kuisebmond is separated from the central business district (CBD) by a light industrial area and a railway line; it is separated from Narraville, the coloured township, by the main national highway. The posh white suburb of Meersig is on the far south-western edge of town, ‘buffered’ from both townships by the CBD. The apartheid-era racial makeup of each area still largely holds. What integration has occurred has been purely unidirectional; while newly wealthy black and coloured families have moved into ‘town’ in recent years, out of a population of well over 40 000 there were by all accounts exactly three white people in Kuisebmond in 2008-2010, including myself and an American Peace Corps volunteer.

Reliable statistics on Kuisebmond in particular and Walvis Bay in general are difficult to come by. The city’s own website cites a population of 60 000 from the 2001 census (Public Relations Division 2005). United Nations documents put the 2010 population at 65 000 (UN Habitat, 2010). In March 2010 I called the municipality to ask about their own estimates of population size; a planning officer reported to me that the number was probably between 80 000 and 100 000. “People flock here,” he said. “It’s growing all the time.” The official related an anecdote from a vaccination campaign in 2007; the city ordered 49 000 doses in line with official population estimates, but ultimately needed to order 30 000 more.

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9 I attempt to reconstruct these and other statistics in more detail in Chapter 5.
Plate 2: Map of Walvis Bay including Kuisebmond. Kuisebmond, circled in black, is separated from Narraville by the highway, and from the rest of town by the train tracks; its upper boundary is the ocean and the sand dunes (Google 2015b).

The difficulty of obtaining reliable data is enhanced by the fact that the South African government in all likelihood manipulated Walvis Bay’s population figures for political reasons until 1994 (Billawer and Ekojo 2002). There are rapid fluctuations in population tied to the labour market. Moratoria on certain fish stocks, for instance will drive many fishermen to return to rural areas, but also eventually drive out factory workers as well; conversely, a spike in commodities prices may drive hiring at the local mines. This, combined with the difficulties of gathering even basic vital statistics in developing countries (AbouZahr et al 2007), makes
rapidly-urbanizing African settings especially challenging. The majority of the city’s population lives in the townships, where these difficulties are multiplied. The rapid population growth – even if difficult to quantify – was putting an obvious strain on local services. Schools, for instance, were oversubscribed to the extent that many school-aged children left Walvis Bay to be enrolled elsewhere (Hartman 2010). All of this has major implications for health, development, and policy.

Kuisebmond was similar to townships in other parts of sub-Saharan Africa – a crowded and almost exclusively residential community. Unlike many townships, though, Kuisebmond was serviced by the city with mains electricity and water. There are actually no ‘informal settlements’ per se in Walvis Bay\(^{10}\), and housing stock in the townships was in the main fairly good: permanent houses were built with cement walls and tile roofs. Kuisebmond is not a place of abject poverty, but similar to that described by Kiran Desai (2006) in India, a community on the ragged periphery of the global economy, corners littered by its plastic flotsam, full of houses . . . common to those who had struggled to the far edge of the middle class – just to the edge, only just, holding on desperately – but were at every moment being undone, the house slipping back, not into the picturesque poverty that tourists liked to photograph but into something truly dismal – modernity proffered in its meanest form, brand-new one day, in ruin the next.

Small doorways would open to reveal cramped rooms filled to bursting with overstuffed old lounge suites from lay-by stores in town. There were no areas that were obviously and consistently wealthier than others. Kuisebmond is certainly poor by Canadian standards, but

\(^{10}\) In southern Africa, a ‘township’ or ‘location’ usually refers to a formal residential area created for blacks or coloureds under apartheid, and still generally inhabited by those groups. They are impoverished but usually well-established and serviced. ‘Informal settlements’ are inhabited by ‘squatters,’ and usually more temporary, unserviced, and deeply impoverished.
compared to many places in sub-Saharan Africa it is stable, safe and well-developed. The fact that even Kuisebmond’s tap water is potable is itself remarkable.

It is a sandy place – as Kuisebmond grows it is simply expanding further into the stark wastes of the Namib desert. Sand blows under doors, through laundry, into eyes; although main streets are tar sealed, most smaller or newer roads are simply packed sand sprayed occasionally with a salt matrix. In my neighborhood, cars often got mired in the softer sand of our yards and needed pushing or towing back onto the firmer sand of the road. Every 200 meters, powerful searchlights are perched atop massive standards. An apartheid-era relic, the lights nonetheless come blazing on every night at 20:00; my house was close enough to one that I had to shut the curtains to get to sleep. Normal lampposts light the CBD and white residential neighborhoods. David Lush (1993; 4), writing about Katutura (the large black township in Windhoek) on the cusp of independence, also found these searchlights compelling. “The city council,” he reports, “said the spotlights were installed to provide those living in the township with light, but residents believed that the glaring beacons . . . were there for the benefit of the police in times of civil unrest.”

Physically, the township covers a large area; although people live packed closely together, the housing is exclusively one-story. Lots, or ‘erven,’ are allocated by the city and connected to mains services. A single residential lot in Kuisebmond normally featured one-story, three- or four-room houses. Most lots also feature a handful of small shacks known as ‘ghettoes,’ – these are usually unserviced, single-roomed dwellings cobbled together from
salvaged material\textsuperscript{11}. These are rented as a source of income or let to extended family members.

The combination of small, overfull houses and a collection of ghettos made for very high population density. I conducted a survey with my research assistant to get some idea of the density of an average lot. I was particularly curious to learn about density for several reasons, not least was the city’s hugely high rate of tuberculosis – could this have anything to do with people living crammed together in small spaces with poor ventilation and shared bathroom facilities? We used a random number generator to choose lot numbers from a municipal map, and simply knocked on doors to ask how many people lived on the lot, and how many ghettos were on the property. Our sample of 36 had an average occupancy of just over 14 people per lot; the most crowded lot was home to 32 people, spread among one house and 9 ghettos.

Kuisembond had outlets of major supermarkets, post offices, churches and its own schools, but it was clearly not designed to be particularly self-sufficient. Instead, it was built to fit the odd apartheid-era planning requirements of keeping the \textit{swart gevaar} (the ‘black menace’) simultaneously dependent \textit{and} at arm’s length. The vast majority of all administrative and commercial outlets are located in town. Even the state hospital, catering almost exclusively to low-income black and coloured patients, is in town. Walvis Bay’s average income is substantially higher than the national average, but marked by substantial inequality; this is particularly noteworthy since Namibia is already the most unequal society on earth as measured both by income (UNDP 2010) and by household wealth (Davies et al 2008).

\textsuperscript{11} The idiosyncratic use of the term ‘ghetto’ is interesting here, but I was unable to learn more about its origins.
I previously mentioned the other reason that Walvis Bay merits such scrutiny is its epidemiology. For even while Namibia was celebrating independence, and the Walvis Bay economy fueled strong growth, a spectre had begun to haunt the city: the spectre of AIDS.
The microbe is nothing. The terrain is everything.

-Louis Pasteur\(^1\)

HIV FOUND FERTILE GROUND in Namibia – particularly in Walvis Bay, in Windhoek, and in the country’s northwest. Although HIV arrived relatively late, prevalence exploded at a shocking rate and left nearly one quarter of all Namibian adults infected less than 20 years after the first case was diagnosed. In this chapter, I explore why Namibia should have been hit so hard by the epidemic, and why specifically Walvis Bay’s unique combination of political-economic, socio-cultural, and geographical factors were especially conducive to the spread of the virus.

The Human Immunodeficiency Virus, or HIV, is a member of the retrovirus family, a group of viruses that replicate in the reverse transcriptase or RNA (rather than the DNA, as with most viruses) of host cells. HIV targets the immune system and leaves its host incapable of

\(^1\) Stillwagon (2002), among others, cites this popular (though possibly apocryphal) quote without attribution; the original source remains elusive. Some take is as Pasteur’s deathbed refutation of germ theory; here it helps to highlight the centrality of ecological factors in the epidemiology of HIV in Walvis Bay.
fighting off a number of infections that are non-fatal to bodies with healthy immune function.

The advanced progression of immune deficiency and the presence of certain of these ‘opportunistic infections’ define the onset of AIDS, or Acquired Immune Deficiency Syndrome – not itself a virus but a collection of symptoms issuing from the common cause of infection with the HI virus. HIV belongs to the ‘lentivirus’ genus (from the Latin for ‘slow’), so called because its long incubation period results in the virus killing its host relatively slowly (Schoub, 1999); untreated but otherwise healthy HIV patients usually progress to full-blown AIDS roughly seven to ten years after exposure, and die of immune failure and cumulative opportunistic infection one to two years later, though these timelines can vary greatly (Barnett and Whiteside, 2006).

The precise origins of the HI virus remain a mystery. Though theories abound, ranging from the biblical to the conspiratorial, the most commonly accepted explanation is zoonotic: HIV is most likely a form of a retrovirus found in chimpanzees, mangabeys, and some other African primates, called Simian Immunodeficiency Virus (SIV) that ‘made the leap’ from a primate host to humans. When exactly this leap occurred is unknown, but Pepin (2011) dates the single common ancestor of all known strains of HIV to roughly 1921. The condition now called AIDS was first formally described in the medical literature roughly 30 years ago. The United States Centers for Disease Control (CDC) publishes a weekly report of death and disease in America, widely circulated to help researchers and medical practitioners identify trends and spot outbreaks. On 5 June 1981, the Morbidity and Mortality Weekly Report described a cluster of 5 young male patients who died of pneumocystis carinii pneumonia (PCP), a rare infection normally found only in patients with highly compromised immune systems. The authors conjectured that the conditions were caused by an environmental factor, the “homosexual lifestyle,” or a then-unknown sexually transmitted infection (STI). The focus of the article was
PCP, but all the patients also had oral thrush and extremely low T-cell counts, and four of the five also had cytomegalovirus (CMV) infection (Gottlieb et al, 1981).

These and many subsequent deaths from what we now call AIDS (but was at the time referred to as Gay-Related Immune Deficiency, or GRID), were identified before the HI virus was postulated as the causative agent of ‘acquired’ immune deficiency. As the number of reported cases rapidly multiplied and their geographic distribution spread, the search for the cause intensified. In 1983, Luc Montaigner and colleagues used tissue taken from the lymph glands of an AIDS patient to isolate what they called Human T-Lymphotropic Virus III– the virus now known as HIV (Barre-Sinoussi et al, 1983).

Once the viral agent was identified, attention increasingly focused on where HIV had first emerged, and how it had traveled to its victims. Author Randy Shilts’ bestselling account of the early history of HIV in North America, And The Band Played On (1987), gave rise to the notion that a Canadian flight attendant named Gaëtan Dugas was the epidemic’s key vector. This was misquoted, sensationalized, and otherwise distorted by an eager and ill-informed press to the extent that Dugas was portrayed as “Patient Zero,” the index case who spread HIV across the entire continent. This position has subsequently been refuted: although Dugas by his own admission had unprotected sexual encounters with hundreds of partners per year, and continued to do so after being diagnosed, it is highly unlikely that a single person bears responsibility for the entire epidemic, and impossible for that person to be Dugas. More likely, Shilts identified Dugas as “Patient Zero” through a simple misunderstanding: in a 1984 epidemiological study by the CDC, Dugas was shown to have links with several AIDS patients

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2 Acquired immune deficiency is distinguished from primary immune deficiency, caused by a number of congenital genetic disorders, and from secondary immune deficiency, which is induced by drugs as in antirejection medication for transplant patients, or the treatment of autoimmune disorders.
from California. As the sole non-Californian in the study, he was referred to as ‘Patient O,’ for ‘Out of California’ (Auerbach et al, 1984). The letter ‘O’ was subsequently misread as a zero by Shilts, among others (Sapatkin 2013). More importantly, Dugas died in 1984 and there are in fact many people who died of AIDS long before him. As diagnostic criteria are standardized and testing technology refined, an archaeology of AIDS has developed around archival tissue samples and case histories from North America, the Caribbean, Europe and Africa.

Some of these early cases are still in dispute, but it is now well established that HIV has infected humans since at least the middle of the 20th century. A Norwegian sailor referred to by the pseudonym ‘Arvid Noe’ died of Kaposi’s Sarcoma in April 1976, after a decade of typical symptoms of HIV infection. His wife and the youngest of their children died in December 1976 and January 1977, respectively. Subsequent analysis of preserved tissues from all three confirmed the presence of HIV-1 of the ‘O’ type, most commonly found in west Africa (Jonassen et al, 1997); Noe is known to have sailed to west Africa, and to have contracted (and been treated for) sexually transmitted infections at least twice while a sailor. These are the first confirmed cases in Europe (Frøland et al, 1988).

The first case in North America has remained a topic of more controversy. A handful of patients who died of PCP and other opportunistic infections in the 1950s and 60s have been postulated as early HIV cases, but this relies only on case histories and not on preserved tissues (Huminer et al 1987). Some of these early cases have subsequently been confounded by conflicting test results (Lange et al 1991), but one seems nearly certain. In 1969, a black male in his mid-teens named Robert Rayford died in St. Louis, Missouri. He was mostly non-communicative and very little information about his sexual history (or preference) or personal and family medical history was gathered – even his exact birth date remains unknown. By the
time of his death he had spent months in hospital; what began as persistent edema, fatigue, malaise and a severe chlamydia infection had progressed rapidly and his autopsy revealed simultaneous infections with herpes, CMV, Epstein-Barr virus, and Kaposi’s sarcoma. His death was a mystery to the team of specialists who attended him, and they decided to preserve tissue samples for future testing. As the HIV epidemic spread across America, one of his doctors decided to have his samples tested; they were shown positive using two older (but standard and reliable) HIV testing methods (Garry et al 1988). Newer testing technologies will unfortunately never be applied to this mystery: the last remaining samples of Rayford’s tissues were stored in a laboratory in New Orleans and were destroyed by hurricane Katrina (McMichael, 2007). For the time being, this seems most widely recognized as the first case of HIV in North America. It is important here to note that the population of St. Louis peaked in 1950 (shortly before Rayford was believed to have been born), driven mostly by industrialization, shipping, and immigration (Gibson and Jung 2002) – the same changes that had erupted so forcefully in central Africa earlier in the century.

The earliest confirmed case of HIV in Africa – and the world – is currently that of a male patient whose tissue samples were collected in Kinshasa in 1959; a preserved sample of his blood tested positive for HIV-1, the most common strain on earth (Zhu et al 1998). It seems increasingly likely that small numbers of humans have been exposed to SIV and HIV for much longer than this, but that the Human virus only began to spread efficiently in the second half of the 20th century. Recent work by Michael Worobey and colleagues conservatively estimates that SIV, the primate ancestor which gave rise to the human virus, is at least 32 000 years old (Worobey et al 2010). An earlier paper, also by Worobey and colleagues, compared the earliest
Congolese sample, from 1959, with another taken from a woman living in Kinshasa in 1960. Together, they are the oldest known samples of HIV-positive tissue, and were collected only a year apart from patients living in the same city. However, phylogenetic analyses revealed that the viruses in each patient were highly divergent, suggesting that the “diversification of HIV-1 in west-central Africa occurred long before the recognized AIDS pandemic.” Worobey and his team place the common genetic ancestor of both patients’ strains of HIV to the beginning of the 20th century, with HIV making the ‘jump’ to humans between 1884 and 1924; they consider Congo in general and Kinshasa in particular to be the pandemic’s likely epicenter (Worobey et al, 2008). Subsequent research has confirmed this general area, pointing to the tropical borderlands of southeastern Cameroon and Congo (Pepin 2011).

On balance, it seems probable that the HI virus was present in central Africa – and perhaps elsewhere – for many years before becoming known to medical science. It traveled under the radar during a period when there was little foreign attention on infectious disease in Africa. Even after the advent of more sophisticated investigative techniques, what medical research did take place there was more focused on outbreaks of novel pathogens like Ebola, Marburg and Lassa fever (Chin, 2007). A striking example of just how endemically stable HIV may have been in remote populations is offered by the work of a team of researchers who drew blood samples looking for Ebola in a remote region of what was then Zaire in 1976. They realized, as AIDS came to prominence, that their archived samples might be a useful source of information about the roots of the disease. First, they tested their saved samples for HIV, then returned to the same remote Zairian region to repeat their protocols. They discovered that HIV prevalence was 0.8% in 1976, and exactly the same – 0.8% - a decade later in 1986. They
tracked patients identified as HIV-positive from the first cohort and found 3 of the 5 had died (apparently of AIDS), and a fourth was symptomatic. The fifth was asymptomatic. They concluded that rural life was actually conducive to containing the epidemic at low, stable levels within isolated communities (Nzilambi et al 1988).

When the pandemic exploded with such force at the end of the 20th century, then, it was not because of the sudden arrival of a novel virus. Instead, it was the result of a series of complex changes that managed to disrupt the traditional containment of HIV and spill the virus out of its isolated reservoirs. Massive shifts in African life occurred during the early- to mid-twentieth century, including urbanization, globalization, decolonization, and the emergence of cash economies and labour migration. Simultaneously, many traditional social arrangements – including structures of authority and kinship – were undermined or replaced altogether as new populations moved into new environments and arranged themselves in new ways at an unprecedented rate. Pepin (2011) observes how dramatically men outnumbered women in many of the new cities that were early flashpoints of HIV. These and other socio-cultural and political-economic changes thoroughly restructured life on the continent and combined to make Africa’s sexual networks3 more efficient at transmitting HIV (Thornton 2008). Further, the state structures that the virus would have encountered during this period were ill-equipped to offer much resistance.

The Congolese example is instructive, since many of the problems it experienced have plagued other African states since independence, beginning in the late 1950s. Indeed, 

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3 I leave out here the important role that might have been played by parenteral transmission of HIV, especially passing the virus on through unsterilized syringes. Hooper (1999) and Pepin (2011) both argue variations on this topic, especially the importance of syringes in early ‘amplification events’. Transmission in southern Africa remains mainly heterosexual, though needle sharing is implicated in the recent surge in incidence in former Soviet states.
following the above study, rates in the Congo steadily increased to an estimated 4.9% in 2002 (USAID, 2002). Under Mobutu’s rule, which ended in 1997, social services were progressively hollowed out until it was “less of a country and more of a Congo-shaped hole in the map” (Dowden 2008); gathering accurate data became increasingly difficult, but studies among female sex workers in Kinshasa showed rates as high as 24% (Vandepitte et al 2007).

Political upheaval and instability have marked sub-Saharan African since the middle of the 20th century (Meredith 2006), making long-term planning and large-scale policy efforts difficult. In many countries, corruption has been a persistent problem. Massive flows of migrants strain already weak social services, as do market shocks, and war. Weak infrastructure and human capital (especially due to failures in education and low baseline health) have been compounded by the disastrous effects structural adjustment programs have had on public health systems since the 1980’s (Schoepf 2004), rendering many states almost totally incapable of delivering basic medical services, let alone mounting sophisticated public health campaigns. The social upheavals that struck the Congo coincided with the period when HIV flourished; thereafter, however, civil war locked the country into a sort of brutal stability. Some authors (Epstein 2007) have observed that HIV prevalence has traditionally been highest in relatively peaceful, stable countries and lowest in war zones, where conflict impedes human movement and disrupts sexual networks. Congo’s HIV rates actually fell during the civil war, whereas Mozambique’s rates rose dramatically when the civil war there ended. The same brutal stability held in South Africa and Namibia under apartheid until the early 1990s, when HIV rates rocketed upward. This is a marked difference from pathogens like cholera, which thrive in the broken infrastructure of war zones and humanitarian crises; HIV seems instead to
thrive in contexts like post-independence Namibia where relative political and economic stability allows social and sexual networks to grow.

It now seems reasonable to conclude that HIV took off in Africa in the middle of the century for many of the same reasons that it did in North America in the 1980s, in sub-Saharan Africa in the 1990s, and in Eastern Europe and central Asia today. In each case massive disruptions saw large numbers of people leaving behind their rural communities and engaging in new social relations, in tenuous and often dangerous work, in the midst of elaborate sexual networks and the erosion of traditional authority and state support. In short, the arrival of this pathogen in many parts of the world coincided with the creation of an ecology perfectly suited to its proliferation, and with the simultaneous dissipation of so many of the structures that would have contained it.

I digress into places and times distant from Walvis Bay not only to establish the general background of HIV, but to expose larger themes common to the city today. Many of the factors that fueled the earliest stages of the epidemic are in place now in Walvis Bay: high levels of migration and urbanization, massive upheavals of lifestyles – new movements of people and capital creating an ideal environment for generating and transmitting recombinant strains of HIV. The city’s unique ecology is central to my research, and should be central to efforts to prevent, contain, and treat HIV.
HIV and AIDS in Namibia

The first case of HIV in Namibia was recorded in 1986. Given new discoveries about the early history of the virus, however, it seems likely that the virus had arrived earlier than this and simmered unchecked at a low level. Unfortunately, government intransigence in the early stages allowed the virus to gain a toehold. In the late 1980s, Namibia was in the final stages of its long and bloody fight for independence from South Africa. In 1990, the state of Namibia was born as a parliamentary democracy; the left-wing South West African People’s Organization (SWAPO), the former liberation army, won a majority in the country’s first election (O’Linn 2003) and have held a majority since.

SWAPO’s platform was staunchly socialist, and the party received support from the Soviet Union; they were also strongly informed by Pan-Africanism, and committed to redressing the crimes perpetrated under apartheid (Wallace and Kinahan 2011). Despite nationalizing many sectors and drafting a uniquely progressive constitution, SWAPO’s early response to the arrival of HIV was marked mainly by indifference and ineptitude. Their reluctance to engage with the growing problem was in some senses consistent with the Pan-Africanist strands of their platform⁴. Specifically, government characterized HIV as a European import, a problem only of concern to homosexuals – homosexuality itself being labeled a foreign (or non-African) phenomenon (Lorway 2006) – and dragged their heels in mounting a rational response. By 2002, Namibia’s HIV prevalence, at 21.3%, was the 5th highest in the world (MOHSS 2010).

It is impossible to know how exactly HIV arrived in the country, but the geographic distribution of prevalence rates is striking. HIV has long been centered in Namibia’s cities, from

⁴ South African president Thabo Mbeki would take a similar stance years later, espousing an ‘AIDS denialism’ and wariness of antiretroviral drugs that was itself informed partly by Pan-Africanist thought.
the coast at Walvis Bay, through the capital, Windhoek, and on to the northeast border with Zambia, Botswana and Angola in the Caprivi Strip. This Z-shaped slash traces the route of the “trans-Caprivi corridor,” the most important shipping route in Namibia. This trade artery opens, at the northern end, to the heart of Africa via Botswana, Angola, Zimbabwe and Zambia; at the southern end, via the Walvis Bay harbor, it opens to the rest of the world (see Plate Three below). The city of Katima Mulilo, a trading and transit junction at the end of the Caprivi Strip, has long had the country’s highest rates. At the worst of the epidemic, adult seroprevalence reached a staggering 43% (MOHSS 2010). It seems likely that HIV entered the country through one of these high-prevalence gateways.

Plate Three: The central coast of Namibia including Walvis Bay. The main highway toward Windhoek can be see running through Swakopmund and Okahandja (Google 2015c).

Despite the high rates in some parts of the country, other areas remained relatively unaffected. Richard Lee describes low rates of HIV among the Kalahari San; Phillipe Talavera
found similarly low rates among the Kaokoland Himba (2002). The San and the Himba are the two Namibian tribes remaining most engaged in traditional subsistence patterns, and the most geographically isolated from the rest of the country’s population. Both Lee’s and Talavera’s accounts include the suggestion that low prevalence may be due to ecological factors. In the case of the San, political-economic equality enables women to refuse sex partners and to secure subsistence without recourse to transactional sex. Their communities are isolated from major shipping routes, but have access to condoms and have readily integrated them into cultural conceptions of sexuality (Lee and Susser, 2002). Further, these communities experience relatively little emigration and, more importantly, virtually no immigration, and maintain some traditional social structures and modes of production.

Many of these qualities mirror those of the isolated rural communities in which the HIV epidemic was contained at a stable level in the middle of the last century. Lee (2005) supports this argument with the results of a multi-site ethnography comparing HIV in three Namibian communities. He noted a correlation between HIV prevalence and various social factors: the isolated, egalitarian San communities’ low rates contrasted sharply with the double-digit prevalence in Awaambo communities with higher urbanization, mobility, and inequality, characterized by an obsession with “cash, cars and cellphones.”

**Incidence and Prevalence Today**

The Namibian government has changed its position on HIV and adopted a ‘public health’ approach to prevention and treatment in line with the World Health Organization. Still, no prominent politicians have ‘come out’ to speak about being personally affected (let alone infected) by HIV. In 2008, the opposition Congress of Democrats (CoD) party sparked a heated
debate in Parliament by suggesting that condoms should be distributed in prisons. Several SWAPO Parliamentarians – themselves former political prisoners under apartheid – vehemently opposed, arguing that there was no need for condoms in prison, since male prisoners never have sex with one another (Weidlich 2008).

Namibia does hold an annual National Testing Day, which is well attended and well publicized, and the release of biennial Sentinel Surveys is always a major media event. There is still, though, some lack of urgency in public discourse and a degree of popular resignation and fatalism that is jarring when compared, for instance, with the passionate resolve of the (recent) independence movement. This aside, the response has substantially improved since the early days of the epidemic.

HIV prevalence has declined in Namibia after reaching a peak in 2002. This downward trend is good news. It is also, however, a complex indicator with many potential explanations. First, the recent response to HIV in Namibia has been effective: testing and treatment have been made universally available and public knowledge about the disease is good. When my wife worked at a school in Swakopmund, she quickly became used to 7-year-olds singing songs about condoms. Second, high levels of AIDS-related mortality among HIV-positive Namibians would have the effect of lowering overall prevalence, given a relatively stable incidence of new cases. That is, HIV-positive Namibians would be removed from the population faster than they were replaced by new cases, assuming a five- to ten-year ‘mortality lag’ from the surge in incidence in the 1990s. Third, it may be that the peak observed in 2002 was simply a statistical ‘blip.’ Namibia’s prevalence over time can be described with a best-fit line (as a two-year moving average) that actually bypasses the high point of 2002 and plateaus after the slow,
steady incline from 1996. Under this scenario, prevalence isn’t so much reduced, as it is ‘back on track’ after an abnormal uptick. (See Figure One below.)

![Figure 1: Estimated Adult HIV prevalence (%) in Namibia, 1992-2010, with two-year moving average trend](chart)

Fourth, HIV sentinel survey data warrants careful interpretation. In 2008, Namibia’s set of national prevalence estimates was based on HIV testing of 8174 pregnant women (MOHSS 2008). Although antenatal serosurveys are the standard, accepted method of estimating national prevalence in developing countries, they naturally require extrapolation beyond pregnant women and into the general population that may introduce some error. By 2010, Namibia still had not conducted a national ‘baseline’ survey – such surveys are, of course, expensive and logistically complicated. Small-scale population testing has been conducted in

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5 This involves testing the blood (for HIV, among other things) of women visiting antenatal clinics during their first pregnancy. Normally, a wide cross-section of pregnant women readily access medical care and consent to have blood drawn; by definition pregnant women are also sexually active and not using contraception. (WHO 2005)
Namibia, and the results have in some ways contradicted the trends in antenatal data: Aulagnier and colleagues (2011) sampled 1700 households in Windhoek and found an adult prevalence of 11.8% in 2006/2007, and 14.6% in 2009.

Various other methods of estimating national prevalence have been proposed, though upon close inspection none is apparently more accurate. In 2007, India revised its national estimates downward from 0.91% to 0.36% (equal to approximately 2.7 million cases) as a result of using ‘door knocking’ instead of antenatal sentinel data. ‘Door knocking’ (literally a process of discreetly conducting rapid tests and questionnaires house-to-house) aims to address some of the limitations of antenatal data. The size of India’s population meant that their revised statistics actually caused a substantial lowering of estimates of the total number of HIV-positive people worldwide (UNAIDS 2007).

Because Namibia’s HIV sentinel surveys only sample pregnant women, the MOHSS data cannot tell us directly about HIV in the country’s male population. UNAIDS/WHO (2008) data indicate that of 180 000 adults (aged 15+) infected with HIV in Namibia in 2007, approximately 110 000 (or 61%) were female; in 2010, the proportion had fallen slightly to 101 000 females out of 170 000 (59%). UNICEF (2013) reports that 190 000 Namibians were infected in 2011, of whom 100 000 (59%) were female. Approximately 16.4% of males aged 20-24 report participating in higher-risk sex compared with just 3.6% of similarly-aged females (UNAIDS 2013). However, HIV rates among this age group are higher in women (6.5%) than men (2.7%). Sentinel data (MOHSS 2010) suggest that the highest prevalence has gradually shifted to older age groups, and now peaks (in antenatal surveys) among women aged 35-39, at 29.7%, followed closely by women aged 30-34 at 29.76%.

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6 During the same period, national antenatal prevalence was actually reported to have fallen from 19.9% to 17.8%.
Antenatal HIV data also yield information about the historical prevalence of HIV in Walvis Bay. Antenatal surveys were first conducted in Namibia in 1992; Walvis Bay was not included as a testing site until 1996. That year, prevalence was 29%: this was the second-highest rate in the country, after Oshakati. Oshakati is the capital of Awaamboland, and sits against the northern border on the highway from Angola to South Africa. In 1996, Walvis Bay’s prevalence was matched (at 29%) by Katima Mulilo, the border town at the end of the Caprivi Strip and a major junction on the highway from Walvis Bay to the Zambian Copper Belt. Was Walvis Bay the epicenter of Namibia’s HIV epidemic? In light of the early history of the virus elsewhere in Africa, it seems likely that it entered Namibia at its busy border points and took hold locally before moving into the rest of the country via trade routes. Walvis Bay’s prevalence has trended downward since peaking in 2004, but has always appeared to be independent of national trends, and has always remained significantly higher.

Figure 2: Antenatal HIV prevalence in Namibia and Walvis Bay, 1998-2010. (Chart by author, with data from MOHSS 2010.)
Data on HIV prevalence that I obtained from several other sources were too inconsistent to be used. The paucity of quality data in the region is a common complaint, but in this case the problem is compounded by the lack of data accurately disaggregated by age and gender. More robust data is available from South Africa, however, which roughly agrees with the Namibian estimate that something on the order of three fifths of people infected with HIV are female. In a nationwide cluster stratified sample of rapid HIV tests in 2008, approximately 56% of South Africans living with HIV were female. Prevalence was higher in males only in the 2-14, 40-44, 50-54, and 60+ age groups. Overall, prevalence was highest (at 32.7%) among women aged 25-29. Male prevalence peaked later, at 25.8% from ages 30-34, though it maintained a level of roughly 19% through age 44; female prevalence, conversely, drops steadily from its peak (HSRC, 2009).

Given this uncertainty, and the experience of India, could door-knocking surveys also yield different prevalence statistics in Namibia? One problem with door-to-door surveys is that they tend not to capture people at a higher risk of infection because they are absent or refuse testing. Janssens and colleagues (2008) compared the results of a door-knocking survey in Windhoek in 2006-2007 with official antenatal serodata taken in the same neighborhoods at the same times. The Janssens study found that people in Windhoek who refused testing had prevalence rates on average 3 to 4 times higher than the general population. This suggests that door-knocking surveys are themselves subject to biases that may result in inaccurately low prevalence estimates. A later paper (Janssens et al 2010) further complicates this issue: in

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7 Importantly, this study concerns only those who refuse testing, not those who are absent – door knocking surveys would also often miss sailors, truck drivers, and other groups of frequent travelers often considered at higher risk.

8 Men who refused to test were four times more likely and women who refused to test three times more likely to be HIV-positive than those who voluntarily participate.
reviewing door-to-door survey data from Windhoek, researchers discovered that a single nurse had submitted falsified results with HIV prevalence 3.6 times higher than the other seven testers ($\chi^2 p=0.0001$). Excluding this nurse’s results from the sample lowered estimated HIV prevalence of the entire group from 12.7% to 9.6%. This result indicates the extent to which door-knocking surveys can also be dependent on human factors, for better or worse.

All of this is to suggest that the exact numbers of Namibians living with HIV is difficult to determine with complete accuracy. However, the general downward trend in HIV transmission has been durable across multiple national serosurveys and should be greeted with cautious optimism.

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**Highly Active Antiretroviral Therapy**

The treatment of HIV began in 1985, when a drug named azidothymidine (AZT) showed promise in clinical trials. AZT had actually been developed as an anticancer drug in 1964, but was shelved when animal trials showed it to be insufficiently effective; its efficacy in combating the HI retrovirus, however, was apparent almost immediately (Yarchoan et al 1986), and it was approved by the FDA for use in AIDS patients in 1987 (Broder 2009). AZT is a *nucleoside analog reverse-transcriptase inhibitor* (NRTI), a category of drugs that slow the reproduction of HIV by interrupting the process through which the virus’ RNA synthesizes DNA in host immune cells. Several other antiretroviral drugs, operating through different physiological pathways, were
subsequently developed. ARVs do not cure HIV – they slow the reproduction of the virus to such an extent that the immune system is able to recover and mount a defense. Even when replication is slowed to a halt, a cure remains stymied by persistent ‘reservoirs’ of virus deep in inaccessible tissues. The only person to date confirmed cured of HIV, Timothy Ray Brown, combined a long course of ARVs with chemotherapy and a transplant of CCR5-negative bone marrow for (non-HIV related) cancer (Hütter et al 2009). Brown remains HIV-negative despite stopping HAART, but the exact mechanisms of his cure are still poorly understood and clearly unsuitable for public implementation.

Treatment was revolutionized in August of 1995, when David Ho suggested a novel approach to hitting HIV “early and hard” with a combination of several antiretroviral agents simultaneously (Ho, 1995). This approach, known as Highly Active Antiretroviral Therapy (HAART), involves combining at least three different antiretrovirals – usually drugs which operate through different pathways and limit the development of drug resistance. HAART has since become the standard treatment for HIV, and is now so ubiquitous that some commentators have suggested dropping ‘Highly Active’ from the name; virtually no patients still use single-drug ‘monotherapy’ (Sax 2012). It is important here to distinguish ARVs – the drugs themselves – from ART – antiretroviral therapy. The latter generally involves triple therapy with ARVs, but (especially in Africa) might also involve prophylactic antibiotics, macro- and

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9 Currently, there are 6 types of antiretroviral drug besides NRTIs: non-nucleotide reverse transcriptase inhibitors (NNRTIs) and protease inhibitors (PIs) were the next categories developed. More recently, fusion inhibitors, maturation inhibitors and integrase inhibitors have become more widely available in the developed world, but not in Africa. CCR5 receptor antagonists do not actually target the HI virus, but rather target HIV-specific receptors on immune cells; this medication is also not widely available in the developing world.

10 CCR5 is the name of the immune cell receptor that the HI virus ‘latches onto.’ Some people, who carry the CCR5-Δ32 deletion variant, naturally lack this receptor and are therefore essentially HIV-immune.
micronutrient supplements, and non-medical interventions under the general umbrella of ‘care,’ including counselling and job training.

AZT went to market as one of the most expensive drugs on earth. In the developed world, it was prohibitively expensive\textsuperscript{11} except for wealthy patients and for voluntary participants in clinical trials. In the developing world, access was virtually impossible except through personal channels (De Cock et al 1993). As later ARVs were similarly expensive, a protest movement emerged to advocate for lower pricing and wider access to treatment. These movements have been tremendously successful on several fronts, including negotiating with drug companies, organizing bulk purchases, and paving the way for generic production of medication. By the middle of 2001, \textit{Médecins Sans Frontières} were already able to provide generic triple-therapy for $295 per year (Médecins Sans Frontières 2001).

**HAART in Namibia**

In 2003, the Namibian government pledged to make HIV treatment available to all citizens in need. This development came on the heels of a ‘trial rollout’ of a PMTCT program (see \textit{Introduction}). The program was supported by major influxes of foreign aid, and facilitated by many of the fundamentals of Namibia’s economy: relatively strong infrastructure (including the communications and supply chains crucial to a widespread rollout), political stability, and a small population. In short order Namibia had established a successful rollout that performed better than expected in achieving both broad coverage and the prevention of mother-to-child transmission (Nattrass 2008).

\textsuperscript{11} In 1989 median household income in the USA was $30 000 USD, and a standard course of AZT cost roughly $8 000 USD per year. Given historical inflation rates, this would be roughly equivalent to $14 500 USD in 2012. (USCB, 2013)
Initially, Namibia’s public-sector rollout used widely accepted WHO standards for determining who was eligible for treatment. These guidelines recommended that adults and adolescents start treatment in WHO stage I, II, or III only if their CD4 cell count\(^\text{12}\) fell under 200/mm\(^3\), or in WHO stage IV\(^\text{13}\) regardless of CD4 count. In addition, the Namibian government created ‘social criteria’ for public HAART. Patients had to:

- have a fixed residence for the past three months
- not abuse drugs or alcohol
- be able to get to the clinic for every follow-up as needed
- abstain from sex, or always use a condom
- ‘be committed’ to taking the medicines correctly, for life, and,
- find a treatment supporter. (MOHSS 2003)

In 2010, the government adopted a revised set of treatment guidelines, again in line with WHO recommendations, that expanded eligibility to more people. These guidelines make any patient eligible for HAART who is in stage III or IV, or whose CD4 counts are below 350, regardless of their clinical stage. The social criteria remained in place, with the addition of “not having unstable psychiatric disorders.” Social criteria, including that of the treatment supporter, were described as “necessary, but should not be an obstacle to accessing HAART.” These guidelines offer the opportunity for patients to nominate a local NGO as their ‘supporter,’ or for clinicians to exercise judgment in determining eligibility (MOHSS 2010b).

At the Walvis Bay HAART clinic, the standard first-line treatment for (non-pregnant) adults in 2009 was d4T ( stavudine) with 3TC (lamivudine) and NVP ( nevirapine) or EFV

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\(^{12}\) This is a measure of the number of CD4 cells per volume of blood. CD4 lymphocytes are white blood cells, and play a crucial role in fighting infection; CD4 count gives an impression of the overall status of the immune system.

\(^{13}\) WHO stages are roughly defined as follows: Stage I patients are HIV positive but asymptomatic; Stage II patients have lost less than 10% of body mass and begun to suffer some minor recurrent infections; Stage III patients have lost over 10% of body weight and suffered fever, diarrhoea, or persistent serious infections; Stage IV patients are wasted and bedridden, and suffering from a life-threatening OI including pneumonia, extrapulmonary tuberculosis, or Kaposi’s sarcoma.
(efavirenz). The commonest second-line combination was AZT (zidovudine), ddI (didanosine), and IDVr (indinavir). These drugs are all well-established and well-tolerated, and in most cases available in easy-to-use ‘fixed-dose combination’ tablets: these reduce the overall pill count and simplify the HAART regimen. AZT can be associated with anemia, and nevirapine with skin rashes and hepatotoxicity. Efavirenz can have central nervous system side effects, including mood disorders, while NRTIs (including ddI and D4T) can cause peripheral neuropathy. Efavirenz is also contra-indicated for pregnant women and for women of reproductive age (because of potential teratogenicity), unless coupled with contraception (MOHSS 2003). All these drugs were provided free of charge by a dedicated HIV pharmacy inside the clinic itself. Counselors, nurses and doctors were also in the same building, so that every step of the HAART process could happen under the same roof. Testing, consultation and follow-up were similarly free of charge. Much of the clinical work was ‘task-shifted’, with nurses handling routine work and doctors primarily dealing with complicated patients. In light of staffing shortages in many African HIV clinics, this approach has been shown to expand coverage and streamline clinic operations but maintain quality standards (Callaghan et al, 2010). Some patients were given transport to the clinic, though these were usually hospital inpatients or prison inmates, rather than patients too poor to afford transport.

I visited a private pharmacy in Walvis Bay to ask after the cash prices of standard first-line HAART drugs. I requested information on one month of adult-dose AZT – 3TC – NVP. The pharmacist immediately snapped to attention and seemed keen to be quite helpful, discrete, and friendly. She disappeared with my notebook, and returned almost 10 minutes later with detailed computer printouts of the prices for (30x) AZT-3TC-NVP and for AZT-3TC-EFV, a common alternate first line combination, and for the price of a high-powered second line. “If
you want to come back and speak to ______,” she said, “he’s very good with this stuff.” The prices I received were as follows:

- AZT-3TC-NVP: $749.23 NAM
- AZT-3TC-EFV: $704.31 NAM
- TDF-AZT-3TC-LPVr: $1785.47 NAM

The role of the private sector in HAART rollout is outside the scope of this thesis. It is important, however, and I revisit the question in subsequent chapters. My own position as a white foreigner undoubtedly affected my experience at the pharmacy, but some working-class blacks would have access to HAART through private insurance as well. Anecdotally, many patients reported that the desire to access private care was because of perceived increase in their personal privacy, not because of superior quality. One counselor shared with me the popular perception that private care caused more side effects: “some people say the private medicine is too strong.” Some research has begun to examine the role the private sector plays in the national treatment plan in Namibia (Van der Veen et al 2011; de Beer et al 2009). Ultimately, though, public clinics now provide antiretrovirals free of charge to almost everyone who is eligible.

Although it is a widely-used benchmark, the WHO is often reluctant to define ‘universal access’ in absolute terms, and the mathematical formulae and policy rhetoric surrounding the subtleties of ‘access’ and ‘coverage’ are remarkably complex. A common guideline is to define ‘universal access’ as that which is extended to 80% of the population in need. Namibia’s public-sector rollout began in 2003, and reached 20% of all eligible patents in 2004. In the next two

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14 By way of comparison, I could buy a loaf of bread for $7 NAM, one month of thyroid medication for roughly $50 NAM, and a course of antibiotics for $100 NAM. A rental flat in a very nice neighbourhood might cost $4000 NAM per month. Private antiretroviral patients would clearly be very lucrative. On 1 January 2010, 1 USD was worth 7.39 NAM.
years, coverage leapt to roughly 70%. By 2007, this figure had reached an estimated 88%. In terms of absolute numbers, roughly 52 000 out of 59 000 eligible\textsuperscript{15} patients in Namibia were receiving antiretroviral therapy from 57 different sites nationwide by 2007 (UNAIDS/WHO 2008).

In 2010, the United Nations began to promote the concept of ‘treatment as prevention’ (UNAIDS 2010b). It had long been understood that, by lowering viræmia, ART should theoretically make patients less likely to transmit the virus. It was only by 2010, however, that a substantial body of data began to establish just how remarkably effective HAART could be at preventing (rather than just treating) HIV. One clinical trial involving 3381 African couples found that partners of HAART patients were 92% less likely to become infected with HIV than those whose partners were not on treatment (Donnell et al 2010). This drove a push to expand ART coverage, and to implement a new ‘test and treat’ policy of HAART initiation immediately upon testing positive for HIV rather than waiting to reach a clinical cut off such as WHO Stage IV or a CD4 count of 200. Some have cautioned that this approach would lead to a proliferation of drug-resistant strains of HIV (Sood et al 2013).

Has rollout lowered the incidence of HIV in Namibia? This question is difficult to answer, partly because of gaps in the country’s incidence data, and partly because widespread rollout really only began in 2004. Wagner et al (2010) argue that before we roll out a ‘test and treat’ program, we need a ‘find and treat’ program: surveillance systems are still imperfect (as detailed above) and might therefore produce flawed estimates of the demand for HAART.

\textsuperscript{15} The changing definition of eligibility in 2010 would mathematically drive down coverage rates by increasing the absolute number of ‘eligible’ patients.
Figure 3 below compares new cases of HIV in Namibia (from over 100 000 per year to less than 10 000) with the (total) number of patients receiving HAART (from zero to over 16 000).

![Graph showing new HIV infections and patients receiving HAART from 2003 to 2011](chart)

*Figure 3: Number of patients receiving antiretroviral therapy and new infections of HIV in Namibia, 2003-2011. (Chart by author, with data from UNAIDS 2013)*

Using absolute numbers of new infections and of patients receiving HAART allows us to sidestep the problems described above with rates. This is doubly important considering the recent changes in ART eligibility cutoffs, which overnight brought large numbers of previously ineligible or ‘borderline eligible’ patients into the pool of those awaiting treatment. The data show a negative correlation between HIV incidence and antiretroviral access, though there is some suggestion that incidence was already falling before the rollout began\(^ {16}\) (UNAIDS 2013).

There are two final points to consider with regards to the relative efficacy of ‘treatment as prevention’ in Namibia: the first is that many projections about the population-level impacts of

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\(^ {16}\) HAART would also be expected to increase the total number of people living with HIV by reducing AIDS-related mortality.
HAART on incidence rely on very optimistic levels of access and adherence (Hayes et al 2011) topics which I explore at length in this thesis; the second is that treatment itself currently remains the focus of the campaign, for reasons of health and of human rights, and any knock-on effects on incidence are the secondary benefit and not the primary goal of rollout. In this latter regard, it seems clear that Namibia has been quite successful in rolling treatment out quickly and effectively, and a modest impact on incidence should not reflect negatively on the efficacy of the program itself.

* * *

Walvis Bay’s connections to the rest of the continent and the world probably made it one of the first places in Namibia where HIV took hold. A set of socio-cultural and political-economic changes made the city particularly susceptible to a rapid and wide spread of the virus: exposure to the global economy via the sea, the fall of apartheid and subsequent increases in mobility, and the emergence of altogether new arrangements of people, power, and capital. The problem was then allowed to grow out of control by a slow, inefficient response. Fortunately, the subsequent response has been decidedly more focused; the progress Namibia has made in rolling out treatment free of charge has been remarkable. The question of whether the country has achieved ‘universal access’ is to some extent semantic; the vast majority of eligible patients are now receiving treatment free of charge through public-sector clinics. I discuss this rollout at greater length throughout this thesis, but anecdotally, both patients and caregivers report that it is largely successful.
In Namibia, I was not examining an urgently deployed system of “triage” (Nguyen, 2010): most patients who needed HAART had access to it, free of charge, in quality public clinics. I was instead curious to examine the patterns that might start to emerge in a ‘mature’ public-sector rollout, both in terms of access and outcomes. In Chapter 3, I describe the questions I asked and the methods I used to answer them.
 CHAPTER THREE
QUESTIONS AND METHODS

What we need to question is bricks, concrete, glass, our table manners, our utensils, our tools, the way we spend our time, our rhythms. To question that which seems to have ceased forever to astonish us. We live, true, we breathe, true; we walk, we go downstairs, we sit at a table in order to eat, we lie down on a bed on order to sleep. How? Where? When? Why? Describe your street. Describe another. Compare.

-Georges Perec, L’infra Ordinaire

I went to Walvis Bay hoping to examine the patterns emerging in a well-established public-sector rollout of HAART, both in terms of access and outcomes. The complex relationships involved in shaping treatment at the population and personal level demanded a mixed-methods approach. I wanted to blend a quantitative analysis of health data with a subjective, reflexive approach to in-depth ethnographic detail. Below, I explain my research questions, describe my methodological approach, and elaborate on some of the ethical challenges I encountered in the course of my work.
QUESTIONS

Like most Anthropological projects, my questions are brief but not simple. What are the treatment outcomes in Walvis Bay’s HAART program, and how is their distribution explained? In other words, who benefits most from HIV treatment, and why?

I first visited Namibia in 2003, the same year that the government committed to rolling out HAART for all eligible citizens. In the intervening period I’ve been able to watch the country’s highly successful rollout in progress. By 2012, Namibia was one of only three countries with a generalized epidemic to have achieved universal coverage; its coverage rate of 88%, according to the WHO’s stricter 2010 guidelines (Kamwi et al 2012), is one of the highest among developing countries (WHO, UNAIDS, UNICEF 2011).

Across the early 2000s, rollout was an urgent priority in the global HIV community, and several large developing-world HAART cohorts were closely watched. In some respects, early research on large-scale rollout programs was unsatisfying. Indicators were blunt (patients were either ‘enrolled or not,’ ‘living, dead, or lost-to-follow-up’) and patient populations treated as an undifferentiated mass. Undoubtedly, this was a function of the constraints of this early period, when research agendas were being hammered out and rollout was an urgent race against time. Still, I wanted some better indication – qualitative or quantitative – of the patient experience of HAART. Had anyone disaggregated treatment outcomes? Did some patients do better than others? Did some slip through the cracks? And if so, were there any sorts of patterns to predict which patients ‘made it’ and which didn’t? Most early research along these

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1 By 2010, Botswana, Namibia and Rwanda were estimated to have antiretroviral coverage rates of approximately 93%, 90%, and 88% respectively (WHO, UNAIDS, UNICEF 2011).
lines focused on important but fairly intuitive clinical factors: patients coinfected with active tuberculosis responded less readily to treatment, or patients with dangerously low CD4 counts upon treatment initiation were more likely to die than those initiating with healthier immune systems (Hogg et al 2001).

It was two separate studies from Brazil that dug further into the human dynamics of treatment and the effects of socio-cultural and political-economic factors on treatment outcomes that helped set my research direction. Fonseca et al’s (2007) study of the relationship between AIDS mortality (in a context of public-sector HAART treatment) and ‘race/colour’ and gender suggested some powerful questions I might ask in Namibia. João Biehl took some of these issues substantially further in his striking ethnography Will to Live (2007). Biehl describes his book as a search for “alternative epidemiological evidence” (14) about HAART rollout in Brazil. Set in a favela hospice in Santiago, it follows a set of patients from 1997 to 2002, exploring how treatment works on an individual level in a developing-world context. More broadly, the book explores how rollout moves from ‘triage’ to an entrenched, long-term public health response. This exploration rests in part on Foucauldian themes of biocitizenship and governmentality, in concert with some other contemporary work: Vin-Kimh Nguyen (2010) is particularly concerned with these themes in his work on HIV in Francophone west Africa, and Adriana Petryna (2002) in the aftermath of Chernobyl.

Originally I felt that several factors might impact treatment outcomes, but that as a group women would probably fare the worst. At conferences I heard everyone from local NGO actors to Stephen Lewis and Bill Clinton describe women as the true victims of the HIV pandemic. During my 2003 research on Windhoek’s PMTCT pilot program, I found that women almost invariably lacked meaningful support from their partners. (Among the most striking
findings was that of the 280 women in the pilot, only four had ever had their partner attend a single counseling session with them.) Research has subsequently confirmed that social support is an important determinant of treatment outcomes, and becomes increasingly important over time\(^2\).

Given what I knew about Namibia, it seemed reasonable to assume that women would have poorer treatment outcomes than men. Perhaps they would regain health more slowly than men, or show higher morbidity and mortality rates than male patients? Perhaps their lack of spousal support would be reflected in lower rates of participation in treatment, or poorer adherence? Namibia is still a deeply patriarchal country. ‘Patriarchy’ is a famously abused term, that and one that can be applied and misapplied to manifestations of power in a wide variety social structures and processes. Still, when I began this project many of the things that were traditionally assumed to derail HAART in sub-Saharan Africa – food insecurity, domestic violence, unemployment – seemed to affect Namibian women disproportionately. In such a context, lifelong adherence to powerful drugs would surely be a struggle.

Ultimately, what I found was exactly the opposite. Nearly everything I found confirmed that men were generally worse off in every stage of HIV testing, treatment and care in Namibia than women. This is the story I hope to tell in this thesis.

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Methods

In studying rollout programs in sub-Saharan Africa, three countries stand out as early 21st Century ‘success stories’: Namibia, Botswana and Rwanda. Unique across the continent, these nations have managed to reach universal\(^3\) levels of ARV coverage. They also, therefore, offer a glimpse of what might lie ahead for other nations by indicating the challenges and successes associated with wider treatment coverage and a ‘maturing’ rollout scheme – in the earliest stages of rollout, benefits may be concentrated on small subsets of patients, especially the relatively well-off (Wouters et al 2007). Any of these three countries would be a reasonable place to study a well-established rollout scheme. I was also interested, however, in the forces of globalization and culture change – forces that are quite pronounced in Namibia. The country has held my interest since I first visited in mid-2003. I made subsequent research trips in 2006 and 2007, and returning for my dissertation research seemed an obvious choice.

Within Namibia itself, choosing a field site was fairly straightforward. The country is very sparsely populated\(^4\) and its population of 2 million is fairly widely distributed. Roughly two-thirds live in the country’s far north, spread thinly across rural areas. In most of the rest of the country the harshness of the climate, the locations of extraction-based industries, and paucity of agricultural land tends to concentrate people in small towns and villages. Most of the country is roughly divided along ethnic lines, except in the capital, Windhoek, and at the coast in Walvis Bay and Swakopmund. In 2008, Walvis Bay’s HIV prevalence was also higher than Windhoek, Swakopmund, and the aggregate national rate.

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\(^3\) Bearing in mind the specific caveats concerning the definition of ‘Universal Access,’ as discussed in Chapter 2.

\(^4\) With a population density of 2.6/km\(^2\), Namibia is the second-most sparsely populated country on earth, after Mongolia.
In Walvis Bay, I found a Namibian city that is also typical of an increasingly common form of African urbanity: heterogeneous in ethnicities, economies and aesthetics, Walvis Bay is in its own way more similar to Cape Town, Lagos or Nairobi than it is to other Namibian centers. It is arguably more dynamic, more mixed and more globalized than the capital. Walvis Bay is also an epidemiological powder keg: the HIV prevalence was estimated to be 21.4 in 2008 – well over the national average of 17.8% (MOHSS 2008). Walvis Bay, therefore, seemed like perhaps the most appropriate place for me to start asking questions about what lies around the corner for public-sector HAART not only in Namibia, but in other rapidly growing, rapidly globalizing cities in sub-Saharan Africa.

I had three main methods of research in Namibia, though like most anthropologists I found that many of my most enlightening moments occurred during conversations with colleagues or cab drivers, listening to pop music or reading t-shirt slogans. These serendipitous moments are virtually impossible to anticipate but frequently form the core of anthropological insight. After preparing my project in Toronto and waiting for visas and ethics clearance in Windhoek, I began my formal research in progressive stages summarized below.

**Key Informant interviews**

I relied on key informants to help me set my research agenda. I knew upon arrival in the field that I was interested in exploring the question of treatment outcomes. However, I suspected that gaining entry into the HIV community might be difficult, and that the paucity of published data on HIV in Namibia would require that I begin by doing a lot of groundwork with expert locals. Further, I hoped that starting with local experts would help me to avoid asking
redundant research questions. Lastly, I found great value in describing my research goals directly to key informants – some of whom were doing research of their own, and all of whom immediately intuited my agenda.

Finally, like many field anthropologists my key informants helped me not only as primary sources, but also as social gatekeepers. Although many of the medical professionals in Namibia are foreigners, they nonetheless tend also to be respected, trusted, and well-integrated members of their communities who are well placed to facilitate meetings and introductions. I was able to rely on some existing social connections when I started this project, but was constantly reminded that Namibia is a very small place. Personal relationships are the key currency of most transactions, and after learning about my project, my key informants were able to suggest others whom I should meet (and usually to furnish me with the personal introductions that are a golden key in Namibia).

My key informants were professionals in the field of HIV treatment, including nurses, doctors, administrators, counselors, and community outreach workers, totaling 13 people in all. Sampling was hierarchical and opportunistic: I began by introducing myself to (and seeking research clearance from) the directors of local organizations. In most cases these officials became informants; they also suggested further interviewees, and introductions then proceeded in a snowball fashion. I followed a semi-structured interview protocol, asking a set list of questions and allowing unlimited time for meandering answers and follow-ups.

Interview sessions with key informants were held in private, by appointment, at the workplace of each interviewee – primarily the hospital, clinic and testing center. In every case, sessions took place behind closed doors. I did not make audio recordings of these interviews, but wrote responses in my notebook at the time and then wrote more comprehensive
interview notes immediately afterward. Throughout my time in Namibia I used audio recording sparingly. I found that the presence of a recording device, however unobtrusive, was often enough to make interviewees self-conscious and to colour their responses. Notebooks, on the other hand, rarely seemed to arouse much interest.

Out of respect for the confidentiality of our conversations, I do not individually identify any of my key informants. Where the data they offered to me is described in this text, it is anonymized but not aggregated. Further, their own demographic identifiers (including years of service and level of training) are described in the aggregate rather than individually. Walvis Bay is a small place; although all of my key informants participated freely and signed consent forms, these extra degrees of discretion seem warranted. More detail about the process of these interviews, and a description of the results, is in Chapter 4.

Clinical Data

After setting my agenda through my first round of key informant interviews, I began collecting clinical data. I hoped to use quantitative information from the clinic – specifically, demographic information on indicators like mortality, morbidity, presenteeism – to check the impressions offered by my key informants. Ideally, these clinical statistics would verify (or at least elaborate) their instincts.

When I arrived in Walvis Bay, the HIV clinic was located near the center of the downtown, several kilometers from Kuisebmond. The old, run-down building had an unused room that was turned over to me to begin my quantitative analysis. My first step was to get some sense of the patterns in mortality among the clinic’s patients. Mortality is a ‘blunt’
statistic, but is also unequivocal and universally salient in a way that some other outcome measures are not.

I did this manually, starting with an analysis of the ‘death ledger.’ This is a hardbound notebook kept at the clinic and updated by the head doctor, noting the specific details of all the clinic’s patients who had died in HIV care. On page after lined page, the doctor’s own careful hand spelled out each victim’s ID number, date of death, date of birth, and usually a cause of death. I combed through these results, attempting first and foremost to create a set of basic descriptive statistics for the demographics and clinical details of patients who had died in care. The results of this basic analysis gave me my first rough thumbnail sketch of outcomes (albeit at the broadest possible level) at the clinic.

Halfway through my stay in Walvis Bay, the HAART clinic moved to a new, purpose-built facility. The new building was clean, spacious, well equipped, and integrated with TB services and general walk-in care. Most importantly, this building was located in the township itself. The move was vitally important for patients, who were spared a long and tiresome walk – or an expensive taxi ride, given Walvis Bay’s lack of public transit. In retrospect it seems bizarre that the ARV clinic was ever not located in the township, since virtually all of its patients live there.

For my research, one of the most important aspects of this move was a rationalization of the clinic’s record-keeping system: records were moved into a dedicated room, and the computerization of patient files accelerated greatly under a team of full-time data clerks. By

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5 The question of causes of death is complicated in HIV care, and has some bearing on this thesis. Some mortality is quite clearly non-HIV related (accidental deaths, for instance, of which there were a few in the ledger). However, many natural-causes deaths in HIV patients are difficult to parse out; this remains a topic of debate in the medical literature. Even in the case of suicide, should patients who may have developed AIDS dementia or taken contra-indicated medication (the impact of certain HIV medications on suicide rates are discussed in Chapter 5) be considered AIDS-related deaths?
the end of my stay, I was able to generate reports from the clinic’s database on virtually all patients quickly, and fairly easily retrieve files from the records room. It was a tremendous improvement and opened a window into a substantial body of data. Therefore, after my initial work with the death ledger, I used the clinic’s computer database to explore broader trends in treatment and care. I was interested in exploring patient demographics, and in using the database to identify trends in pathways through HIV care, including delays between diagnosis and the initiation of treatment, rates of loss-to-follow-up, incidence of complications and frequency of changes in drug regimes, and so on.

I was also able to identify trends at the individual patient level, including changes in body mass and CD4 count. Finally, I also gathered data on voluntary counseling and testing and on HAART; I was primarily interested in using descriptive statistics to understand broad trends in presenteeism and outcomes. Walvis Bay’s patterns in voluntary counseling and testing are indeed unique; I describe this at more length below. My analysis was based on data collected through standard monitoring and evaluation processes at New Start, the government’s public HIV testing center in Kuisebmond. New Start’s clerks carefully tracked visitor information each month; they were able to generate anonymous reports outlining how many patients had presented for testing, and further break down this group by gender, HIV status, and other indicators.

Accurate data can be notoriously difficult to gather in developing countries, a fact driven home by the difficulty of finding consistent estimates of Walvis Bay’s population. I am quite confident in the quality of the data I gathered from both the clinic and the testing center, however; both use well-trained clerks to manage comprehensive modern monitoring and
evaluation programs. Further, clerks were invariably conscientious about ethical concerns and worked with me to ensure the data I used was appropriately anonymized.

My main goal in gathering quantitative data was to see whether my key informants’ insights were verifiable and quantifiable. Further, I wanted to develop a sense of the broader context that surrounded individual patients in the clinic. My use of analytic statistics is relatively limited; because I am using secondary data, the analysis is necessarily post-hoc and not the result of a purpose-designed cohort. Nonetheless, the statistics serve to corroborate my key informant interviews and to link the experiences of individual patients with a broader context. The results of my quantitative analysis are presented in Chapter 5.

**Participant-observation**

At the core of my project was a long period of participant-observation. Anthropological research on HIV naturally tends to focus on the ‘observational’ rather than ‘participatory’ half of its traditional methodological dyad. In the era of AIDS, ‘participating’ in unprotected sex, needle exchange, or other such practices at the core of transmission seems at best questionable and at worst a reckless blend of academically unethical and personally suicidal (or perhaps the reverse). It might nonetheless bear mentioning that I was never romantically involved with any of my participants. There are a few examples of anthropologists writing about their sexual encounters with subjects; whether the sexual relationship was unrelated to the project, as with *Sneaky Kid and its Aftermath* (Wolcott 2002)

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6 *Sneaky Kid and Its Aftermath* was written by anthropologist Harry Wolcott, and included a discussion of the author’s sexual relationship with a young man who was participating in Wolcott’s study on public education. It has become a catalyst of sustained debate over ethics, methods, and the limits of the ethnographic relationship.
sexual encounters in the field the core of his ethnographies of gay communities in Europe by conducting post-coital interviews and detailing his experiences in his books (Bolton 1995). Though he acknowledges that some of his partners died of AIDS, Bolton maintains that he couldn’t learn what he did without sleeping with his informants, and that the perspectives that this sort of insight provides should play a larger role in informing HIV research and policy (Carrier and Bolton, 1991). More recently, Adams and Pigg et al (2005) have explored the ways in which development projects can overwrite (intentionally or otherwise) local sexual norms.

Monographs featuring first-person accounts of life with HIV remain relatively rare\(^{7}\). Although increasing numbers of researchers are committing to long periods of in-depth research in high-risk communities\(^{8}\), and to analyses of the ‘social lives’ of HIV clinics (Tantchou-Yakam 2009), if the only way to truly ‘live’ the experience of living with HAART is to be infected and take medication, HIV-negative researchers will always be doomed to observe at arm’s length. Instead, I prioritized participation in daily life in Kuisebmond, time spent with patients, and involvement in the clinic and the community center.

For better or worse, however, I did eventually have some small measure of first-hand experience of living with immune deficiency while in Kuisebmond. In 2009, I became seriously ill and was forced temporarily to leave Namibia for immediate treatment at a tertiary center. I was diagnosed with an autoimmune disorder and put on a long course of heavy immunosuppressison therapy. It was a surreal irony to find my immune system so hamstrung while researching HIV; the toll this illness and its treatment took on my physical and mental health was as close as I ever hope to come to personally enduring even the most minor trials of HIV infection.

\(^{7}\) One important exception is Samaria and Strand, 2006.

\(^{8}\) See for instance Hunter, 2010.
Like people living with HIV, I feared contracting coughs and colds; even paper cuts took weeks to heal. HIV suppresses immune function virally by disabling T-cells; my medication suppressed it chemically, especially by inhibiting normal inflammatory responses. At least superficially, though, the results were similar. I developed fungal infections and eventually drug-induced hepatitis that yellowed my eyes and skin. While some antiretrovirals can cause lipodystrophy that disfigures the face, I suffered the trademark facial swelling of Cushing’s syndrome (sometimes called ‘moon face’). When I left Walvis Bay, my primary condition – uveitis – had stabilized and my drug regime was starting to wind down. It took another year for the side effects of my immunosuppressants to wear off.

I won’t suggest – for a moment – that I can understand the horror of an HIV diagnosis, nor living with the stigma that it often carries. Nor will I suggest that my illness was as harrowing as HIV, or HIV as comparatively minor as my autoimmune problem. But I did experience at first hand – through participation – some of the singular anxiety and depression and the quotidian mundanity (pill boxes, endless checkups, countless blood tests, side effects and drug schedules) where some seeds of understanding the treatment experience lie. Like many of the patients I worked with, my illness (and its aggressive treatment) sometimes terrified me, and sometimes it was merely a distraction. And sometimes – albeit rarely – it disappeared from my mind altogether.

Ethics

My research project, including my interview protocols and use and storage of data, were given ethics clearance by the University of Toronto’s Office of Research Ethics (Protocol
Reference #23246) and by the Office of the Permanent Secretary of the Ministry of Health and Social Services of Namibia (Reference 17/3/3).

I chose to work only with patients above 18 years old, Namibia’s age of majority. I have several reasons for this decision, though there is a great need for more research on paediatric HIV. There are challenges in obtaining informed consent from children, particularly for speaking with them at length about medical problems. Practically speaking, there are also some difficulties: very few HIV medications exist in paediatric formulations, especially in the developing world, and many laboratory tests (including CD4 and Viral Load) and even standard measures like BMI are not advised for use with children. This makes meaningful quantitative comparisons across groups of child patients difficult. Lastly, anthropological research on paediatric HIV patients – particularly the sort of research I intended to conduct – introduces complicated epistemological questions: what can we learn about child patients qua children and qua patients? Are children indeed ‘agents’ of their own care, or are they rather ‘indices’ of the care offered by their adult guardians?

Patient confidentiality is a central pillar of ethics in health research. In most important ways, maintaining patient confidentiality in this project was straightforward and proceeded exactly as I had anticipated pre-departure. The clinical data I accessed via computer was stripped of names immediately, leaving each patient a virtually anonymous entry in the database. In fact, reports were generated from the start without names attached to patients at all, only numbers; at least with quantitative patient data, names were not stripped per se, so much as not even present in the first place. Although I treated each entry with the respect it deserved as a human being, I was able to examine the entirety as anonymous numbers.
Stored data was handled in accordance with the University of Toronto’s “Data Security Standards for Personally Identifiable and Other Confidential Data in Research.” This document is largely based on the “TAHSN Security of Personal Health Information Used for Research Purposes,” a set of guidelines governing all stewards of personal health information across the University of Toronto health science network. Per these guidelines, and as mentioned above, my quantitative data was always de-identified from the earliest possible stage. Further, this data was stored locally, on my own computer, and was never connected to a server locally or accessed remotely. I used hardcopy very rarely – on just three occasions I used hardcopy printouts of (de-identified) attendance statistics from the NewStart Testing Center. In my home, my own computer was stored behind a locked door and always password-protected.

I recorded information from key informants and ethnographic subjects in field notebooks. Their names were always coded immediately upon entry, and the coding key kept separately (in a different room) from the notebooks themselves. Before beginning interviews with new participants, I explained my work carefully and went through a waiver-signing process. Above all, I prioritized informing my participants and ultimately trusted in their ability to make decisions about their ongoing participation.

During my time in the field, I did not experience any adverse events that required notifying the Office of Research Ethics at the University of Toronto, nor the Research Office of the Namibian Ministry of Health and Social Services. More practically, though, I encountered

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11 This document is itself grounded in the Province of Ontario’s 2004 Personal Health Information Protection Act, a widely accepted standard for best practices in clinical care and research.
situations in my day-to-day life that presented personal ethical challenges for me. Once, walking through the clinic, I ran into a woman I knew from a store I shopped at in town. I had no idea she was a patient at the clinic, and I suppose she’d had no idea I worked there. Should I acknowledge her presence, or pretend not to see her? It was these fleeting moments that presented me with ethical challenges. In the end, I did sit down with her and have a conversation. She had some time ago been diagnosed as HIV-positive; she was in counseling though not yet treatment, and doing very well. I assured her that I would tell nobody that I had seen her at the clinic; she brushed this off and said it was no problem. This ultimately was another situation in which I seemed far more preoccupied than the very pragmatic people around me.

In Kuisebmond, I stuck out. As mentioned in Chapter One, I was one of 3 whites in the township (out of a population of perhaps 50 000), and the only one with a car. My old blue truck became readily recognizable, and I was often surprised by friends and colleagues piecing together fairly accurate schedules of my movements based on where various people had reported seeing me driving. I worried that I might develop something of a ‘King Midas effect’ – if I became both easily recognized and closely associated with HIV, it might be problematic for patients to be seen talking with me outside of the clinic. There are limits to how much I would ever be able to ‘blend in’ while living in the township.

However, I was involved in a handful of activities outside of my work at the clinic. First, in day-to-day conversations I generally told people that I worked at the Multipurpose Center. The Center was known to work in HIV outreach, but was equally well known for work in so many other aspects of community life that my work there would not automatically be associated with HIV. Further, the center had hosted foreign staff in the past – many in positions
completely unrelated to HIV – which made my presence there unremarkable. Second, I was involved in opening a bicycle shop in Kuisebmond through the Bicycle Empowerment Network, an international NGO. The shop was successful and well known in the township, and I was happy – for several reasons – to be closely associated with it.

Finally, I regularly adapted to the different interview preferences of my participants. I sometimes found patients wanted to have impromptu chats on the street. Some preferred to talk in my car, parked somewhere quiet. Others insisted that we speak in their homes, or in mine. I met with some patients at the clinic, and others at the Multi-Purpose center, and some chatted with me by mobile phone. One of the most powerful and insightful conversations I had in all my years in Namibia took place huddled under a blanket in the bed of a pickup roaring down the highway. As a general rule I simply rolled with these situations as they unfolded, accommodated the conversations whenever and wherever they arose, and above all tried to err on the side of discretion and informed consent.

It is important to acknowledge my own positionality here. My identity as a white male undoubtedly affected what I experienced in the field, and how I subsequently interpreted those experiences. To some extent this embrace of the inevitability of subjectivity is the entire point of ethnographic research and what distinguishes it from the empirical sciences – as Latour and Woolgar (1979: 247) once noted, “the only difference is that they have a laboratory. We, on the other hand, have a text.” I discuss gender at great length in this thesis and my subjective experiences of it are important; in particular I think my ethnographic interviews were probably shaped, more so at first, by my gender. Further, I have no doubt that I was received differently in Namibia generally because of my identity. Being white and male carried some degree of
social privilege that I was able to lever to my advantage in some situations. I moved with comparative ease through some of the country’s bureaucracies, for instance, and was able to more comfortably and safely inhabit some of the male spaces in the city: I walked the streets in the evening, I could visit the Mission to Seafarers at the port (which was closed to women), and I could move about the shebeens, or informal bars, near my house.

There were also some costs: it was also clear that even after a long period in the field, it was difficult for me to fit into Kuisebmond, especially given the city’s troubled recent past. People occasionally hurled racist abuse at me on the street, and in some of my interviews – particularly with women still committed to traditional Awaambo values – I struggled to pierce the veneer of polite deference that kept me at arm’s-length. My race came with a set of class assumptions: although many in the township considered me wealthy, I was of course a student with modest (by Canadian standards) means. I used to tell my Namibian student friends that the most important economic difference between us was not cash, but credit: when my health failed my insurance was quick to secure me a med-evac that would be out of reach for almost everyone else in Kuisebmond.

Some gendered and racial stereotypes persist in work on HIV, and of course I write against that background. Hogan, surveying representations of HIV, remarks that “just as the Negress is a good, strong black woman – selfless to a fault – so is she a prevailing conception that structures many representations of women and AIDS . . . by and large, women’s puritanical self-abnegation is the bedrock of narratives and visual culture on AIDS” (2001; 130). Conversely, men are often depicted as belligerents in the war on AIDS – as predators or vectors. I hope that the things I learned from male patients helps to counter this narrative somewhat.
The better to engage with other perspectives, I sought the help of two local research assistants. Both were women a few years younger than me; one was Awaambo and one Damara. Adelheid is fluent in Damara and English (with Afrikaans a strong third), and had lived for several years in Walvis Bay. Frieda is fluent in Awaambo and English (she also speaks conversational Afrikaans); though born in the city, she had recently returned from university studies in Windhoek. These women helped me with translation and facilitating interviews, and regularly met with me to check my interpretations of information I had gathered. More generally, they explained and unfolded countless aspects of life in the township, telling me stories and jokes, inviting me to events, and introducing me to people. I was extremely fortunate to have their help: obviously as black women from different tribes, we could among us combine a variety of insights. More importantly, both are sensitive interviewers and thoughtful interpreters, and caring friends; unsurprisingly both went on to successful professional careers shortly after I left Namibia.

As a whole, these research methods gave me a multifaceted view of HIV treatment – and life in general – in Walvis Bay. The data that I gathered, along with reviews of literature and secondary data, form the basis for the rest of my thesis. In the chapters that follow I present my main findings, and attempt to contextualize and analyze them. I begin with the results of my interviews with my key informants, who almost unanimously and spontaneously told me that women fared far better than men on HAART.
These men of ours... they have such small, fragile hearts.

-HIV Counsellor, Walvis Bay

To begin exploring the question of patient outcomes in Walvis Bay, I asked medical professionals, counselors and NGO staff members about their impression of the HAART rollout. My main hopes in conducting these key informant interviews were to identify key trends in outcomes, refine my research questions, and find a place in the local HIV community. Below, I present the results of these interviews.

My interviews began with a long, rich discussion with two key informants at the HIV clinic on a Monday afternoon in 2009. The building was quiet, slowly unwinding in the lull before closing time, and we had already been talking for an hour when one of my informants started to describe patient outcomes in the clinic:

“Some people start treatment and they have no problems from the word 'go.' They come back no problem at the six-month follow-up, and their CD4 is up and they’re great. Then there’s another [patient] who struggles.”
“Why?” I asked. “What do your ‘star’ patients have in common?”

She thought for a moment, looking at the ceiling with a searching expression. Then she nodded, confident in her answer, and said,

“Mostly women.”

In retrospect, this conversation cemented one of the central themes of my research, and I spent much of the rest of my time in the field – including in my many key-informant interviews – exploring the issue of how gender and HAART interact.

Two important themes emerged clearly from discussions with my key informants. First and foremost is that the rollout program in Walvis Bay was a success: all informants described the program as working well, and of the three respondents who flagged problems, all agreed that the problems were isolated and individual rather than systematic. Second, most agreed that women had better outcomes than men. If the program was well established and operating as it should, why were men falling behind?

**Interviews**

My interviews were conducted with 13 key informants who worked in HIV testing, treatment and care in Walvis Bay. First sessions always began with an informed consent process, which included signing a waiver and answering a set of basic demographic questions (including job title, training, and experience). Next, I described my research; many of my informants were university-educated, and some were conducting graduate research.

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1 The report from a senior expert that paediatric patients fare best is very interesting, but beyond the scope of this study; I only include patients above 18, Namibia’s age of majority.
themselves. Most people appeared (or at least politely pretended) to be interested in learning about my project, and it helped to contextualize our conversations. In almost every case, the questions went both ways, and I found myself answering their queries about my background, my work, my family, and my life in Canada. Then, I conducted a simple 5-question interview. The questions were as follows:

1) What is your subjective impression of the ARV rollout program in Walvis Bay? What seems to work well, or not well?

2) Describe the patients you’ve worked with personally. (Age, gender, employment status, income, tribe, etc.)

3) What seem to be the main benefits of ARVs for them?

4) What seem to be the main challenges?

5) Thinking of the benefits and challenges of ARVs, how are these distributed among your patients? Do some benefit more than others?

I allowed unlimited time for answers and for follow-up, in a semi-structured/open-ended fashion. Our interviews almost always opened into long conversations, in which we revisited some questions or elaborated on them through anecdotes. I specifically chose this format in hopes of balancing two of my objectives. First, I hoped to gather data to answer my basic questions about treatment and outcomes; second, I hoped to get help in refining the next steps in my project. Following Davies (2008) and DeVault (1990), I maintained some control over setting the interview agenda, but sought to cooperate with my informants in mutually seeking out topics and allowing discussions to reflect changing understanding and shifting priorities. To this end I continued to meet regularly with all my key informants. I also continued to conduct interviews, albeit increasingly in the form of longer, unstructured, open-ended conversations, with all key informants as our relationships evolved.
In sum, the collected wisdom of my informants supports the hypothesis that real differences exist in treatment outcomes. These differences are not randomly distributed through the patient population, but instead follow a predictable pattern in which women ultimately fare better than men. The results of these interviews are summarized in Table 1.

<table>
<thead>
<tr>
<th>Informant</th>
<th>Role/Years Experience</th>
<th>Overall Impression of rollout</th>
<th>Which patients fare best?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NGO worker / 4 years</td>
<td>Most patients do well; visibly poor outcomes are a small minority</td>
<td>Women, are more active in care; the employed, the wealthy; those with support.</td>
</tr>
<tr>
<td>2</td>
<td>HIV Clinic Nurse / 4 years</td>
<td>Systematically good; problems are individual</td>
<td>Women</td>
</tr>
<tr>
<td>3</td>
<td>HIV Clinic Nurse / 2 years</td>
<td>Overall good</td>
<td>Women</td>
</tr>
<tr>
<td>4</td>
<td>HIV Clinic Nurse / 1 year</td>
<td>Good; marked improvements in health</td>
<td>Women; literacy is important</td>
</tr>
<tr>
<td>5</td>
<td>HIV Clinic Nurse / 2 years</td>
<td>Mostly good, so far</td>
<td>No big differences; perhaps women adhere better</td>
</tr>
<tr>
<td>6</td>
<td>HIV clinic Counselor / 3 years</td>
<td>It works well for 90% of patients</td>
<td>Women; hope for their families is most important</td>
</tr>
<tr>
<td>7</td>
<td>HIV Clinic Counselor / 3 years</td>
<td>Good; education is crucial</td>
<td>Women; they believe the disease could kill them, but men are in denial</td>
</tr>
<tr>
<td>8</td>
<td>HIV Clinic Counselor / 2 years</td>
<td>Mostly good; there’s a need for more education</td>
<td>Women; coloured patients fare worse than black</td>
</tr>
<tr>
<td>9</td>
<td>HIV Clinic Counselor / 1 year</td>
<td>Good; more people making healthy lifestyle changes</td>
<td>No big differences</td>
</tr>
<tr>
<td>10</td>
<td>HIV Clinic Counselor / 3 years</td>
<td>Good; patients are excited and generally happy</td>
<td>Women, motivated by their children; men drink too much</td>
</tr>
<tr>
<td>11</td>
<td>HIV Clinic Counselor / 4 years</td>
<td>Good; patients are becoming curious and more knowledgeable</td>
<td>Women; men don’t make lifestyle commitments</td>
</tr>
<tr>
<td>12</td>
<td>Medical Officer / 3 years</td>
<td>Good; many ‘Lazarus stories’</td>
<td>Children of both genders respond best</td>
</tr>
<tr>
<td>13</td>
<td>Medical Doctor / 2 years</td>
<td>Very good</td>
<td>Women; late presentation and co-infection, especially with TB, are major problems</td>
</tr>
</tbody>
</table>

*Table 1: Key Informant Interview Results*
Quantitatively, the results speak for themselves. Eleven of the thirteen respondents unequivocally indicated that they thought female patients fared best; one further interviewee agreed, but less strongly. Interestingly, the respondent who maintained that there was no important difference in patient outcomes had the lowest combination of training and experience of all key informants. I have not created a system to ‘weight’ experience and training in order to rank respondents; given the results it doesn’t seem necessary. Qualitatively, many of the topics raised and the ways in which they were discussed recurred throughout my time in Namibia.

Below, I discuss the results of these interviews with quotes from key informants, and place them in context with references to broader literature. The results are grouped into thematic areas for clarity in the order in which interview questions were asked. First, the general impression of the HAART program; second, the benefits of HAART rollout; third, the challenges; and fourth, the key differences in treatment outcomes between different groups of patients.

The HAART Program in Walvis Bay: Overall Impressions

Respondents reported that the rollout was a success. One experienced and highly qualified professional described the program overall as “very, very good” and related several stories of patients who couldn’t walk when they started treatment and were now back to being breadwinners for their families. He reported that default rates were very low, and that most failures were due to adherence problems and late initiation, rather than any sort of systemic failures with the program. One counselor suggested that although the rollout was very effective, there was still an unmet need in the coloured community: “we need to talk to our
people. They’re dying silently.” Too often, she said, the coloured community dismissed HIV as “a Kuisebmond problem.2” Although some respondents complained that the success of the program was hindered by reluctant or ignorant patients, most acknowledged that in general “the people are learning . . . about treatment, about nutrition – they’re becoming better patients.”

Perhaps the most striking endorsement of the rollout’s success was the nonchalance with which respondents met this question. In many cases, they would simply shrug and gesture as if to say, “look around!” To them the program was obviously stable, mature and meeting needs well.

Key Benefits of HAART Rollout in Walvis Bay: Patient Hopes

Among the most important effects of HAART rollout is the hope it gives to people, HIV positive to not. One counselor explained to me that many patients enter care in a poor state. They hope that, having made the step to acknowledge their status and seek care, they will recover quickly and “get their jobs back.” Then, she said, it is the counselor’s job to “put on the brakes,” to manage patient expectations and to “explain that this is a process.”

Several informants volunteered that the main thing their patients hoped for when entering HIV care was weight gain. Loss of more than 10% of body mass is considered an ‘AIDS-defining’ event – a hallmark of advanced HIV infection. Even the loss of smaller amounts of weight, however, can carry great social stigma, and thinness is obviously visible even from afar. Patients wanted first and foremost for HIV treatment to help them gain weight. (The wasting

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2 Henry Trotter reports the same phenomenon in Cape Town, where the coloured majority frequently dismiss HIV as a “black problem.” (Trotter 2010)
associated with advanced HIV infection has a long cultural history in sub-Saharan Africa: early cases of the disease were referred to as "slim" (as in, "He caught 'slim' in Kampala last year") in Uganda the 1980s (Serwadda et al, 1985). Fatness remains a valued cultural aesthetic in Kuisebmond; my wife learned this first-hand (and to her surprise) when my friends would greet her by remarking "you look nice and fat!" and repeatedly asking her, "are you sure you haven't gained weight?")

In Namibia I was frequently struck by the use of food imagery and metaphors; these seem to have common currency across much of the continent (Boddy 2015). People often complained about corrupt politicians or administrators by saying, “they’re eating our money.” Bread was commonly used as a metaphor, with men almost universally glossed as ‘breadwinners,’ (successful or otherwise), and women invariably preoccupied with ‘feeding their family.’ To emphasize the struggle to make ends meet during particularly hard times, people would exclaim, “we don’t even have bread!” Kentucky Fried Chicken was sometimes seen as the food of the working class, and more than once I heard blacks in Kuisebmond who had worked their way up the management ladder declare that they had ‘arrived’ by saying, “I’m not eating Kentucky.” The association between thinness, illness, and poverty was a complex and tightly woven one, and surely accounts for much of the stigma associated with wasting.

After weight gain, patients were concerned with dermatological symptoms; above all they were anxious to see their skin clear up. This is not always straightforward, however. HIV infection is associated with various skin lesions, but some antiretrovirals can cause rashes. Further, ARVs can cause lipodystrophy, often resulting in a unique body composition, including

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3 The history of the use of the term ‘slim’ is actually quite complex, and the subject of some debate. For a thorough discussion, see Thornton, 2008; pp 117-129.
sunken, hollow cheeks, a rounded belly, and sometimes a fat pad between the shoulders known as a ‘buffalo hump.’ Two counselors explained that these symptoms are particularly worrying to their patients: “people in the community are getting clever,” one remarked, adding that the general population of Kuisebmond is increasingly able to recognize the signs of HIV and side-effects of HAART.

The third most commonly reported goal of patients, according to key informants, was a general improvement in health. This was glossed in various ways, including a desire to “feel better” or to “feel like themselves again,” and was sometimes combined with broader goals, such as increased wellness or a sense of hope. Some informants reported that for many patients this improvement in wellness was measured against a social goal: "they want to be well enough to go back to work," or "they want to feel able to look after their family." One respondent described the “general improvement in the social lives” of many patients, including a renewed sense of being integrated in the community.

The first two categories of patient concerns are especially interesting, since cosmetic (non-AIDS-defining) weight and skin issues tend not to factor significantly in the clinical decisions taken by public-sector doctors in Kuisebmond. Body mass is regularly recorded during checkups (and can trigger an AIDS diagnosis), but CD4 count, viral load, liver function tests and haemoglobin counts are far more important in driving the course of treatment. From the clinician’s perspective, patients might be seen to be preoccupied with secondary or tertiary issues. From the patient’s perspective, however, the proximal threat is social stigma and its attendant woes, not renal failure or hepatotoxicity.
Testing

Structures in place for voluntary counseling and testing for HIV in Kuisebmond were mostly described as successful, and respondents felt that the availability of HAART buttressed testing efforts. According to key informants, men apparently turn out in substantial numbers4. “We have some days when it’s all men [at the Voluntary Counseling and Testing Center]” one informant said. She credited much of this turnout to the efforts of outreach groups, who promoted testing across the township. However, she felt that the greatest impacts had been from workplace promotion, where men were concentrated in higher numbers and perhaps more receptive to health messages. Indeed, the testing ratio used to be tipped toward women, but had reversed in recent years to such an extent that men now actually outnumber women at the government-run voluntary HIV counseling and testing center in Kuisebmond. This phenomenon appears to be unique to Walvis Bay; anecdotal reports from Windhoek, Swakopmund, and other centers suggest that women greatly outnumber men in Namibian VCT generally.

There were gendered dimensions in the cultural dynamics of testing itself, in addition to the demographics of patient turnout. One HIV counselor suggested that many men actually preferred the ELIZA test, because it involved a venous blood draw; it seemed a more ‘serious’ test. The new rapid test, which uses a drop of blood from a finger prick, did not inspire confidence: “if AIDS is so deep in the blood, how can a simple test find it?”

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4 I confirmed this with a review of the records of the Kuisebmond VCT center; this and other statistics are discussed at more length in Chapter 5.
The HAART Program in Walvis Bay: Challenges

My key informants also shared with me the challenges that hinder HIV treatment in Walvis Bay. Again, these responses were open-ended and unprompted, and have been grouped under thematic subheadings.

Pharmaceutical side effects

Interestingly, most key informants downplayed the difficulty presented by side effects. This might be written off as nurses and doctors trying to protect their professional turf, but HIV counselors and testers concurred. “Side effects? That’s one in a thousand,” said one respondent. Another suggested that something like "ten percent of patients might get side effects," but as long as patients are counseled to expect and understand them, side effects don’t present a major challenge. Clearly, the (orders of magnitude) difference between one in one thousand and one in ten is substantial; my reading of both responses was that my respondents were not trying to attach accurate statistics to the problem, but rather to use a figure of speech to convey that the problem was real but not significant.

A general consensus was that HAART was increasingly well tolerated and dosing increasingly well modulated, and that the availability of a broader range of second- and third-line drugs made switching regimes in the event of complications easier than ever. The clinic regularly tested liver enzymes (drug toxicity can damage the liver and prompt a change in treatment regimes; hepatitis and alcoholism are also highly prevalent in Walvis Bay) and hæmoglobin (the antiretroviral drug AZT can impair red blood cell production, and clinical ænemia is an indication to switch AZT out of a cocktail). However, drug substitutions were generally considered a straightforward event.
Stigma and Shame

Six key informants directly and without prompting mentioned social stigma or shame as obstacles to HIV testing, treatment and care. Broadly speaking, stigma was described as powerfully felt by many patients, and impeding care by preventing patients from presenting at the clinic, from learning their status, and from seeking support from friends and family.

One nurse explained to me that “it’s very hard for people to disclose [their HIV status] because of the way HIV has been socialized. It’s hard to explain this in Canadian English . . . but here most transmission is sexual, so people assume you’re promiscuous.” (We had recently discussed that transmission through injection drug use is much more common in Canada than in Namibia, so perhaps this is why she thought it might be hard to explain in ‘Canadian English!’)

Some informants suggested that this stigma might in some ways be gendered. One flatly stated “men are ashamed to be seen by others at the clinic.” Another offered that “if you test a man today and then give him a date for follow-up, usually he’ll come back. Things are going fine and he’s interested until you start talking about the treatment criteria . . . especially about treatment supporters. Then the face changes.” The 'social criteria" (that is, aside from medical criteria like CD4 cutoff, TB treatment status, or AIDS-staging) require that patients identify a 'treatment buddy,' who will share their contact information at the clinic and agree to join the patient for an initial counseling session. Finding a buddy therefore means disclosing to at least one person, but it also means acknowledging a degree of dependence and vulnerability that are unacceptable to many men, and part and parcel of the (stigmatized) social construction of HIV.

Conversely, a nurse at the HIV clinic speculated that “a majority of our female patients haven’t disclosed” to their partners. She guessed that most would keep their HIV status secret
from their partners for two to three years, if possible. Women, she said, disclose their status to friends, but not partners.

A counselor related one of the most striking anecdotes about the consequences of stigma to me. He described a typical scenario in which a woman discovers that she is pregnant; perhaps her husband is at sea or in the mines. At an early antenatal visit, she discovers that she is HIV positive. The woman is not working, and relies completely on remittances from her husband for subsistence - as such, she does not want to tell him about her status when he returns home. She makes plans to have a “traditional birth” in the north\(^5\) and possibly begins to default on her treatment. The child then misses out on PMTCT protection, and traditional birth attendants are sometimes uninformed and unprotected; he suggested that there are anecdotal accounts of traditional birth attendants becoming infected through their work. The baby then stays in the north with its grandmother (there are also, he said, anecdotal accounts of grandmothers and other caregivers becoming infected in this way), and the woman returns to Walvis Bay.

This anecdote illustrates the number of problems that are secondary to HIV stigma in Walvis Bay. It is obviously not stigma that makes women dependent on breadwinning husbands, that makes access to modern, sterile childbirth more rare in rural areas, or that leaves traditional birth attendants untrained in the prevention of mother-to-child HIV transmission. However, the entire story hinges on the fear a woman has of disclosing her status to the people she should be able to trust the most: her partner, her family, or her midwife.

\(^5\) The majority of Namibia’s population are ethnic Awaambos who live in the north of the country; “going to the north” is often shorthand for returning to one’s home village.
**Discrimination**

Stigma seemed less frequently to manifest as professional discrimination. One informant reported with some ambivalence that some patients fear “our Spanish bosses will fire us!” (Many of Walvis Bay’s major fishing operations are Spanish-owned.) In order for fishermen to get extended refills of medication and be excused from follow-up appointments, they need to present the clinic with some proof that they will be at sea for a prolonged period. The reluctance of fishermen to share their status with their employers limits the clinic’s ability to help fishermen manage their treatment\(^6\). The counselor followed on by explaining that fishermen cannot be fired because of their HIV status, as guaranteed by the constitution - this is clearly explained during counseling session. Still, “the message doesn’t sink in.” He wondered whether this was genuinely because of persistent misconceptions, or was based on fear and denial.

**Denial**

Interpersonal stigma was also reported to give rise to denial. I heard several variations on this story: “Sometimes you get a couple where the husband is on treatment and the wife is just trying to hide away and ignore things. This often leads to default.” In this case, stigma might be said to be preventing the HIV-positive husband from fully and frankly discussing his HIV status with his wife; it also prevents his wife from fully coming to terms with the situation and offering her husband support (or seeking support for herself).

Denial was variously described as a product of fear or of ignorance. One counselor who had volunteered at the National Testing Day in 2008 (an annual, nation-wide HIV testing event)

\(^6\) Importantly, even fishermen who do disclose their status and receive long-term drug refills can find themselves running short when they are waylaid by mechanical problems or foul weather.
remarked that ‘re-testing’ had been a problem. “People test positive at one location and don’t believe it, so they come to another location and re-test,” he explained. I thought that any test is a good test, and the cost of ‘retesting’ is one that the government should happily bear. However, my informant in this case was annoyed by re-testing and considered it a sign not of vigilance or personal responsibility but of denial.

**Poverty, Hunger and Unemployment**

Five respondents described poverty and related problems as impediments to successful treatment outcomes. For some respondents, poverty, hunger, and unemployment were so inextricably connected as to be virtually synonymous. A response that was representative of many was, “the people need food; they’re unemployed. Maybe five or ten percent have this problem.” One respondent offered a more nuanced approach, agreeing that “[hunger] is a problem, but it only comes out later.” She explained that food insecurity was usually a second-order concern after the more immediate problems of stabilizing seriously ill patients. Conversely, one informant who had immigrated to Walvis Bay from a substantially more impoverished African nation believed hunger affected many patients: “this country looks OK, but look closer on the ground and there’s lots of poverty.”

Some respondents, though, were skeptical: they acknowledged that patients cite hunger as a symptom but wondered about its clinical significance, its causes or indeed its authenticity. “People complain, but I don’t know. How many people really go to bed without a meal in this town? Maybe they complain because they think they’ll get something.” The clinic does in fact offer food supplements to patients who complain of food insecurity; one respondent said “when patients complain about hunger and poverty, when they complain that the treatment makes them weak and makes them struggle, we send to them to Médicos.” Médicos Del Mundo
is a Spanish non-governmental agency that operates in two Namibian regions, one being the coast. Among other services, they provide a food supplement called “e-pap.” E-pap is a corn- and grain-based meal, delivered ground to a fine flour in sacks. It is enriched with a broad variety of micronutrients, and designed to be whole meal replacement. Interestingly, the distinctive design of the sacks came to be recognized in the townships; one informant told me that women would often bring empty tins of Nestlé baby formula to the clinic, and fill them with E-pap before walking home.

The relationship between poverty and HIV incidence in sub-Saharan Africa is by no means straightforward. Poverty has traditionally been assumed to be a risk factor for HIV infection; Thabo Mbeki famously claimed at the 2000 International AIDS Conference in Durban that poverty causes AIDS (Boseley 2000). This commonsense assumption has been contradicted, however, by peer-reviewed evidence demonstrating a positive correlation between HIV incidence and income in sub-Saharan Africa (Shelton et al 2005; Vinod et al 2007). More recently, Parkhurst (2010) has confirmed the correlation between wealth and HIV in several African countries, but also noted that risk across wealth quintiles was evening out over time in some countries (and that a great variety between countries and genders persisted). This all suggests that the relationship between income and HIV infection is complex and dynamic, but it still seems safe to assume that, post-infection, greater wealth (and with it great

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7 I visited the coastal offices of Médicos Del Mundo and interviewed two staff members. MDM’s coastal offices are administrative and do not actually distribute product directly; instead, they give e-pap to suppliers, including the MOHSS. “Send them to Médicos” might therefore be a euphemism for providing food aid.

8 In retrospect this appears likely to be more evidence of Mbeki’s evolving hard-line ‘AIDS Denalism’ rather than a nuanced position on the political ecology of HIV.
access to food and medical care) should be protection. At present there is no comprehensive data assessing the relationship between wealth and HIV incidence in Namibia.

Although most key informants denied that pharmacological side effects were a major obstacle to treatment, some did acknowledge that pills could make patients hungry. HAART has been demonstrated to increase resting metabolic rate (Shevitz et al 1999), and increased sensation of hunger associated with HAART (and concerns about food insecurity) have been identified as a barrier to proper adherence in several sub-Saharan African countries (Hardon et al 2007; Weiser et al 2010). Further, micro- and macronutrient deficiency have been implicated in poor treatment outcomes (Marston and De Cock 2004; Fawzi et al 2004), suggesting that nutrition interacts with HIV and HAART in complex ways, and that the quality of a patient’s food may be as important as the quantity. I also noted that patients in Windhoek complained of increased hunger and the problems of food insecurity in 2003 during a study of a pilot trial of the PMTCT program.

Some informants commented on the gendered dimensions of labour in Walvis Bay and the ways in which this interacts negatively with HIV treatment and care. Although the city enjoys lower unemployment than most of the country (and particularly compared with rural areas) the most lucrative positions (mining and seafaring) are still male-dominated. Factory work (particularly at fish processing and canning plants) is almost exclusively female, however. Unemployed women are often dependent on breadwinning male partners or relatives, placing pressure on both parties. This impedes efforts to encourage full disclosure, and a fear of poverty means that, according to one informant, “women worry that they’ll get deported to the north.” I discuss employment as a gendered phenomenon in subsequent chapters.
**Stubbornness, Ignorance and Illiteracy**

Four respondents specifically described some combination of stubbornness, ignorance or illiteracy as challenges to diagnosing and treating HIV in Walvis Bay. Some saw this as a problem unique to the city, with one (foreign) respondent exclaiming, “we don’t read here! [Patients] have been four or five years on treatment and they don’t even want to know what they’re on! There’s no interest! They just say, ‘I take two white ones and one blue one.’”

United Nations data (United Nations Statistics Division, 2012) from 2010 place Namibia’s adult literacy rate at 89% for males and 88.5% for females, though in conversation several informants lamented the quality of the country’s public education system. Another remarked, “people still just don’t want to listen. Especially here in Walvis Bay, people are just so stubborn.”

While the tone was often frustrated, other respondents also seemed resigned or saddened by the profundity of the misinformation or ignorance that they had to confront on a regular basis: “some patients just don’t understand the need for HAART and adhering.” This message is especially upsetting coming years after the nation-wide rollout of HAART and the constant presence advertising and ‘social marketing’ about HIV. One counselor explicitly stated that “people who study do better,” citing the need for patients to be actively, knowledgably engaged in their treatment.

It was in this topic that more specific discussions about gender differences started to emerge, with respondents singling out men as particularly susceptible to struggling as a result of ignorance or stubbornness. One suggested that the needs of male patients demand a unique approach: “we need a program for men. Most men are just ignorant - they don’t even want to find out their results.” Whereas men “have a really hard time understanding and explaining to
their employers, and getting letters for their sea time, women who work at factories never need to disclose to their employers.

Ignorance was reported to be a problem not only in treatment but in testing, where men were sometimes more difficult clients than women. One HIV tester told me that more men than women are skeptical of testing technology, saying “if this virus is so small, how can you find it in the blood? How can it make me sick?” One informant, a counselor, related a striking anecdote about testing veterans of Namibia’s liberation struggle. “With the combatants, they’ll say ‘don’t talk to me about some virus. I’ve killed men, I’ve seen men killed.’” A counselor at the clinic said that fishermen in particular tended to wave off a diagnosis or a discussion about treatment by saying, “I don’t have time for that.”

In cases like these, it is difficult for me to distinguish between ignorance and fear, between fatalism and denial. My respondents also seemed despondent about these situations: “men have misconceptions that eat away at them. They get sick by their own thoughts.”

**Depression**

Only two interviewees mentioned depression specifically as an obstacle to treatment. “Patients aren’t telling the nurses about depression,” said one. “They are stressed at initiation, some of them even accuse the nurses of disclosing [their HIV status to others in the community].” Eventually, she told me, the clinic becomes a safe place, and patients are relaxed and even upbeat. “But,” she asked, “what happens when they leave here?” I discussed suicide with several key informants; in some cases this came up in the context of discussions about

---

9 By getting letters from their employers confirming that they will be at sea for long periods, fishermen are able to receive a large enough supply of ARVs to last their duration of their trip (instead of returning regularly for refills).

10 This history’s of Namibia’s ‘struggle’ is described in Chapter 1.
depression, or more broadly about gender differences in challenges and outcomes. I discuss the problem of suicide at more length in Chapter 5.

**Fear**

Four respondents described fear as a major barrier to treatment success. Undoubtedly, fear can also be tied up in anxiety about poverty, a consequence of stigma and discrimination, and can obviously be understood as a natural consequence of an HIV diagnosis. However, the ways in which fear was described were unique, and bear considering. In particular, all four respondents spoke of fear as a gendered phenomenon, ascribing fear more to one or the other gender, or speculating about different causes and effects of fear.

One counselor confidently said, “the most fearful people are the women. The men don’t worry, they don’t believe it can really kill unless they can see it.” This suggests not that men are unafraid but simply in denial. This was supported by a second counselor, who observed that “women have [male] partners, but they always come in with their cousins or something. I don’t know why - maybe the men are afraid. Yes . . . maybe the men are afraid - that’s why they don’t want treatment.” Her colleague sighed, “ah, it’s like we’re still in those years when the women have to do everything!”

Another counselor, though, had a slightly different view of how fear operated in his patients. Both women and men, he argued, were fearful when it came to testing, disclosing, and starting treatment. “Women are scared, that’s why they come in. The main problem for the men is shame.” He considered shame a combination of stigma and fear, and believed men were most ashamed of being seen by others as HIV positive – especially by being ‘outed’ by being at the clinic. He reflected that while fear seemed to drive women into the clinic, it also seemed to drive men away.
Differences in Treatment Outcomes

The question about how outcomes were distributed among the treatment population in Walvis Bay was the last one on my interview instrument. However, as is clear from several of the responses above, this question was already on the minds of many informants and emerged in other conversations. Eleven of thirteen respondents stated that women had better treatment outcomes than men. I summarize their responses below only briefly; much of the rest of this thesis is dedicated to exploring these questions.

Adherence

Five respondents cited adherence as a key reason behind differences in treatment outcomes. All agreed that women were more compliant, adherent patients. “Women are more eager to learn; they have better adherence,” said one. Another speculated that men were equally ‘eager’ in the clinic, but hamstrung by unhealthy lifestyles: “men want to take tablets, but they also want to drink and smoke.” This concern about substance abuse derailing HAART was echoed by another respondent, who emphasized the commitments required by treatment: “is a change . . . it’s harder for men to follow. They’re abusing alcohol more.”

Motherhood and Treatment Entry Points

Four respondents suggested that motherhood was an important factor shaping women’s outcomes for the better. “Women want to be there for their family,” one said. A second concurred: “Women are just women . . . they’re there for their families. They think, ‘if I die, who would look after my family? They adhere not only for themselves.” This was echoed by a third respondent, who also noted that the prospect of protecting their children from HIV motivated many women: “they’re happy to have negative children!”
During one of my earliest interviews, an HIV tester suggested that women have better outcomes than men because of “cultural” factors. She particularly emphasized what she called the “mothering instinct in our black culture” which causes women to prioritize the needs of (present or future) children. This, she felt, was a massive source of strength: “I’ve seen women who don’t even cry when they get their test results. One said, ‘that’s OK – I’m not the first and I won’t be the last. But I have to be strong.’” She contrasted this with the plight of men, who in her experience often seemed fatalistic, ignorant, or lost: “these men of ours . . . they have such small, fragile hearts.”

Importantly, motherhood offers a natural entry point to care that men lack: when women are found to be pregnant, Namibian doctors include an HIV test in their standard battery of antenatal care. Unsurprisingly, four respondents observed that women usually enter treatment earlier in the course of their illness than men. Conversely, one respondent guessed that the Tuberculosis Clinic was a more natural entry point for men than women, therefore men were often more sick than women when they arrived at the clinic.

Counselling

Two respondents argued that counselling had a major impact on treatment outcomes. One, who believed that women generally had better outcomes than men, qualified this opinion by saying that “once they go through counselling, men and women are the same.” Another long-time counsellor agreed that counselling was crucial, but argued that men and women experienced counselling quite differently: “men accept diagnosis with more difficulty. They are still ignorant – they don’t want to face reality.”
Conclusion

In these conversations, I was uncovering the core themes of my project. The ways in which my key informants suggested a nuanced approach to understanding how medical and social phenomena might play out differently in the unique context of Walvis Bay was instructive. I increasingly came to appreciate the city as a unique environment where a complex interaction of political-economic and socio-cultural forces shaped the experience that men and women had of HIV.

These interviews paint a picture of a HAART rollout that is stable, maturing, and in the main quite effective, though clearly more effective at capturing and retaining women than men. Repeated interviews with several informants working in various capacities in HIV treatment and care in Walvis Bay confirmed this. Once this consensus seemed firmly established and the themes it developed seemed saturated, I was curious to test my informants’ insights. Would their impressions be confirmed by the clinic’s own data? This drove the next stage of my research: a review of primary and secondary data on patient outcomes. The primary data came from the Walvis Bay clinic itself, whose computerized records made reviewing outcomes straightforward. The secondary data came from a systematic review of the literature on HAART in sub-Saharan Africa. I discuss this process in the chapter.
While there has been an expectation of gender inequality that favours men, the evidence indicates that we are doing a disproportionately poor job of providing them with the medical assistance they need.

-Edward Mills, Nathan Ford, and Peter Mugyenyi

I used the results of my key-informant interviews to guide an investigation of HIV statistics in Walvis Bay. Were my hunches, and those of my informants, borne out by the data? Were there meaningful differences in quantitative measures of patient inputs, like testing rates or points of entry? Or did differences emerge in patient outcomes, like mortality?

This chapter begins with an investigation of demographic indicators along six key stages of the HIV ‘pipeline’ Walvis Bay. These are: one, the population of the city itself; two, the HIV prevalence in the city; three, the New Start HIV-testing center; four, clinical intake, where patients are processed, counseled, and assessed for the readiness to start HAART; five, the cohort of patients who have actually started HAART; and six, the outcomes of patients on
HAART. I conclude the chapter with a comparison of the results in Walvis Bay with a broader survey of the literature on access and outcomes in sub-Saharan Africa.

**Step One: The Kuisebmond Population**

My attempt to estimate the population of Walvis Bay was not merely an exercise in frustration though, as mentioned in Chapter One, it was difficult. I proceeded with the goal of approximating roughly what proportion of the city’s eligible patients might be accessing treatment. By creating a flow chart of the HIV treatment and care process, I hoped to identify breakages in the pipeline.

Given the difficulties of estimating the city’s population, it is a complex and tentative matter to try to create a statistical universe for Walvis Bay. Without knowing exactly how many people are in the city, and exactly how many of them are HIV positive, we cannot properly discuss the city or all its HIV-positive, HAART-eligible citizens as a ‘population.’ Instead the analysis that follows must, strictly speaking, be said to describe those eligible who respond to the offer of treatment at the HAART clinic (since treatment is offered to all who know they are HIV-positive and otherwise eligible), rather than describing treatment itself across the city’s ‘entire’ population (Günther 2011). Since many of the data points (including national census data, clinic statistics, and municipal records) used to generate this statistical population were drawn at slightly different times and were presented with differing degrees of confidence, we must accept some margin of error as 'baked in' to the results.

Pepin (2011) has described the tremendous importance of cities with skewed gender ratios as incubators and amplifiers in the early history of the HIV epidemic. Indeed, to trace the early spread of HIV in Africa is to trace a map of gender imbalance in new African centers: from
Kinshasa to Abidjan in the west and Bujumbura and Kigali in the east, southward via Katanga to Zimbabwe, and thence to the mining communities of southern Africa. These cities all shared disproportionately high numbers of males, and rapid rates of socio-economic change.

Walvis Bay’s gender ratio is similarly skewed. The 2001 census reported that 58% of the city’s inhabitants were male; in the 2011 census this number had fallen to 54%\(^1\). In 2002, Billawer and Ekojo cited various unpublished sources reporting the city’s overall population as between 54% and 59% male; they also note that the sex ratio was most skewed in the townships, reaching 63% male in Kuisebmond. They further observe that Kuisebmond is by far the most densely populated part of the city, and home to roughly two-thirds of the population. They explain these demographic phenomena with reference to the town’s economic structure, suggesting that males were more likely to travel to Walvis Bay alone and secure employment before bringing partners or families to join them. They also cite the legacy of apartheid, under which only workers with employment contracts were able to stay in the city. The effects of Pass Laws on demographic composition have been well documented in South African mining communities (Campbell 2004).

It seems reasonable to expect that the lingering effects of apartheid – officially ended in 1994 in Walvis Bay – should fade over time. However, the city’s economic structure has not changed significantly during the same period, which may explain the persistent sex ratio difference and relatively slow rate of change toward gender parity. As a country, Namibia’s sex ratio has not changed significantly from 2001 to 2011: The national ratio was 95:100\(^2\) (or 51.3%)

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1 Namibia conducts their national household census every ten years. Since Walvis Bay was South African territory until 1994, it is unfortunately not included in the 1991 survey.

2 The standard international format for expressing gender ratios is (number of males):100 females; in the case of a ratio of 95:100, the percentage of males can be derived from \(\frac{95}{195} \times 100\%\).
female) in 1991, and 94:100 (or 51.6% female) ten years later in 2001. In 2011, that ratio had moved very slightly toward parity at 96:100, or 51.02% female, country wide.

In the 2011 census Walvis Bay’s population was listed as 61 300, of which 53.3% were male. Even city officials acknowledge that this figure was in all likelihood low; at the time their ‘working figure’ was 70 000 (Adams K, 2013). Beyond these official figures, we are forced to make some assumptions: assuming that the population distribution and gender ratios described above by Billawer and Ekojo have remained relatively stable, we can say that 40 867 (that is, two thirds of 61 300) people “officially” lived in Kuisebmond in 2011; 25 746 men and 15 121 women.

We have arrived at a ‘working population’ of 61 300 people in Walvis Bay, with a substantial bias, especially in Kuisebmond, toward working-age males. Given these estimates of the size of the population, and of the gender ratios, what might the burden of HIV be?

Step Two: HIV in Walvis Bay

Namibia's national antenatal survey estimated the country's prevalence to be 18.8% in 2010; in Walvis Bay, it was 19.6%. Bearing in mind that antenatal surveys only give HIV data among pregnant women (who are by definition at higher-than-average risk) that may or may not extrapolate accurately out into the general population, we should seek whole-population

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3 This gender ratio is comparable with some other extraction labour-based cities around the world. Fort McMurray, Alberta, for instance, is a community about the size of Walvis Bay: that city’s 2011 census showed a population of 61 370, of which 33 450 (54.5%) were male. Men were also over-represented (at just over 60%) among Fort McMurray residents who were neither married nor living with a common-law partner (Statistics Canada, 2012). The city is now the epicenter of a province-wide outbreak of syphilis (Government of Alberta, 2010) that may feature the highest per capita rates in Canada (Cutler 2008). Young men are considered the highest risk group for HIV in the city (Richardson, 2012). Ethnographic research has identified a number of structural factors that also make it difficult for young people in the city to seek out STI testing (Goldenburg et al, 2008).
estimates for HIV in Walvis Bay. Sadly, general population surveys of prevalence are very rare in Namibia; almost all the country's data is derived from antenatal surveys. The Namibian government has still never done a national ‘baseline’ survey.

We can, however, attempt to estimate the general population HIV prevalence in Kuisebmond by comparing two sources from Windhoek in 2008. In the 2008 antenatal survey, prevalence at the Katutura State Hospital (the public-sector hospital in Katutura, Windhoek’s black township) was 21.7% while in Walvis Bay it was 21.4% (MOHSS 2008). The Walvis Bay data is collected from 5 sites: two are located in Kuisebmond, two located in town (and frequently predominantly by black and coloured patients) and one in Narraville (the coloured township). It therefore seems reasonable to assume that the prevalence rates at Katutura Hospital and the Walvis Bay sites would offer a sample of roughly similar groups: predominantly black, poor Namibians of heterogeneous tribal backgrounds living in urban townships.

To date the only peer-reviewed estimate of HIV prevalence in the general population (as opposed to pregnant women) in Windhoek was conducted in 2008-2009 by Aulagnier and colleagues. They found an HIV prevalence of 14.6% among a representative sample aged 12 and above; 13.4% in males and 15.6% in females (Aulagnier et al, 2011). Assuming that the proportional relationship between antenatal and general prevalence is similar in both cities, we can estimate the prevalence in the aforementioned Walvis Bay sites:

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4 Importantly, antenatal prevalence for these sites diverged in the 2010 survey, with Katutura rising to 23.4% and Walvis Bay falling to 19.5%. This would of course yield a lower estimated adult prevalence for Walvis Bay in 2010, assuming a constant adult prevalence rate in Windhoek from 2008-2010.
\[
\frac{21.7}{14.6} \approx \frac{21.4}{x}
\]

Adult HIV prevalence in Walvis Bay \( \approx 14.4\% \)

Given the above assumptions, adult HIV prevalence would be approximately 14.4% in Kuisebmond in 2010. Further, assuming that the gendered prevalence rates also remain proportional, we can estimate that male prevalence in Kuisebmond at 13.2%, and female prevalence at 15.4%.

This appears, to date, to be the first general-population prevalence estimate for Kuisebmond. It is confounded by at least three things which are quite difficult to quantify: a skewed gender ratio, considering the usual difference in male and female HIV prevalence; the high levels of mobility in the city, which may involve a net gain or loss of HIV-positive residents\(^5\); and the city’s age structure, which is highly biased toward the working-age demographic which currently has the highest rates of HIV in Namibia\(^6\).

<table>
<thead>
<tr>
<th></th>
<th>Population</th>
<th>HIV-Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Males</strong></td>
<td>25 746 (63%)</td>
<td>13.2% (n=3398)</td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td>15 121 (37%)</td>
<td>15.4% (n=2329)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>40 867</td>
<td>14.4% (n=5727)</td>
</tr>
</tbody>
</table>

*Table 2: Population and HIV Estimates for Kuisebmond, 2010*

\(^5\) It is still unclear whether, in the aggregate, rates are more affected by HIV-positive migrants coming to Walvis Bay to seek medical care, or choosing to leave for their home region. In-country mobility is actually rather limited in Namibia. Of the country’s 13 regions, only in two – the Capital region, Khomas, and the coastal region, Erongo – was a majority of the population born outside of the region (Central Bureau of Statistics, 2010).

\(^6\) Aulangier and colleagues, cited above, calculated HIV prevalence for everyone over the age of 12; this is problematic since under-19s regularly have the lowest HIV prevalence in Namibia’s sentinel surveys (see for instance MOHSS 2010).
In sum and given the above caveats, it seems reasonable to suggest ~14.4% as a workable minimum estimate of general-population HIV prevalence in Kuisembond, broken down to 13.2% and 15.4% among males and females respectively (see Table 2 above). Using our population estimate of 40,867, this would yield approximately 5,727 cases of HIV in 2010: 3,398 males and 2,329 females. If this is the theoretical number of total HIV cases in the township, how many of them have actually been diagnosed?

**Step 3: Voluntary Counseling and Testing**

I frequently visited Walvis Bay’s “New Start” VCT clinic – a government-funded center for voluntary HIV counseling and testing in the heart of Kuisebmond. The New Start was a tidy, well-run place with comfortable waiting rooms and a professional staff. It was located near a major shopping center, and inside a compound that also housed the Walvis Bay Multipurpose Center and a daycare center run by a Catholic charity. Patients at New Start were given HIV rapid tests, anonymously and free of charge; patients did often have to wait in a communal waiting area or pass by one another in the corridors, but no names were ever used. Because of advances in rapid-test technology, waits were always short (generally just minutes), and the testing procedure always involved pre- and post-test counseling.

The New Start shared with me their monthly statistics from October 2008 to September 2009. These statistics offer a thumbnail sketch of testing access rates and of test outcomes; clearly, many people in Walvis Bay use the New Start center to learn about their status. Importantly, there are some other ways in which people might learn of their status that are not captured by this data: pregnant women are tested automatically (HIV testing is part of
Namibia’s standard battery of antenatal procedures), private doctors also perform HIV tests, and some companies in the city of workplace HIV programs.

During the 12-month period from October 2008 to September 2009, New Start performed 5697 tests. In total, 559 tests were positive; a rate of 9.8%. When disaggregated by gender, the figures show disparities in both access and outcomes (see Table 3 below).

<table>
<thead>
<tr>
<th>Gender</th>
<th>Positive</th>
<th>Negative</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>259 (8.8%)</td>
<td>2668 (91.2%)</td>
<td>2927 (51.2%)</td>
</tr>
<tr>
<td>Females</td>
<td>300 (10.8%)</td>
<td>2470 (89.2%)</td>
<td>2770 (48.8%)</td>
</tr>
</tbody>
</table>

Table 3: HIV test results by gender, Walvis Bay New Start Center, October 2008 - September 2009.

Slightly more men than women were tested at New Start across the course of twelve months. Women tested positive at slightly higher rates than men, however. By expressing these testing data in a four-way table (see Table 4 below) we can calculate the relative risk (RR) of a positive HIV test for female patients with the formula below:

\[
RR = \frac{a}{c} \div \frac{a+b}{c+d}
\]

Table 4: Relative Risk for male and female VCT clients, October 2008-September 2009.

Women in Kuisebmond were more likely than men to test positive for HIV at the New Start center, with a relative risk of 1.224 (p = 0.0121; 95% CIs 1.05-1.43). Put another way, of the total positive test results returned at VCT during the period, 53.7% were female. The fact
that positive tests occurred at New Start at a slightly lower rate than the population prevalence estimate above (9.8% versus 14.4%) suggests various interpretations, including that perhaps the highest-risk populations are being diagnosed elsewhere, or HIV-negative clients are returning for re-testing often\(^7\). That so many men are attending the VCT is itself remarkable, however, and several staff mentioned that the Kuisebmond center had had more success in attracting men to test than most centers in Namibia. They attributed much of this to outreach programs in shebeens and workplaces. Indeed, the national Demographic and Health Survey (MOHSS 2008c) reported that across all age groups 50.9% of women but only 32.0% of men in Namibia report having ever been tested for HIV and learned of the results.

This phenomenon bears further investigation: research in northern Namibia (Smith and Morrison 2006) has suggested that those who know HIV patients personally have fewer stigmatizing beliefs and a greater perception of personal risk; Creel and Remal (2011) use survey data to show Namibians who are interested in being tested are more likely to consider themselves at risk of infection, to have knowledge of testing facilities, and to have strong social support. The Kuisebmond VCT was well known and easily accessible, and considering the township’s high HIV rates, virtually everyone would know someone living with HIV. On the other hand, many people living in Kuisebmond are new migrants who have been separated from traditional structures of support.

However, considering the population and HIV prevalence estimates from Steps 1 and 2 casts these testing data in a different light. We have estimated that 59.3% of all people living

\(^7\) The VCT figures include patients who have re-tested, but re-testers are not disaggregated by gender or status. Overall, roughly 20% of all tests during the period were re-tests. This figure also presumably reflects the fact that, since women generally have higher HIV rates than men in Namibia, a testing clinic with a preponderance of male patients ought – all else being equal – to have slightly fewer positive tests.
with HIV in Kuisebmond are male, and yet they comprise only 51.2% of visitors to the testing center; gender parity would require an extra 451 male visitors per year. This suggests a break in the pipeline: although many men are indeed reporting to testing in Kuisebmond, a substantial number are missing.

Next, I wanted to find out what lay between the testing center and the clinic. Because these two facilities are a mile apart and operate separately, patients who have already mustered the motivation to test must then repeat the process anew at the clinic. Were patients who tested positive actually reporting to the HAART clinic and entering into care?

**Steps Four and Five: Inputs at the HAART Clinic and Entry into Care**

During my time in Walvis Bay, the HAART Clinic was in the process of moving to an electronic records system, and two full-time data clerks managed the computer system and produced monthly monitoring statistics for the MOHSS. In some cases, files were incomplete or ambiguous, but reviewing the clinic’s databases was generally fast and easy.

As described above, there are significantly more men than women in Kuisebmond’s general population. Men also outnumber women at the New Start testing center, albeit by a smaller margin, and made up 46.3% of positive tests in Table Two above. Are men therefore reporting to the HAART clinic in great numbers? A systematic review of 23 ART programs including over 200 000 patients across Africa (Druyts et al 2013) identified that men are significantly less likely than women to enroll in ART programs, continent-wide. In Walvis Bay, I found the same phenomenon: despite making up a smaller part of the general population and the HIV-positive population, women outnumbered men in treatment.
On their first visit to the clinic, patients report to a reception desk, where they are formally brought into the HAART process. For the purposes of clinic records, all patients who attend the clinic and undergo a first assessment are considered “in care.” This means that they are within the umbrella of the clinic, entered into its database, and eligible for a variety of services including counseling and antibiotic prophylaxis. As mentioned in Chapter 2, not all patients who are HIV-positive are eligible for HAART – eligibility depends on disease progression (or CD4 count) and a variety of social factors, including completion of counseling, identification of a treatment supporter, and a commitment to healthy living. In this section, we will analyze patients who are ‘in care,’ but have not started HAART.

In rural South Africa, Lessells and colleagues (2011) report that among patients who have entered general HIV care but are not yet eligible to begin ART, men have lower odds (OR: 0.80, 95% CI 0.67 to 0.96) of retention in care. Obviously much hangs in the balance during this tenuous period between intake and initiation; it is the source of much of the gendered attrition in Walvis Bay’s HAART program. According to absolute patient counts at the clinic, women outnumber men in both the pre-ART and ART stages (see Table 5 below).

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-ART</td>
<td>966 (41.8%)</td>
<td>1345 (58.2%)</td>
<td>2311</td>
</tr>
<tr>
<td>ART</td>
<td>1069 (47.7%)</td>
<td>1173 (52.3%)</td>
<td>2242</td>
</tr>
<tr>
<td>Total In Care</td>
<td>2035 (44.7%)</td>
<td>2518 (55.3%)</td>
<td>4553</td>
</tr>
</tbody>
</table>

*Table 5: Patients 'In Care,' Pre-ART, and on ART at Kuisebmond clinic, February 2009*

Considering our estimate that approximately 59.3% of HIV patients in Kuisebmond are male, men seem significantly under-represented at the doors of the clinic. They make up only 44.7% of patients in care. According to my key informants, the fact that more women are in the
pre-ART stage does not reflect higher female attrition at initiation. More likely, it is explained by the fact that men tend to arrive at the clinic at a later stage in their illness, requiring immediate initiation rather than the counseling, antibiotic prophylaxis, and ‘watchful waiting’ indicated for patients who present at an earlier stage of infection.

I tried to test this hypothesis by measuring health status at initiation, though this was difficult: I could only gather data on baseline CD4 count for a subset of patients (n=591) who had been entered into a separate research cohort. Men (n=269) had a mean baseline CD4 count of 140, whereas women (n=322) had a mean of 168.5. Both of these mean CD4 values are well below the indicated value for initiating HAART; men, however, have significantly lower values (p=0.0001). Population reference ranges for CD4 counts vary widely, but studies of HIV-negative baseline values in Kenya (Bosire 2013) and Senegal (Mair et al 2008) show women to have consistently higher CD4 counts than men; measuring the clinical impact of gender differences in baseline CD4 values in Kuisebmond is difficult since the clinic had no standardized method of recording morbidities. However, in South Africa (Bassett et al 2009) and Uganda (Mills et al 2011) patients with low baseline CD4 count are more likely to be lost from care and to die, even after controlling for gender.

I was also able to examine statistics for patients who had died after entering care, but before starting antiretroviral therapy. Though the sample size was small, the figures were stark (see Table 6 below):
Table 6: Deaths among HIV-positive patients in care but not on HAART, February 2009

Using the above table we can calculate that men were over six times more likely than women to die before starting HAART (RR 6.27; p=0.018; 95% CIs 1.36-28.93). The small sample generates adequate statistical power but warrants caution in generalizing the results. Still, it seems reasonable to suggest that the post-enrolment, pre-HAART stage is a crucial link in the pipeline, and one at which the attrition is disproportionately high for males.

Step Six: Treatment Outcomes

In this section, I analyze definite, quantitative treatment outcomes: default, loss-to-follow-up (LTFU), and death. In subsequent chapters I examine treatment outcomes more holistically, including a consideration of the lived experiences of patients themselves. Some of the data for this section was more difficult to gather, either because it was not computerized or because it was gathered and stored by various departments within the clinic (a defaulter’s file might, for instance, be held in the pharmacy department while awaiting a refill pickup, or eventually moved to the nurses’ station for filing). The sample sizes are also small: the clinic, fortunately, enjoys a fairly low mortality rate.

Patients were considered defaulters at the clinic after failing to report for three months. Because no central means existed of tracking all defaulted patients at the clinic, I instead used a

\[ RR = \frac{a/(a+b)}{c/(c+d)} \]

---

\(^8\) This notion is uncommon in much HAART outcomes research, as is the idea that survival itself actually constitutes an outcome.
random number generator to draw random samples from a selection of patients whose files were marked as ‘defaulters’ (n=47) and compared them with a matched sample of randomly-selected ‘adherents’ (see Table 7 below).

<table>
<thead>
<tr>
<th></th>
<th>Adherents</th>
<th>Defaulters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td>15 (32%)</td>
<td>27 (57%)</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td>32 (68%)</td>
<td>20 (43%)</td>
</tr>
</tbody>
</table>

*Table 7: A random sample of defaulters and adherents at the Kuisebmond clinic, February 2009.*

In this sample, men were significantly more likely than women to default (RR 1.67; p=0.0143). Default, of course, is not synonymous with death: defaulted patients can return and resume treatment. Still, as discussed at more length below, defaulters have disproportionately high mortality rates, and the fates of those determined to be ‘lost to follow-up’ in many HAART cohorts in sub-Saharan Africa are generally grim (Yu et al, 2007).

I studied all the patient deaths that occurred after starting HAART at the clinic. Of a total of 254 patients, I removed 15 who were minors. I also had to remove 84 entries that were incomplete, leaving 154 deceased patients with workable information. Patient deaths showed a marked gender disparity: of the 154 recorded deaths, 92 (59.7%) were male. Assuming that the ratio of male:female deaths at the clinic has remained constant, we can establish the relative risk of death for all males in care as of February 2009 (see Table 8 Below):
Table 8: All patient deaths at the Kuisebmond clinic as of February 2009.

<table>
<thead>
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<th></th>
<th>Died</th>
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<td>Men</td>
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<td>Women</td>
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Men are therefore almost twice as likely as women to die in treatment and care at the clinic (RR 1.799; p=0.0003; 95% CIs 1.31-2.47). Put another way, if men and women were at an equal risk of death, we would expect almost reversed numbers: a proportional distribution would be 69 male deaths and 85 female deaths.

I calculated time to death for all HAART-patient deaths (n=155) that were adequately recorded at the clinic (see Figure 4 below). The findings were surprising: of the patients who had been tracked from initiation to death at the clinic\textsuperscript{9}, males and females seemed to have nearly identical survival times.

That a majority of mortality occurs within approximately one year of initiation is an expected result based on research from elsewhere in southern Africa; Coetzee et al (2004) showed a virtually identical trend through 24 months of HAART for a large and well-established cohort in Cape Town. The final male death was recorded while 7 female patients still lived, though this occurred at 96 months (or eight years) after initiation, a remarkably long follow-up period for any HIV cohort in sub-Saharan Africa.

\textsuperscript{9} It is important to note here that these estimates leave out dead patients who are lost-to-follow-up or otherwise outside the clinic’s reach. I return to this problem below.
Three patient deaths during this period were due to suicide; all the suicides were male.

Durkheim's (2006) notion of the relationship between social control and suicide may be instructive here; as described in Chapter 8, women often reported that while their roles as mothers required them to care for their health – a role which would furthermore constitute an injunction against suicide – men were unencumbered by such obligations. Worldwide, women attempt suicide more often than men, but men generally use more lethal methods and succeed more often (Värnik 2012); the clinic did not formally collect data on attempted suicide. Mark Halman (2009) alerted me to the risks of the antiretroviral medication Efavirenz in patients of black and Hispanic ancestry; both groups carry a variation on cytochrome P450 that can disturb metabolism of the drug and increase the likelihood of psychological side effects, including suicide. However, none of the suicides described above had Efavirenz in their HAART cocktail.
In Summary: the HIV Care Continuum in Kuisebmond

Taken together, the above figures give us some impression of the gender dynamics of the HIV care continuum in Kuisebmond (see Figure 5 below). In short: men predominate in the general population in Kuisebmond, and more men than women arrive at the New Start center for HIV testing (though this difference is proportional to their ratio in the population). Men and women have similar rates of positive tests at New Start, but women report in greater numbers to the clinic for follow-up. Once they have entered care, women are more likely to initiate treatment than men; in care, however, men are more likely to die.

There are some very encouraging observations here, not least that men and women are readily accessing safe and free HIV testing in large numbers. However, it also seems clear that there are some gaps in the HIV ‘pipeline’ in Walvis Bay. Specifically, men are being lost between testing and care, and during the transition from ‘care’ to HAART. Many of these findings are consistent with studies of HIV treatment cohorts elsewhere in sub-Saharan Africa; below, I survey the literature on gender and HAART on the sub-continent, with particular attention to differences between male and female treatment outcomes.
Figure 5: Gender and the HIV care continuum in Kuisebmond, 2008-2010.
Gender and HIV treatment outcomes in sub-Saharan Africa: a Literature Review

In order to compare the findings from Walvis Bay with the rest of sub-Saharan Africa, I conducted a systematic review of the literature on gender and HIV treatment outcomes. I searched for: (gender OR sex) AND (HAART OR ART OR antiretroviral) AND (outcome OR survival), in the EbscoHost Gender studies database, the Social Science Citation Index, and Medline; the latter two indices were searched via Scholar’s Portal. I repeated this search protocol in the proceedings of the IAS World AIDS Conferences from Barcelona 2002 to Vienna 2010.

I limited searches to articles published between January 1995 and January 2013, and only reviewed articles published in English. Although I was concerned with sub-Saharan Africa, I accepted at first vetting articles from any country; results from outside sub-Saharan Africa were considered for comparison. Finally, I accepted only human-subject research, and, once again, excluded research on children. The primary literature review yielded 1267 articles, of which 63 met inclusion criteria. I subsequently conducted bibliography mining and a search for grey literature through Google Scholar.

The results were clear: across sub-Saharan Africa, men have worse treatment outcomes than women. When they arrive for treatment, they are older than women, are at a more advanced stage of illness, and suffer from more co-infections. This differs markedly from Europe (Moore et al 2003), North America (Nicastri et al, 2007; Cescon et al 2013; Meditz et al 2011) – the situation in Asia is more ambiguous (Braitstein et al 2008), though some studies show poorer outcomes among men (Chasombat et al 2009). Below, I discuss the main results of this literature review by thematic areas.
Immune Status at Initiation

Among the most important and consistently reported findings is that men generally begin HAART in poorer health than women. This is most obviously demonstrated by measures of both CD4 count and viral load at the initiation of treatment (though caution is merited in causally linking either measure with outcomes). This phenomenon is usually attributed to men presenting later in the course of their illness than women (having given the virus more time to progress) rather than any sort of innate difference in male physiology.

In Burkina Faso, Saleri and colleagues (2009) found that women present to the hospital for HIV care with significantly higher CD4 counts than men (166.1 vs 110.9); they speculate that this may be because women are often captured through PMTCT programs. In Tanzania, Mosha and colleagues (2013) report similar findings: men had an unadjusted relative hazard of death of 1.94. As noted above, men are also more likely than women to be lost after testing positive but before starting treatment. This liminal pre-treatment space seems disproportionately dangerous for men, a finding that is consistent in meta-analysis of programs across sub-Saharan Africa (Mugglin et al 2012).

Retention and Loss-to-follow-up

Male patients were consistently at greater risk of loss-to-follow-up (LTFU) than women. This phenomenon was observed in Tanzania (Hawkins et al 2011), Mozambique (Auld et al 2011), Uganda (Bajuirwe et al 2009), Cote d’Ivoire (Toure et al 2008), and Malawi (Chen et al 2008). The Malawian study linked male mortality to poor compliance and loss-to-follow-up, underlining the importance of simply remaining in regular contact with the clinic while on HAART.
Importantly, a separate study (Yu et al 2007) has explored the ‘true outcomes’ of patients reported as lost-to-follow-up in northern Malawi by tracking individual patients who had lost contact with medical care. Among a large cohort including central and peripheral hospitals, further investigations proved that fully 50% of patients reported as LTFU were in fact dead. In Mozambique, Caluwerts and colleagues (2009) report similar findings: among patients who could be traced after being reported lost-to-follow-up, 55% were dead. This suggests that high rates of LTFU among males may also lead to an underestimation of overall male mortality on HAART.

**Treatment Failure**

Several studies report that treatment failure, usually measured as persistently high viral load despite HAART, is more common among men than women. Barth and colleagues (2011) report that independent of CD4 count, male gender was a predictor of virological failure (OR 1.7, 95% CIs 1.2-2.3). In South Africa, a five-year follow-up with HAART patients near Cape Town (Boulle et al 2010) showed that female sex was independently associated with higher gains in CD4 count. In England, Moore and colleagues (2001) also find that men are at a higher risk of failure, and that women may achieve virological suppression faster than men.

Drug substitutions, the switching of one or more of the ARVs in a HAART cocktail, is sometimes used as a proxy measure to treatment failure: it can indicate the rise of drug-resistant virus or accumulation of intolerable side effects. In South Africa, Sanne et al (2009) report that women are in fact twice as likely as men to have experienced a drug substitution. They attribute this partly to women’s higher susceptibility to drug toxicities, and partly to the changes in treatment demanded by pregnancy.
Masculinity

Only a very small number of studies explore the importance of gender roles in treatment outcomes; most of the epidemiological studies cited above are primarily descriptive rather than critical, and virtually none use qualitative methods in any depth. There is clearly a need for more such research; this has been recognized for several years (Hirsch 2007), and some work has focused on gender as a social rather than biological factor in treatment. Fitzgerald and colleagues (2010), for instance, used ethnographic methods to describe HAART among men in South Africa as riven with complexities related to gender roles and alcohol abuse.

In rural Zimbabwe, Skovdal et al (2011) identify masculine gender roles as an obstacle to men’s access of HIV services. Importantly, they also separately describe (2011b) how masculinity can also interfere with women’s treatment; men’s refusal to engage with HIV generally means that women lack spousal support and often have to resort to taking ARVs secretly. A meta-review of HIV testing uptake across sub-Saharan Africa (Musheke et al 2013) reports that men may also remain the gatekeepers for women’s HIV testing, though women benefit from their roles as caregivers through increased access to medical care.

Mortality and the ‘First Inversion’

Overall, men in sub-Saharan Africa have higher mortality on HIV treatment than women: meta-analyses from across the continent establish male sex as an independent predictor of mortality (Brinkhoff et al 2009; May et al 2010). This finding is durable across many countries, including Malawi (Taylor-Smith et al 2010), Nigeria (Desilva et al 2009), Uganda (Kipp et al 2010; Alibhai et al 2010), Burkina Faso (Saleri et al 2009) and South Africa (Cornell et al 2009). As
mentioned above, this is the opposite of virtually everywhere else in the world, where men have superior treatment outcomes. This African ‘inversion’ seems persistent across time and, as noted above, between countries. Evidence for racial differences in ART metabolism and outcomes under statistical control are real but relatively minor (Gilbert et al 2009; Tedaldi et al 2008), which suggests that the factors driving excess male mortality in sub-Saharan Africa are social and environmental\textsuperscript{10}. The precise reasons why men have higher mortality rates than women are a main focus on this thesis, and bear much further study.

The Second Inversion

A second ‘inversion effect’ seems to be at play in the above-mentioned HIV studies. While in many developed-world research cohorts males greatly outnumber females (Soon et al 2012), the opposite is true in sub-Saharan Africa. Muula and colleagues (2007) performed a meta-analysis of 22 HAART studies in 7 countries across southern Africa and found that “proportionally more females are on HIV antiretroviral treatment than men, even when the higher HIV infection prevalence in females is accounted for.” This suggests that while rich-country HIV cohorts may be underpowered with regards to the outcomes of female patients, the opposite may be true in Africa. If men are under-represented in treatment and research cohorts, this impairs our ability to gather strong evidence and shape policy.

Conclusions

The data clearly supported the responses of my key informants, and elaborated on them in some ways. Men have poorer treatment outcomes than women in Walvis Bay, and on other measures including entry points and retention in care, they fare worse than women. These

\textsuperscript{10} I mean ‘environmental’ here not in the sense of ‘pollution,’ but in the broadest sense of the patient’s socio-political context, including built infrastructure and cultural milieu: a critical political ecology of HIV.
statistics offer a description, however – not an explanation. How do we explain this gender disparity? The next stage of my project was to investigate the reasons behind this disparity of outcomes by conducting long-term, in-depth ethnographic fieldwork, spending time with HAART patients at the clinic, in the community, and in their homes, to learn about their experiences of HAART. What about their daily life and their movement through the Walvis Bay ecosystem would explain their infection, their entry into care, and their pathway through treatment? What follows is my description of this process, and an elaboration of the lessons that a close study of the lived experience of HAART offers about the forces shaping treatment outcomes in Kuisebmond.
There was no respect anywhere left for him in his home, in the town, in the whole abandoned star.
- Graham Greene, *The Power and the Glory*

*With the information I gathered from my key-informant interviews and statistical analyses, I began the process of ethnographic research in Kuisebmond. My primary goal was to examine the daily lives of HAART patients in order to understand the factors that might affect their trajectory from infection through treatment. In order to do this, I recruited patients at the clinic. I posted signs soliciting volunteers, and asked councilors to discuss my project with potential participants. From these patients I sought narrative information on life histories, treatment journeys, and day-to-day experiences; I also gathered clinical information from their health passports. Through my time with them, at home, in the community, and in the clinic, I also made observations about their interactions with the world of HIV treatment, and the wider community of Kuisebmond.*

*My early work with the clinic death records had set several questions in my mind. One of the clearest lessons from that data was that men consistently arrived at the clinic later in the*
progression of their infection, and in worse health, than women. I came across one such example while reviewing the files of dead patients at the HAART clinic. In the halting prose of the Emergency Room, the attending doctor notes:

**xx/x/2007**


-11:10 Gasped and passed away. No breathing, no pulse.

Shortly thereafter, the doctor updated her now-dead patient’s record with a review of his condition. It provides a staggering image of a body that has been brutalized by immune deficiency:

- P.W.A, PTB Relapse, ?MDR
- Pneumonia, oral candidiasis
- O/E, chronically ill-looking, cachexic
- Severe resp. distress.

Translated, this terse list means that the patient was living with full-blown AIDS, and suffering from a relapse of pulmonary tuberculosis – possibly a multi-drug-resistant strain. He also had pneumonia when he died, and his body’s immune system was so weakened that his mouth and throat had been colonized by the sorts of fungal spores (candidiasis, or thrush) that normally grow on dead bodies. In addition to his severe respiratory distress, the patient’s body was wasted, withered, and feverish.

I read this patient’s file with horror. He was nearly the same age as me. An unemployed man in his 30s, he lived in shared accommodation and had named his parents as his treatment supporters. He had been as far as secondary school (‘junior high school’ in the
Canadian system) and was unmarried. He tested positive for HIV in September of 2005, and started HAART right away. His treatment seemed off to a good start: by December he had gained three kilograms, his adherence was good, and his doctor reported his response as ‘clinical’. No unusual laboratory tests indicate potential problems, and the patient himself reported no illnesses during that period.

In March of 2006, he arrived for a scheduled follow-up appointment having deteriorated significantly. He had lost over 5 kilograms – all the weight he had gained on treatment, and another two besides¹. His doctor decided to change his treatment regimen in order to avoid complications with an ongoing tuberculosis infection. Thereafter he disappears from the HAART clinic’s records; the emergency room doctor who was the last person to see him alive notes that he had been declared a defaulter after finding no record of antiretroviral prescription refills since March 2006. It was almost a year later, in early 2007, that this man staggered, gasping, into the emergency room, to play out the terrible scene described above.

Presumably when he initially tested positive, his illness had already progressed enough to start treatment immediately; why did it take him so long to enter care? When the downward spiral began, why had he waited so long, most likely in increasing agony, before seeking help? What had become of the parents who were supposed to be supporting his treatment? Pneumonia and candidiasis would be readily treatable with a straightforward short course of medication. Even multi-drug resistant TB could be treated free of charge in Walvis Bay; there were several TB-DOTS dispensaries² located right in the townships. His initial

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¹ This amounted to a 10% drop in body mass. The World Health Organization considers the unintentional loss of 10% or more of body mass to be an indicator of Stage II or Stage III HIV infection (WHO 2007).

² TB-DOTS stands for Directly Observed Treatment (Short-course) of tuberculosis. It is provided via small dispensaries housed in shipping containers throughout the township.
months of treatment had clearly improved his health, and held out the promise of improving it further. Why had this man come to the emergency room 10 minutes before he died?

While in Namibia, I read fiction by authors like Hemingway, McCarthy, Greene and Matthiessen. During cold Walvis Bay evenings, they were often a welcome distraction. I later came to appreciate, however, that what these stories had in common was that they concerned men – and men specifically, *qua* men – who had to struggle to survive while making sense of a world around them that had fallen apart. It’s not surprising that this thread should run through the back of my mind when I approached the bookshelves; in many ways it describes the world that I saw around myself daily, turning in a widening gyre. The old order was not holding, and the one that was replacing it was still in flux – the roles and the rules were unclear. Sadly, the books were almost invariably scripted more lyrically and their tensions resolved more harmoniously than the human drama that I saw played out daily in Kuisebmond. Below, I discuss the lives of some of the men I came to know there. In Chapter 8, I describe at greater length the question of masculinity and the ways in which social forces in Kuisebmond impacted on men’s lives.

* * *
Isaac

I first met Isaac\(^3\) at the community center. A 43-year-old from Damaraland, he had some training and experience as an electrician but when we met was unemployed. Our first meetings, across two successive mornings, were slow, difficult - at times painful. He was rail-thin and moved with obvious discomfort; he winced at the sunlight and appeared both glad to have company and almost impossibly weary. Isaac and I spoke in English and Afrikaans, both of which he spoke well. We sometimes were joined by Adelheid, my Damara research assistant; in some circumstances he preferred to explain complex matters to her directly in his first language. At first, Isaac spoke quietly, but occasionally flashed a smile and cracked a joke that hinted at the man he might have been in better health.

He enjoyed talking about his youth; a subject that usually lead to long – if sometimes rather wistful – conversations. Often his stories of the 'old days,' like those of many people I spoke to in Kuisebmond, were tinged with equal parts of magic and regret. Isaac related that as a child in Damaraland, he didn’t participate in “cultural things.” He remembered girls he knew going into isolation upon menarche, and then being brought out for lavish feasts. He fondly remembered the traditional dancing, “at weddings, at the King’s day feast,” and now felt sorry that he hadn't participated more actively in these things. “I saw them but didn’t experience them. When I was young, I wasn’t interested. I wanted to work in the fields, tending the donkeys and goats.” For him, as for so many in Kuisebmond, the past was very much another country: a place removed not only in time but in space, held over in the rural areas which were the preserve of 'tradition' and 'culture.' Kuisebmond was not so much modern as ahistorical; a place without a meaningful shared history and, for most, no real sense of a future, either.

\(^3\) No real names are used for patients.
Damaraland, conversely, is the ancestral home of the Damara, a KhoeKhoe-speaking group of pastoralists. The territory stretches from the inland edges of the Namib desert north of Walvis Bay to the Kalahari on the east. It gives way on its northern edge to the more lush and densely populated Ovamboland. Though the Damara and Nama (another KhoeKhoe-speaking group) had ranged in the area for many years, Damaraland’s borders were formalized when it became one of ten semi-autonomous Namibian ‘Bantustans’ under apartheid in 1980 (Sinvula 2005).

Isaac left Damaraland to come to Walvis Bay for work as a young man, during the South African occupation. I asked him about his memories of life under apartheid, and his response was surprising: of all his memories, life in Kuisebmond under South African occupation seemed among the fondest. “Back then, life was easy. There was no problem finding work, nobody was struggling, not like now. There were problems, but Kuisebmond wasn’t too strict. On the roads there were checkpoints, sometimes. Sometimes at night the police would come on raids, coming into your house and asking for passes. I worked as a labourer, in the factories – several jobs. And I was single, so I had money, and space to walk around.”

This notion - of having 'space to walk around,' is a central one in Isaac's story. Metaphorical space – whether it could be read as elbowroom, money, independence, or even sexual liberty – was something dear to him, and something he had lost. It was particularly interesting that he remembered his life under apartheid as one of relative freedom: in his story, HIV had been one of the most important forces that disrupted this life, impinging his freedom, and ultimately eroded his space to walk around.

I asked Isaac how he came to be diagnosed with HIV, and what his journey to care had looked like. He speculated that he had probably been infected by an unidentified sexual
partner; he had no particular interest in dwelling on this. The story of his test itself was similarly brief: “I went to the New Start [the government’s chain of Voluntary Counseling and Testing Centers] and was positive, and they sent me to the Coastal Clinic. First I fetched my sister and then we went together for follow-up. At the clinic they gave us counseling and a follow-up date, but I was scared and I ran off. I didn't want to believe it. I started drinking.”

Turning to drink at such a difficult time seemed reasonable, I supposed, particularly for someone already living in near-hopeless conditions; a ‘lost weekend,’ while regrettable and detrimental to health, is ultimately understandable.

“How long did this last?” I wondered. “A week? A month?”

“One year.”

My mouth hung open as we looked over his health passport⁴. By the time his sister managed to convince him to go back to the clinic, his CD4 count was 91 and his body was feebly fighting pulmonary tuberculosis; doctors placed him at WHO Stage II. He needed two months of in-patient care before he could be released and begin regular ambulatory HAART and TB-DOTS. He claimed that before his sister badgered him into seeking help, he was “thinking of going” for medical care himself; my Damara research assistant, Adelheid, and I were both skeptical of this claim.

This episode was sobering for Isaac, however. He stopped smoking and drinking, altogether: "one day I look at the bottle in front of me . . . I pushed it away. Aah, my life . . . sorry." His recounting of this period suggested that it marked a major shift not only in his behavior but perhaps in his personality. Throughout all the conversations we’d had to that

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⁴ Patients in the Namibian public-sector health system are issued ‘Health Passports.’ These documents look rather like an old Canadian bankbook and are used to record key data from each health visit. Between visits they are held by the patient, rather than at the clinic.
point, Isaac was able to speak about his previous self with a levity that seemed impossible in the present. It was hard to escape the impression that HIV had left him not only ill, but broken.

Since stabilizing on TB and HIV treatment, Isaac said that he has also made peace with his HIV status, rather than blaming or questioning himself. "It has come and I must accept it," he said. He also offered that he has "put [his] faith in God," though in retrospect Adelheid and I were unsure how exactly he meant this. To us, it seemed more likely that this was a sign of his acceptance and resignation rather than his piety per se. Since then, Isaac reported, the course of his treatment was straightforward - his visits to the clinic were fine and he was satisfied that his health was slowly improving (see figure 6 below).

Figure 6: Twelve-month change in Isaac's Body mass (in kg) after initiating HAART

HAART was obviously working as it should for Isaac; clinically he was responding well and needed nothing more that could be offered specifically at the clinic. Instead, it seemed that Isaac's challenges came primarily from his home life, which he described as a morass of betrayal, mistrust and desperation. When I asked him whether he had any specific challenges with HIV, the first thing he said was, "if a woman's friends tell her to go to the clinic, she says,
'OK!' But men will say, 'ayé! Oclinical!' It’s not good." Below, I describe some of the challenges he encountered.

**Food**

Among the most pressing concerns for Isaac was food: he simply was not able to access a steady supply of healthy food on his own. Further, when he did manage to secure food, he wasn’t able to refuse when his dependents (several step-grandchildren; he had no biological children) asked for it. He reported that his wife and stepchildren sometimes stole food from him, and that when they had food of their own, they would eat it privately in their rooms rather than share with him, claiming, “there isn’t enough.” As a result, Isaac said that he often had to take his ARVs on an empty stomach, and would then lie awake the whole night with hunger pangs. His descriptions were not of a household trying together to meet the challenges of poverty. Instead it seemed very much that Isaac’s family members were willing to actively sacrifice him in order to secure more for themselves.

The relationship between food security and HIV outcomes is positive and well established: in Uganda, food-insecure patients are more likely to default (OR 1.56, 95% CIs 1.10-2.20) than those with a reliable food supply (Weiser et al 2014). Anema et al (2009) point out that food security and HIV are often complexly intertwined, as clearly seemed to be the case for Isaac. A lack of food impacted negatively on his ability to stay on treatment, and his health suffered as a result. This in turn undermined his ability to find work or otherwise secure support himself, making his food security more precarious still.

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5 Though his first language is Damara, Isaac was speaking here in a kind of Oshiwambo creole which, as mentioned in Chapter 1, is common in Kuisebmond. “O Clinica” is a common example of appropriating foreign words into Oshiwambo with the article "o" and an appropriate suffix. Factories, for instance, were usually called “O Fabrika” after the Portuguese.
Family

Isaac confided that his wife didn’t care about his health, and didn’t support him emotionally or materially. Although she was also HIV positive, she continued to smoke and drink. Isaac’s sister was mostly supportive but would also, sometimes, withhold her support. One woman who lived nearby had been a regular source of support: she had employment and would occasionally offer him food. However, she worked until late in the evening, most days, and Isaac found that walking to her house in the cold while suffering with his sore feet (possibly attributable to peripheral neuropathy, a painful side effect of some ARVs) quite difficult.

In all of our conversations, in fact, Isaac only fleetingly mentioned his wife, and lingered barely longer on his sister and his extended family in Damaraland. Here again he seemed not only ill but alone – cut adrift from relationships with friends and family, and relying on his own meager resources to survive. Positive social support has been identified as an independent predictor of successful HAART outcomes in South Africa (Wouters et al 2009); clearly Isaac suffered for having nobody to rely on.

Masculinity

Several months after we first met, Isaac and I had a long conversation about masculinity. We often chatted about more mundane, day-to-day things, while sitting in my car or waiting at the clinic. This time, however, we met in mid-summer at the community center. His health seemed better, and he warmed to the more philosophical topic quickly. “It’s always tough to be a man in Namibia. Women always get their way.” He offered that whenever he went into shops, the clerks invariably helped female shoppers but not him. I sensed that there was more
to this situation than a frustration with discrimination at shops, though, and prodded him further.

Eventually his thoughts coalesced into a meditation on gender roles in Kuisebmond. Isaac felt trapped by the impossibility of achieving masculine ideals, particularly in Kuisebmond’s cutthroat cash economy. “Even at home, men have the responsibility to feed the family. They always say, ‘Men are the breadwinners!’ and if you can’t feed your family, people blame you, insult you.” Isaac sometimes avoided my eyes, or sighed with an air of resignation or defeat when we spoke. Now, though, he gathered himself and said with a rare strength and conviction: “if you’re not a breadwinner, nobody cares. Nobody sees you.”

For many months afterward I remembered the power of that statement as it hung the air. Sick, alone, and bound by gender roles that marked him as a virtual non-person, Isaac saw no future for himself in Kuisebmond. These themes reverberated months later in conversations we had about his plans for the future. At that moment, though, I remember the depth of Isaac’s emotional desperation, and his inability to make masculine roles work successfully for him. Work was so central to his identity that without it he had lost not just esteem but visibility, even personhood.

He also felt this disproportionate pressure applied to HIV: “it could be that the woman brought HIV into the home, but the man is blamed. I used to stay home – it was my wife who went out to nightclubs.” Gender was also very much on Isaac’s mind when it came to his ability to access support: “Some men have support from the families, that’s what makes them strong. Support is always from the family first, and women get it.” Isaac’s own family had not been fond of his wife when they first married. Since they had both become HIV positive, however, Isaac’s family helped his wife, and not him. I asked about the role of outside support – what
about friends, churches, the community at large? “If a man goes to the church for help, they’ll say he’s lazy, he’s not looking for work, and what what. If women go, they get helped. Men can’t complain. If you do, you’re lazy.”

I discussed this issue later with Adelhied, who had also moved to Kuisebmond from Damaraland. She agreed with Isaac, but was even more emphatic: “Being criticized when you’re a man is brutal. If you’re not a breadwinner, they’ll say you’re gay. They’ll call you names if you stay home . . . ‘This moffie\(^6\) man of mine – there’s only a day left before you’re wearing my panties!’”

It is difficult to overstate just how disrespectful and damaging such comments are in context. Banter in Kuisebmond was generally respectful and jovial; mild disagreements usually took the form of teasing, and in the main most people were non-confrontational. The comments above are rightly described as brutal, and illustrate the striking severity with which certain aspects of masculinity are enforced and reproduced in Kuisebmond by men and women alike.

One of the last times that I had an in-depth conversation with Isaac, we were sat in my car on the narrow sand road in a newer, poorer section of Kuisebmond. His health still on the mend, he was interested in turning the conversation toward his thoughts about the future. “Money is important. If I get some, I can get goats and cows\(^7\) and start to make profit from them.” Having money for show was not important to him, he said, but money for investment.

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\(^6\) Moffie is a semi-derogatory local word (not native, however, to any local language) that is loosely translated as ‘effeminate’ or ‘gay.’ It probably connotes something more like ‘fairy’ or ‘fag’ in English slang (Trotter 2014).

\(^7\) Isaac estimated at that point that a goat would cost roughly $500 NAM and a cow $1000 NAM.
His plan was to leave town and return to the country in order to become a farmer. “My future’s not in town,” he said. He didn’t like life in the city any more – didn’t like the high costs, didn’t like having to ask his neighbors for money or food, didn’t like the crime.

He knew many people in a similar position – people who had come from the country imagining work would be easier to find, only to become disillusioned. “You don’t have to struggle in the country – it’s easier to live a good life.” It’s hard to evaluate this claim: there is certainly an element of nostalgia at play here, and an extent to which the grass is always greener on the other side. Unemployment in Walvis Bay was certainly well below the national average, but self-sufficiency outside the cash economy was virtually impossible, whereas traditional ‘employment’ metrics in rural areas might fail to capture people outside the cash economy practicing subsistence agriculture, herding, or petty trade. Isaac thought that after he moved he might still come back to the city sometimes, if he had a car, but had already done some research and learned that there was a HAART clinic in his village in Damaraland. “The doctors just have to write you a letter and you can transfer.”

He acknowledged that he would still bear responsibility in this new life of his; “even on the farm, men should always be the breadwinner.” When he imagined his life in the future, he figured that he would send meat and money to his wife and stepchildren who, tellingly, would remain in the city. What made life easier on the farm is the lack of pressure to display wealth, save perhaps for looking good at church on Sundays.

It is remarkable to note the extent to which Isaac himself had embraced the aesthetics of masculinity, even as he struggled with them. His positive account of life under apartheid seems to hinge on his ability to find work, spend his money, and enjoy the social freedoms this
afforded him. His desire to return to life in rural Damaraland after the failure of the city to provide opportunities similarly hinged on a faith that the countryside would allow him the degree of self-sufficiency and economic freedom he needed. So many other things are missing from his narrative – the company of friends or family, concerns about his health or wellness, even a broader desire to engage with the community, with religion, with politics. The notion that a man was not a man – was indeed barely even visible – unless he had paying work had done him obvious injury and continued to damage him as we spoke. Why remain wedded to so deadly a belief?

I have previously written on the seemingly endless human ability to adopt contradictory or even mutually exclusive points of view – particularly in matters of health (Callaghan 2006). Among the Khumbu Sherpas of Nepal, I found that many people would simultaneously subscribe to both personalistic and naturalistic etiologies to explain illness; a person might say, for instance, that a stomach problem or respiratory infection was caused both by bacteria and by an evil spirit. I came to appreciate this as simply a form of pragmatism: people are keen to recover, and at least in the Khumbu region a wide variety of healers (including western-trained doctors, monks, shamans, Tibetan Amchis) could address illness from different perspectives. The wisest approach for many Sherpas was therefore to visit all available healers in hope that at least one of them worked, though of course I was left wondering which healer they truly ‘believed’ in. A particularly wise Sherpa informant once answered this question by saying, “You feel sick and your wife makes you some ginger tea. Then the doctor gives you antibiotics and the Amchi gives you some herbs; maybe you see the Shaman and go to the monastery. And then after ten days you feel better. So, which one worked?”
In the case of Namibian gender roles, however, the payoff seems limited. Sherpas could ‘buy in,’ however shallowly, to various health systems in hopes that one would cure them. In Kuisebmond, by contrast, many of the men I met seemed fully invested in local masculine identity despite the fact that it appeared to do them no favours whatsoever.

I tried tracking Isaac down as I wrote up my thesis; I learned that he had disappeared from treatment shortly after I left Kusiebmond in 2010. On the last line of his file, a clerk had hastily noted: “xx/xx/2010 – STOP – poor adherence (toxicity?).”

Simeon

When Simeon and I met, he was in his late 30s, and lived with his girlfriend and their two children in Kuisebmond. He was originally from Awaamboland, in northern Namibia, and counted Oshiwaambo as his first language. He worked as a contractor, especially on finishing and renovation projects, specializing in things like painting and tiling. We immediately got along well, and seemed to have lots to talk about. Compared with Isaac, Simeon earned a good living. He admitted that margins were very tight in his business, but that large contracts could bring in big paydays. He reckoned that he could earn about $20 000 NAM per month, this was divided with his girlfriend, and he frequently worked on cycles of one month on and one off. As with much of the labour in Walvis Bay, Simeon’s was lucrative, demanding, and tenuous.

Simeon was very open, very candid, and seemed genuinely to enjoy our conversations – not only about his life but about mine, and life in general. At the time of our first formal interview, he had been on ARVs barely 6 months, but seemed cheerful and in good health. As with many of the other men I met in Kuisebmond, however, he had had a long road to treatment. He often peppered me with technical questions about his treatment that suggested
both a natural curiosity and, perhaps, a lack of counseling at the clinic\(^8\): “Ever since I started treatment my knees hurt when it’s cold – why? Can I eat chilies while I’m on this medication? Will I really have to take it forever?” Simeon had lived in Kuisebmond for 18 years, though he maintained strong ties with the north. He spoke excellent English but relatively little Afrikaans; during one of our conversations my Awaambo research assistant, Freida, joined us, but generally we met alone.

As we sat one afternoon in my kitchen, Simeon told me how he came to be diagnosed. In 2004, a nagging cough brought him to the clinic for a TB test. During that visit, the staff conducted an HIV test – this is a matter of course in most clinics in sub-Saharan Africa, given how closely the two diseases are intertwined. He tested positive for TB, but did not go back for his HIV test result. “At first, I felt shame. I was nervous,” he said. The remarkable and tragically common element to his story is that after this visit to the TB clinic, Simeon actively avoided learning about his HIV status for the next three years. Try as he might, though, he could not ignore his steadily deteriorating health.

By 2007, Simeon says he “felt ready to go for HIV testing.” Just as he was preparing to go to the New Start center, he was offered a lucrative, 8-month contract working at the far end of the Caprivi Strip in the country’s extreme northeast; he took the contract, and his girlfriend returned to her village in the north. During one of their regular phone conversations, she mentioned that she wasn’t feeling well – Simeon replied that he wasn’t either. Upon returning to Kuisebmond in November of 2008, they finally went together to be tested at the New Start

\(^8\) This despite the fact that Simeon’s health passport indicated that he had had at least four counselling sessions, over the course of his first year in care.
clinic in Narraville\textsuperscript{9} - fully four years after Simeon’s visit to the TB clinic. “It’s faster and more friendly in Narraville,” he said. Both he and his girlfriend tested positive for HIV. He returned 6 more times to the clinic for CD4 tests, and left town to spend Christmas in his village in the north, before finally starting HAART in April of 2009.

When Simeon began HIV treatment he weighed 49kg and his CD4 count was only 72. I had a hard time squaring this image with the man I saw in front of me, who had already gained at least 5 kgs, appeared fit and healthy, and reported that his treatment was going along well (see Figure 7, below).

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{Figure7.png}
\caption{Twelve-month change in Simeon’s Body mass after initiating HAART, kg}
\end{figure}

When I asked him about that period, Simeon said that in retrospect shame and fear were probably most central to his long journey to treatment. “That time, I was afraid. I was thinking in a stupid manner. My friends and I used to say, ‘I’ll never give blood for an HIV test!’ But with that story, many people die. Even hangings, shootings – many are afraid of that, too.” Although he had several male friends in treatment, Simeon acknowledged that many of his

\textsuperscript{9} Narraville, formerly the ‘coloured’ township under apartheid, is separated from Kuisebmond by the main highway. It may be faster because it serves a smaller and lower-risk population; Frieda and I suspected that Simeon might also have found it ‘friendlier’ because he was unconcerned about seeing people he knew there.
friends who were positive didn’t want treatment. “People call this the ‘Shame Disease,’ you know? People see you’re positive and spread the word around. So most of the people who come out are women.”

When I asked Simeon about his challenges in treatment, he tended to wave it off. Simeon’s file, however, did show that he had been rebuked about adherence and reporting to the clinic by the staff there. One day while sitting on my stoop and watching a friend return from work dressed the trademark overalls of township labourers, Simeon chuckled and finally acknowledged that work was at times a problem. He frequently had to leave town on short notice, and could not afford to say no to contracts — even when they might mean missing a follow-up appointment or — perhaps more dangerously — a drug refill. He lamented that scheduling at the clinic was difficult; he couldn’t simply call and re-arrange appointments. Importantly, the clinic’s pharmacy would offer long-term refills for patients who were considered eligible due to work. Generally, this service was used by fishermen who anticipated long stretches at sea. By presenting a note from their employer, they could receive several months’ worth of pills. Since he was self-employed, Simeon did not feel he was eligible for this service.

As for social pressures, these barely registered for him at all: Simeon had made peace with the social stigma attached to HIV. Determined to uncover whether Simeon felt any of the massive weight that Isaac reported, I asked him if he worried about “word being spread around” about him: “Are you ever concerned about being seen at the clinic? Are you worried that people might see you and start talking?” He acknowledged that this could happen, but was ultimately unconcerned: “you know the story, they’re blaming people who are positive. They’re talking about them.” He shrugged and said, “who sees me? Who cares.”
Simeon seemed in many ways the opposite of Isaac. His occasional minor problems with adherence and appointments seemed virtually identical to those of any busy traveling professional, and the money and esteem he gained from his labour arguably offset the ill effects anyway. Crucially, he seemed to have exactly what Isaac lacked: a supportive partner, fairly stable income, and ‘space to walk around.’

The most recent word from Kuisebmond is that Simeon is still on treatment at the clinic, making all his appointments and feeling well. As always, he says, “no complaints.”

**Jonas**

When I met Jonas, he was in his late 30s. Tall and lean, he was invariably forthright and relaxed during our conversations. He was the only male informant I had who had actually been born in Kuisebmond; he spoke eloquent English and was chatty and introspective. He also spoke Damara, Nama, and some Afrikaans; for our first visit we were joined by Adelheid, but thereafter met alone at my flat. He was unemployed when we met, but I later learned that the city employed him a few times each year for short-term labour work that paid roughly $1500 NAM each time. Though he was unmarried, he and his girlfriend of 17 years had four children together.

Though Jonas sometimes spoke of the “time before” with wistfulness, he seemed very much at peace with his diagnosis and his treatment. Like Simeon, Jonas’ journey began in the TB clinic. He was taking TB-DOTs when he started to feel ill and show some symptoms of HIV. After about two weeks of feeling “really, very sick” he went to the hospital. There, he was found to be HIV-positive. Jonas said that before going to the hospital, he had “already given
[himself] over to death.” After the hospital staff explained to him how HAART could work, however, he decided to try it.

He started HAART immediately. Other than a treatment substitution, shortly after initiation, to an alternative first line of medication due to side effects (peripheral neuropathy in the feet), Jonas has had a good response to treatment and no troubling side effects. “These days,” he said, “the biggest problem is I get dizzy when I’m taking tablets with an empty stomach.” He ranked employment as his biggest challenge: he wanted dearly to find work in order to buy more and better food.

Jonas had told his family about his HIV status from day one, and they had always been supportive. He attributed this to their being a “very spiritual” family of born-again Christians. When I pointed out that this kind of family support was often rare for men, he speculated that trust and shame were the keys to HIV in every relationship: “maybe that’s why some men don’t disclose. Even with your girlfriend, if you don’t disclose, it’s a disaster. You both need to get tested first, then reconcile your sex life!”

When I asked if he experienced any social pressure, he acknowledge that some of his male friendships presented him with challenges. When he was out with his friends, he said, “there’s always some pressure to hit on the girls a bit, even if you’re not going to act on it really. Just to stay sharp.” Adelheid, sitting with us, sighed loudly at this, but Jonas continued: “if I’m moving on a girl, they’ll say, ‘oh not him. He’s positive!’” He also said that at times his in-laws were critical of him for not measuring up, “as a man,” but his girlfriend stands by him.

Several months later, in a separate conversation, he reflected that although the demands of masculinity could be damaging, a male friend of his had in fact been a role model shortly after his diagnosis. This friend had gone through a terrible period, “he lost his parents,
his job, his house, everything, but he kept up.” This friend took help where he could find it, and maintained a positive attitude. Jonas figured that it was this – more than the ‘training sessions’ he’d had in stress management from the HIV support group at the community center – that had saved him. “If he can deal with that,” he said, “I can deal with HIV.” This was one way in which Jonas was different from many of the men I knew: non-competitive relationships with a male friend were rare in the township. In Jonas’ case, it also seemed genuinely helpful to him.

Among the women I interviewed, several acknowledged that men did face some challenges, but still complained that men were to blame for many of the township’s social ills. I was in fact becoming accustomed to my focus group discussions turning into a mass airing of women’s grievances toward their husbands and boyfriends. When I confronted Jonas with this, he agreed. “It’s true what the women say. Men do sleep around, especially when they have money. Men with money aren’t satisfied with one woman.” He continued, “men are always competing. So the more women you have, the more successful you are – a real man. And men are always talking about these things, taking notes. So everyone’s aware.”

Asked whether some of this wasn’t also the fault of women, he replied, “of course, it depends on what the man’s role in the community is. If he’s a singer, or a soccer player, or a fisherman – if he’s a big man – the ladies will compete for him. They’ll know that Sandra was with him, Paula was with him . . . they’ll be competing for a big man.”

Jonas concurred with the attitudes that other men had about the role of work in defining masculine identity. “Men should be the pillar of the home – providing food, caring for the wife. It’s even in the bible.” When I countered that work was hard to come by, he insisted
“men must be creative. Working with their own hands, or being self-employed. Even guys selling mielies\textsuperscript{10} on the corner are feeding their families.” He was also aware that these expectations came at a cost to men, and that women still could count on social support that men lacked.

This topic subsequently opened into some long discussions about being a man in Kuisebmond. He felt that while women were afforded material and social support by their friends, their families, and even the government, men were expected to be independent. A man alone, he said, is expected to find work and buy bread. If a married man brings that bread home, his wife will divide it up and offer him none: “how can you expect to eat! It’s for the children!” In one of the few times that Jonas seemed to me to be genuinely upset, he sighed, “Women often insult unemployed men, telling them to get work. This breaks me down inside, breaks my manhood down. It’s emotional torture.”

As with my conversation with Isaac, Jonas’ words here have stayed with me very clearly since. Even for Jonas, normally my most effusive interlocutor, speaking of emotional torture was striking. Clearly Jonas felt not just constrained or pressured by the demands of masculinity, but actively wounded by them. It seemed to him, he explained, that being a man was above all about winning respect – principally by earning money and “doing public things.”

Overall, however, Jonas seemed to have internalized these attitudes somewhat less than other men, or was at any rate able to reflect on them in the abstract: he was unemployed and clearly not working at selling mielies on the corner himself. When I asked Jonas if he was considering such a scheme, he laughed and said he was thinking about it. This ability to

\textsuperscript{10} Mielies in this case is another term for ‘mieliepap,’ a township staple made from ground maize meal, or roasted corn on the cob; I do not think I ever saw a single man selling food at the roadside.
consider gender roles without wholly measuring his current self-worth against them seemed to set him apart, and to afford him ‘space to move around’ without damaging too greatly his sense of himself.

In the middle of March, during my last year in the field, we met at my house for a long conversation. Over lunch I asked Jonas to reflect on his own treatment success. By that point he had been on HAART longer than most of the men I worked with, and seemed to have a very sanguine attitude toward it. He said simply, “some men don’t want to believe they’re positive. Me, I heard I was positive and I switched to positive living and I’m doing OK. Some guys just drink the tablets\(^{11}\) just because – they don’t care. But you have to drink them and believe. Every time I drink it, I think about getting stronger.” He put great stock in positive living, but Jonas acknowledged that it had not been easy to change his old habits: “I used to go out on weekends, to drink and smoke. But I listened to the nurses. I have the same friends, but I don’t go out like before.”

I pressed him further on this point. So many men obviously found it impossible to simply change their lifestyles, or to leave behind their old identity. “Why,” I asked him flatly, “did you change?” He looked at me with some confusion. I realized in retrospect that his confusion stemmed from my question rather than his answer: how could I be so obtuse? He squinted at me, tilted his head, and replied, “Because I want to live longer.”

I learned that after I left the field Jonas continued to do well on treatment, reporting good adherence, no side effects, and good general health.

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\(^{11}\) ‘Drink’ here is a Namibian English synonym for ‘take’ or ‘swallow.’ Although some ARVs exist in liquid formulations, adults in the clinic were exclusively given tablets. ‘Drink’ and ‘eat’ were also sometimes used as a synonym for ‘consume.’ Reckless spenders might, for instance, be said to ‘drink’ or ‘eat’ their money carelessly.
Erastus

I met Erastus through a mutual friend in Kuisebmond halfway through my stay. He was actually not on HAART when we met, nor exactly in care; his story is compelling, however, for the glimpses it offers into the difficulties of submitting to testing and treatment, and unique challenges that HAART presents to some people in Kuisebmond. His conflicting narrative combined a deeply self-conscious township hyper-masculinity with an equally self-conscious reliance on the ‘positive living’ discourse of HIV counselors.

Erastus was born in the north, and had come to Walvis Bay in 1993. He was only a few years younger than me, and we always had lots to talk about. He was unmarried and lived with his father, who was a fisherman. Erastus also worked in a steady and well-paying job for a fishing company. He tended to work long shifts on deep-water boats, averaging 25 days at sea and between three and five days ashore. This meant that we could not always meet often, but we managed to stay in touch regularly. His Afrikaans was stronger than his English, so we often spoke Afrikaans with each other; Adelheid, whose Afrikaans was much better than mine, joined us for only one meeting; for several others we were joined by Freida. Once, after Frieda, Erastus and I had had a quick chat in my car while I gave him a lift, she watched him walk away and said, “what a gentleman.”

“Really?” I asked.

“He just walks like one . . . Fishermen – those guys have swagger. Guys that put on this look – the shoes, the shirt tucked in, walking that way. When the ladies see him . . . wow.”

During a conversation in early 2010, Erastus explained to me that he had learned his status three years earlier, in February 2007. He and a group of his (male) friends had decided

12 I have translated our Afrikaans conversations here into English.
to go to New Start and be tested, “just for fun.” He remembered that after emerging from the testing center, none of his friends discussed their results: “some were laughing and joking, some were not. But nobody said anything.” By that point in 2010, he still had not told his friends or family; he said he would tell them once he finally became quite sick, “just so they know.” He quickly followed on by saying that he had told his ‘Kuisebmond girlfriend,’ but not his ‘Northern girlfriend,’ who he was planning on telling “soon.” Several months later, he told me he was still “planning on telling them very soon.”

Erastus’ journey into HIV care was painfully slow, and continued well after I left Kuisebmond. After testing positive at New Start, he was referred on to the clinic for counseling. He underwent counseling and found it straightforward: “they wrote on my [health] passport, ‘he understands everything, he’s ready to start.’” All he needed was a CD4 test, but here things went awry. He was shuttled between various facilities: a Kuisebmond clinic drew his blood, but he was told to collect the results at the HAART Clinic at its old location in downtown Walvis Bay. They didn’t have the results and he spent some days going back and forth before he had to go back out to sea. As of that meeting in 2010, he had still never seen the results over two years later.

He told me that he wanted to start HAART: “Yes. The answer is yes.” He sighed that it was simply impossible given his work schedule. However, he was conscious of his health having recently begun to deteriorate: his skin and lips were getting worse, and he had a nagging cough that no amount of cough syrup seemed to help. At one point he put his hands around his waist and I was surprised to see how thin he’d become. “Yes,” he said, “I’m losing weight.” He maintained that he felt no pain, though, and was still able to do heavy work. If only he could
get the tablets, he said, taking them on the boat would be easy. “It’s not difficult. I’ve got my bag, my water bottle, and they go by my bed. I could take it on time, no problem.”

I began to sense that Erastus was hoping that perhaps I would somehow be his conveyance to treatment. I encouraged him to return to the clinic, and assured him that the clerks could easily and quickly pull his file. I offered him rides, and offered to accompany him to the clinic to introduce him to some friendly staff there. Ultimately our various plans came to nothing. When I asked him if he feared the stigma of HIV, Erastus admitted that among his friends “nobody would ever say they’re positive. But they talk about HIV. They’ll say it’s dangerous, that guys should wear condoms – watch out!” He continued that although he thought HIV was quite serious, he wasn’t sure how serious his friends were when they talked about it. Some people are ‘known’ as positive, he added, but only the ‘extreme cases,’ “the ones who are skinny, with sores. They’ll say, ‘oh, that one’s in trouble.’”

When I asked him why he had two girlfriends, Erastus was vague. “I don’t know why. Maybe because I stay a long time in Walvis Bay without going to the north. That’s why I take another girlfriend here. I know it’s not good, but a man is a man – we are weak at times.” Erastus spoke perhaps more often and more explicitly of being a man than my other informants, sometimes prefacing statements with, “Nie, ek is a man.” (No, I’m a man.) He spoke often of the importance of money not only in his relationships with women and his friends, but more generally as a key component of masculinity. When once I pressed him further on this, he replied, “you know, I think the problem is, of $2000, maybe $700 goes to the north and the rest is in your pocket.” He would then go to the shebeen with his friends and quickly spend another $100. “Then the girls get interested – they’re following me because
they’re looking for money\textsuperscript{13}. Money is important: you shouldn’t waste. You should always wear sharp clothes, even if they’re not new.”

Most of our conversations about masculinity returned to this area. Erastus almost never mentioned his father, except to say that he knew nothing about Erastus’ HIV status. Only once, during a conversation about reluctance to seek medical care, Erastus sought to distance himself from other men: “Some guys will never go.” At this point he had a small fit of coughing, then continued on, “Some guys would cough and say, ‘I’m a man,’ and never go to the clinic and then die. I don’t believe that kak. I didn’t have an example from my dad, I just go to the clinic for myself.” He ruminated for a moment before adding, “I think a man who doesn’t want to take tablets is stubborn, or an alcoholic. Or he just doesn’t want to live longer.” I asked him why a man might not want to live any longer. “I’m not sure, but if a man is given tablets to be healthy but still doesn’t want to, it’s because he wants to die. A man is a man, but he is still human. By taking risks, you lose your life. It’s not worth it. I don’t take risks.”

This passionate speech was very much at odds with much of his behavior. For virtually the entire time that I knew him, Erastus continued to avoid reporting to the clinic and my offers of helped seemed forever to conflict with his schedule. His health passport recorded that he had told his counselor that he understood the risk of drinking alcohol while HIV-positive, and that he abstained. I knew this to be untrue; while we did not drink together, I had seen him in shebeens in the township and more than once had offered him a lift when he was carrying – or smelling strongly like – beer. During one of our final days together, he seemed quite drunk all

\textsuperscript{13} Erastus could have used a few different words of township creole here but opted for \textit{geld}, the Afrikaans word for money that also, interestingly, connotes gold.
day. His health passport also consistently noted the sorts of clinical indicators (especially an elevated alanine transaminase, or ALT, score) that indicated liver damage.

Freida, impressed as she was by his gentlemanly bearing, said she found it difficult to trust Erastus. Stories of delays and hassles at the clinic were common enough, she said, but it was always difficult to distinguish between genuine cases of bad luck and convenient excuses to avoid harsh reality. “I have one friend who says his sample has been lost . . . six times!” I also struggled with understanding Erastus’ motives, at times. I referred to him in my fieldnotes as ‘The Elusive Fisherman,’ and frequently found myself having to go back and fit together the shifting pieces of his stories after we spoke. His earnestly stated embrace of the confessional tones of ‘positive living’ (Nguyen 2013) clashed with his observed behavior and his track record of delaying, denying, and otherwise avoiding a confrontation with his HIV status. He obviously had internalized township ideals about men as promiscuous, reckless, sharp-dressed and strong. It seemed to me that it was this conflict that held the source of his prevarication, his drinking, and his evasions.

My attempts to trace Erastus were, of course, incomplete, but nonetheless encouraging. Some months after I left the township he had finally started HAART, and the clinic was working with him to accommodate his work schedule by offering him flexible appointments and long refills when he was at sea.

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Some consistent themes emerge in considering the stories of the men I interviewed. Although some appeared ultimately to be enjoying more successful treatment – or indeed more comfortable lives – than others, all had been or continued to be paralyzed by the constraints of masculinity. The pressure of masculinity expressed itself in different forms – fear, skepticism, despair, competitive promiscuity, flashy spending, or reckless fatalism – but it was always qualitatively different from the way women experienced HIV and HAART.

Early on in my stay in Kuisebmond, I was asking an HIV counselor about masculinity. She sighed and described a discussion she had had with a patient who was a former combatant in the SWAPO liberation army. He had just tested positive for HIV; when she tried to open a conversation with him, he said “don’t even bother telling me. I killed people and have seen people killed, this is nothing to me.” After hearing several similar stories from other counselors, I built up an impression of a masculinity that creates men who are unwilling or unable to believe that an invisible virus that kills its victims slowly could ever be a real concern, or who don’t plan on living long enough to be killed by it anyway. It also forced me to reconsider the traditionally binary, oppositional models of gender roles: ultimately, although masculinity may be hegemonic in the township, it is not necessarily empowering.

Folklorists use the term ‘repertoire’ to refer to the options available to a storyteller. Not only the list of stories or melodies, but also of shared tropes and symbols, of overarching themes, and of common reference points to draw upon in the construction of a narrative (Georges 1994). For many men in Walvis Bay, the repertoire was narrow – the available ingredients of masculinity limited and in many cases simply inaccessible. Employment was hugely important, but out of reach for fully 35% of the men there, if not more. The outward accoutrements of financial success – sharp clothes, a fancy car – were similarly important, but
with access to formal employment so elusive, cash was otherwise dependent on crime, the black market, or the unpredictable generosity of family and friends.

In the next chapter, I survey the literature and draw from focus-group discussions in order to explore how the stories of these individual patients fit into the broader picture of life in Kuisebmond.
Death didn’t seem so serious a consequence compared to a life of being humiliated daily.

-Philip Hilts, *Rx For Survival*

**IN THIS CHAPTER,** I place the experiences of the men described in Chapter 6 in broader context by examining the social construction of masculinity in and out of the clinic. A predominant masculine identity emerges that is fundamentally incongruous – perhaps even mutually exclusive – with the demands of good HIV patienthood, particularly as constructed at the HAART clinic. I explore some of the manifestations of this gender identity, in men’s attitudes and activities, and in the township’s cultural aesthetics. My overall goal here is to move beyond the lives of individual men toward an understanding of how male gender roles interact with health and HIV treatment.

I postulate here a sort of ‘toxic masculinity,’ a way of being that demands risk-taking, disregard for health, drinking, materialism, and sexual conquest; this clashes powerfully with the demands of the HAART rollout program. It is also precarious: long gutted by apartheid and poverty, buttressed by precarious and dangerous employment, and dropped into the harsh new
urban environment, masculinity in Kuisebmond is forever at risk of being undermined. In other words, while I observed female gender identities to be stable\(^1\), male identities were relative – precarious, tentative, and constantly triangulated against the status of other men and a set of elusive social standards. It is important to note that these are broad characterizations of the dominant manifestations of gender roles; I discuss below that several patients in Kuisebmond were indifferent to (or resisted) them.

I begin with a consideration of the 'ideal patient,' as both socially constructed and clinically mandated. Rollout programs involved a set of ideas about how patients should behave, enshrined not only in the ‘social criteria’ for HAART (described in Chapter 2) but implicit in variety of aspects of the program’s organization. Next, I explore local definitions of the 'ideal man,' through a variety of social phenomena in Kuisebmond. I illustrate this chapter with references to the literature and to my participant-observation in the community. I also report on the results of a series of focus-group interviews that I regularly conducted with an HIV support group.

This support group was based out of a Christian church in Kuisebmond, fairly close to my house. The group used the church space for its weekly meetings, but was for all intents and purposes secular. Of the roughly three-dozen members, only 4 (including the president) were men; between 15 and 20 members might attend the average meeting. The support group did offer access to some income-generating schemes (while I was attending meetings, they were working on securing a sewing machine and enough fabric to produce dresses to order), and occasionally offered members to donor-funded workshops or training sessions. Mostly,

\(^1\) Female gender identities are discussed at length in Chapters 8 and 9.
though, the group truly offered social support: meetings were loosely structured and unless a member was called on to report on a recent workshop, the proceedings were largely conversational. Sometimes members aired grievances or spoke about personal struggles, and sometimes they asked for help with homework. Meetings were usually conducted in English, Afrikaans and Oshiwambo; for that reason I always attended with my Awaambo research assistant.

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Making Ideal Patients

Among the defining traits of neoliberal health interventions – especially those on the scale of HAART rollout in sub-Saharan Africa – is a set of normative values that transcend the purely medical. Contemporary understandings of this phenomenon are deeply rooted in Foucault’s descriptions of early sanitation projects as a form of biopower. More recently the concept has been expanded to describe the ways in which pharmaceutical rollout programs stamp their values on the bodies of the ill, creating what are variously called biocitizens (Petryna 2002) or therapeutic citizens (Nguyen 2010).

Biological Citizenship

I don’t intend here to belabour these concepts, but will describe how the social criteria for HAART in Kuisebmond involved an implicit set of values that clash with ideals of masculinity as defined below. HAART demands of its adherents a sort of ‘rebirth:’ a commitment to ideal patienthood, the demands of which are almost totally incompatible with the demands of masculinity.
The question of how ‘ideal patients’ are constructed by the state’s health systems – especially in international contexts – has received a great deal of attention in recent years. Most of these discussions involve some consideration of the role of governments in creating new forms of what is commonly called biological citizenship. Adriana Petryna, in *Life Exposed* (2002: 6), an ethnographic account of the results of the Chernobyl disaster, describes biological citizenship as “a massive demand for but selective access to a form of social welfare based on medical, scientific, and legal criteria that both acknowledge biological injury and compensate for it.” The disaster in Chernobyl makes an apt comparison with HIV in Namibia: in both cases governments were caught unawares by the enormity of the destructive power of a crisis they had either ignored or misjudged; further, the repercussions of the problem were amplified by a slow and inadequate response; lastly, the state response, in both cases, clearly involved a selective access to medical treatment based on determinations of biological citizenship.

João Biehl applies this analytic lens to the problem of HIV treatment in Brazil in 2007 in *Will to Live*, describing what he calls “a pharmaceutical form of governance” (73). Biehl was primarily describing the shift from a pre-HAART era of high mortality (his ethnographic encounters occur mostly in a hospice) to the early stages of Brazil’s (quite successful) treatment rollout. He also examines the normalizing logic of the neoliberal HIV response, and the “inductive property of the acts of counseling and testing” (243). Here again, the health system is seen as creating certain sorts of subjects; this is a process whose stakes are life and death when it comes to determining who is eligible for treatment.

Most recently (and most closely related to my own research), Vinh-Kim Nguyen has taken a similar approach to describing HAART rollout in sub-Saharan Africa in his ethnography *The Republic of Therapy* (2010). Nguyen elaborates on the notions of biological citizenship and
pharmaceutical governance in describing the epidemic in Francophone West Africa in the late 1990s, especially in light of the ‘confessional technologies’ in ARV rollout programs that enforce a set of attitudes and behaviors in HAART patients. These programs are usually suffused with the language of self-help and repentance – HIV must be confronted and purged with zeal.

All of this work shares a common grounding in Foucault’s work on biopower, particularly as described in *The Birth of the Clinic* (2003) and *The History of Sexuality*. In these works Foucault may perhaps have been prone to describing large, amorphous forces without ascribing them to any particular actors. His notion of power is bureaucratic and ultimately diffuse: rather than being exercised by sovereigns it is everywhere emergent, constantly constituted through agreed-upon forms of knowledge and truth, or regimes of political economy, education, or media. In this imagining, power and resistance go hand-in-hand, and delineate one another’s boundaries in a productive discursive relationship. Biopower, then, is a particular form of power that (literally) subjugates bodies, regulates their behavior, and prescribes their proper appearance, function and maintenance (Rabinow 1991).

The aforementioned authors have subsequently engaged these ideas by grounding them in ethnographic detail. Foucault’s ideas have some use in my own work, especially his consideration of how the medical project – inextricable, often, from the state – creates and controls subjects. In telling the stories of individual patients, and in reporting the voices of various professionals in the HIV system in Kuisebmond, I hope to balance an awareness of the massive, often unseen, political-economic and socio-cultural structures that shape rollout with a respect for the agency of individual patients. That is, while Namibia’s HAART rollout is a large-scale public-sector project funded by infusions of donor aid and shaped by certain forms of
scientific knowledge, I found examples of patients who had charted unique courses through the HIV treatment and care continuum.

The above processes must also be filtered, in Kuisebmond, through the powerful forces of globalization, urbanization, and culture change. Even as the normative values of donor-funded health development projects assert their influence, the city itself is changing rapidly. All of these social forces naturally have major implications for gender (particularly in the context of HIV treatment), and a nuanced conception of gender is required. This is especially true if we consider health behaviours as not just a side effect but an actually constitutive aspect of gender roles, an action that “constructs the person in the same way that many other social and cultural activities do.” (Saltonstall 1993) This is doubly important: it means that men, in some sense, become men by eschewing health care. In Kuisebmond, therefore, drawing more men into care means actively requiring them to abandon some crucial elements of the masculine project. Health-seeking behavior is not socially validated, nor is it perceived as an act of love, of responsibility, nor of obligation. Entering care is, for many men, an act of surrender.

Making Ideal Patients in Kuisebmond

Within the Kuisebmond clinic itself, the behaviors required of patients are clear. Social criteria for care can be read largely as an inventory of submission: giving up alcohol, which (as discussed at length below) is a large component of masculine identity; submitting to optimal adherence\(^2\) for life – a surrender of autonomy and authority that clashes badly with local values; and recruiting a ‘treatment supporter,’ involving not just disclosure but a fundamental forfeiture of independence. Although the head doctor was male, most of his colleagues were women: on an average day the staff would be four-fifths female. The donor handbooks,
posters and pamphlets displayed and distributed at the clinic often featured males as aggressors – pressuring women into unprotected sex, in two examples, and urging a woman not to take her tablets in another. Rarely were men featured as positive exemplars; the sub-campaign directed at men featured silhouettes of bodybuilders flexing their biceps, urging men to “be strong.”

By comparison, the health-seeking role was a socially esteemed one for women in Kuisebmond. I discuss this at length in Chapter 9, but perhaps most important is the role of motherhood: it offered not only a pathway into care, it also gave women an opportunity to be seen as responsible and proactive. I saw no such opportunity for male patients: although entering treatment was supported at the clinic and through many community organizations, there was no heroic narrative around treatment for men as there was for women. In all my time in Kuisebmond, I never heard someone say “he is entering treatment for his family” or “it’s the right thing to do for his children.”

It is again important to note that I am describing broad generalizations here, not hard and fast rules. The rules of the rollout – and the norms of the township – naturally gave rise to resistance, and different people exercised this power in different ways: surely patients occasionally lied about meeting the clinic’s social criteria for treatment; in the community some men were able to ignore or transcend norms about their gender, and some women refused to be ‘compliant patients’. In Chapter 6, I described how Simeon had decided that risk-taking, flashy spending and carousing were less important to him than his relationship with his wife and children. He and his wife supported one another, and he cared not one whit whether other men in Kuisebmond considered him to be ‘cool,’ ‘macho,’ or adequately masculine. Isaac had also resigned himself to leaving the township as soon as he could, to return to a traditional life
in the country. Having opted out of the pursuit of ideal masculinity in Kuisebmond, however, he was cut almost entirely adrift: his spouse considered him an emasculated loafer and he had almost no friends to support him. Therefore, while striving to maintain toxic masculinity was frequently detrimental to HAART, resistance by no means guaranteed good health.

**Fear**

As described in Chapter Four, fear was a powerful factor in HAART, but one that operated quite differently for male and female patients. As it turns out, the clinic’s constructions of patienthood may in fact have increased the anxiety men felt about treatment. There were very few male HIV counselors at any of the clinics in Kuisebmond, but I had the good fortune to meet two of them; one in particular became a friend and a key informant. During a long conversation with him about the question of fear, he explained it to me this way: “you see, there is the positive fear, and the negative fear.” He went on to explain that negative fear – which was the sort experienced by men – was likely to keep them away from the clinic. Men would be so afraid of worst-case scenarios, he said, and often find the clinic such an alienating place, that they stayed away from care. By contrast, he said, women feared dying or becoming too ill to care for their families, and so their fear actually drove them toward treatment. The role of fear has not been meaningfully explored in peer-reviewed research, but forms of the backbone of two evocative, powerful works about men and treatment in South Africa: Liz McGregor’s *Khabzela* (2005) and Johnny Steinberg’s *Three Letter Plague* (2008).

These books both feature male protagonists who prevaricate about HIV testing and treatment while their interviewers look on in frustrated horror. Khabzela, also known as Fana
Khaba, was a hugely successful South African radio personality who refuses to acknowledge his illness and initiate antiretroviral therapy; he eventually dies the slow, agonizing death of AIDS. *Three Letter Plague* centers on a young man known as Sizwe who, despite being at risk of infection and having access to free treatment through MSF, refuses to take an HIV test.

Fear also came up during my support group conversations. One chilly March afternoon, we had moved into a shipping container on the sand in the churchyard because the choir was practicing in the hall. Sitting along the walls in plastic chairs, we were discussing the problem of stigma, when some of the women started laughing at how men’s fearful anxiety often clashed with their own bold female pragmatism. The group president, as usual, said nothing while the women dominated the discussion. “Once I saw two men in the shop. They said, ‘let’s buy some apples and grapes.’ The other said, ‘no! if people see us they’ll think we’re sick!’” The women laughed uproariously, and another added, “or, if a man has two or three girlfriends, he doesn’t want to go to the clinic because then all the women will find out!”

The general idea was not that men were generally fearful or cowardly. Far from it, in fact – as I discuss below, a cavalier attitude about risk and personal safety was an important component of masculine identity in Kuisebmond. But with regards to health and health-seeking behavior, women (perhaps rightly) saw men as unable to live up to the demands of HAART, even though women themselves found these demands fairly straightforward. Several of the women started chuckling about men being fearful not just of treatment, but of HIV testing, too. At this point, one of the two men in the group stood up and said, “the HIV statistics are that way [ie., with higher prevalence among women] because women go for more testing. If men were testing, it would be fifty-fifty.”

“So why don’t more men get tested?” I asked.
He looked around, waiting for some church volunteers who were passing by the door of the container before he continued, “Pride. A fear of going. Maybe they don’t want to admit to being sick. It’s just the nature of men.”

“Maybe he’s scared of meeting his girlfriend at the clinic!” offered a woman sitting nearby. This drew laughter and seemed to take some of the momentum out of his speech. Still, he continued, “Men say the counseling they get isn’t enough – it isn’t made for men. Men think if they get tested they’ll die quickly. Maybe there should be counselors who go to the men when they’re alone, like when they get back from the sea.”

Here again, another woman interjected that she had – in her capacity as an outreach volunteer – tried this approach. It worked on Day One, she said, but on Day Two, when the men saw her coming, they scattered. The increasingly beleaguered speaker carried on, “Men are different. They’re difficult. If you speak to 60 men, maybe only two or three will listen. If you bring up HIV, they’ll all assume you’re positive, you’re sick.” A woman sitting next to her agreed, saying “the last time I was at the clinic, there were many men there. They didn’t want to be helped first, so they kept moving all over the clinic. The nurse would say, ‘OK, people at the front get their passports first,’ so the men would move to the back, and what what. It took a long time before the nurses figured it out!”

Several women took over, relating with increasing frustration anecdotes that illustrated their problems with men as patients, clients, or simply as men. As with some of our meetings, this one was going to involve a great deal of gossip, joking, and airing of grievances. As we prepared to move on to other matters, one woman put a capstone on the topic when she sighed and exclaimed: “Men don’t really have the heart! They’re killing themselves and their
wives! Some don’t want to take their pills onto the boat – some even throw their pills away! They get sick, they can’t work, and then it all starts . . .”

* * *

Making Ideal Men in Kuisebmond

I saw the ‘toxic masculinity’ described above reproduced in many ways in daily life in Kuisebmond. The ideals of masculinity on the streets of the township were of course different from those inside the clinic, but they were also fundamentally different from those in rural areas. Below, I begin with a survey of masculinity as a theoretical concept before considering how township masculinity was reflected in popular culture, at work and at leisure, and in attitudes toward money and risk.

I have argued throughout this thesis that the township is unique as a social context and a disease ecology. A generation ago, Pendleton (1974) remarked that the townships of Namibia and South Africa were unusual in the ethnographic record for being complete communities structured neither by caste nor class, but by apartheid: a massive external force that made township life fundamentally different from rural life. He argued that it was so different, in fact, that under Barth’s (1969) definitions, township dwellers might in some ways be considered a distinct ethic group.3 Pendleton described the Katutura of the 1970s as a dynamic place marked by unsettled social relationships; Mark Hunter (2010; 2010a) describes the townships of South

3 It is important to explore, even briefly, Pendleton’s point here. Barth insists that ethnic groups are defined through self-ascription (Keyes 1997), and apartheid was obviously externally imposed: people were quite literally (and often arbitrarily) classified by the apartheid bureaucracy. Pendleton, however, maintains that townships cannot be understood as extensions of (well-studied) rural Africa, but as fundamentally, phenomenologically separate social systems.
Africa today in similar ways. The same was very much true of Kuisebmond: old gender roles were destabilized and new ones were emerging, and many of the relationships that bound rural life had fractured.

**Considering Masculinity**

**Relative Masculinity and the Fragility of Triangulation**

I turn now to considering the nature of the gender roles that were emerging in the township context. Of course, there is a danger in implying that gender roles are discrete, or investing too heavily in the thoroughly critiqued but still popular notion of “two fixed, static, and mutually exclusive role containers” (Kimmel 1986: 521) in which males and females are forever bound as men and women. Indeed, I do often treat sex/gender as a binary in this thesis; the reasons for this are partly pragmatic, as explained in the introductory chapter. However, the frequent use of a “men and women” dichotomy below is not a reflection of uncritical thinking about gender. I argue that the filling of these ‘role containers’ is a hugely important and by no means straightforward process; rather than the essentialist discourse thoroughly critiqued above by Kimmel, I describe the Namibian process as socially constructed (after Courtenay 2000) and performative (after Butler 1990).

In particular, Courtenay’s conceptions of gender seem useful for considering the construction of masculinity in Kuisebmond. Courtenay suggests that marginalized men – and I argue here that many of the men I met at the Kuisebmond clinic were marginalized in various ways, even if masculinity itself was hegemonic – frequently turn to new means to reconstruct their masculine identity. These have been referred to as “protest masculinity” (Connell 2005) and “compulsive masculinity” (Silverman and Dinitz 1974; see also Parsons 1947), among other
terms; I refer to them here as ‘toxic masculinity.’ In a sense toxic masculinity might be considered a ‘weapon of the weak,’ (Scott 1987) since it involves a set of behaviours that is accessible even to the poorest and most marginalized men in Kuiebmond: an embrace of risk and danger, drugs, drink, quick spending and unsafe sex.

Courtenay and others argue that gender is an action rather than a state; something constantly and dialectically redefined by the actors involved. “Masculinity,” he argues, “requires compulsive practice because it can be contested and undermined at any moment.” (2011: 153) Courtenay’s perspective is helpful here: in Kuisebmond, “contested” masculinity was produced mainly through adhering to a set of toxic beliefs and behaviours. Successful adherence to this repertoire (and simultaneous eschewal of the ‘feminine’) earns men esteem in the eyes of other men and perpetuates the legitimacy of this construction of masculinity. In short, men define themselves for and through other men. Courtnay concedes that this is socially reproductive of men’s poor health; I argue that the patriarchy as I encountered in Kuisebmond was unsustainable.

For anthropologists, this concept of gender calls to mind Geertz’s (1973) assertion that *homo sapiens* “is an animal suspended in webs of significance he himself has spun.” It also invites the paradoxical conclusion that people are both constrained by gender, and active agents in its delineation: Richard Reeves (2004), writing on masculine identity in contemporary North America, argues that “men remains stuck in cages of their own creation.” This quite closely approaches my own conceptions of how male gender identity is produced in Kuisebmond.

\[4\] In every case these terms refer to a valence of masculinity that is ‘hypermasculine,’ and frequently dangerous or self-destructive.
One of the chief differences between the construction of male and female gender identities in Kuisebmond is that masculinity was contingent, relative, relational, even fragile, and forever being triangulated and re-established based on other men. I contrast this (at greater length in Chapter 9) with female identities that were stable, flexible and durable; in short, I conceptualize them as *relative* masculine and *absolute* feminine identities. This is in some sense an extension of Bordieu’s (1998) suggestion that a man’s masculine identity must first and foremost be validated by other men. Masculinity could never be finished, never be ultimately achieved; its pursuit, however, was clearly dangerous for many men.

On the streets of Kuisebmond, I was reminded daily of how men triangulated their positions whenever men greeted each other. For instance, Oshiwaambo greetings always seemed to me to be preoccupied with positioning the respondent in relation to his status, his family, and his possessions. Greetings were often quite lengthy; a typical one would go like this:

-How are you?
  -Fine.
-Is it good?
  -Yes.
-How’s your mother?
  -Fine.
-And the cows?
  -Fine.
-Did you get rain?
  -Yes.
-Is everyone [in the family or village] fine?
  -Yes . . .

This might continue on for minutes, usually with a series of questions about a procession of progressively more distant relatives or less important animals and possessions (cows were
always first). An Awaambo friend explained to me that “if you just say ‘how are you,’ you feel guilty. It’s not their responsibility to tell, it’s your responsibility to ask.” This is representative of how many men established and maintained their identity by comparing it with the men around them. Obviously this meant immediate feedback and the opportunity for great local prestige when a man achieved some measure of success in the eyes of other men; its wages, however, were constant anxiety about status and the impossibility of ever fully ‘arriving’ at perfected masculinity.

**Work**

My interviews with men (and many women) reinforced the centrality of economically productive labour to the construction of masculinity in Kuisebmond. In fact, I consider work to be the quintessential masculine activity in Kuisebmond. In this regard, it could be argued that labour’s primary value is partly economic, but mostly symbolic – that beyond staving off the worst of poverty and providing subsistence, work is most important as a socially reproductive process. That is, labour for men was not only about earning cash, but about labour itself: men wanted to appear busy, to seem to others to be engaged in productive work.

In 2010 I had a conversation about outreach programs with a friend in Windhoek who was a long-time HIV activist. He had reflected at length on gender dynamics in HIV programming after failing to attract men to his organization’s HIV and HAART information sessions – sessions that were invariably dominated by women. His frustrations led him to believe that too many organizations like his ignored the importance of employment for men. My friend emphasized that it was not just employment itself that was important, but the appearance of employment: even HIV testing and treatment required men to be (and be seen
to be) at leisure in the middle of the day – an unbearable shame for many. “Men need to be workers,” he said, “strong and not sick. You ask them to come in to test in the middle of the daytime, after the humility of unemployment, and, well . . . [they say] ‘do you mind if I sit this one out?’”

With official unemployment in Windhoek hovering just over 50% at that point, however, work was beyond the reach of the majority of men, leading many to simply pretend to work or to blow off daytime commitments with vague statements about ‘being busy.’ The value of ‘busyness’ was a recurrent theme in support group discussions: when once I asked why the group was predominantly female, one woman answered, “guys are busy. They say they don’t have time to join support groups.” Another woman quickly agreed, saying, “they don’t want to pick up their medications. They’re always in a hurry!” My activist friend sympathized with this: “what can you do? You have to live the lie.” This had led him to an ingenious solution to the problem of male attendance: his organization had started asking women to bring male partners and relatives to what they billed as ‘after-work braais.’ Men, he said, needed to “perform” their masculinity by “working nine-to-five, even if they’re unemployed. Even if ‘working’ is sitting at the bar from nine to five.” Thus his after-work events were hugely successful, even among men he knew to be out of work (many of whom would thank him personally for accommodating their schedules). “You plan for 40 and get 400,” he laughed.

Paul Willis’ (1977) observations of working class England are instructive here, but there is also a more recent tradition of social research on the intersection of HIV and labour. In

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5 Formal unemployment was, of course, higher in the township of Katutura where my friend’s programming was centered.

6 Braai is short for the Afrikaans word braaivleis (literally, ‘roast flesh’), and is used as a noun or verb in southern Africa to mean something like ‘barbeque.’
Uganda, for instance, Siu and colleagues (2012) find that while labour is a key determinant of masculine identity, it interacts in complex and contradictory ways with testing and treatment for HIV. Some men, for instance, found that treatment allowed them to regain their vigor and to work harder, thereby fulfilling both their families’ material needs and the men’s own desires to be seen (and see themselves) as hardworking breadwinners. Others reported that it was work colleagues who encouraged them to seek care, and supported their progress through the testing and treatment continuum. Conversely, some men found that disclosing their status damaged their reputation and compromised their ability to find work; some on treatment reported that side effects hampered their productivity. This too had both material consequences – in lost wages or opportunity costs – and a negative impact on men’s self-image.

Closer to Walvis Bay, Tvedten has explored the importance of labour to masculine identities in a shantytown in northern Namibia’s largest city. It is worth citing at length his description of how men who did not earn became dispensable within the functioning of poor urban households, where cash income was vital. Today the notion of manhood as protector and provider of the household is in the process of becoming impossible for poor men in Oshakati’s shanties to relate to, and manhood has increasingly come to be about simply producing children whilst escaping any responsibility for those children’s upkeep. The frustration and feeling of inferiority this instills in poor men is palpably noticeable, particularly in their frequently finding outlets for it in their withdrawing from immediate family relationships, their use of violence and their excessive use of alcohol. (2011:150)

This is quite similar to the position many men found themselves in in Kuisebmond. Breadwinning and labour itself had long played a central role in defining male identity, but the nature of productive labour had changed dramatically in recent years. Traditional subsistence was all but impossible in Kuisebmond, and although unemployment was nominally lower in
Kuisebmond than elsewhere in Namibia, this was cold comfort for the thousands of men in the township who could find no meaningful work.

The men who did find work were also, however, thrust into a strange new set of social and economic relationships. Labour involved working for cash alongside a group of strangers, and competing for rare job openings against countless other people in the coldly indifferent capitalist job market rather than securing work through family contacts. In much of rural Namibia, wealth is still reckoned in heads of livestock, acres of land, or other (productive) assets; earning cash was a necessity in the city, but much of it evaporated in the form of rents, bills, and other ‘unseen’ expenses. Finally, the traditional support networks that underpin rural subsistence – extended family and village headmen, for instance, who could be relied on to step in in the case of crop or livestock failures – are not reproduced in the townships, their absence amplified by the persistent inability of the Namibian welfare state to extend care with much breadth or efficacy.

Clearly, much of the work available to men in Walvis Bay (fishing, mining, and allied industries) was both lucrative and dangerous. The large body of literature on mining in South Africa is an obvious touchstone here\(^7\), but helpful comparisons may also be made with other subcultures in which risky work helps define masculine identities, including Mohawk men working in high steel (Blumenfeld 1965). Peter Matthiessen’s elegiac book on the fishing communities of the Eastern United States, *Men’s Lives* (1988) was named for Sir Walter Scott’s epigram, “it’s no fish ye’re buyin, it’s men’s lives.” I sometimes visited the Mission To Seafarers adjacent to Walvis Bay’s port, and the crewmen there were all painfully aware of the history of wrecks along the Skeleton Coast (Maletsky 2006; Menges 2006). The same could be said for

\(^7\) See for instance for the work of Catherine Campbell (2003 and 2004).
uranium, diamonds, tin, copper, and many of the other industries that drew men to Namibia’s coast for work; gold miners around the world, for instance, suffer well-established patterns of increased morbidity and mortality (Eisler 2003).

Still, even dangerous labour may operate in an unintuitive way to keep men safe. Many southern African companies have realized the brutal actuarial math that means keeping workers alive is not only ethical, but cheaper than constantly replacing them (Rosen et al 2004). Indeed, it was South Africa’s mining companies that led the way in providing counseling, testing and treatment through workplace HIV programs (Charalambous et al 2007). Private sector programs were generally able to achieve good outcomes, even before HAART was widely available in the public sector (Feely et al 2007). In discussions with HIV-sector professionals and Ministry of Health and Social Services employees around Namibia, many insisted that much of Walvis Bay’s success in recruiting men for HIV testing and treatment was down to widespread workplace outreach. I still find it difficult to say conclusively whether labour played a negative or positive role in men’s lives. The ambiguous relationship between labour and men’s health is clearly complex, and merits much more qualitative and quantitative study, especially in relation to HIV.

**Money and Materialism**

Invariably, the first thing that men in the townships looked at after my face was my shoes. As mentioned above, employment was quite important in the townships, but so was wealth: work and money, though, were not necessarily causally connected. Money *qua* money was the primary concern: wealth, in Kuisebmond, was not a train to be ridden but a station to arrive at. Beyond the basics of daily survival, wealth was really useful only insofar as it facilitated conspicuous consumption – in other words, it was no use being rich if nobody knew
it. This manifested itself most obviously in clothing: men of means broadcast their wealth by wearing it, opting for long, luxuriantly pointed shoes, elaborate belts with rhinestone-encrusted buckles, and generally spotless, well-pressed presentation. The studiously disheveled look of European cool was completely eschewed, with men opting for prominently displayed name brands, crisp new hats, and even pinstripes for their day-to-day clothing. When men wore blazers or jackets they left the sleeve tags on, even stitching the tags back on if they came loose, ensuring everyone could see the tailor’s name.

Cars were another, though obviously less accessible, means of displaying wealth. A good friend of mine in Swakopmund was a manager at a large Namibian company; we often chatted about money and male identity. He related an encounter he had recently had with the head of the labour union at his company. The union representative, after an off-site meeting, took my friend aside and complained that my friend’s car wasn’t expensive enough. A late-model Korean SUV, the car did not, in the union representative’s opinion, befit a man of my friend’s status. On behalf of the union, the representative urged him to buy a BMW, an Audi, a Mercedes, or something equally glamorous: “when you meet a minister or something,” the rep explained, “you should have the nicest car.” It is hard to imagine a comparable conversation between labour and management ever occurring in Canada.

The women I spoke with usually spoke of money in pragmatic ways, and especially in terms of supporting their families. Men, though, were more likely to be expected to display their wealth, to earn the esteem of men and the affection of women by demonstrating openly that they had disposable cash. Once I was driving through the Kuisebmond when I spotted a colleague from the Community center. I had just picked up the post, so I pulled over to hand it
to her. As we chatted, she mentioned that she liked my car: “it’s nice – really nice. You look like a real man.”

The Shebeen

Shebeen is an Irish Gaelic\(^8\) term (originally *sibin*) once used to refer to any informal bar where alcohol was sold illicitly; the nearest colloquial English translation might be ‘booze can’ or ‘speakeasy.’ Shebeens are now mainstream, quasi-legal, and ubiquitous in the shantytowns of southern Africa, and certainly popular in Kuisebmond. They were a common entrepreneurial endeavor, in part because demand is high, overhead is low, and the regulatory environment very lax (Kangootui 2012); they were also, however, an important social hub: homes in Kuisebmond did not offer many comforts, and the township was almost totally bereft of public spaces, so the shebeen was a natural gathering point. In this way little has changed in Kuisebmond over the years: Moorsom (1984: 40) describes life on the (male-only) labour compounds of apartheid as cramped, filthy, bereft of social outlets or privacy, and ultimately "indescribably bleak;" the shebeen was the only social space open to male labourers.

I contrast the shebeen with the church; the former was in some sense the quintessential male space in Kuisebmond, and the latter, female. In some important ways the shebeens of Kuisebmond seemed different from those of more established communities like Khayelitsha, the sprawling black township outside Cape Town (Otter 2007). Specifically, Kuisebmond's shebeen culture seemed more standoffish, whereas the shebeens of less transient communities were usually friendlier, more social places. When I chatted with other men at the shebeen,

\(^{8}\)It is believed that the term came into Southern African usage via Colonials – especially through immigrants in the police forces (Mager 2010), though the pathways it may have taken are complex (Huston 1947) and by no means intuitive.
several of them independently mentioned to me how lonely Kuisebmond was, especially for people who were new in town. Shebeens are also almost exclusively male spaces, and for this reason I was curious to learn more about them.

To this end I frequented a shebeen near my house. Sometimes I only stopped in briefly to pick up a quart of beer on off-sales; a few times I went with friends from the neighborhood, and often I went alone to watch football matches on TV and have a drink. It was not, objectively speaking, a pleasant place. It was a single room, perhaps ten meters on the long side, which opened onto the road – the design was essentially that of an open garage. It sat level with the street, spilling light out onto the sand where are few plastic chairs offered extra seating and a grill fashioned from an old oil drum cooked cheap cuts of seasoned meat. The first time I went, I noticed that of the 25 people there, only two were women. Most were drinking African lagers, bought in cheap one-quart bottles and shared. Spirits were more costly and are usually eschewed.\footnote{Importantly, these were products of multinational brewers like SAB Miller; home-brewed millet or sorghum beer, known as 
tombo, was not drunk in shebeens. Generally, tombo was brewed in small batches by entrepreneurial women and sold from their yards for pennies – it was often drunk as a mid-day refreshment, but the alcoholics who relied on it were considered the worst of skid row. Tombo might be said to symbolize the traditional rural antithesis of the urbanized modernity of the conglomerate-produced lagers (Mager 2010).}

The ‘bar’ itself was really just a walled-in bolthole in the corner, staffed by a stone-faced young woman behind steel bars spaced just wide enough to pass a bottle through. There were a few plastic tables, a few unpadded stools, and a broken couch along the wall: it wasn’t much of a place for sitting. High against the ceiling was a small television; especially during major tournaments it showed soccer matches almost exclusively. On the wall, behind steel bars, was a small jukebox that only played a few discs, and always at maximum volume from blown speakers. The sound was oppressive – deafening in the shebeen itself, and carrying powerfully
around the neighborhood. In the corner beyond the bar were the toilets; whenever their door was opened, the place would smell of stale urine.

One of the chief masculine virtues in the shebeen, as in many other spheres of male public life, was unruffled passivity: a facial expression, bodily disposition and general social attitude of massive indifference were the norm. Mostly the men in the shebeen would chat, drink, and play pool or watch television, but a large number would say nothing all night. Despite everything, and given the cheek-by-jowl life of the townships, the shebeen was still a place to go that was at least potentially social, and not home. They were male spaces, and offered relief in some sense. For many men with jobs, their work was stressful and dangerous; for unemployed men, the tedium of empty days spent in crowded houses or drafty ghettos was suffocating.

However, for HIV patients especially, drinking to excess is dangerous. Hahn et al (2011) report that sub-Saharan Africa has the world’s highest rates of binge drinking, and that alcohol abuse plays havoc on HAART in many ways. Some HIV-specific research (Woelk et al 2010) finds an association between alcohol use and lower CD4 counts, and that alcohol use at baseline is associated with poor adherence. In Luderitz, another migrant town on Namibia’s coast, Nichols and Parsons (2010; see also Nichols et al 2012) find that the density of shebeens in a neighborhood is positively correlated with HIV prevalence, even when controlling for socio-economic status. When I asked the support group why men drink, a flurry of answers came back: “if you stop drinking, people will think you’re positive;” “people think if you drink red wine you get more blood;” “they’re in denial!” The answer that stayed with me the longest, however, was when one member said simply, “men drink because they don’t want to lose their friends.”
As with labour, I am conflicted over the role the shebeen plays in HIV and HAART. Men who arrived in the city looking for work were stripped of the support networks and social structures they had at home. Social isolation itself is strongly and independently related to a number of morbidities and to all-cause mortality (House et al 1988; Brummet et al 2001), and isolation would make the decision to test – and the challenge of confronting a positive diagnosis and life on HAART – all the more difficult. The shebeen offers a much-needed opportunity for social connection and perhaps even support, but is also such a toxic environment (synonymous as it is with alcohol, tobacco, bad food, risky sex, and even violence) that it is difficult to know if the social support of the shebeen is a net positive. Recent research has suggested that, by some metrics, health burdens associated with alcohol present a larger risk for men in southern Africa than any other single factor (Hawkes and Buse 2013). Here again, the unique social dynamics of Walvis Bay present complex challenges.

**Popular Culture**

Advertising, fashion, music, and other aspects of daily consumer culture in Kuisebmond reflected – and helped reinforce – several key aspects of masculinity. By and large, popular culture promoted images of men that were hypermasculine: aggressive, promiscuous, materialist and perhaps above all centered on respect. Respect in particular has been dissected as an arbiter of masculinity by several observers: for Bourgois (2003) it underpins the struggles of inner-city drug dealers in America; James Gilligan, the prominent analyst of criminal violence in America, states

I have yet to see a serious act of violence that was not provoked by the experience of feeling ashamed and humiliated, disrespected and ridiculed, and
that did not represent the attempt to prevent or undo this ‘loss of face’ - no matter how severe the punishment, even if it includes death (1996: 110)

Popular music repeated a specific masculine aesthetic at full volume, from the windows of taxicabs and the dance floors of shebeens. Gazza was one of the two most popular musicians in Namibia during my time there. One of his hits featured the chorus “I know you’ve got a boyfriend, but I’m the man tonight.” Tate Buti, an up-and-coming Namibian artist who also had major radio success at the time, was more explicit in singing about a dominant, philandering, hypersexual masculinity. His most prominent hit in early 2010 was called ‘Ekiya,’ or ‘Thorn.’ Most locals understood the song to be allegory for HIV, but Buti’s litany of people pricked and killed by the thorn featured only female names: “the Thorn killed Frieda, it killed Sylvia.” The refrain of another of Tate Buti’s hits excused his sexual pursuit of a young woman with the refrain, “even a small bird is still meat.”

For many men, reproducing masculine values was a simple matter of broadcasting them on t-shirts. A popular logo was “RICH GUYS FINISH FIRST,” and another was “MONEYMAKER.” The most striking example was one in bright red, featuring five words in block capitals that covered the front of the shirt entirely:

MONEY
EQUALS
LOVE
SEX
POWER

Perhaps the most semiotically pure exemplars of this genre were the various bits of clothing (including hats, shirts, and even shoes) simply emblazoned with a likeness of Benjamin
Franklin. The ideal espoused in much of Kuisebmond’s pop culture was not middle class comfort but the rococo ostentation of American hip-hop oligarchs: the goal was not security or even leisure, but to literally be draped in money. Importantly, the signifiers of wealth here are US dollars. Obviously the Rand or Namibian dollar would be more immediate and practical as actual legal tender, or perhaps the Euro or Pound Sterling - both of which were readily available in the harbour and trading well above the US dollar at the time. But in Kuisebmond, the US dollar signified a sort of super-saturated capital – more than just money, it was wealth.

The importance of showy fashion and conspicuous consumption had not nearly ascended to the level of i’khothane, a trend that by 2010 had swept Soweto and other townships around Johannesburg. I’khothane parties usually involved rival groups having loud parties featuring dance competitions, drinking, and the destruction of expensive goods: a remarkably violent expression of the tensions inherent in township materialist aspirations (Jones 2013). Where once simply wearing designer clothes signified wealth among young men in the township, at the i’khothane they seek respect and status by burning or ripping up expensive clothes and shoes, along with burning cash or wasting food and alcohol. For Stephen Ellis (2013) these displays are of a piece with the aforementioned emphasis on expensive cars. I’khothane also has historical precedent in the osweko (a Zulu appropriation of ‘swanky’) parties held in South African mining compounds in the 1950s. On weekends, miners would host traditional Zulu dances punctuated by osweko parades in which contestants would parade before a crowd (and a panel of judges) to show off their formal clothes (Nkosi 2011).

Another striking way in which masculinity was reproduced in Kuisebmond was through advertising: alcohol advertising, in particular, quite transparently equated beer with

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10 These likenesses were copies of his engraved portrait (in green and black) on the American 100-dollar note.
masculinity. Tafel lager, a popular choice in township shebeens and generally considered a workingman’s (and a partier’s) beer, was particularly blunt. Their prominent posters and billboards in Kuisebmond bore messages like:

**TAFEL: WHAT GUYS REALLY WANT**

**TAFEL: OF COURSE GUYS HAVE TASTE**

**TAFEL: THE FASTEST WAY TO A GUY’S HEART**

The gender values of South African beer marketing have been well-documented: the industry’s attempts to reflect complex or changing gender roles have almost invariably failed and been replaced with advertisements relying heavily on images of male bonding through sport, drinking, and labour (Mager 2010). At least while I was in Kuisebmond, it was hard to imagine these advertisements changing dramatically any time soon.

**Risk**

In many respects, the Namibians I knew were risk-averse people, ‘conservative’ in the classic sense of the word. Change was not sought out for its own sake, and foreigners were viewed with a degree of wariness[^11]. Still, I frequently saw behavior that most people would objectively call ‘risky.’ I regularly found myself staring in disbelief – and then hurrying away – as men chatted on cellphones and lit cigarettes *while* pumping petrol into their cars. This felt so needlessly dangerous to me as to be almost suicidal. I once rebuked a friend at a petrol station for this recklessness, and he coolly replied, “I use a condom every time. Just let me have this.”

[^11]: Sophisticated, organized crime was generally blamed on Nigerians, who were considered almost unimaginably exotic, and Malawian or Tanzanian faith healers and witch doctors were considered possessed of special, arcane skills not available to their Namibian counterparts.
I sometimes rode shared minibuses, called *combis*, from the coast to Windhoek: these journeys would take about four hours if all went well. I remember during one trip listening for hundreds of kilometers to the droning of the seat belt alarm as our driver steadfastly refused to buckle up. As we approached a police checkpoint near Okahandja he casually pulled the seatbelt across his torso; as we pulled away, moments later, he undid the seatbelt again. He repeated the process at a second checkpoint outside Windhoek. This struck me as a crucial point: he was actively rather than passively choosing to eschew the seatbelt: repeatedly taking it off rather than simply not putting it on in the first place. Namibia’s highways are astonishingly dangerous by any measure: the country records more traffic fatalities per 100 000 deaths than any other country on earth, at a rate is 2.5 times higher than the global average (Sivak and Schoettle 2014).

Does this behavior count as ‘risk,’ as classically defined? It is difficult to say what the driver might have by way of reasonable expectations about the outcomes of his actions, and whether he could be said to be measuring a reward against danger. Similarly, a man lighting a cigarette at a petrol pump must only hope to be perceived by random passersby as blithely unconcerned for his own well-being – at the potential cost not simply of an increased risk of cancer, but at an increased risk of spontaneous combustion. I have previously described a prominent masculine aesthetic of unruffled ‘cool’ in Kuisebmond, and indifference to health may be its ultimate expression.

In these cases it seemed men were ignoring rather than measuring danger, which seems to delineate the difference between ‘risky’ and ‘reckless.’ For this reason, I believe that masculine identity at its core may be about the ability to express power, particularly against long odds. That is, the decision to eschew treatment or to casually step into dangerous
situations may in fact be an act of resistance – an assertion of agency in the absence of other, safer means of establishing identity. Here again the pursuit of masculine identity in the township is toxic, and can turn deadly. A culture of AIDS-related fatalism has been well described in Namibia; it occurred to me sometimes that life was valued so cheaply that many men would rather risk possible death, as Hilts argues above, than suffer a loss of esteem.

Conclusions: Toxic Masculinity

We have seen several examples of how masculine values are represented and reproduced in Kuisebmond. Mager (2010) argues that shebeen culture may be best understood through the Geertzian interpretive lens. If a Balinese cockfight somehow explains local social structures (Geertz 1973), so the scene that plays out in the shebeen might also be a dumbshow of the struggles and values of masculinity in Kuisebmond: a cavalier attitude to life and limb expressed through dangerous work and risky leisure, a struggle for respect based on materialism and womanizing, and the constant triangulation of status against the positions of other men. Masculine identity emerges as, above all, unstable: contingent, dynamic, imperfect, and relative, forever being measured and refined, but never perfected.

For some men, masculinity was not entirely toxic – it was simply their bad luck that it was a way of being altogether incompatible with the treatment they needed for a disease they would carry for the rest of their lives. Indeed, many of those same qualities had been the making of them: theirs is the story of the new, globalized African urbanite. By being stubbornly independent and willing to take great risks, these men had escaped rural poverty and earned money and the respect of their peers. They had braved the challenges of moving far from their families and starting a new life in an unfamiliar place. HIV, however, demanded of them
virtually all the things they had found the need to leave behind in their rural villages in order to succeed in the city: compliance, subservience, a conservative attitude toward risk and health, and a strong set of social support networks.

Some aspects of this phenomenon have been reported elsewhere. In concluding *Three Letter Plague*, Johnny Steinburg laments that

> There are few men left in Lusikisiki who do not know where to go to be treated for AIDS. . . . Tens of thousands of men have benefited from this movement, but only a tiny minority will ever join it. Most will never make ARVs a right for which they will fight, or HIV the substance of their self-assertion. They are too ashamed. To embrace lifelong treatment . . . men need something else entirely (2008:326).

Robert Lorway (2006: 442) describes masculinity in the townships of Windhoek as “less stable, socially ambivalent.” This contrasts in some ways with Campbell’s (2001:282) description of masculinity in South African mining communities as characterized by “bravery, fearlessness, and going after women.” Lorway finds a great deal of struggle, and notes that homosexual encounters (if not ongoing relationships) are relatively common among self-identified ‘straight’ men. I contend, however, that in both cases it is sexual conquest of any sort that is central, and that masculinity is something that is struggled toward with a frequently self-destructive desperation, though rarely perfected.

The struggles inherent in navigating a new urban life in Kuisebmond are reflected in Namibia’s other urban centers. Lorway (2006:443) remarks that in Katutura “the pursuit of a life that is more economically and socially liberated requires taking on multiple and contradictory masculine subject positions.” I argue that in Kuisebmond masculinities were not only contradictory but often simply broken: unhealthy and unstable. This is an argument that has gained growing attention in recent years. Cornell and Myer (2013: 849), for instance, have
called for a focus on the factors that impact ART for men, and rejected “the implicit assumption that advocating for men's rights in a situation of sex inequity automatically undermines the rights of women.” This question has been taken up – albeit recently and slowly – by other researchers in Africa. Siu and colleagues’ (2014) work mentioned above identifies the ways in which the contradictory demands of masculinity in rural Uganda complicate HIV testing. Schneider and colleagues (2011) report similar findings in South Africa, highlighting the importance of employment and social (or romantic) relationships for men in accessing ART services. Some have questioned the extent to which the “narratives of masculinity” – especially those associated with work, crime, or health (Gibbs and Jobson, 2011) might be so unsustainable or unhealthy that they become mutually exclusive with efforts to mitigate the impacts of HIV.

Importantly, others have questioned the very idea of ‘masculinity’ as a monolithic concept, adopting the position that the many varied forms of masculinity require a nuanced approach in the context of HIV (Butler 1990; Mane and Aggleton, 2001). This position is particularly apt in my own work: Namibia is clearly a patriarchal country insofar as men hold the vast majority of positions of political power, and remain dominant in unreconstructed family and community relationships. Patriarchy, however, is nowhere evident on the clinic floor. Staff members are disproportionately female, and women outnumber men among the patients. Female nurses and receptionists loudly hector noncompliant patients, and many of the expatriate staff members have little interest in affecting the deference required by the sclerotic gender roles of some local tribal traditions.

Therefore, oppositional and essentialist views of gender – sometimes unfortunately crystallized in HIV programming discourse as a conflict between ‘oppressed’ women and
‘dominant’ men – emerge as unhelpful, at least, and probably inaccurate. The idea of women as a universally homogeneous (and homogeneously oppressed) group is no more useful than that of men as universally dominant. Silberschmidt (2001) reminds us that even in a patriarchy, not all men have equal access to power, and the existence of patriarchal structures is not sufficient proof that all men are hegemonic, nor that all women are subservient.

The avenues that are available for Namibian men to enact various of the key values of masculinity were shrinking; in Kuisebmond, most of the ones left were at least mutually exclusive with good patienthood, if not outright pathological. Many reported that work was a key component of male identity, but unemployment was remarkably high. Many of the available jobs were quite dangerous and physically demanding, and often subject to the whims of a massively complex global market. On the surface of it, ART is beneficial to work. The literature on ART and quality of life has established that treatment leads to significant improvements not only in mental health but in work performance and rates of absenteeism (Beard et al 2009). Most of this literature, however, is still not disaggregated by gender. Further, the mechanics of improved health and work performance ignore the reality of massive unemployment and dramatically shifting patterns of subsistence; men in Walvis Bay cannot be self-sufficient nor rely on the usual networks of extended family to find labour. Instead they are subject, quite suddenly, to the forces of global capitalism.

* * *

Where then is the patriarchy? Most obviously, it appears in what seem to be the paroxysms of a form of masculinity in its death throes: a culture of needless recklessness,
desperate alcohol abuse, and self-destructive violence. If there is a patriarchy in Kuisebmond, it is one that every day authors its own destruction.
I get my strength, vision and purpose from my children. What would happen to them if I die? I need to do my best for them while I’m here.

-Female HIV Patient, Walvis Bay

**IN JULY OF 2009, I travelled briefly to Cape Town to attend a meeting of the International AIDS Society. While there, I visited some old friends and colleagues from the University of Cape Town and Médecins Sans Frontières. I had a long, rambling dinner one night with a friend who was a medical doctor and public health researcher; she had many years of experience and was one of my most trusted mentors. By then my own research in Kuisebmond was well underway and several of the findings described so far in this thesis had started to become apparent. I asked her whether any of them were similar to her own experiences in South Africa. She smiled, with a look that suggested that I had finally arrived, that I had finally learned an important lesson, and started to tell me a story.**

Lusikisiki is a small town in the southeast corner of South Africa, a few miles inland from the ocean. It is less a town than a collection of small villages scattered around a commercial
trading center, in the beautiful rolling hills of an area called the Wild Coast. These villages are typical of much of the rest of Eastern Cape Province: one of the poorest and most sparsely populated provinces in South Africa, it was formed after the fall of apartheid by merging the Bantustans of Ciskei and Transkei. It is an area that has been largely left out of even the modest gains accrued by poor South Africans since the end of apartheid. In Lusikisiki, an estimated 80% of all residents live below the poverty line, relying on a marginal subsistence economy and some trade in the center.

It was here, in 2003, that Médecins Sans Frontières (MSF) decided to open a HAART clinic. While the South African government prevaricated on rolling out HAART – and even, in fact, prevaricated on accepting the orthodox scientific consensus on HIV and acknowledging a causal link between the HI virus and AIDS – the simple Lusikisiki clinic managed to enroll over 2000 patients on treatment in less than three years (Ford N et al 2006). The clinic was already known among HIV researchers, since MSF diligently (and prolifically) chronicled their experiences there in peer-reviewed literature, at conferences, and through their own publications. The clinic – and its wider context – landed suddenly in South Africa's popular consciousness with the publication of Steinberg’s acclaimed Three Letter Plague in 20081. While the book centers around a young man who struggles with the decision to get tested for HIV, the remarkable work of MSF’s head doctor, Hermann Reuter, and the rest of the clinic team feature prominently in the narrative.

The decision to roll out treatment specifically in Lusikisiki was partly humanitarian, in line with MSF’s mandate to offer urgently needed care where it is least available. It was also, however, partly political. By opening a clinic in one of the most impoverished, remote areas of

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1 The book was published in North America as Sizwe’s Test.
the country, MSF hoped to demonstrate to the South African government that nation-wide rollout was possible. This is all to say that when my friend visited the Lusikisiki clinic, she was meeting some of the poorest, least-educated new HAART patients in the country – people who for all living memory had been relegated to the periphery of South Africa’s economy and its consciousness. Indeed, the clinic had been purposely chosen by MSF for this reason. My friend, who had visited the Lusikisiki clinic as it scaled up its HAART rollout some years before our dinner, was therefore understandably surprised when, after a perfunctory discussion with a group of local patients, one calmly asked her when advanced new drug formulations would be available at the Lusikisiki clinic: “Siza kufumana nini ufixed-dose combinations?”

For my friend, this story had become something of a punch line, a crystallization of the ways in which the language of HIV and development programs had been grafted onto local discourse2 and simultaneously created a generation of activist 'expert patients.'1 For me, it also underscored the extent to which this process remained primarily in the domain of women. I had had similar experiences with several female patients in Kuisebmond: in late June 2009, a woman approached me at the clinic to ask about an article on HIV that she had seen online. She carefully put the print-out in my hand from the website of a Kenyan newspaper; I knew from experience how limited public internet access was in Walvis Bay, and how much time, energy and money she must have invested in seeking out this information. The article (Gathura 2009) summarized work by Rafick-Pierre Sékaly and colleagues (Chomont et al 2009) that showed some promise in identifying and 'smoking out' viral reservoirs in HIV-infected tissue.

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2 This certainly is not limited to South Africa. During a focus-group conversation in Kuisebmond, I heard a group of Awaambo speakers use the phrase “o-chaningo behavia.”
I had to admit to her that I had not seen the story yet, even though I tried to keep up to date on HIV news. In my defense, this was a breaking pre-publication report of cutting-edge research from the journal *Nature*. "Is this a cure?" she asked. "When can we get it?" Her hope was palpable, as was her despair – and, perhaps, slightly suspicious disbelief – when I told her that, from what I could tell, this was a promising preliminary finding that was still probably many years from practical use.

This woman, just like the women in Lusikisiki, might be seen as earnest or naïve. She might alternatively be considered demanding and empowered; the 'exigent' female HAART patient was indeed a bit of a stereotype among HIV workers in Namibia (a topic I return to in Chapter 9). This assertiveness often paid off, but for some women, a readiness to invest hope or trust in the wrong places too often led to disappointment. Above all, though, these women were engaged: the woman standing before me asking about research and the rural patients in South Africa shared a keen involvement in their own treatment, and actively sought out answers from a wide variety of sources.

In this chapter, I explore the experiences of female patients at the Kuisebmond HAART clinic. I ask why the female experience of HAART seemed so different, both quantitatively and qualitatively, both clinically and culturally, from the male experience. Why did an HIV diagnosis or a prescription for a lifelong course of treatment spell despair for men, but in women prompt steely resolve or even renewed hope?

Why was it that I knew, before she even mentioned it, that those faraway patients in a remote corner of South Africa who had asked my friend about fixed-dose combinations were all women?
By the time I began my in-depth interviews with female patients, it already seemed clear that women were faring better on HAART than men. I was increasingly convinced that social (rather than strictly biomedical) phenomena might explain much of this gender disparity. One counselor attributed women’s superior treatment outcomes to what she called “the mothering instinct.” She matter-of-factly explained to me that, “in our black culture, there is a value on child rearing. Even if you don’t have your own children you would be expected to care for someone else’s.” Indeed, almost all the women I knew in Kuisembond attached tremendous importance to providing and caring for present or future children.

It is important to note that by and large the women I spoke with did not necessarily consider themselves saddled with parental obligations, so much as blessed by them. They were of course acutely conscious of the realities of having another mouth to feed, especially when struggling to make ends meet, and in the face of such difficulties it was not uncommon to send children away to rural areas to be cared for by extended family. However, children were also a source of personal pride and social prestige: becoming a mother marked the transition from girlhood to womanhood, and even in the relatively cosmopolitan city, it was still the norm that married Awaambo mothers wore skirts and covered their heads while unmarried women or girls wore trousers. (Although marriage was not synonymous with child bearing, both were important social signposts of the passage from ‘girl’ to ‘woman.’) Motherhood was also a source of strength, and here the differences between women and men were pronounced. One counselor remarked, “I have seen many women who don’t even cry when they get their status.
One of them said to me, ‘that’s OK. I’m not the first with HIV and I won’t be the last. I have to be strong.’”

Women were virtually synonymous with family, in the same way that men, as discussed in Chapter 7, were synonymous with labour. Indeed, my Awaambo research assistant (a young woman recently graduated from the University of Namibia) explained that men were always in some senses peripheral figures in their own families: “we’ve been socialized to think that our fathers aren’t family . . . the matrilineal side is more important. That’s how we’ve been raised.”

The ethnographic record confirms that Owaambo tribes traditionally reckoned descent through the matrilineal line, though most village- and household-level authority was wielded by men (Estermann 1957).

The relative unimportance of fathers seemed borne out in the preponderance of unmarried mothers in Kuisebmond. There was virtually no stigma attached to giving birth out of wedlock, which I found odd considering just how many women professed to be devoutly Christian. Curious to learn just how entrenched these attitudes were, I asked a close Damara friend whom I knew to be both a single mother and a regular church-goer. I assumed her faith was strong: she (and several other women I knew) regularly sent text messages to my mobile phone containing Psalms, or ‘chain-letter’ messages containing blessings or prayers against curses3. “Wouldn’t your pastor be upset if you were pregnant before you got married?” I asked. She looked nonplussed: “No, no, it’s not a problem. Especially if it’s by the same father. But ok, maybe after the third child, they might say it’s time to start looking for a man.” Freida,

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3 I am still not sure about the extent to which these messages were the product of a general piety or specific concern about my own doomed soul.
when I asked her about it later, concurred: “fatherlessness isn’t a big deal. A child wouldn’t really ask their mother, ‘who is my father?’”

Within marriage, husbands were often said to expect their wives to produce children, though some informants told me that these expectations actually came more strongly from extended family. Single men might earn some social capital from fathering children as a sort of sign of virility, but this could also be achieved (perhaps more easily) by appearing to be successful with women at bars and nightclubs. Tvedten (2011) also describes this phenomenon in one of northern Namibia’s new urban centers. Through ethnographic work in the shantytowns outside Oshakati (the largest city in northern Namibia), he discovered that as men have lost both economic and political hegemony, their household authority has also eroded: many men increasingly feel ‘redundant.’ Women, conversely, maintain their position as the progenitors of kin lines, and are increasingly finding power in new socio-cultural and political-economic roles. He considers that, at least in Namibia’s shantytowns, the female gender role has changed from one defined almost exclusively by child rearing to one more generally based on social reproduction. In light of growing male unemployment, this includes primary breadwinning, but also increasingly involves household decision-making and socialization (151). In short, the new social arrangements brought about by township life create, for many women, increased responsibilities, but also afford increased power.

Clearly, the experience of HAART was filtered for men and women through an entirely different set of gender roles. To what extent were these gender roles helpful to women, and to what extent were they harmful? Time and again, female patients and the people who worked with them emphasized the importance of children; they also emphasized attitudes of
compliance and passivity, and simultaneously of earnestness and empowerment. Some were frustrated by these attitudes even as they acknowledged that they might save women’s lives. I explore some of these themes below through excerpts from conversations with women taking HAART at the Kuisebmond clinic.

**Valerie**

Valerie was 40 years old when we met at the clinic in Kuisebmond. Her divorce had recently been finalized, and she now lived with two of her three children (her oldest child was 20 years old and lived in her own house with her children). Although she was in treatment in Kuisebmond, Valerie lived in the Coloured township, Narraville, and like most others there counted Afrikaans as her first language. However, she spoke such fluent English (along with some Oshiwaambo) that we usually used that; sometimes we would switch to Afrikaans when she was flustered or trying to emphasize a point. She was the only Coloured patient I discuss in depth in this thesis. She was born in the south of the country, but had come to Walvis Bay before Independence; originally she had good work through the trade union, but since losing that work four years ago, had survived primarily on odd jobs, petty trading, and some income from her divorce settlement.

The first time we met, we sat in my car: Valerie didn’t want too many people to overhear us. From then on, however, we always chatted at her house; in retrospect I suspect that Valerie needed that first meeting to take stock of me, but thereafter we became fast friends. We would sit in her lounge room or lean against the kitchen counters, something usually bubbled slowly away on the stove as we chatted. Her four-room cinderblock home was unremarkable by Narraville standards. In that neighborhood, compared with Kuisebmond,
ghettos were quite rare, and it was more common to see the houses of wealthier families decorated with ornate cement and ironwork, and small gardens. Her home was simply furnished and very lived-in: the cheap, powdery, pastel whitewash – ubiquitous in homes in Narraville and Kuisebmond – had been rubbed shiny by years of oily use. In the corner, sitting atop some crates covered by a floral bed sheet, was her television; I never saw it turned off.

My discussions with Valerie were wide-ranging: by turns jovial and grave, she was as happy chatting about cooking as she was about religion, her sex life, or her experiences during the war. Our conversations, especially as regards HIV and HAART, eventually coalesced around a handful of broad themes, described below.

**Motherhood**

Valerie had clear ideas about gender roles. Once, in the course of a long conversation, I asked her, “what makes you a woman?” Without hesitation, she answered, “being a mother.” She shrugged this off as a simple, even obvious, matter of fact, and added that she got her “strength, vision and purpose” from her children. “What would happen to them if I die? I need to do my best for them while I’m here.” She was unequivocal that motherhood was a vocation, in both the ecclesiastical and secular senses, and frequently spoke of caring for her family as not just a responsibility but a “duty.”

Valerie was also acutely aware of how gender roles shaped treatment and health-seeking behavior: she often spoke of subordinating her pride or her fear to family responsibilities, and lamented that men lacked the ability or will to do so. “The problem is that men don’t open to themselves – they keep everything to themselves. They feel that if they talk,
they’re weak, not ‘man enough.’ That’s a traditional thing, wanting to be strong. Women are talking; men struggle by themselves.”

She saw risk as gendered, as well. She believed herself to have been infected with HIV by her ex-husband, and saw men generally as more likely to bring HIV into a relationship. “I’m not a risk-taking person – I’d rather be careful. Anyway I’m not sexually active any more. But men are very careless – they don’t think about their families and their kids. Women always think about their kids – they’re the only ones who can really take care.”

Food

In recent years, Valerie had struggled more to make ends meet. Still, she saw money as an almost entirely subjective issue: unlike many people who considered it very important to appear to have money, and feared the stigma of poverty, Valerie didn’t worry about wealth or material success per se, but instead conceptualized the problem as one of survival. “It’s different person to person. Yes, money is needed to survive, but we believe.” Valerie was a pragmatic person, but on the subject of money was rather impassive; she remembered having once had more money, but not in any wistful or nostalgic way. “Before I met my husband, I had money – I had enough for the kids. It wasn’t much, but we got by.” What money she did earn came from irregular work, doing things like driving second-hand cars from the harbor at Walvis Bay up to Angola for resale. On those trips, she would bring back Angolan fabric and linens to re-sell in Narraville. She acknowledged that friends and family had supplemented this meager income: “Everything we have comes from the Lord. The furniture came from my daughter, the stove from my sister, the fridge . . . it’s all a blessing.”
Valerie thought that attitudes about money were largely gendered, and often a function of greed or some other moral turpitude. When our conversation turned – as it often did – to gender and the problems of breadwinning, she said that as a woman she was relieved that “it’s not important what the neighbors think, about money. I’m a very easygoing person, and if I need something that I don’t have, I’ll just go and ask my neighbor – for some sugar, or whatever. That’s why some people are doing the wrong thing – they’re too worried about money. Praise God that I’m not worrying about this.”

For Valerie, then, poverty *qua* poverty did not present a major obstacle to her treatment. This may be a function of her position in the Walvis Bay social hierarchy: as a coloured woman living in Narraville, she would have historically enjoyed privileges that would be beyond the reach of a black woman across the highway in Kuisebmond. However, it was also clearly a function of Valerie’s attitude. Poverty was merely another test of her fortitude – as a woman, as a mother, as a Christian – and one she addressed matter-of-factly. She took for granted that by her very nature she had the strength to endure the challenges of poverty, and had an abiding faith that she would get by. At least for as long as I stayed in Kuisebmond, she did indeed seem to be managing.

**Compliance**

If the downside of male tropes about ‘strength’ and ‘independence’ was that they often lapsed into a paralyzed stubbornness, some female gender roles had their downsides, too. In medical terms, a patient’s propensity to consistently and accurately follow a doctor’s orders is called ‘compliance.’ This is a technical term, but a telling metaphorical one, too, since it implies the malleability and deference that have traditionally been expected of women in many of
Namibia's ethnic groups. My key informants in the medical community did indeed indicate that women by and large were more likely to follow their advice to the letter, and this also seems supported by gendered default rates in, for instance, South Africa (Kranzer et al 2010). However, when women too readily put their trust in the wrong people, this compliance could tip into misplaced credulity.

In Valerie’s case, her devout faith was very much a source of strength for her and for her family, as is clear from much of what she says above. However, shortly after we’d met it began to conflict with her treatment: Valerie complied more with her pastor than her doctor. I decided to ask her about it one morning at her house, and Valerie explained at length her faith, and her ideas about the role that it had played in the course of her illness and treatment.

Valerie's faith, it turned out, was a larger part of her life than I had realized. She followed the pastor of a new Evangelical church of the sort that are spreading quickly across sub-Saharan Africa. Her faith in him was complete, and like many such church leaders his message centered primarily on purification, rebirth, and healing in many forms: “Miracles are happening. People are getting jobs . . . things are happening,” Valerie said solemnly. She told me that she believed faith (and perhaps faith alone) held the answer to all manner of problems, from the medical to the economic. “So, you fight [disease or misfortune] with spiritual warfare. You use the blood of Jesus and the Holy Ghost fire. Sometimes God gives you visions, sometimes he doesn’t. But you have to do it, and you’ll see changes in your life. The Bible says that when Jesus came, he healed. You’ll enter the kingdom if you believe – Lazarus was raised. But it’s about belief, and obedience. It’s about trust.”
“It’s already happening: one week ago I stopped taking my tablets, and I’m fine. I used to have skin problems, and I would itch if I stopped for a day, but now I’m fine. I think I’ll stop the pills and see at my next test, in July\(^4\). I’ve been praying and fasting.”

We met again one morning about a week later; as usual we sat together in Valerie’s house, while she babysat her grandchildren and her son clambered around on the roof trying to fix the TV aerial. All the while the television, as always, was turned on, turned up, and tuned to the Bible Network. Since our last talk I had been consumed with worry about her. I had resolved to talk with her that day about her decision to stop taking her tablets: I explained that I thought a combination of prayer \textit{and} medication would be best, and that as a friend I would encourage her to stay on treatment. She seemed to agree with me, at least to some extent, and replied that she would take her medication "sometimes."

From time to time I drove Valerie to church; it was 30km north in Mondessa, the black township outside Swakopmund. I knew Mondessa fairly well, since my wife had taught at an elementary school there and I had lived for a while in Swakopmund town. As we wound through the narrow streets, I spotted a rather out-of-place car – a high-end Volvo that was conspicuously shiny and new, and altogether out of step with its ramshackle surroundings. “It’s just here,” Valerie said, indicating I should pull over behind the Volvo. She noticed me eyeing the car up and said solemnly, “that’s the pastor’s car . . . he’s been very blessed.”

\(^4\) This conversation took place in early March.
My attempts to trace Valerie after I left Kuisebmond came to nothing. In late 2010 she stopped visiting the clinic; some said she had moved to the north, but the clinic considered her ‘lost to follow-up.’

* * *

Maria

Maria was 38 years old when we met, an unmarried Damara woman living with a long-term partner in Kuisebmond. Her home language was Damara/Nama, and though we sometimes had quick chats in a broken mix of English and Afrikaans (and my few shaky words of Damara), we usually met for longer conversations in the company of my Damara research assistant, Adelheid. Maria was a friendly, relaxed mother of three who described her challenges with a remarkably calm lucidity.

She had actually been born in Kuisebmond, during the South African occupation. This was important, since it entitled her to South African citizenship and, through a loophole left over from the days before the handover, a South African pension. The South African government pays people living with HIV a pension that is substantially more generous than the Namibian government’s pension. She could continue to claim this pension until she changed her residency papers, though as long as staying nominally South African carried such a benefit, she had no plans to switch.

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5 Whether Damara and Nama are separate languages or dialects of KhoeKhoe is the subject of some debate; in daily conversation in Namibia 'Damara' and 'Nama' are usually used individually to denote ethnicity, and usually used together (as in 'Damara/Nama') to indicate language.

6 Maria reported that her pension, in 2010, was 1010 ZAR/month, whereas the Namibian pension was only $370 NAM/month. (The Namibian dollar is pegged to the South African Rand.)
For me, this was another fascinating example of how Walvis Bay was a unique place, caught up in a complex web of relationships with the globalizing world. For Maria, it was an absolutely crucial lifeline. When I asked her what kind of support she received, she deadpanned, "none." Pressed for more, she said simply, "It's just my pension money. That's all we have. If that's finished, I just go to bed hungry. I put food on the table for my children, even if I go to bed hungry."

Maria discovered that she was HIV-positive in 2002, when she was pregnant with her second child. She was surprised by the diagnosis, which came about via routine antenatal bloodwork at a time when she was symptom-free. She was given counseling and scheduled for regular CD4 tests at follow-up. About three months after she delivered a healthy baby, her own health deteriorated quickly; she became weak and tired. She recovered in the hospital, but did not start HAART until 2007.

At first, she had real difficulty with side effects: “my muscles were stretching, like people with epilepsy.” She found the side effects especially pronounced when she took her tablets on an empty stomach, and often had to resort to changing her schedule to accommodate this. Sometimes, for instance, she would take her ‘morning’ tablets in the evening, once she’d secured some food. The aforementioned pension started paying out just a few months after she started taking HAART, and had made her life substantially easier. The only other side effect of note, to her, is that she felt like her sex drive had increased – sometimes so dramatically, she chuckled, that it was hard to control.

I once asked Maria if she knew how she’d been infected. “When I was first tested, I didn’t tell [her partner at the time]. He told me he was going to Windhoek,” but then mutual friends spotted him driving around in town with a woman known locally to be a sex worker.
Maria went to the other woman’s house and confronted her boyfriend. “She was HIV-positive and everyone knew it. I accused him of bringing the HIV, of infecting me.” She thought for a moment and added, "it used to bother me more. Now I've made peace. As the years went by, it was like . . ." here she looked at the sandy street, "it was like the wind blowing it away. Now it's all blown away, and it's fine."

Much as she felt she had made her peace, it was also clear that Maria, like many of the women I spoke with, had suffered greatly through being stigmatized and ostracized, sometimes by those closest to her. Although some friends and relatives knew her HIV status and supported her, Maria felt betrayed by her own mother, in whom she had confided her status shortly after her diagnosis. Her mother responded by rejecting her and publicly disclosing Maria’s HIV status. Maria was typically sanguine about it, emphasizing that the past no longer bothered her, but that the experience helped her to empathize with the newly diagnosed: "maybe that's why some people don't want to disclose - they see what happened to me. Sometimes I regret telling my mother."

During a conversation in the summer of 2010, I asked Maria what was most important to her. We were sitting side-by-side in the front seats of my car, watching the lagoon and sharing a snack; she held her out her right hand out over the gearshift, and counted the spread fingers on her right hand:

my children,
my family,
being healthier,
getting married to my boyfriend, and
buying a house.

She had already arranged a loan for the last, and generally felt optimistic about the future. When she was pregnant, Maria said, her first priority was to be healthy for her child; now that
her children were older, she was allowing herself to look ahead. Our discussions about her future also involved broader conversations about gender roles. When we spoke about her partner and an ideal marriage, she explained, “a man’s duty is to be the breadwinner. He earns the money.” As a woman, she felt she was responsible for using that money to buy food and prepare it for the family. “A good woman nurtures,” she explained, “and a good man earns. I will feel like more of a woman when I have a responsible man, kids, a new house . . . then I’d be a housewife – a real woman.”

During one of these discussions, shortly after I had had a series of dispiriting conversations with male patients who were struggling to find work, I pressed Maria on the question of breadwinning. What, I asked, if a man sincerely wants to be a breadwinner but cannot? What if he simply cannot find work no matter how hard he tries? Her response was remarkable:

“It’s OK if the woman works,” she said. “Then the man must stay at home, cook, clean and change the nappies. If a woman gets work, the man takes housewife duties . . . and he is less of a man. But I probably wouldn’t leave my children alone with a man, because, you know . . . they molest, and things.”

After the interview I sat down for a debriefing session with Adelheid, trying to understand what I had just heard. I asked her what she made of Maria’s comments about leaving her children alone with a man. “That molestation thing is true, in this day and age,” she said. “Even if it’s your boyfriend or the kid’s father. You know how men are these days – there’s no age that’s safe, especially if it’s a girl.”
OLIVIA

I met Olivia through my work at the community center, where she was involved with a support group. When we met, she was 32 years old and unmarried; she was born in the north, but had come to the coast in 1998 in search of work. She spoke English and Oshiwaambo, and though she’d left high school after grade 10, she had plans to complete her grade 12 equivalency in the coming year. Olivia was a cheerful, smiling woman, though the more I learned about her difficult past the more surprising this attitude seemed to me.

Olivia was diagnosed with HIV in 2001; this makes her one of the longest-infected patients I spoke with. Although South African patients diagnosed with HIV in 2013 had a near-normal life expectancy if they started HAART promptly (Johnson et al 2013), the prognosis for Namibian patients in the pre-HAART era was grim. Olivia was obviously a survivor.

She explained with some difficulty how she was referred for a test when her baby became ill. Two years later, the baby and the baby’s father both died, within months of each other.

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7 CD4 count is a measure of the number of CD4 lymphocytes present in a cubic millimeter of blood; it is used as a measure of immune function, and by extension of the progression of HIV infection. See Chapter 2, pages 50-51.
other. As difficult as this time was for her emotionally, she still felt relatively healthy herself, with a CD4 count of 220 – slightly too high to begin treatment under the old WHO and Namibian Ministry of Health guidelines. Though she was ineligible for HAART, Olivia started volunteering at the clinic soon afterward. Follow-up testing showed that her CD4 count continued to hover just about the cut-off of 200, aided, she said, by her post-diagnosis commitment to "positive living." Undeterred, she managed to leverage her position at the clinic: she got another consultation, spoke with nurses and counsellors, and successfully lobbied the doctor to start her on HAART.

Immediately after starting treatment, Olivia experienced serious side effects: “I was sick and sick!” Her first-line cocktail gave Olivia a rash, diarrhoea, and headaches. She switched to a second-line regimen, which mitigated many of her side effects, but she still experienced a (different) rash. For Olivia, treatment side effects had remained a problem even as her dosing was refined and her condition stabilized. She obviously suffered from lipoatrophy – she had the lantern jaw and hollow cheeks that are a trademark side effect for some HAART patients. She felt frustrated by the changes in her body: “I used to be fit, I tell you! This is not my normal body!” She struggled with fat distribution, and found that she had added weight in her breasts and upper body. She was also developing a fat pad between her shoulders (sometimes called a ‘Buffalo hump,’) that she suspected was connected to the presence of the NRTI Tenofovir in her HAART cocktail. Because of experiences with previous substitutions and side effects, however,

8 ‘Positive living’ is another piece of English development-work jargon that has been absorbed into the vocabulary of local HIV patients. Positive living generally involves a variety of health choices including diet and exercise, but also implies some degree of commitment to a variety of personal and social behaviors that Nguyen calls “confessional technologies” (Nguyen 2013).

9 Lipoatrophy is a redistribution of fat reserves around the body.
she has been warned that there are not many alternative drugs left for her. For now, she tolerated side effects as inevitable, but told me - in the voice of the activist patient - that she was forever enquiring about new treatment options.

Otherwise, Olivia identified food security as her main problem. Though she continued to volunteer, she had no formal employment. As an assertive and savvy patient, however, she had found ways to make HAART easier. For instance, in the days when the HAART clinic was still located in town (before it moved to its new location in Kuisebmond), Olivia was one of relatively few patients who were able to pick up drug refills at a sub-clinic in Kuisebmond. In the distinctive vocabulary of the HIV workshop, she told me, “I really like this decentralized treatment.” She followed this immediately by mentioning that she had completed ‘expert patient’ training in Windhoek, at a donor-funded workshop attended by select members of her support group.

Given her status as an ‘expert’ and experienced HAART patient, I was especially curious to hear Olivia’s opinions about gender differences in treatment. We sat on the concrete picnic tables in the community center’s courtyard, sharing a bag of fruit and watching children run in and out. “The support group is mostly women,” she said. “I think women are just more serious. Maybe men lack knowledge.” In her role as a volunteer, Olivia often joined other volunteers in visiting shebeens for HIV outreach sessions. “But the men don’t go. Maybe it’s just ignorance,” she said with a wave of the hand. “I tell them I’m who-and-who, and that I’m HIV-positive for what-and-what years, and they think I’m lying to get them for testing. They think people with HIV should look ‘sick.’”

By contrast, she said, “women have a sensitive heart – they accept their status, but men don’t. And if you don’t accept your status, you won’t disclose and improve.” This forthright
acceptance was, for Olivia, a crucial step in dealing with HIV. “I want to be healthy for my kids. So I have to live positively and try to do my best. When we do the health education, men say, ‘if I found out I was positive, I’d kill myself.’” This exasperated her: “even though they have children! Who would care for them?” She later went on to clarify her position by offering a nuanced view of women’s sensitivity that simultaneously includes a receptiveness to medical advice and a strong resolve in the face of fear and stigma. “Maybe [a man’s] heart is . . . they can’t think like women, because they’re men. They always say, ‘oh, women are so sensitive!’ But [men] are the ones who don’t want to be seen at the clinic. But it’s your life! It’s your health!”

It was, of course, quite easy to stay in touch with Olivia after I left Namibia. Whenever I ask her how she is doing, she invariably replies, "fine fine!"

Selima

Selima was 38 years old and unmarried, when we met at the clinic. She had come to Walvis Bay several years ago after leaving the north in search of work. At least as of 2010, she had not had much success, and at the time had no formal employment. She worked hard at selling jewellery and cosmetics, though, and estimated that she might earn something like $NAM 150-200 per month; she sometimes encountered difficulties in providing for her 11-year-old daughter. She spoke some English and Afrikaans, but we usually met in the presence of my Awaambo translator, Frieda.

Selima had been diagnosed with HIV in March of 2007, and started HAART a year and a half later in late 2008. She sought me out at the clinic one day after seeing a poster I'd put on the waiting room bulletin board soliciting participants for my research. She was always quite
chatty and open, and insisted, as we went through my ethics protocols, "it's OK, many people know my status!"

As with some of the other women I spoke with, Selima suspected that she had been infected with HIV by her (ex-) boyfriend. I had heard about the mistrust and secrecy that HIV often brought to relationships, and several friends told me stories about the ridiculous lengths couples went to in order to hide their status from one another. I had assumed these stories were apocryphal, until Selima offered one of her own.

She recounted that in 2007, she had started experiencing pain in her feet. Since she had access to money through her boyfriend, at that stage, she visited a private hospital for a consultation. There, she was diagnosed with high blood pressure and given a prescription for antihypertensive medication. Around the same time, her boyfriend had also claimed to be on blood pressure medication himself. After filling her prescription at the pharmacy she noticed, though, that her pills looked completely different from his. She decided then to go the VCT for an HIV test.

Selima tested positive. She was referred on to a small clinic in Kuisebmond for CD4 monitoring and counselling, but was not yet eligible for HAART. Almost from the start she was able to recruit support: she lists one relative and one friend as her 'treatment supporters,' and they often attended counselling sessions with her as she learned about what her HIV diagnosis meant for her future. Eventually her CD4 count dipped below the treatment threshold, and Selima was sent to the HAART clinic to start taking medication.

When I asked Selima about how she had found HAART so far, she simply said that it had been "fine," aside from some minor gastrointestinal issues she suspected were drug side effects. However, she then went on to tell me that in mid-2009 she was referred to the state
hospital for x-rays and found to have pulmonary tuberculosis. In patients who are co-infected with TB and HIV when they enter the HAART clinic, the standard was to try to finish a course of TB medication before starting HAART. In Selima's case, since she had already started HAART when her TB was discovered, she was now taking both medications simultaneously. This heavy treatment regime was quite taxing, as suggested by the regular liver function monitoring in her health passport, but Selima seemed to take it in her stride.

When I asked her where she found the strength for this daunting battle, she replied, "I get a real sense of my purpose from my daughter." She also regularly attended the ELCIN (Lutheran) church, and considered her membership in that faith community important to her well being. Selima was further motivated by helping her family: her father had died, her mother was old and infirm, and she placed a tremendous importance on supporting her daughter. She saw herself, despite her ill health, as the pillar of strength at the core of this family: “sometimes I think, if I die, they will suffer.”

This strength was a recurring theme: Selima considered herself strong and believed that this predated her diagnosis: “when I went to get tested, I wasn’t scared. I had no idea of my status, but I’ve always been brave. But still I was scared when I found out the result.” This, to her, was at least partly attributable to her gender. Though she sometimes considered that “men have a harder time of it” in seeking out treatment and dealing with the repercussions of positive diagnosis, she also considered that men were the authors of many of their own sorrows. During a long conversation about gender roles in Kuisebmond, she sighed, “men are too ashamed. Women just go. Sometimes, men have many girlfriends, so they are shy.” Showing perhaps the wariness that was the result of the backstory to her diagnosis, she explained that fear of being spotted by their various girlfriends meant that “men don’t want to
be seen at the clinic. So, they want to go to the private clinic, and women go to the public.

That’s it! Women go to the public one; boyfriends sometimes don’t go at all! ”

When I followed-up on Selima, I learned that she had successfully completed her TB treatment and was still responding well to HAART.

Figure 9: Selima’s CD4/mm$^3$ count before and after initiation of HAART, 2006-2009

SONIA

Sonia and I met at the clinic shortly after she started HAART; a counsellor had mentioned to her that I was hoping to interview patients, and she sent a message to my phone. A 25-year-old woman with two children, she was originally from Awaamboland but had come south looking for work in 2008. She was nearly fluent in English, so we tended to have conversations alone at the clinic. Sonia had casual part-time work at a fish factory, though this work was irregular. If no fish had come in, or while certain fisheries were under annual moratoria, she did not work.
Sonia had tested positive for HIV in 2006, while living in Oshakati. At the time she was completely asymptomatic, and had tested almost on a whim after seeing advertisements for the local New Start testing center. At first she simply didn’t believe the test result, and ignored her status for two and a half years. Finally she re-tested in Walvis Bay upon moving, and was once again diagnosed positive. She continued to ignore her status and lived mostly symptom-free - albeit in denial - until she fell pregnant in 2009. During her pregnancy, a blood test revealed that her CD4 count had fallen to 99 and her haemoglobin to 8.9. Despite a lack of outward symptoms her body was succumbing to infection; anaemia would only accelerate her downward spiral (Obirikorang and Yeboah 2009). “My blood,” she sighed, her voice grave, “was very weak.” In the final months of 2009, she started HAART. “Deep down, I always knew it [the initial HIV test result] was true, I just wanted to believe it wasn’t. I was troubling myself with so many questions, and my friends and family weren’t supporting me.”

“I finished grade 12 with 24 points. The Auntie who was paying my fees and supporting me gave up on me when she heard my [HIV-positive] status. Maybe she thought there was no need because I would die soon. I moved in 2008 and lived with another Auntie at first, but she also chased me away when she heard I was pregnant. She said, ‘how can you get pregnant when you’re HIV-positive?’” Upon learning of her HIV status, the father of Sonia’s children also left; now, she lived in a ghetto on the plot of a member of her extended family in Kuisebmond. However, she said that she mostly felt accepted by the friends and family around her: “only one cousin stigmatizes me.”

In many ways I found the question of social stigma around HIV in Kuisebmond confusing. There was no doubt that social stigma was real: people were often mistreated and rejected when their HIV status became known, and ‘self stigmatization’ meant that many HIV patients
also racked themselves with guilt and self-recrimination. But why should stigma be so persistent for a disease that had infected or affected virtually every single person in the township? The wasted and pock-marked AIDS patients of the pre-HAART era were increasingly rare, and replaced by a new generation of empowered 'expert patients.' When would public attitudes catch up with this new reality?

During one of my last conversations with Sonia, we were joined by Frieda. Sonia revealed to us that she did sometimes feel discriminated against at work. “The other women at the factory can be very mean. They talk about someone who’s positive like they are dead already. Me, I’ve got grade 12, but they will say [when they think I cannot hear] ‘she’s a nice girl, but who will pay for her corpse?’ But lots of those women are also at the clinic! They gossip that they saw you at the clinic, but they only know because they were there too!”

This wasn’t the only aspect of work at the factory that she found challenging. “I work nights. It’s very difficult – you have to lift heavy boxes, and work very fast, as the fish go by on the line so quickly.” In her matter-of-fact way, though, she bore it: “it’s really only good work if there’s no other option. What are you going to do? You can’t live without bread.”

During a later interview in 2010, I asked Sonia about why some patients seemed to struggle, and others succeed. “The problem with many people is they don’t take their tablets on time, don’t rest, eat well, drink water. And these people who smoke, and take alcohol – it’s no good! The tablets won’t work! Some people even have unprotected sex – how can you expect to stay healthy? They hear the message, but they’re ignorant. And when they drink, you know . . .” She considered fatalism to be a precipitate of the HIV diagnosis that often derailed healthy living and HAART: “people say, ‘I’m [HIV] positive, so it doesn’t matter.’ But
imagine high blood pressure. You have to take a tablet every day for the rest of your life. And with high blood pressure, you could die any time!”

As for herself, Sonia felt that HAART had started helping her even after a few months. “Before, I always felt weak and tired. Now I’m stronger.” She reported that she didn’t actually have a treatment supporter, but was interested in perhaps finding a support group. When I asked if she wanted more counselling, she said she didn’t see the need: “nothing about treatment is difficult.”

At her last follow-up, Sonia’s health continued to improve and her response to treatment was 'clinical.'

* * *

In Sonia’s case, her early denial mirrors that of several male patients I spoke to. She also faced a gauntlet of challenges – upheaval, unemployment, rejection and stigma – that would be hugely difficult for any person to tackle. At some point, though, a break occurs. She is sent into treatment via antenatal care; from her description she might have continued living in denial.
indefinitely if it weren’t for her pregnancy. Then, the birth of her children seemed to give her a motivation and purpose that many male patients lacked. Despite all the obstacles before her, she found treatment itself altogether straightforward and accepted it with resolve.

Sonia’s story, of course, is not unique. Most of the female patients I spoke with mentioned motherhood as somehow critical to their survival. There are two important ways in which motherhood might interact with HIV in Kuisebmond. First, many women were diagnosed with HIV in the course of routine antenatal care. This is an absolutely crucial detail: it means that women did not need to separately muster the strength to receive a stand-alone HIV test. Instead, they were automatically tested while attending the clinic for ‘healthy-mother’ check-ups. These visits were not just easy to make but indeed culturally esteemed: they were the mark of a good mother – and, as important, the mark of a good woman.

Second, when diagnosed with HIV - especially if diagnosed in the course of antenatal monitoring - women would already have a built-in 'motivation' to stay healthy. Children were universally valued by men and women alike, though child-rearing seemed to remain primarily the concern of women. While many of the male patients I met seemed ultimately rudderless, women almost always mentioned their children as a crucial anchor. Children gave women hope for the future, a focus for their energy, and an ever-present incentive to stay well. Moreover, their status as current or future mothers meant that women could often count on a slightly higher degree of material support from friends and family: the imperative to support children would often override even the strong social stigma.

Motherhood alone, however, does not fully explain the differences I observed. One thing that clearly emerges from conversations with these patients is that women consistently
seemed more resilient than men, despite facing many daunting challenges. I argue that this is in large part because of how female identity was defined in Kuisebmond. The content of female identity, as described above, was obviously important. Equally important, though, was the nature or form of this identity. Whereas male identity, as described in Chapter 7, was generally more brittle, tenuous, and relative, female identity seemed altogether more flexible, durable, and absolute.

In the next chapter, I explore some of these issues with reference to the literature, to focus-group discussions, and to my own experiences as a participant-observer in Kuisebmond.
CHAPTER NINE

WOMEN II

What right had I to value her less than the dead bodies in the square? Suffering is not increased by numbers: one body can contain all the suffering the world can feel.

-Graham Greene, The Quiet American

HAVING MET SEVERAL female patients and learned more about their experiences, I attempt in this chapter to put their experiences into broader context. As in Chapter 7, I am concerned here with both the construction of the ideal female patient and the ideal woman in Kuisebmond: how were the values of donors and health programmers reproduced in the clinic, and how were female gender norms reflected in daily life? I explore these questions through reference to participant-observation, focus-group discussions, and academic literature with, again, the goal of moving beyond the experiences of individual patients and toward an understanding of gender roles in Kuisebmond.

I have described masculinity as a brittle, contingent thing in the township; female identity was the opposite: durable and certain. Where men seemed hobbled by their gender roles, women actually appeared fortified by theirs. Although they certainly embodied a great
deal of suffering, women also seemed able to draw from a wider variety of deeper, more reliable wells of strength, support, and identity than men. The women I spoke with were unequivocal about their status as women — it was something whose attainment was absolute and permanent, and (perhaps most important of all) irrevocable. A girl could be assured of achieving womanhood by becoming a mother, whereas fatherhood was often described as irrelevant. While this might appear to be a reductive or paternalistic cultural imperative, the urban setting in fact allowed women more choices to develop their identity: while it was highly regarded to marry, stay home, and raise children, women could also establish status through entrepreneurial success, education, or community leadership. Many of the mothers I knew were happily unmarried, and able to leave their children in the care of relatives in order to pursue further opportunities without being judged negatively. These were all seen as valid — and socially esteemed — paths. Conversely, most of the men — and women — I spoke to still considered ‘breadwinning’ (usually imagined as remunerative manual labour) to be the irreplaceable cornerstone of masculine identity. Outside of this, the options for men were very few.

**Making Ideal Patients**

In Chapter 7 I discussed Foucault’s idea of biopower, and the observation that, far from being objective scientific projects, large-scale public health programs often enforce social values. The most helpful recent work in this vein might be Nguyen’s (2010; 2013), whose analyses of HAART rollout in francophone West Africa are usefully applied to understanding how female patients interacted with the program at the Kuisebmond clinic. Nguyen describes how HIV programs mandate a ‘confession’ (that is, disclosure and sharing of HIV status) as a
prerequisite for treatment; confession is framed as a pillar in a cathartic, revelatory process: HAART as self-reinvention. On this latter point, women in Kuisebmond seemed at an advantage. Below, I discuss how women were able to strategically and fluidly adopt a variety of different social roles far more easily and successfully than men. Further, in the Namibian popular imagination, women have long been tied more closely with the church (Cleaver and Wallace 1990), and with a constellation of social values including piety, ‘confession,’ and mutual support and dependence.

This is to say that in many important respects the values of Kuisebmond’s HAART rollout\(^1\) were essentially female values. Patient pamphlets, posters and counseling protocols were explicit that adherence was the central requirement of initiating treatment, demanding full compliance – a submission to the dictates of the program for life. Patients were also required to disclose their HIV status to someone who would become their ‘treatment supporter’ and attend counseling sessions, which meant not only publically recruiting social support but also confiding. The program also suggested abstention from alcohol, though (public) alcohol consumption by women was stigmatized in Kuisebmond anyway: shebeens, as discussed in Chapter 7, were male spaces, and drinking mainly a male activity.

Finally, much of the advertising around HIV, inside the clinic and out of it, featured images of women as ‘good’ patients and men as aggressors or vectors of HIV. One common poster, for instance, featured a warning about HIV above a photo of a young man dressed in ‘street clothes’ apparently propositioning a tidily-uniformed schoolgirl in a classroom. Even if only for epidemiological reasons this may be justified – women, after all, do have higher

\(^1\) I should emphasize here that I am not speaking about individual clinic staff, but rather of the overarching values of the MOHSS criteria, which were uniform in public clinics nationwide.
incidence than men in Namibia, and sexual violence against young women is rampant (Jewkes et al 2005) and implicated in the spread of HIV (Andersson 2008). However, it also reproduces a set of narratives about women as victims of HIV, and validates a sick role for them. Those sick roles (Kleinman 1980), in other words, were constructed as feminine: in accordance with narratives of confession, compliance, and social dependence, to be a good patient was to be a good woman.

In sum, a crucial difference in the gendered experience of the rollout is that for men, complying with the demands of HAART meant losing face, but for women compliance was actually virtuous.

**Fear**

When my counselor friend spoke of women and men as experiencing, respectively, “positive” and “negative” fear, he suggested that the same feelings of fear that motivated women to seek treatment kept men away. That is, both men and women were afraid of HIV—afraid of becoming sick, of being stigmatized, and of dying. Virtually every Namibian knew someone who had died a terrible death from AIDS in the days before HAART, and had seen firsthand the stigma that patients often faced. But while this fear paralyzed men, women were more likely to worry that getting sick would compromise their ability to look after their children or care for their extended family. This over-rode their other concerns and led them to seek and adhere to treatment.

Women were afraid of losing the ability to care for their families, both because of the stigma that would surround such a failure, and because of their very real concerns that nobody else would take their place as caregivers. The female patients I discussed this with in Chapter 8
tended to express it as a remarkably clear-eyed pragmatism: they were at times scared, anxious and despondent, but usually explained that they quite simply had to get on with things.

**Making Ideal Women**

In this section I describe the construction of female identity in Kuisebmond, as reflected through a variety of social phenomena including institutions, social roles, and values.

In Chapter 7, I argued that male gender roles in Kuisebmond can helpfully be understood through Will Courtenay’s (2000; 2011) theories of masculinity as relationally defined against other men but forever unstable and imperfect. Female roles, conversely, might be better understood through some aspects of Judith Butler’s (1990) conception of gender as socially performed. I argue that women had a solid bedrock of stable, absolute identity – women of course had aspirations and conflicts, but their fulfillment was not a matter of existential crisis as it was for men – and on top of that bedrock were able to perform a wide variety of gender roles that were socially respected and beneficial to their health. For Butler, gender is a process, something that we ‘do’ rather than ‘have.’ This seems a particularly useful way to theorize feminine identities in Kuisebmond: women were able to draw from a wider and ultimately healthier inventory of gender identities than men.

Among Butler’s foundational arguments is that gender is socially performed, independent of sex and any physical, bodily reality (1990). I am arguing here that motherhood was a key arbiter of feminine identity in Kuisebmond: of course, pregnancy is by definition exclusive to the female sex – a function of anatomy rather than culture. Further, in the popular imagination of the townships gender is still primarily binary, and divided along anatomical lines (per John Money’s definitions of sex and gender, as discussed in the Introduction). Still, what
makes Butler’s ideas salient here is that while motherhood offered women a stable, valued
gender identity (and one entirely inaccessible to men), women could also perform a wider
repertoire of social roles to define themselves. Women had the option of maintaining the
female roles traditionally esteemed in rural areas; especially among Awaambo women in
Kuisebmond, for instance, it was common to cover one’s head and eschew trousers for skirts
after being married. However, women could also adopt the habitus of ‘modern’ women:
entrepreneurial, independent and empowered. This is all to say that in public and in private
life, women had options: they could wear flashy western clothes or conservative traditional
dress, could affect deference in the clinic and earnest assertiveness in the support group; they
could study at the university or work white-collar jobs in the city, and return home on holidays
to pound millet at the family homestead. More and more women also took on blue-collar
factory work of the sort that was traditionally reserved for males. This contrasted strikingly
with the narrow repertoire available to men, who primarily had to work, carouse, and disregard
their health at pain of losing status.

Nussbaum (1999) argues that Butler’s gendered performances are thin, transitory – they
involve only the modest choices of single actors in single moments and are as such not political
per se, but parodic: “hungry women,” Nussbaum says, “are not fed” by these small acts of
rebellious performance (39). But at the grass-roots level it was clear that, every day, women in
Kuisebmond were able to adopt different valences of ‘female behavior’ to achieve different
ends, including, often enough, to secure food for their hungry families. This perhaps points up
the limits of the utility of Butler’s theory in Kuisebmond; she holds out relatively little scope for
resistance, imagining instead that human actors are suspended in complex webs of power
relations that they are forever reinforcing, however unwittingly. She holds that we cannot
ultimately reject but only ironically comment on these relationships within the tight confines of existing social structures (1997: 100).

I argue that in Kuisebmond, however, women had found substantive and powerful ways to resist gender norms, or indeed forge new gender identities, and that resistance (though it often came at a cost) had brought many of them real victories. It may be that when Butler imagined such a modest scope for resistance, she had not considered communities undergoing social upheaval on the scale seen in globalizing, urbanizing Africa: by leaving the rural village and moving to the city, a woman could access a whole new gendered repertoire.

Although this state of affairs is most apparent in Namibia’s new urban centers, some historical and ethnographic evidence suggests the roots have long been in place. Describing Awaambo gender roles before and during the liberation struggle, Hishongwa (1983) says that traditionally women were seen as vessels of social values, with childbearing as the event that marked the ‘completeness’ of development into womanhood (rather than marriage per se). In the pre-colonial context women did not go to war, but instead took over male roles (including household and village authority and social decision-making) when men were away raiding or fighting. Under apartheid, the homeland system left women behind in rural areas when men went to work; in these situations women already had a model by which to shift roles once again. I suggest that this model stands today when women move to the cities and are divorced from rural social and family structures.

**Motherhood**

Motherhood was the fundamental arbiter of womanhood in Kuisebmond. While men might lose their jobs or disposable income, a woman’s status as a mother could never be taken
away from her. The regional ethnographic record describes the importance of motherhood (see Solway 1992, below), but some research also suggests that quite apart from cultural traditions motherhood has been politicized in some ways in Namibia. Soiri (1996) notes that during the resistance struggle, many women came to see gender equity as an important component of the broader project of liberation. The family sphere became politicized, and the household itself a site of resistance – a woman’s space – in which the very act of mothering, providing, and protecting was an active (rather than the stereotypically silent, passive) assertion of female agency.

Solway (1992) notes that, among the Bakgalagadi of Botswana, social status is indeed a gendered phenomenon and, for women, one very much tied up with reproduction. However, Solway also emphasizes the importance of nuance: a blunt comparison of the status of men ‘versus’ that of women will often elide the important fact that status is contingent and varies across time and with social contexts and categories. That said, I argue here that the distinguishing characteristic of female gender identity in Kuisebmond is that, compared to male identity, it was altogether more stable. In addition to affording a basis for an identity as an adult woman, motherhood was also a guarantor of social capital and often of support. A woman who had left her rural life behind to seek greater opportunity in the city could nonetheless count on her parents or other extended family in rural areas to care for her children. Many people indicated to me that for a man to ask his neighbors for food was a shameful thing, but for a woman – and especially a mother – it was permissible (if only somewhat embarrassing). In focus-group discussions, women often emphasized that even if she had no children of their own, a woman was expected to be a caregiver: one participant
summed this up by saying, “men don’t have sympathy. Women drop out of school to care for their parents – men never would!”

Motherhood was also crucial as an entry point into medical care. For many of the women in the clinic, pregnancy had been their entry point into HIV testing, treatment and care. This is vitally important: it is estimated that only 51% of people living with HIV in sub-Saharan Africa know they are positive, so simply making people aware of their status is vital (UNAIDS 2013, 50). Across the region, women are more likely than men to know their status – presumably because of antenatal testing (ibid, 52). Not only are women more likely to know their status, they are more likely to act on it: across sub-Saharan Africa, female gender, pregnancy, and having children are all independently correlated with early entry into HIV care (Kigozi et al 2009). Further, antenatal HIV testing occurs within the context of an existing medical intervention – pregnant women are already, by definition, ‘in care,’ have a preset schedule of follow-ups, and an in-built excuse to go to the hospital. Whereas a man who reports regularly to the clinic might arouse the suspicion of his friends or jeopardize his reputation, a pregnant woman visiting the clinic is not only unremarkable but indeed laudable. Finally, pregnancy is highly valued socially in Kuisebmond – pregnant women who are diagnosed with HIV at least receive that terrible news during a period of otherwise strong social support and esteem.

The support group members recognized the role that pregnancy played in testing and treatment. When I asked about gender and testing behaviour, one woman remarked, unprompted, that “most women only go to the clinic when they’re pregnant!” During the ensuing conversation about pregnancy, however, some members of the support group suggested that the pressure women’s families put on them to have children might increase
their risk of contracting HIV. “They pressure you to have children and get married. But your family doesn’t know your status! So you give in to the pressure. And then the woman always gets blamed!” Several other women joined in at this point, with one exclaiming, “men might sometimes say, ‘if you don’t want to give me a child, maybe the neighbor woman might?’ Even the family might push the man to have children with another woman if the wife doesn’t!”

Visser and colleagues (2008) find that in the townships outside Pretoria, South Africa, a majority of HIV-positive pregnant women decide not to disclose their status to their partners out of a fear of abandonment. Cooper and colleagues (2007) find similar results in the townships of Cape Town. There, they report that motherhood was such a crucial component of female identity that a positive HIV diagnosis did not altogether diminish women’s desire to have children; worryingly, however, they also found that perceived stigma prevented many of these same women from discussing reproductive issues with their health care providers.

Though the mothers I spoke with were invariably proud to have children and deeply committed to their roles as mothers, it also seems clear from the above that many felt personally or socially coerced into pregnancy. The demands of performing the dominant mode of gender in Kuisebmond were, in this sense, felt just as heavily by women as men. Thus the apparently protective aspects of motherhood in the context of HIV, and the social capital associated with raising children, must be weighed against its place in women’s own conceptions of their life trajectory and agency over its course. This aspect of pregnancy and motherhood bears much further study.
The Church

I contrast the church with the shebeen, and argue that if the latter is the quintessential male space in the township, the former is the quintessential female space.

Christianity came to Namibia in 1806, with the arrival of envoys of the non-denominational London Missionary Society; Weslayan Methodists and Rhenish missionaries arrived a few decades later. (Wallace and Kinahan 2011) Christianity found a strong foothold in the country. Especially during the war, it spread quickly; by the 1960s Namibia’s rates of Christian confession were among the highest in Africa (Soiri 1996). While cash economies and labour migration restructured Namibian life dramatically, these forces at first involved mostly men. As Hishongwa (1983) notes above, women were often left behind in rural villages; the colonial and apartheid economies had no interest in spreading technology to rural areas, so the departure of men cut rural productivity in addition to hollowing out families and social structures. While women did indeed assume many traditionally male leadership roles, a very real gap of social and material needs persisted. Into this vacuum came the church, which many women remember as a crucial source of support when men went to work or to war (Soiri 1996).

For many young women at the clinic, the war might be a distant memory, if it was a memory at all. However, most middle-aged Namibians still remember the war as a lived reality; much of the literature on the socio-psychological experiences of (and lingering impacts of) war has traditionally focused on men, though this is changing (Sideris 2003).

Cleaver and Wallace (1990) describe the church in contemporary Namibia as very much a woman’s place: though still bound by the usual gendered rules of Christianity (including prohibitions on female clergy), women form the backbone of most church communities, and can use the church to achieve positions of leadership and high social standing. I was
particularly struck by the popularity among women (as discussed in Chapter 8) of new Pentecostal churches. These churches tended to promote narratives of healing and personal enrichment, and drew many women with a blend of faith and something that might look to North American audiences like self-help or motivational speaking. When stories emerged of HIV patients who believed they had been cured through prayer, the patients were almost invariably women (Nembwaya 2013).

Why were these churches so popular among women in Kuisebmond? Patterson (2011) suggests that in the past epidemics and socio-economic crises in Africa have given rise to religious movements, citing the Lumpa and Aladura movements in Zambia and Nigeria, respectively. The growth of these movements is often tied to weak or failing states: churches step in where governments are unable to provide material support or services, and, as importantly, when newly urbanized populations find shantytowns bereft of traditional social structures. “Churches,” she says, “provide an alternative vision that contrasts with modernization and capitalism” (16). This certainly seemed to explain some of the appeal of churches in Kuisebmond: in addition to hope and spiritual fulfilment they offered tangible support that often was not available elsewhere – support groups, training, income-generating schemes – and, like shebeens, were a rare social hub in a frequently lonely, indifferent place. The church, like the shebeen, brought together people from various tribal or kin backgrounds and offered them a shared experience. Of course, it is reasonable to conclude that the church was a healthier environment than the shebeen, but this is not always and automatically the case.

Joining a Pentecostal church can also be understood not simply as naiveté, opportunism, or a response to structural conditions, but as an expression of agency and even
an act of resistance. Many of the women I knew who belonged to such churches had joined alone; their husbands or partners did not attend services. The Pentecostal churches in Kuisebmond clearly provided an alternative community that women sometimes joined in spite of personal risks. In a widely publicized case in May of 2010, a man in southern Namibia murdered his wife by dousing her in petrol and setting her alight after she decided to leave the Roman Catholic faith to join a new Pentecostal church (Menges 2010).

In many ways HIV had been internalized into the liturgy of mainstream Christian denominations. I attended a few weddings while in the field, including a Coloured wedding in a suburb of Cape Town and a Damara wedding in a rural area some hours inland from Walvis Bay. It was interesting to note that HIV had worked its way into the wedding traditions in both places. I saved the program from the Namibian wedding, which included a copy of the vows the couple read before the Minister; a selection taken from just before the blessing for the Groom and Bride reads:

**Minister:** Thank you for seed time and harvest and all the good in your creation.

**Groom and Bride:** Bind us together O God so that we might become an inspiration to each other. Help us to understand each other, our strengths and weaknesses, and in doing so become strong partners in the extension of your kingdom here on earth. We especially pray that in the face of all difficulties such as ill health, unemployment and especially HIV/AIDS in which many relationships crumble, that our partnership would never wane.

This is an obvious example of the church advising its adherents to respond to HIV with love and care. Other churches, however, had more conflicted relationships with HIV. The Roman Catholic church in Namibia – despite the Vatican’s history of intransigence on many aspects of HIV – had a long tradition of local leadership on the disease through the organization Catholic AIDS Action, whereas the Lutheran church (which is generally socially progressive in Europe)
was decidedly more conservative in its approach, long refusing to countenance the use of condoms.

Many of the country’s Pentecostal churches, concerned as they were with rebirth and regeneration, appeared at times to offer parishioners faith healing and miracle cures. Here, it seemed that – like the shebeen – the social benefits of being a member of such a church could be outweighed by the harms. I argue that this was the unfortunate flipside of this particular female cultural aesthetic: church communities undoubtedly offered crucial solidarity to female patients, but faith and compliance could also manifest as credulity. In my experience, women were disproportionately involved in churches promising healing and prosperity, and invested faith, hope, and money in herbal cures, witchcraft, and conspiracies. In my time in Kuisebmond, the only people who approached me to discuss such things were women. One positive aspect of masculine standoffishness in Kuisebmond is that it might at least be protective against charlatans who would take advantage of the fear or desperation of HIV patients. Hopelessness, after all, precludes false hope.

In June of 2010 I visited a new Pentecostal church in Kuisebmond. Inside the church was a large stack of cardboard boxes painted in a terra-cotta red and labelled THE WALL OF JERICHO. During services parishioners would put their names on slips of paper inside these boxes; the boxes had labels that included ‘incurable disease,’ ‘separation,’ ‘unemployment,’ ‘witchcraft,’ ‘suicidal thought,’ ‘misery,’ and ‘debts.’ The wall would then be knocked down in dramatic fashion during the service – a remarkable effect considering the church hosted four services daily. I was met by four young staff members at the church, who were friendly but wary when I asked them about the church’s position on HIV, HAART, and healing. The group’s de-facto spokesman replied “we use faith with intelligence. Some diseases are spiritual but some are
physical. People aren’t Superman – even pastors. That’s why we encourage everyone to go to the doctor for testing.” He would not elaborate on which diseases were spiritual; if I had any other questions, he added, he would have to pass them on to the Bishop.

On a March evening in 2010, I raised the question of religion with the support group. The members – many of whom attended mainstream Lutheran and Catholic churches, but a few of whom also attended Pentecostal churches – were concerned about the mixed messages from the faith community. “I saw a TV show with a man who dreamed he wasn’t supposed to take his TB medication anymore . . . and some sort of spiritual leader. And another where a man was told not to test, by an angel! These messages shouldn’t be on TV!” Her friend countered, “if you live by the book, you’re fine.” This sparked a long and lively discussion, during which the men in the group remained silent. One woman protested, “but some people won’t test because they think it shows weak faith. If you have faith and go to these Pentecostal churches, the disease will go out of you.” Several women agreed that this was a problem: “I also know one of these who quit ARVs. She became so sick, I had to fetch her and take care of her. She recovered and went back to the same church straight away. Her condition is getting worse now . . . she’s also been born again.”

It was a short leap between some of these Pentecostal churches and the trade in ‘herbal cures’ and traditional healers. A sizable market existed for patent medicines that spuriously promised relief from various ailments (including, especially, HIV) for a sizable cost. This advertisement in The Namibian on 22 June 2010 was a fine example:
VIRAKIL TONIC.

ViralKil is a powerful herbal tonic developed specifically to assist HIV/AIDS patients.
Halts reproduction of the virus, is a powerful immune stimulant, cleans the liver and improves skin complexion.

I called the listed phone number to ask for details. Maria, whose name was listed on the ad, answered the phone and explained that a bottle cost $165 NAM, and might last up to 2 months. She explained to me that “it doesn’t cure [HIV], when a person is infected it boosts the immune system so that they don’t pick up all sorts of other infections.”

Also common were newspaper advertisements and pamphlets for healers. There was a certain sameness to these advertisements – they usually combined boasts of the exotic provenance of the healers’ skills and medicines (“our powerful herb from Jamaica,” “Dr. Sheikh Sharif from Nigeria”) with a remarkable tally of the conditions amenable to his work (“safe abortion, control of money, unemployment, blood pressure.”) One flyer I collected in Cape Town featured a clip-art image of an AIDS ribbon. Consultation fees were listed as ZAR 50\(^2\), and “people with HIV/AIDS can be helped on Symptoms @ ZAR 220.” According to government figures (Statistics South Africa, 2010), at the time the median (gross) monthly income among the employed was ZAR 2800. These healers and their tonics therefore would cost a substantial percentage of the take-home income of those patients lucky enough to even have any income at all. The Namibian government was concerned enough about the proliferation of these patent medicines that the Ministry of Health and Social Services ran a series of public notices to alert the public about the advertising and dispensing of medicines.

\(^2\) The Namibian dollar (\$NAM) is pegged to the South African Rand (ZAR); they trade at the same rate.
One such notice on 7 July 2010 in the Informanté, a weekly tabloid, warned that “most of the advertisements make spurious/misleading claims” and that “any person dispensing medicines without a license in therefore committing an offence.” Sadly, these wordy black-and-white ads were overshadowed by a larger full-colour ad on the same page for an herbal product called “Wonder Healer.” In a cruel twist, Wonder Healer boasted the power to cure a miraculous list of ailments (at a cost of $NAM 145 per bottle) due to the inclusion of African potato, hypoxis hemerocallidea; AIDS denialists (including South African Health Minister Manto Tshabalala-Msimang) once touted African potato as a cure for HIV (Nattrass 2007). It has subsequently been shown not only to be ineffective against HIV but to seriously interfere with some antiretrovirals by interrupting cytochrome metabolism (Mills et al 2005). This state of affairs would be deliciously ironic if it weren’t so sad.

Exigence, Agency and Passivity

During an interview with an AIDS service NGO in Swakopmund, a manager there remarked that women with a positive HIV diagnosis seemed to undergo dramatic changes in their personalities. A Francophone, she struggled for a moment to find the right word, before continuing in French: “the women especially, they become so . . . exigeantes.”

This was a very different facet of female identity in Kuisebmond, a complex and compelling counterpoint to deferent compliance that seemed especially to emerge in the context of HIV. The NGO manager went on to explain that women were often pushy, assertive and demanding, but also agents of their own care – their own champions in the clinic and the community. I certainly noticed this in my own daily life; although I agreed with my friend’s observation about women infected with HIV – and had indeed encountered many exigent
women in the course of my research – it clashed with something I had encountered just as often: a profound sense of passivity, even fatalism.

The adoption of exigence as a strategy was vividly illustrated in the different ways in which men and women asked for my help in Kuisebmond. For instance, my journal from a single day in March 2010 records two telling interactions at the clinic:

... saw Mrs. C in the records room for the first time in a while. ... we chatted and as I left, she said, “I hope the next time I see you, you bring some apples.” [I sometimes brought snacks to share with the clinic staff.] Then I saw Mr. D near counselling. He told me when I arrived that he wanted to chat, and hovered around until I was done work. He followed me out to the courtyard ... making small talk, looking around at the other staff coming and going, and dodging my questions about what was on his mind. He insisted we walk out of the compound, out of the parking lot, and finally out onto the street before he finally (with a last look over his shoulder) said “I want to go overseas ... I’ve got family there. Can I find work there, and stuff? I’m going to change my life when I get over there.” His secrecy bordered on paranoia but among guys, it’s not at all uncommon ... just like Mr. F only asking my help by email, and Mr. G’s text messages ...

By comparison to men, women were remarkably forthright about asking for help, and this was reflected in their positions not only on the street, but in the clinic and the support group. Allison (1986) echoes Hishongwa’s observations (1983) above that some of this may have historical precedent in the ethnographic record. In many Namibian communities women have a history of perseverance through warfare, and this dislocation and upheaval has inspired a tradition of female fortitude, constancy and boldness – a culture of women accustomed to holding the family together under awful circumstances, largely in the absence of men. Allison’s interviews with elder Damara women suggest that in the past women occupied a lower place than men in their social hierarchy, but that they were functionally independent insofar as they
had very different roles in daily life and had the power to take up their own causes if men wouldn’t act on their behalf. She illustrates this by means of an interviewee’s anecdote about activism in colonial-era Damaraland. In light of rising rates of STDs, the (white, male) colonial Doctors had started to perform pelvic exams on Damara women at the local clinic. The interviewee and other women were upset by this practice, deeming it culturally inappropriate and pressuring local men to take their concerns to administrators. When Damara men wouldn’t take up the cause, the women themselves banded together and marched to the clinic to protest. Eventually, the colonial administrators capitulated and brought in several (female) nurses to perform pelvic exams thereafter. (Allison 1986)

This spirit of independent advocacy was reflected in the HIV support groups in Kuisebmond. While the group that I regularly attended was nominally led by a male President, the vast majority of members were female, and it was they who dominated the agenda and the discussions. When I asked about their motivations for joining the group, the women were initially pragmatic and reported that the main support the group had to offer was food. One woman said gravely, “we all know the need.” At first, the other women struggled to identify non-material ways in which the group had helped them. One laughed and said, “I once got a mosquito net from this group!” This elicited hearty laughter from everyone in the group³, and a series of knowing jokes about the idiosyncrasies of donor aid. “Well, maybe when I go to the north . . .” she chuckled. The women were very pragmatic about leveraging the support group to meet their daily needs, in a way that seemed too forthright for men.

³ There is no malaria at Walvis Bay (nor indeed any of Namibia, outside of the far north) nor any substantial number of insects to speak of.
However, there were also clearly other benefits of membership. After some reflection, one woman offered, “I joined to feel shameless. When I walk, I’m not walking alone.” Another nodded, and added, “When I’m at home I don’t feel OK, but when I come here I forget my problems. I wasn’t free to speak with the others – now I am.” This prompted a quick response from a woman who very much embodied the spirit of earnest empowerment that many women adopted in the group: “you are discriminating yourself! Self-discrimination! Even other people don’t know your status but only you do, and you’re discriminating yourself. You’re seeing people on the street and saying ‘Aye! They must know that I’m HIV positive!’” At this point, the church choir started rehearsing. As it became harder to speak over their voices, we got up to look for a new place for the meeting. We went out to check the empty shipping container in the churchyard that we sometimes used for meetings. One woman tried the door, but couldn’t budge it. One of the men stepped forward and said, “let me try.” She answered loudly, “I’m as strong as a man! I don’t need you to do it!”

At the clinic, the community center, and the support group, it was almost exclusively women who lobbied for recognition and support. As I left Kuisebmond, the support group was in the process of establishing an income-generating scheme that would see them sharing a few sewing machines to produce traditional dresses; they would share the income and plow a percentage back into buying new material. The Kuisebmond bicycle shop was run, after several changes of staff, entirely by a small group of dependable women who were quite comfortable walking to work every morning in boiler suits and walking home every evening covered in grease and chain oil. They had also started letting surplus land near the shop to another group of women to labouriously grow a small vegetable patch; the gardeners were working on a deal
to supply a local hotel with fresh produce. All around me were examples of women who were assertive, bold, empowered – demanding access to treatment and assistance, and refusing to assume the deference toward males (and especially elder or professional males) that was often traditionally expected of women.

However, this is not to say that all women had abandoned compliant behavior: this exigence was undercut by a countercurrent of passive resignation. In late 2009, a good friend of mine lost her job. She had about a month’s salary saved up, and had decided to invest it in opening her own hair salon. She gave virtually all her savings to a local salon owner who had offered to train her in hairdressing and manicure. The large sum was to buy all the materials she would need for training, including salon products and manuals, plus the cost of tuition. The trainer absconded with the money, disappearing for a while and, when she returned, claiming to have no idea who my friend was. The products she’d purchased were meanwhile locked up in a garage. A few other friends and colleagues subsequently admitted to having been similarly swindled by the salon owner.

I was incensed. My friend, a single mother, had had to move out of her flat and into her mother’s (already crowded) house, and try to eke out a living from child support payments and irregular pieces of work that amounted to charity. She was talented and often did peoples’ hair in the community anyway; opening her own salon would likely have brought in a steady income. I told her we needed to take action. I offered to put her in my car right that minute and drive her to the salon so that she could confront the owner herself, or drive to the police station so that she could make a sworn statement – I even had a lawyer friend in Windhoek who could threaten a civil action. She declined on all fronts. I was frustrated – this was her money. Why didn’t she want to fight for it? Rather than rage or even frustration, she seemed
to meet the situation with resignation. When I asked her why she didn’t want to take action, she wistfully said, “it’s not worth it.”

My feeling was that to turn her back on this problem meant giving up, it meant abdicating her authority to steer crucial events in her life, abandoning the useful stance of exigence. It meant denying, in a real sense, her personhood. Over time, I revised my position to accept that what seemed to me to be an embrace of helplessness or victimhood was perhaps an adaptation to a life in which the default position was not always control, where effective and autonomous agency was not a rule but one option out of many.

Nancy Scheper-Hughes (1993) has described how mothers in Brazilian favelas adapt to the staggeringly high rates of infant mortality there by basically remaining less attached to their newborn children until those children have grown old enough to appear to have a good chance of survival. Similarly, I came to wonder if the detachment I found in Kuisebmond might be a sort of insulation from a lifetime of serial disappointment. Sometimes, in Kuisebmond, water stopped flowing from the faucets for days at a time. The post was unreliable, bureaucracies were sclerotic, and civil servants were often aloof, corrupt, or simply impassive. The threats of war and apartheid were gone, but had been replaced by something more unsteady and pernicious. Like David Foster Wallace’s ocean-going boats, women in Kuisebmond faced a daily erosion, ravaged by what they floated in. They had long since recognized that an impassioned or infuriated response to all of these quotidian injustices was ultimately unsustainable, or at least not the right tool for every job, and had instead acquiesced, finding ways to muddle through with the least amount of disappointment and exhaustion.

This makes it all the more remarkable, then, to consider how many women managed to balance this resignation in some situations with a position of earnest assertiveness in other
situations. The ability to assume two such different positions was part of a larger pattern of pragmatic flexibility that defined a large part of female identity in the face of HIV in the township.

Work

Labour qua labour was not a strong component of female identity in Kuisebmond, though many women did of course work. Instead, a sort of entrepreneurial spirit seemed more important than work itself; women valued providing for their families more than browsesweat per se, and there were many ways to provide. This included factory work, but it also included collecting a pension or other government benefits, child support payments, or help from extended family. For many women, though, the ideal was to start their own business. Indeed, the township was packed with beauty parlours, catering services, seamstresses and spazza shops. There was also a booming market in motivational speakers, leadership seminars and self-help books aimed at entrepreneurial success; in my experience women enthusiastically subscribed to all of these in greater numbers than men.

Among women in the support group, work seemed more closely tied to empowerment than income. At a meeting in early 2010 I asked them whether work was important in dealing with HIV, and another very lively discussion ensued. At first they conflated – as was common in Kuisebmond – employment with food⁴. Employment was important, they said, for patients on drugs that have to be taken with food. One woman moaned and exclaimed that her new tablets were causing her frustrating side effects. When she told us her regimen, another woman exclaimed “that’s Efavirenz – it’s a heavy tablet! That one is very heavy . . . you can’t

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⁴ The rich symbolic value of food in Kuisebmond is discussed at more length in Chapter 4.
take it without food!” The woman sitting next to her cut in to correct her by adding, “it’s only a problem when unemployed people take it – you need to take them with food!”

Subsequently, we started to discuss the value of employment – did it confer self-esteem or empowerment? One woman emphatically stated that “people who are working – they use condoms [ie., employed women insist on condom use], but people who are unemployed – they don’t.” To this, a woman sitting nearby retorted, “I’m unemployed!” If she was expecting sympathy, she did not get it. Instead, a third woman broke in to use her own story to aver that women should find their own work: “You could sell kapana\textsuperscript{5} – you don’t have to depend on a man! We should end this. I had a useless husband – no condoms, no money – so I started doing domestic work and I’m not dependent on any man. He took everything and then died in 2005 – if I’d depended on him, I’d be dead now!”

**Violence and Resistance**

The defiant independence and strength that I noticed among many women in Kuisebmond can also be understood as a strategy of resistance. The attitude expressed by the woman above as she excoriates her unemployed friend underscores the fact that for many women in Kuisebmond, relationships with men were often fraught and violent.

In a survey of gender roles in Walvis Bay and several other sites in Namibia, Iipinge and colleagues (2004) find high levels of mistrust between men and women. Though women are increasingly empowered in many social situations, sexual decision making is still primarily in the hands of men; women report finding it difficult to negotiate safer sex, even (or especially) with

\textsuperscript{5}Kapana is a seasoned, grilled meat popular in Namibian marketplaces and shebeens. In Kuisebmond, women also sold kapana on the roads in the industrial area to fishermen and factory workers on their breaks.
their own long-term partners. In the support group, the question of relationships was always explosive. One particularly animated discussion laid out several of the toxic ingredients that the women in the group identified in their relationships, including mistrust, inequality and violence.

“Most women kill their men with words! They don’t tell them they’re positive, and they hide their pills in a different container. There was a couple in the village, the man was positive first but he didn’t tell the woman. The woman also got positive but didn’t tell the man. They found out when they met one day at the clinic! They got home and started fighting, and were accusing who and who. He said he was there to pick up tablets for his friend. They broke up. The lady was chased out of the house and beaten.”

During the ensuing conversation about relationships, I asked the group if infidelity was a problem. One woman immediately answered, “women have to allow it . . . it’s like tradition.” This received nods and knowing sighs around the room. “Women have to take care,” another woman added. “If my boyfriend leaves me for another woman, he’ll come back to me when he gets sick. But then he’ll also blame the infection on me.” Several women nodded along, but some disagreed outright or offered some degree of nuance. One woman urged the others to be more independent and to reject harmful gender norms: “it’s self esteem! If women aren’t working, they can’t refuse the support from a man. If we’re married and I’m not giving him children, he’ll beat me.” One woman exclaimed, to widespread agreement: “Namibian men like beating!”

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6 Here again, I should clarify that while in wedlock men generally expected their wives to produce children, the role of men as fathers was generally considered unimportant, and having children did not earn a man nearly as much social capital (especially among fellow men) as it did for women. In Kuisebmond, men occasionally asked about my wife, never asked if I had children, and almost always asked me about my truck.
There was also an implicit pressure from extended families. “Your parents are always pushing you to have children. And they’ll push you to stay with a man as long as he provides. If he puts food on the table you stay with him and give him kids.” Echoing Lipinge et al’s (2004) findings above, women acknowledged that financial dependence could create a sort of structural violence that forced them into tenuous positions in their relationships. “Because he’s a breadwinner! Women are different. If he’s got nice money, maybe he gives one woman $1000 and me $2000. Men are always wealthy!” One woman summed it up by recalling an old Damara expression: “a woman has to give her husband a child to repay him for buying her wedding dress.”

**Culture Change and the Definition of Womanhood**

It was sometimes hard to avoid the sense that gender roles were changing before my eyes in Kusiebmond. Although the support group’s President was a man, he was regularly sidelined by the more vocal, dominant women in the group. This dynamic played out during one of our meetings, which began with a report from a group member who had attended a workshop at the Community Center, “on the problems that men bring, all over the country.” I and the groups’ two other male attendees shifted uncomfortably in our seats – I think we all suspected we were due for another long conversation about men. “We talked about alcohol – how it brings disturbances to the house, especially for men.”

“Was it only about difficulties?” a woman asked.

“No, it was about abuses, and not difficulties. It’s abuse that brings problems.”

Soon the conversation turned to the question of the group’s membership, and the challenge of trying to recruit more male members. One of the members asked the president if
he had encouraged any other male patients to join. “Only one, so far,” he answered. “And I’m still working on him.”

“What did you talk about?”

“Actually, we haven’t gone into detail yet . . . he asked me about starting a support group, and I told him it was easy, he just has to show up at the church. He wants to come . . . he will come, one of these days.”

The meeting carried on, with another male member eventually saying “this issue of men . . . men need encouragement to come to support groups.” Several times while trying to speak he was cut off, and needed specific re-introduction by the president to carry on. “It’s better to speak to men one-on-one, to tell them about opportunities. If they decide they’re not interested, then let them go. Sometimes, when a patient speaks to someone who’s positive looking for support or advice, that man will say, ‘go ask someone else, I’m negative,’ or ‘let me be done with this disease!’ Women should start speaking with their men, invite them to support groups – we could begin from there.” One woman, who volunteered at the HAART clinic, replied, “men at the clinic should ask to speak with someone they know. I tried to talk with a guy at the clinic once, and nothing came of it.”

It spite of the obvious challenges that township life presented to women with HIV, during conversations like this one they appeared so much better equipped to navigate health system and its support structures to their own benefit while men floundered.

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Tvedten (2011:152), studying culture change and urbanization in northern Namibia, reports that women there are still beholden to the traditional value of ‘okwiituma’ (roughly translated as grace) in comportment, carriage, and social interactions. Okwiituma also conveys
an attitude of unruffled independence and self-esteem that should be inherent in all but the most destitute Awaambo women. My Awaambo research assistant translated okwiituma as the reflexive form of the verb ‘send,’ as in ‘to send oneself:’ this captures the tension between projecting an image of serene compliance with the ebbs and flows of life, and the earnest strategies of swimming against the currents in the name of urban survival.

Motsemme (2011) describes this phenomenon in the townships of South Africa as a tension between ukuphanta (to hustle) and ukuhlonipha (to respect)⁷. ‘Hustling’ is a necessary strategy for survival, and one that means that virtually anything a woman can do to provide for her family is not particularly stigmatized; this contrasts with more ethically ambivalent male hustling (including the underground economy and petty crime), the fruits of which were usually expensive clothes or gifts for (multiple) girlfriends. By contrast, enacting ‘respect’ in the township – in addition to being a fundamental female virtue rooted in stoicism, resourcefulness, compassion and politesse – requires new forms of social engagement. This often finds expression in church communities and support groups. I saw the same dialectic play out in Kuisebmond, where there was a clear tension between women remaining invested in traditional female roles and abandoning them (and often abandoning toxic relationships at the same time) to reinvent themselves as independent, entrepreneurial urbanites.

Beyond this were a variety of other positions. One female patient I spoke with earned a marginal living as a semi-professional athlete. Another had gone back to school to complete her diploma, and was forever chatting with friends at the community center about her studies. Overall, women seemed more confident in their ability to take on a variety of subject positions

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⁷ These terms are Nguni, originally, but are now in wide use by speakers of many languages in the typically polyglot townships of Durban.
as circumstances dictated, and more confident in their ability to make these situations work successfully.

Culture change, however, is an unpredictable process. The observations that I have made in Kuisebmond are by no means uniform across the country, nor do I expect they will remain constant over time. Heike Becker (2003) finds that the San, whose long tradition of high gender equality is well noted in the ethnographic record, have had an entirely different experience of exposure to modernity, urbanity, and globalization. Becker finds that the San’s peaceful and egalitarian relations have been to a large extent effaced, replaced by imported (hierarchical) conceptions of manhood and womanhood. Concomitantly, gender-based violence has increased substantially. This example should warn us that the ongoing urbanization and globalization of Africa will almost certainly bring a host of changes to gender roles; their trajectory may not be altogether positive, but will certainly be impossible to predict.

Conclusions

In Namibia I noticed among men a distinct lack of earnestness. In conversations, women would sometimes explain to me that they were “struggling.” The word “struggle” is a loaded one in Namibia, where it immediately conjures the liberation struggle of “a luta continua.” However, outside of this context, ‘struggling’ does not necessarily carry a positive connotation. The sense of stoic forbearance it might convey was undermined by an altogether more powerful sense of indignity. This is not to suggest that the people I knew in Kuisebmond

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8 See for instance Lee 1979; and Shostak 2000.

9 This Portuguese phrase was originally taken up as a motto by FRELIMO fighters in Mozambique, but came into common use among several African liberation movements, including Namibia’s SWAPO.
did not work hard, or did not face real daily struggles, or that this made them any less meritorious as human beings. Rather, the culture of Kuisebmond (and perhaps indeed of Namibia more generally) is not one that attaches any particular Calvinist merit or sanctity to work itself, but rather to the fruits of work.

Unlike the silent, sacred daily struggle invoked by the Protestant work ethic, struggling in Kuisebmond was meant to evoke pathos: that a person should be reduced to struggling was a desperate, not a virtuous, thing. To tell a friend that you were struggling could be a veiled request for support: it meant that your ‘grace’ had failed. I used to watch with wonder as taxi drivers would adjust the sound on their stereos, carefully oblivious to the traffic around them, delicately extending three fingers and slowly turning a knob or pressing a button as gently, breezily, even as artfully as possible. Why not quickly switch the dial with thumb and forefinger? So many of the men I knew in Kuisebmond strived for this general appearance of moving through life untroubled, immune to petty concerns. The cultural aesthetic of aloof, unruffled grace clashes powerfully with most foreign-designed, donor-driven HIV programs, which are generally so earnest they could have been scripted by a motivational self-help guru like Napoleon Hill.

Over the years, when I asked friends or acquaintances in the township how they were doing, it was only women who would sometimes ruefully reply, “ah, we are struggling.” This reply was always delivered in the plural first person, and almost invariably accompanied by a wistful sigh, a shrug of the shoulders, or a general habitus that communicated defeat more than resolve. This impression was doubly striking coming from women whom I personally knew to be remarkably strong, and to have managed in the face of long odds with truly incredible resilience. Men never remarked that they were struggling. I knew that, objectively speaking,
several of them were ‘struggling’ according the common definition of the word: struggling
to regain their health, struggling to find work, struggling to manage crumbling relationships,
struggling to fill their stomachs each day. At least in the world of HIV treatment and care, the
men I encountered struggled every bit as much as the women, if sometimes in different ways.

I have come to believe that this lies close to the core of the gendered disparities in
HAART outcomes in Walvis Bay. Men delay initiation, fail to comply, drop out and die or
commit suicide at greater rates than women not because they are ignorant. Nor are they
necessarily more fatalistic, more reckless, nor somehow deserving of the horrors of an
agonizing death from AIDS. Similarly, successful female patients were not successful solely
because they were heroic in some sort of way that was intrinsic to them or inaccessible or men.
The men I met who struggled did so precisely because they could not be seen to struggle. They
struggled because they were so deeply dedicated to a gender role that virtually forbade them
to submit fully to the entire constellation of behaviors and attitudes surrounding the treatment
program. Forced to decide between being good men and compliant patients, they made a
choice. Given the stakes, it hardly seems like a choice freely made.

The social reasons why women in southern Africa are more susceptible to HIV infection
are well established, including high rates of sexual violence, economic disenfranchisement, and
a lack of power in sexual decision-making (Ackermann and de Klerk 2002). Mark Hunter has
explored these issues at greater length, using ethnographic methods to describe HIV risk in the
townships of South Africa (2010). Even though women clearly lag behind men in terms of
economic opportunities, employment, or social capital – and though they clearly are the victims
of a shocking epidemic of daily violence and a disproportionate burden of HIV risk – the
demands of HAART are more compatible with the demands of womanhood. Women in
Kuisebmond could ‘struggle,’ could turn to others for support; they could affect compliance in the clinic and exigence in the support group. They seemed altogether more able to confront the challenges of HIV openly, to mobilize the support they needed, and to operate from a position of secure identities and public esteem.

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Clearly, women in Kuisebmond faced tremendous challenges daily. They also, in the urban environment, found new opportunities and new roles. In the township, both the ‘respect’ and the ‘hustle’ models were available, and both were locally valid. This is the perhaps the key difference between the construction of male and female identities: while men struggled within the toxic confines of masculine identity, women drew from a wider and healthier repertoire. Confronted with a wide variety of obstacles in a rapidly changing environment, women, frankly, just got on with it. This growing strain of independence and empowerment bears further study, and may augur generational changes ahead.

I once asked several women from the support group if they thought that the HAART rollout, all told, was working. They shrugged, and looked at me as if I was a little foolish: they all agreed that rollout was working to such an extent that it was basically taken for granted. Finally, one of the women took a slightly pitying, patient tone, put her hand on my shoulder, and said: “don’t you see our shining faces?”
The AIDS epidemic needed social change to catch fire.

-Craig Timberg and Daniel Halperin, *Tinderbox*

Having surveyed the clinic population in Kuisebmond, and explored the lives of individual patients in treatment there, I turn lastly to a wider consideration of the political ecology of HIV in Walvis Bay. This is an ecology focused primarily on two organisms – human beings and the HIV virus – and the ways in which they interact in a unique environment; I have maintained throughout this thesis that understanding Walvis Bay as a place is crucial to understanding how the HIV epidemic is manifest there. The ecological perspective is a powerful tool to add to the quantitative and qualitative approaches I have taken so far; it shows that a set of structures and dynamics not only shape the transmission of HIV, but also shape its treatment. In this chapter I review some of the growing body of literature emerging around the social ecology of HIV
transmission, and modify the main thrust of this research by applying it to the rollout program in Kuisebmond.

In Chapter 2, I describe Walvis Bay as perhaps the only truly ‘global’ city in Namibia: though smaller than the capital, Windhoek, Walvis Bay is more intensely and more directly tied to global flows of people, resources, capital and ideas. The city is home to several massive multinational corporations and major NGOs, and on the granular level its streets teem with visitors and migrants from across Africa and the world. Globalization is not, however, a coherent policy, nor a single set of levers pulled with a clear purpose. For the purposes of this chapter, I define globalization as above all a process of increased movement, whether of people, capital resources or ideas, especially as facilitated by developments in transport and communication technology (Richardson et al 2014). These changes, however, are often manifest in unintuitive ways, particularly when examined in ethnographic detail.

The earliest form of globalization might have been biological: the line smallpox traces from ancient Egypt to China, Europe, the New World and Australia followed burgeoning routes of trade and exploration. The question is therefore not whether globalization is ‘new’ – it has always been with us – but rather how thick or thin it is, at any one place or time (Nye and Donahue 2000). By this measure contemporary globalization is unique in its speed and intensity, and Walvis Bay is a site of especially thick connections to the globalizing world. Of particular interest to us is how the myriad changes described by the term ‘globalization’ affect human health (whether separately or together). Sol Benatar (2006) has argued that HIV and other emerging infectious diseases are evidence that the post-Breton Woods period of remarkable progress through the last century has, in addition to driving tremendous growth,
fundamentally destabilized the world system\(^1\). These global changes are still unfolding and their trajectory remains uncertain. I have argued (Richardson et al 2014) that health is the ultimate ‘downstream variable:’ in appraising any aspect of the world system, health should be our index of how its impacts are felt at the human level. Simply: insofar as globalization makes us sick, it is broken.

Anthropologists have traditionally referred to chronic conditions like cancer and diabetes as “diseases of civilization,” (see for instance Eaton and Konner 1986; Eaton et al 1988) especially in contrast with the morbidity and mortality profiles of pre-industrial societies on the opposite end of the demographic transition spectrum. Evidence suggests that isolated, traditional communities in rural Africa actually make stable ‘containers’ for HIV at consistently low prevalence, even absent medical care and public health infrastructure (Nzilambi et al 1988). Only with the explosion of a certain mode of ‘civilization’ – dramatically increased mobility, rapidly densifying urban centers, and the attendant changes in socio-cultural and political-economic structures – does the virus escape its reservoir and become epidemic (Faria et al 2014). Given this, HIV is perhaps best conceived of not as a disease of civilization, but as a disease of globalization: a symptom of a series of socio-cultural and political-economic upheavals during the last 100 years.

**Building a Critical Political Ecology of HIV**

I argue that in Kuisebmond there exists a special set of conditions that change the relationship between humans and the HI virus; insofar as HIV and human beings occupy the

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\(^1\) Laurie Garrett makes a similar argument in her monumental *Betrayal of Trust: The Collapse of Global Public Health* (2001), arguing that in many cases the remarkable new wealth and technology of the globalizing world has been so unequally distributed that it has left the world worryingly vulnerable to health crises.
same area at the same time, we can properly discuss Kuisebmond as a 'community' in the ecological sense. Understanding this community requires a holistic perspective that includes attention to the forces shaping human action and the environment, the flows of energy and matter through that environment, and the information that drives feedback and allows analytic scrutiny. This necessarily involves a critical consideration of political-economic factors and the concrete ways in which they affect individuals, populations, and ecosystems. A broad perspective and an ability to highlight dynamic relationships are strengths of the ecological approach, as is its predictive power. It also has limitations: the breadth and depth of the relationships in an ecosystem model can quickly become intractably complicated, and a model is only as good as its assumptions. Of particular concern to anthropologists is that the ecological approach can also elide the level of personal detail that makes ethnographic research so powerful.

HIV has been examined through the lens of vulnerability – some groups have traditionally been considered more vulnerable to infection because of marginalization, disenfranchisement, and stigma (see for instance Buvé et al 2002). Vulnerability in this case is often understood as resulting from an interplay of individual behavior with broad structural constraints. Scholars informed by Ulrich Beck’s (1992) notion of the risk society have begun to lay out a concept of geographies of risk: that is, while modernity affords us greater tools to insulate ourselves from risk, it simultaneously exposes us to greater hazard (Craddock 2000; Mshisha et al 2008). Paul Farmer (1998) invoked the concept of ‘geographies of blame’ as a way of understanding the racial-colonial prejudices that fueled early (mis)understandings of the epidemic. He argued that popular assumptions and official policy alike were rooted in blunt
bigotry toward Haitian immigrants, and a belief that HIV originated (or propagated) in Haiti\textsuperscript{2}.

Farmer also highlighted the crucial connexions Haitians themselves made between HIV and the forces of poverty and American imperialism.

Subsequent research has taken a more rigorous approach to blending ethnography with empirical data. Helen Epstein (2007) and, at greater length and depth, Robert Thornton (2008), focus on the comparative efficiency of sexual networks in transmitting the HI virus through populations. These authors build on Morris’ sexual concurrency theory (Morris and Kretzschmar 1997). This theory holds that, in explaining the spread of HIV, an individual’s total number of sexual partners is less important than the timing of those relationships. Contexts of serial monogamy tend to be less efficient in transmitting HIV, since an individual should theoretically be less viremic (and therefore less contagious) by the time they leave an infected partner and move onto a new relationship. In contexts where multiple concurrent sexual relationships are the norm, however, a newly-infected individual would be far more likely to pass the virus onto several people during the ‘acute’ (and highly contagious) period of infection.

This theory is compelling, but has been critiqued under systematic review (Sawers and Stillwagon 2010) as insufficient to explain current HIV prevalence in sub-Saharan Africa. Both Epstein and Thornton foreground the power of sexual concurrency to rapidly increase network efficiency, and Thornton in particular emphasizes the extent to which sexual networks have been reconfigured by social upheaval in both Uganda and South Africa.

Toward the end of my stay, a handful of foreign donors began to aggressively position “sexual networks” as their next HIV-programming target. Colourful, full-page advertisements

\textsuperscript{2} Pepin (2011) has subsequently uncovered convincing evidence that does in fact show several strains of HIV as having arrived in the United States via Haiti.
ran in national newspapers asking readers to identify their sexual networks and work to “break the chain.” Although the controlling of sexual networks makes great epidemiological sense (and may, as discussed in Chapter 11, play a key role in staunching incidence in sub-Saharan Africa), the message of these ads was often hard to discern at a glance, and even contradictory: what was ‘the chain?’ Were concurrent relationships good or bad? And why, exactly? Ultimately, most of the imported calls for faithfulness and the interruption of sexual networks were received in Kuisebmond like most other imported health messages: well-meaning, earnest, and mostly harmless soundbites that were important to parrot in the donor’s (or doctor’s) office, but otherwise so far removed from daily realities as to be almost irrelevant.

Eileen Stillwagon (2006), conversely, eschews theories of sexual behavior in favor of a more purely ecological argument that foregrounds the effects of host susceptibility and environmental conditions. Her approach builds on research that identifies a variety of biological co-factors that predict HIV infection, including male circumcision and infection with Herpes Simplex 2 (Auvert et al 2001). In particular, she argues that an emphasis on ‘vulnerable groups’ and ‘risky behavior’ misses the crucial differences in baseline health in some sub-Saharan African populations (especially due to chronic malnutrition and high parasite load) that render so many people more likely to become infected and succumb more quickly to AIDS. This is, in short, an application of Pasteur’s argument that “the microbe is nothing – the terrain is everything.”

More recently, HIV has been understood as a product of globalization: a disease that emerged from a central African ‘reservoir’ and was spread, though massive upheavals, across the fault lines that emerged in new social communities and urban environments. This approach has been facilitated by parallel advances in both basic science (including genetic analyses and
dating of viral subtypes) and historical research (including information gathered from colonial archives and the discovery of preserved tissues). Timberg and Halperin (2012), Pepin (2011) Faria et al (2014) and others have employed approaches that might broadly be described as rooted in political ecology to describe the origins of the epidemic. These authors take for granted that HIV arose in central Africa, and share a concern with the effects of rapid urbanization, shifts in labour practices and demographic structures, and the creation of transportation links on the disease ecology of that region. For them, sexual behavior and parasite load are both less important than the processes that disturbed the disease reservoirs of the jungle borderlands of Cameroon and Congo, and rapidly moved hundreds of thousands of people into new places and new social relationships.

This approach is enlightening, but it has a long history: William McNeill, in his 1976 landmark Plagues and Peoples, considered the relationship between humans and pathogens across human history. In 1997, he wrote a new introduction to the book featuring a discussion of HIV, and concluded that

The apparent conquest of infectious diseases between 1884, when Robert Koch first identified the cholera bacillus, and 1976, when WHO succeeded in eliminating smallpox, was assuredly one of the most dramatic disturbances of the older ecological balances ever achieved by human beings. Nonetheless, the way infectious diseases have begun to come back shows that we remain caught in the web of life – permanently and irretrievably – no matter how clever we are at altering what we do not like, or how successful we become at displacing other species. (16)

McNeill’s analysis is remarkable for its profundity and lucidity, but not necessarily its novelty. A line runs from Pasteur’s epigram about the ‘terrain’, to Engels’ The Conditions of the Working
Class in England in 1844 (1993), to Rudolph Virchow’s 1848 report on typhus in Upper Silesia (2006). In every case, the authors draw attention (explicitly or implicitly) to the extent to which there can be almost no extra-medical factors in a human ecosystem. I modify this line of thought by arguing that ecology can determine not only who becomes infected with a pathogen, but how patients subsequently access and respond to treatment.

**Place: Considering the Frame**

Walvis Bay is not a major financial center, nor the home of an important world stock market; its population is relatively small and the place it occupies in the popular consciousness of much of the world is peripheral at the very best. However, it is also a major export hub and is more connected to international trade than any city in the region. For this reason, unique among Namibia’s urban centers and those of some of its neighbors, Walvis Bay should be considered a hub in the global cities network (Sassen 1991).

Importantly, this network is not metaphorical: it is a worldwide group of cities bound up in a very direct, rapid and frequent exchange of people, animals, resources, and information (van Wagner 2008). More importantly, this network of cities also transmits pathogens; some researchers argue that it is the very nature of contemporary global cities that explains many recent outbreaks of infectious disease (Vlahov and Galea 2003). Of course, the consideration of urban environments as unique disease ecologies is not new. John Snow was arguably the progenitor with his groundbreaking work on the Broad Street Cholera epidemic in 1854 (Johnson 2007). Since then, researchers have increasingly appreciated the extent to which

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4 However, see also Tufte 1983.
urban life forces people into new relationships with their environment, and with one another, and the effects that this has on health. Below, I examine Walvis Bay as a city environment.

If we consider energy, matter, and information as the three key components of a human ecosystem (Moran 2008), we can examine each as it appears in Walvis Bay and relates to HIV transmission and treatment. This analysis, combined with an examination of humans as disease hosts and HIV as an agent should in turn inform a discussion of treatment.

**Energy**

Anthropologists have long been concerned with the relationship between a society’s complexity and the intensity of its energy use; it is generally considered axiomatic that the process of ‘modernization’ and increasing cultural complexity is also a process of increasing intensity of energy use (White 1943). Beginning at least with the work of Julian Steward (1955), the harnessing and uses of energy and natural resources have offered important insights into other aspects of societies. Walvis Bay, especially when compared with the vast majority of Namibia’s sparsely populated territory, is clearly a high-energy solution to variety of environmental stresses and an economic model based on massive throughputs of energy. That is, supporting Walvis Bay’s main industries – and even its basic elements of life – is only viable with the importation and exploitation of energy and other resources, which leaves the city almost totally dependent on the periphery, and the availability and cost of its energy sources.

The first energy consideration is solar input, and on this front Walvis Bay is unusual. The city experiences dramatic swings in solar radiation and frequently varies between stiflingly hot, dry conditions and very cold, damp conditions very quickly. This in turn feeds into some of the housing problems described in Chapter 1: living arrangements are densely crowded and often
inadequately insulated or ventilated. People are often prevented by the weather from living outdoors, and need access to expensive and sophisticated housing, heating and cooking solutions as a result. I argue that this explains at least some part of the high prevalence of TB in the city\(^5\). There is such a profound lack of local sources of fuel (this can also be considered a problem of natural resources, or ‘matter’) in the area that self-sufficiency in any meaningful way is almost impossible: firewood is entirely imported, there are no substantial deposits of fossil fuels currently exploited in the area, and the lack of agriculture and livestock precludes the development of ethanol, methane, or even dried manure as energy sources.

At the individual level, this means people in Kuisebmond must buy mains power at city rates and import firewood primarily through the informal market. Walvis Bay produces its municipal electricity at a diesel generating station, meaning that rates are subject to the vicissitudes of the global oil market: that market is volatile at the best of times but was especially so during the period in which I was conducting my research. In constant (January 2014) dollars, world crude prices (per barrel) went from $17.10 in 1998 to $99.06 in 2008, before plummeting to $58.20 in 2009 (inflationdata.com). Offshore oil exploration has recently begun to accelerate at the coast, with several major international operators including Dutch Shell and BP staking claims in the Walvis Bay basin (Ratcliffe 2014). Oil, however, has historically been much more of a curse than a blessing in sub-Saharan Africa (Devlin et al 2008).

Considered in light of the massive energy inputs needed to maintain the population – albeit in poverty for many of them – the city emerges as a uniquely modern phenomenon. In marked contrast to the isolated communities of classic ethnography, Walvis Bay and the people there exist in almost permanent discord with their surroundings. This problem is further

\(^5\) Of course, tuberculosis also synergizes powerfully with HIV, a phenomenon I discuss below.
discussed below as it relates to matter; in both cases the city is almost completely sustained by inputs from large, distant reservoirs of energy and resources, a situation that creates massive external costs. Walvis Bay is a synthetic city kept afloat by the global market; a place that solves many of its ecological challenges by heaping energy on them and exporting the external costs. This solution has so far been successful, but it is precarious – a classic example of the double-edged sword of modern risk described by Beck above.

**Matter**

Regarding matter, Walvis Bay is again a severely constrained environment that relies on major throughputs to sustain itself. Water is the limiting factor, and is so scarce that survival of the population is impossible without a pipeline to a series of fragile and vulnerable aquifers in the Kuiseb river. The only desalination plant on the coast, located north of Swakopmund, feeds the mining industry and is not used at all for residential demand. The city’s substrate is so hostile that it supports only a small number of plants; among them is the *Inara* melon that traditionally supported a small population of Topnaars, though even that appears to be at threat today due to sea level rises and falling groundwater levels (Rowswell and Fairhurst 2011). The lack of grazing makes keeping significant numbers of livestock impossible; marine birds create substantial deposits of guano, but this is locally useless as a fertilizer and must instead be exported.

These local scarcities have the effect of forcing very high levels of mobility. Unlike the stable ‘reservoir’ communities discussed above, Walvis Bay would never have been able to be self-sufficient in any meaningful sense. This is true not only of life-sustaining resources but of commodities. As cities grow larger, they become sustainable only through increasingly dense connexions with the periphery, both for import and export. Walvis Bay is no exception, though
the ‘tipping point’ at which the city’s population becomes unsustainable and requires material support would, as a result of the aforementioned environmental constraints, be remarkably low.

It is also the nature of Walvis Bay’s extractive industries and landforms that certain sectors have been traditionally over-represented there. The proximity to the ore deposits brings miners; the massive natural harbor brings truckers, sailors, and the navy; the rich fishing ground sailors, longshoremen, and associated industry. The population has long been disproportionately male; this has profound effects, which are discussed below.

Because Walvis Bay’s primary industries export raw material, the area’s most valuable matter leaves permanently. This means that the city requires an open pipeline to the wider world – this is in fact its basic subsistence strategy. However, the flows in this pipeline run in both directions: the city exports a small basket of valuable resources, but must import virtually everything else. As with energy, this can be a precarious strategy: the city needs imports to meet its most basic material needs, so its pipelines (literal and otherwise) and its markets can expose Walvis Bay to shocks from across the world. When the Kuiseb River’s aquifers are fouled, the city’s faucets run dry and potable water must be imported in tanker trucks.

Moving this matter around has major implications for health. As discussed in Chapter 7, the coastal highway that is Walvis Bay’s only land connection to the rest of the continent is often deadly: in a country of astonishingly dangerous highways, the Walvis Bay road is among the worst (Sivak and Schoettle 2014). Roadways can be deadly in more subtle ways, however. In Uganda, Emily Oster (2012) finds HIV incidence positively correlated to export volumes (not value, or income), suggesting that the increases in movement associated with export growth
also increase the size and efficiency of sexual networks. Truck drivers can therefore become key vectors and the busiest trucking routes flashpoints of incidence.

Perhaps unsurprisingly, countries with the highest HIV prevalence tend to be those with relatively higher-performing, extraction-based economies that are also closely tied to the global market: hence Namibia, Zambia, Botswana, and South Africa’s remarkably high rates and Angola and Congo’s relatively low ones. The latter two countries rely heavily on natural resource extraction, but years of civil unrest have had the effect of powerfully dampening movement. (Patterson 2008).

**Information**

We can consider information in two different senses for the purposes of this analysis. In the first, information is simply data – points of knowledge that are learnable and socially transmitted within an ecosystem. As discussed in various parts of this thesis – and especially Chapter 5 – there is a real lack of high-quality, accessible information on HIV in many parts of Namibia. (Though Namibia is far ahead of many of its African neighbors, in this regard.) Especially in the early days of the epidemic, HIV was allowed to proliferate in the absence of the ‘antiseptic of sunlight’ – that is, transparent, public, and objective information on the parameters of the epidemic.

Further, despite many years of attempts at education campaigns, misinformation persists, especially among the most vulnerable groups (Burgoyne and Drummond, 2008). A survey conducted in 2012-2013 found that just over 30% of female sex workers in Walvis Bay did not have correct information about HIV, despite their elevated risk (Katuta et al 2014). Anecdotally, a foreign consultant who had conducted HIV education workshops among volunteers and outreach workers in Walvis Bay told me with a sigh in 2008 about the results of
her work. After an intensive training course on the facts of HIV, nearly half of all participants reported confidence in miracle cures and other incorrect beliefs in an exit quiz.

Of course, these discussions are concerned primarily with ‘information’ as knowable facts about the virus and its human hosts. Information in this sense may be less compelling than in the second sense of feedback – information that drives change in system components or processes. HIV has a notoriously difficult relationship with feedback. First, the lag between HIV infection, seroconversion and death is long (on average, 7-10 years). Compared with more aggressively virulent diseases like Ebola, or conditions with obvious ætiology like food poisoning, AIDS traces a long and often murky line through a patient’s life history (Barnett and Whiteside 2006). This lag dramatically impedes feedback – especially negative feedback, which might drive a reversion to ecosystem homeostasis and ultimately reduce population incidence, even if it cannot cure individuals who are already infected. If anything, this aspect of HIV might instead drive positive feedback – the virus takes so long to produce outward symptoms or mortality, and does so in the context of countries with already truncated life expectancies, that for many people it hardly seems a proximal threat. Individuals might therefore see no immediate point in adjusting their behaviors away from infection. Further, at the individual level, messaging about HIV, however useful and accurate, may come into conflict with very real daily struggles around practical matters like food or employment, or socio-cultural conflicts around gender roles and family obligations.

Second, it is important to note that the feedback field is further muddied by the densely cybernetic nature of Walvis Bay as a new African city. The thick connexions the city has to the rest of the country, continent and world mean that HIV cannot simply be responded to in a vacuum. Altering one relationship in the ecosystem naturally has knock-on effects elsewhere,
and the small social and clinical changes attempted by HIV planners, for instance, can be suddenly and massively overwhelmed at the population level by other shifts like market failures, climate shocks, or migration. This is to say that, following the introduction of HIV into the ecosystem, a return to the previous equilibrium may be impossible regardless of the nature of the feedback available, since that previous equilibrium emerged in a world that no longer exists: the virus was introduced along with too many other changes. One of the challenges of new urban anthropology – compared with work among small homogeneous communities – is to address this dizzying complexity (Kearney 1995): a web of entanglements that Fahey (2007) describes as an “exquisite interrelationship of behavior and culture with both the acquisition and spread of . . . infectious diseases.” (443)

**Population**

Given the nature of the urban frame, how can we understand the people of Walvis Bay, and especially those infected with HIV, as a population? On a hot, windy Wednesday in 2009, I visited the offices of a coastal NGO to chat with a friend there about HIV and HAART. He took my notebook from across the table and made a quick sketch in it that looked like this:

![Sketch of population distribution](image)

He had told me once that he hoped to take a Master’s in Public Health: “is that a lognormal distribution or something?” I asked. I had, again, missed the point. “Most of the
patients are doing well,” he smiled. “But there’s a tip of the iceberg” – he pointed to the bit he’d shaded in – “who are so vulnerable. They’re affected by *everything.*”

There may indeed be a ‘tip of the iceberg’ in Kuisebmond who are especially vulnerable; in this section we examine the various population factors that come together to shape infection and treatment there. We are concerned here primarily with a set of population-level concerns, including a high prevalence of young (single) males, high levels of migration, and a series of biological issues including low rates of male circumcision, malnutrition, and syndemics of hepatitis and tuberculosis.

**Circumcision**

Male circumcision has been well established in multiple trials to protect against infection with HIV (Weiss et al 2000; Tobian et al 2014), though it has generated some controversy and strong opposition (Morris et al 2012). Rates of circumcision in Namibia, however, have historically been quite low; the national rate is approximately 20%, with highest rates among the Himba and Herero, both minority populations. This rate compares quite poorly with South Africa (45%) and Mozambique (60%). Further, regional estimates suggest that Walvis Bay’s circumcision rates are among the lowest in the country (Namibia Triangulation Project, nd.). By mid-2014, a nationwide rollout program had attracted approximately 16 000 men for voluntary circumcision, out of over 330 000 men targeted (Tijhenuna 2014).

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6 The Himba are a unique and homogenous group of traditional pastoralists in a very isolated area; Talavera has studied HIV and gender roles among the Himba (2002).
The rollout of a circumcision campaign in Walvis Bay would surely be complicated by mobility: since such a large proportion of migrants arrive as adults, and the population pyramid is largely skewed toward working-age males, the promotion of circumcision aimed at infants would be less effective. The rollout of infant circumcision might therefore be best implemented in rural communities that ‘feed’ Walvis Bay’s migration.

**Syndemics and Baseline Health**

Tuberculosis synergizes powerfully with HIV; HIV can activate latent TB, and TB is an AIDS-defining illness and major cause of AIDS-related mortality (Stillwagon 2006). Walvis Bay is a high-prevalence site for tuberculosis; reporting 848 new cases in 2009 (Musasa 2011). In Walvis Bay, the Ministry of Health and Social Services (2010) reports that 58% of TB patients are HIV-positive. Unlike tropical regions of the continent, however, Walvis Bay has negligible levels of infection with parasitic worms (especially helminthes) that Stillwagon (2006) considers important drivers of incidence. Similarly, malaria is not a significant factor in the area. However, doctors and nurses at the Kuisebmond clinic reported very high rates of hepatitis among patients; I could not gather statistical data on hepatitis prevalence, but liver function tests were commonly conducted. Nurses attributed irregular liver function primarily to infectious hepatitis and alcohol abuse.

**Malnutrition and Chronic Stress**

Malnutrition and other forms of chronic stress may play a role in shaping the vulnerability of the population in Kuisebmond. Malnutrition appears to accelerate HIV replication, or to impair the immune response to HIV (Stillwagon 2006). This problem is pronounced in Walvis Bay because small-scale subsistence agriculture – even at the level of
kitchen gardens – is non-existent. Instead the diet in Kuisebmond relies heavily on cheap, filling, but nutritionally bankrupt staple starches like dried pasta, mealie pap, and white bread. Though outright protein-energy malnutrition appeared not to be a significant problem in Walvis Bay, the macro- and micro-nutrient profile of this daily diet - especially among the poor - could certainly contribute to chronic nutritional stress and impaired immune function. Again, Walvis Bay’s status as a migrant center is important: patients who arrive in the city as adults will already have undergone developmental adjustments to malnutrition.

It is important to note that the link between poverty and HIV incidence can be unintuitive. This is partly explained by the difficulty of controlling for confounders associated with poverty, and with the general lack of prospective studies that effectively track large enough populations. A review of this issue (Gillespie et al 2007) concludes that in some cases wealth may in fact be positively correlated with incidence. Parkhurst (2010), surveying the literature on this topic, argues that in some contexts both poverty and wealth may lead to risky behaviours: while the poor may resort to transactional sex, the wealthy may engage in sex with more partners in wider networks. HIV incidence and income data from 12 countries in sub-Saharan Africa show no consistent trends; Parkhurst (2010) concludes that prevention measures that address individual risk factors are still the most effective intervention to reduce HIV incidence. While the data remain unclear, it seems that although the poor certainly suffer more dramatic knock-on effects from HIV infection, the transmission of the virus itself is always context-specific.

**Migration and Employment**

Moran (2008) argues that, historically, migration has been more important in shaping populations than background birth or death rates, wars, or other factors. This is clearly the
case in Walvis Bay. The city’s population was only 800 in 1946, but had exploded to 27 000 in 1976. This growth was fuelled primarily by the arrival of large influxes of black contract workers from the Namibian interior; at this point only about 10% were foreign born. The workforce of 16 000 included over 9000 black migrant workers (Moorsom et al 1984). From 1977, the city entered serious recession when pilchard stocks collapsed, and over one third of the population left town. Roughly 45% of the city's jobs – over 7500 positions – were lost in the space of three years (Windhoek Advertiser, 1981). Men held the vast majority of these positions; one fish factory hired a mainly female staff in 1982 but closed down shortly thereafter (Moorsom 1984). In South Africa, in-country labour migration has been identified as an independent risk factor for HIV infection among males (Lurie et al 2003); this should give us pause, considering how strongly migration shapes the population of Walvis Bay.

Some data has suggested that employment might be protective: especially in the context of extreme poverty, even marginal employment offers some protection from the worst effects of HIV. Cornell and Myer (2013) find that any non-zero income is positively associated with adherence and survival in urban South Africa. However, employment of the sort most common among men in Walvis Bay has also traditionally been dangerous: in the 1970s, an 'average' workday at a fish factory was 14 hours long and work-related injuries very common (Moorsom 1984).

**The Agent: HIV**

We turn next to a consideration of HIV as a disease agent, and the properties of that agent as it is found in Walvis Bay that make it unique. The predominant strain of HIV in Namibia is HIV-1 group M, subtype C (Hamers et al 2008). It is the most common strain in sub-
Saharan Africa and, in fact, the world; this makes it a good candidate for research and vaccine trials, but also means that the virus exhibits marked diversity (Novitsky et al 2002). Overall, the predominance of subtype C is a mixed blessing for Walvis Bay. While subtype D may be more aggressive and less susceptible to antiretroviral therapy (Kiwanuka et al 2008); however, subtype C is more contagious than other group-M subtypes (Abraha et al 2009). Subgroup C may also present with higher levels of virus in the blood during acute infection, and may shed in the genital tract of women faster than other subtypes (Pepin 2011; 12). Taken together, this suggests that female-to-male sexual transmission of subtype C is especially efficient.

Since subtype B is the predominant strain in North America, Western Europe and Australia, most antiretroviral drugs have been developed and trialed for that strain. Further, some viral load tests have also been developed specifically for subtype-B and may have erratic results with other subtypes (Holguin et al 2008). A closer study of the subtype distribution within Walvis Bay would be illuminating, and this topic bears much further research. Presumably the city’s rates of migration would drive higher heterogeneity, and in turn the prevalence of recombinant strains; the development of drug resistance is a further concern, particularly for HAART rollout.

As a viral agent, HIV is resistant or indifferent to much of the infrastructure (including hygiene and public health infrastructure) that effectively controls some other pathogens. Even in poor sections of Kuisebmond, for instance, houses were served by mains water and modern sewerage. Despite close living conditions, widespread poverty, and endemic sexually transmitted disease, cholera and other fecal-oral pathogens were virtually nonexistent. In late 2013, a cholera outbreak spread across four large regions in the north of the country and the
shantytowns outside Windhoek, but Walvis Bay was spared (Law 2014). On this front, then, the social environment may be more important than the built environment in considering HIV.

As mentioned in Chapter 2, the Namibian government’s long delay in mounting a concerted response to HIV allowed the epidemic to become generalized. Whiteside and Sunter (2000) report that in South Africa the basic reproductive number\(^7\) of HIV is in fact relatively low, at 5, compared malaria, at 100. The virus achieved critical mass by leaping from small, contained reservoirs into the socio-sexual networks of the wider population. The World Bank (1997) first proposed the idea that HIV moves from “nascent” to “concentrated” and finally “generalized” epidemics as it moves out of smaller, higher-risk ‘reservoirs’ and into the general population. Subsequent observational research has confirmed how quickly this process can occur (Nabatov et al 2007). This again suggests that the widespread rollout of HAART should continue: decreasing viraemia and in turn the basic reproductive number of any individual host would reduce prevalence effectively by interrupting the transmission at the interpersonal (rather than structural) level.

* * *

**Impacts on Treatment**

I have argued throughout this thesis that Walvis Bay, as a city, bears study as a unique context for HAART rollout. In some ways, the urban frame presents obvious benefits: the city makes possible centralized care that is efficient and accessible, especially when compared with Namibia’s very sparsely populated rural areas. Walvis Bay also has full in-patient facilities and some tertiary specialists, giving it the capacity to deal with complicated cases. It is natural to

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\(^7\) The basic reproductive number, or \(R_0\), is a measure of the average number of secondary cases of an infectious disease generated by one primary case in a given population (Anderson and May 1992).
assume that Walvis Bay, as a regional capital, should also benefit more than the rural periphery from the services of the state: stronger infrastructure, for instance, and better access to social services. This is indeed the case, but the city is also home to a complex set of political changes increasingly common across sub-Saharan Africa. The ‘structural adjustment’ favoured by the neoliberal development agenda has seen the state pull back and reduce their roles in some aspects of the public sphere, especially with regards to health, and struggling to cope effectively with the problems of globalization (Janes et al 2007; Homedes and Ugalde 2004). Typically, more state functions are taken up by the private sector, or by charity: as the state abdicates many decisions to ‘market forces,’ corporations move through the global space more nimbly, especially absent many checks on their progress (Kieh 2008). This process is indeed playing out in Walvis Bay, with the private sector now taking a more active role in primary health care (something discussed at more length in Chapter 11). In my own experience, the community center in Kuisebmond often conducted ‘HIV outreach sessions’ at shebeens and fishing companies: an example of donor-funded public health programming that went straight to local residents via small and large business, completely outside the purview of government. How this process will play out in Africa’s globalizing cities in the longer term bears close study. In theory, globalization could strengthen democracy and indigenous civil society engagement, through promoting a freer flow of ideas, but in practice this is contentious (Sukai 2010). Below, I discuss some of the specific challenges the urban environment presents for HAART rollout.

Poverty

The role of poverty in Walvis Bay’s HAART rollout is complicated. The city clearly allows greater access to high-quality and specialized medical care. It also offers residents higher
access to cash and employment, but a remorseless competition for the same: in a cruelly
circular logic, it is more difficult to earn cash in rural areas, but because of the viability of
traditional subsistence strategies, it is also altogether less necessary. Furthermore, the city
introduces substantially higher risk: without the traditional safety nets in place in rural areas,
many city-dwellers are forced to ‘go it alone.’

For patients at the Kuisebmond clinic, the urban setting alleviated some of the poverty-
related challenges of HAART. For instance, transport is often cited as a barrier to treatment
(Kagee et al 2011; Tuller et al 2010), though this was essentially a non-issue for the patients I
met, all of whom found the clinic’s township location convenient. This is clearly an advantage
over sparsely populated rural areas. Conversely, food security was a major concern. Although
the city is buffered from the sorts of seasonal shocks or crop failures that could be catastrophic
in rural areas, the cost of food may make the sort of chronic undernutrition described above
more likely. Food insecurity has been identified as an independent risk factor for mortality in
HARRT patients in both the developed (Weiser et al 2009) and developing world (Anema et al
2009). Some evidence suggests food insecurity may be gendered: among HIV patients in rural
Uganda, for instance, Tsai and colleagues (2011) find that severe food insecurity is more
common among women. In terms of exposure to HIV, Miller and colleagues (also working in
Uganda) find that food insecurity is closely related to risky behavior (especially transactional sex
and exposure to violent relationships) among women (Miller et al 2011).

**Movement**

A senior doctor in Walvis Bay once explained to me that movement may be the single
most important factor shaping treatment: it informs (and complicates) almost every stage along
the HIV care continuum. The city’s high levels of mobility drive incidence (through broader sexual networks and the involvement of mobile high-risk populations like sailors, truck drivers, and seasonal sex workers) and prevalence (through the in-migration of those already infected and out-migration age groups with the lowest prevalence\(^8\)).

Mobility also complicates testing and outreach, and confounds treatment. In this thesis I have presented anecdotal evidence of the difficulties faced by patients in Walvis Bay in accessing care: fishermen whose sailing schedules made follow-up difficult, patients arriving from rural areas who lack social support. In cohort studies, migration has been shown to negatively affect adherence (Lima et al 2009). As discussed in Chapter 5, this high level of mobility (which in Walvis Bay includes both national and international migration, as well as seasonal or labour mobility) may even drive loss-to-follow-up, making the tracking of mortality and outcomes more difficult – especially in urban settings (Sanne et al 2009).

Beyond some of these logistical challenges are more nuanced concerns about the effects of movement on the genetic makeup of HIV: in a “world of moving parts” (Wilson and Chen, 2008) human mobility represents a massive force for the spread and recombination of pathogens. The diverse patient populations of globalizing cities present clinicians with a variety of strains of HIV, each with different responses to treatment and requirements for adherence (Peeters et al 2003). Thus the efficiency of centralized care may to some extent be offset by the complexity of care in the urban setting. Understanding the complexities of human movement will be crucial to efforts to prevent and treat HIV in the new urban setting.

\(^8\) As mentioned in Chapter 1, Walvis Bay’s demographic profile is heavily biased toward working age males: young children are often sent home to rural areas to be cared for by extended family, and adults tend to leave when they are too old to work.
Social Structures and Culture Change

In stark contrast with the common image of the sociocentric African community, Kuisebmond was a cold, lonely place. People tended to be socially isolated; the sprawling extended-family networks of rural Namibia were replaced by a loose group of shallower relationships with neighbors and colleagues. Almost invariably, when I asked friends at the clinic what they were doing after work, they answered, “staying in and watching a video.” Writing about the United States, David Foster Wallace (1993) describes this phenomenon as *unibus pluram*: the many, alone. This new social environment also shapes treatment.

The city, as described above, affords some practical advantages over rural areas that simplify rollout and facilitate greater access: population-level treatment is simply easier when people are clustered in centers. It also seemed clear that many women found the urban environment liberating: it presented entrepreneurial opportunities and new gender roles absent in rural areas that allowed them a welcome independence from men. Lindio-McGovern (2012) suggests that women’s health might be one of the clearest indices of how the many manifestations of globalization on Namibia’s coast impact daily lives: women in places like Kuisebmond “embody intersectionalities” of gender, race, and class, and for them there are clearly some benefits to life in the city.

However, the dissolution of traditional social structures also seemed to come at a cost. For men, the city may amplify a modern gender role that is harmful to health (Harrison 2010); among my own informants the new importance of employment certainly created a tenuous definition of masculinity that in turn interfered with treatment. Some research suggests that men in dangerous occupations are more prone to ‘spillover’ or ‘compensatory’ forms of intimate violence (Melzer 2004). Further, rural social structures – though in some ways
perhaps rigid – also undoubtedly offer support. Many informants reported their desire to return to a simpler life in their home village, where they could count on the traditional social safety net offered by extended family and village authorities.

Social support is positively correlated with HAART adherence in South Africa (Ncama et al. 2008). However, Pronyk and colleagues (2008) have troubled the relationship between social structures and HIV. Drawing on a large-scale (n=1063) study in rural South Africa, they suggest that while social capital may protect against infection in males, it is positively related to infection in females. From the point of view of treatment, rollout therefore occurs on a changing field of play: even nuanced social approaches to social structures and HIV yield unintuitive results. As the social and cultural dynamics of communities change, so will the nature of clinical interactions, and the nature of support that patients can access outside of the clinic. This work reinforces just how complex is the interplay between social relationships and health, and how the shift from rural to urban life further compounds this complexity.

Conclusions

Looking to the future, the critical political ecology of HIV in Walvis Bay seems likely to be dominated by new risks and opportunities, especially those presented by globalization and climate change. I have contended throughout this thesis that Walvis Bay is a unique environment, but one that will look increasingly familiar as sub-Saharan Africa urbanizes and globalizes. The forces that make Walvis Bay wealthy and attractive compared to rural Namibia also expose its population to higher risks of HIV, and shape how they access and experience HAART: these are, in short, increased access to quality health care; increased exposure to health risks, especially of contagion, but also through risky work; increased access to cash
employment, but decreased opportunities for some forms of social support and for subsistence agriculture or herding; higher population density, but a lower density of meaningful kinship and social connections.

The degree to which Africa is connected to the global economy seems set only to increase. This will continue to carry some benefits – especially financial benefits for hubs like Walvis Bay, and the benefits of cultural and technological exchange – but also some risks. The 2008 financial crisis, for instance, was grounded in arcane financial instruments in the world’s apex financial centers like Singapore, New York, and London. However, the crash had a profound impact on Africa, including on health: it hampered the provision of services across the continent and constrained household spending on health care (Mensah 2014). While Raddatz (2008) argues that external price shocks historically had very little impact on economic output in sub-Saharan Africa, since 1990 the effect has been significantly stronger. Whether this is merely a cyclical phase or the ‘new normal’ of globalizing economies is unclear, but it seems reasonable to expect that increasing ties to the global economy will expose the continent to the boom as well the bust.

In a modeling exercise examining the effects of an oil-price shock on the population of South Africa, Essama-Nssah and colleagues (2008) find that the harms disproportionately fall on low-income workers. While wealthier South Africans may actually gain through income increases, for the poor (who spend a larger proportion of their income on food and fuel, and would face declining wages and growing unemployment) the negatives of the price shock far outweigh the positives. More recently, several commentators have argued that the ‘Arab Spring’ that began in 2010 in Tunisia may in fact have been sparked by drought and subsequent
wheat crop failures in China (Werrel and Femia, 2013), underscoring the remarkable complexity of links between ecology, culture, and political economy.

The intensity of movement through the city and the density of its links with the wider world will only accelerate. Highways and trains will continue to bring in people and materials from points inland and across the world. Countless truck drivers will take to the road, continuing to expand their sexual circles. And the highway out of Walvis Bay, not the arborescent network of European or American roads, but a single bold zig-zag into the heart of the continent, will continue to cut like a lightning bolt across the country in a flash of light, heat and power. These changes are neither hypothetical nor far in the future: in 2013, the government signed a billion-dollar deal with a Chinese developer to expand the container port in Walvis Bay; the goal is to complete construction in 2017 (Louw 2013).

Beck’s (1992) notions of risk are particularly germane here, since he describes the global risk society as something entirely new, and predicated on our unprecedented level of interconnectedness. We are increasingly unable to insure ourselves against hazards of global magnitude, including nuclear disaster and ecological crises. Similarly, many traditional buffers against infectious disease – public health infrastructure, wealth, and isolation – offer less and less protection. I have previously described globalization in its current form as first and foremost a process of potentials – potential for great reward and for great danger (Richardson et al 2014). It may therefore be useful to consider Walvis Bay and other developing-world hubs as spaces of risk. Along with access to new technologies, new ideas, employment, and other opportunities, these spaces are also charged with new and elaborate risks against which effective buffers are still few.
It seems reasonable to expect that Walvis Bay will therefore continue to be a flashpoint for new, resurgent or resistant infectious diseases. When the H1N1 variant of pandemic influenza arrived in Namibia in 2010, all of the known cases were found on the coast: six in Walvis Bay and two in Swakopmund (Hartman 2010a). Research now seems to confirm (Faria et al 2014) that it was the rapid changes in social structure and the dramatic accelerations and intensifications of human mobility during the urbanization of Kinshasa, Africa’s first modern urban hub, that kindled the current pandemic of HIV-1 type M.

Climate change will also present a tremendous stress to the city in the near future, and in turn have massive impacts on health and medicine. In late 2013, the Namibian press reported on the results of modeling exercises that showed that Walvis Bay is particularly vulnerable to climate change. Rising sea levels, growing desertification and intensifying storms were expected to batter the city (Hartman 2013). The city’s vulnerable aquifers risk being cut off, and desalination at a level capable of providing for the (growing) population would be impossible without massive inputs of capital and energy. Since the city lies so close to sea level – and since foundations are extremely difficult to build in the salty sand – the city is also profoundly vulnerable to even minor changes in sea levels. This includes the crucial infrastructure that drives the city’s economy: the harbor and its associated resources, plus shipping lanes and fishing grounds.

Anticipating these challenges will require thoughtful planning. Walvis Bay and many of Africa’s growing global hubs have the potential to become vibrant, effective contributors to national growth and development. Further, they can become exemplars of successful treatment rollout and centres of excellence for health policy research more generally: it is at
the urban coalface where large-scale interventions will be stress-tested first. However, this process has to date been hamstrung by poor urban planning and government policy (Bryceson 2006). The imperative of state action in the face of these threats is undercut by another aspect of globalization: the retreat of the state and the concomitant rise of the multinational corporation.

A complete analytic or simulation model of the disease ecosystem of Walvis Bay is beyond the scope of this thesis, but it is useful to attempt to describe some of the factors of such a model, and sketch out an approximation of their relationships. The ecological perspective contributes important insights not available from clinical statistics or ethnographic interviews; it is a completely different, though complementary, level of analysis. The evidence suggests that Walvis Bay’s urban ecology is not incidental to the spread or treatment of HIV there. In fact, it is the key determinant shaping the experiences of the patients discussed in this thesis. From this perspective, HIV emerges as the catalyst of a sort of ecological Garfinkel experiment, in which we learn about the workings of a complex system by tampering with it and seeing how it reconstitutes itself (Garfinkel 1984). HIV was a deadly spanner in the works in Walvis Bay, one that has exposed the problems in the city’s human-environment relationships, and its systems of repair.

In the next chapter, I conclude with a look back at the project to survey the lessons learned and try to anticipate the challenges of the future.
Pliny the Elder’s 2000-year-old observation that there is “always something new out of Africa” (itself an appropriation of a line that Aristotle had described as well-worn nearly 500 years earlier) is probably as overused today as it was in antiquity. And yet, much of what I observed in Walvis Bay seems to bear special consideration not least because of its novelty. Many of the problems that occur there are of course a reflection of wider global processes, filtered through a uniquely local lens. Others, however, are altogether new problems that may presage those that will face other parts of the world soon. In this final chapter, I look back on

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1 Pliny first mentions this in Book 8 of his Naturalis Historia: “unde etian vulgare Graciae dictum semper aliquid novi Africam Adferre.” (“Hence the common Greek saying, Africa always offers something new.”) The ‘common Greek saying’ was apparently borrowed from Aristotle’s Historia Animalium and De Generatione Animalium; where Aristotle borrowed it from is unclear. (Pyne and Pyne 2012)
the lessons I learned from the people I met in Kuisebmond, and look ahead at how those insights may apply in changing world.

Globalization, Culture Change, and Health

At this point it seems obvious to point out that globalization is reworking our world, and shows no obvious signs of slowing down soon. In the long term, it may be that the neoliberal free-for-all of open borders and free trade will eventually be moderated and replaced by more selective bilateral engagement, and the development of stronger local bulwarks against global shocks (Richardson et al 2014). This may be a natural reaction as the effects of these shocks are felt more and more widely. The Arab Spring (see Chapter 10) is instructive here, but so are the myriad small ways in which growing numbers of people find themselves affected by changes in prices for (increasingly global) commodities like food or fuel, or currency exchange rates. On the other hand, given the vast changes in the speed and density of the networks across which ideas, resources and organisms, it seems hard to imagine this being wholly reversed.

As for health, the globalized future may be one beset by infectious – rather than chronic – disease (Levy and Fischetti 2003; Quammen 2013). The post-Millenium Development Goals agenda of the WHO and others, are increasingly heading in the opposite direction, with a growing focus on chronic non-communicable disease and mental health\(^2\). However, my position is borne out by compelling evidence, much of which can be ripped directly from a growing number of headlines about everything from influenza to Ebola to antimicrobial-resistant bacteria (Callaghan 2014a; Callaghan 2014b). It is therefore important to heed

\(^2\) In the spring of 2013, I participated in the ‘Beyond 2015’ meetings in Stockholm, where the discussion about specific health burdens was similarly focused on disability, mental health, and aging (Horton 2013; Friberg et al 2013).
William MacNeill’s warning: the last century’s apparent victory over infectious disease may in fact have been a blip – the end of a battle, but not the war.

The lessons learned about identifying and treating HIV in Walvis Bay may therefore prove important for two reasons. First, for what they can tell us about the coming pressures on HAART rollout programs elsewhere in sub-Saharan Africa, particularly as the region urbanizes and globalizes. Second, for the broader implications they hold for future struggles with emergent, resurgent, or drug-resistant infectious diseases at the population level in developed and developing countries around the world.

The story of HAART in Walvis Bay has much to teach us about how globalization and health will interact: in 2009, for instance, the Walvis Bay state hospital turned to the private sector to help support its program to treat multi drug-resistant tuberculosis (MDR-TB). When this outreach started, Walvis Bay had the highest number of MDR-TB patients in the country; and one of the highest general TB rates in the world (de Klerk 2009). As discussed in Chapter 10, some of the burden of TB must be attributable to the housing, climate, and health profile of Walvis Bay. It seems important, however, to consider whether TB is also a natural consequence of the city's status as a global hub. Anecdotally, two doctors in the city separately described MDR strains as having “walked off boats” and into the harbor, spread – perhaps unknowingly – by seafarers foreign and local. The port brings the city great opportunity, but it also brings risk: MDR-TB is an expensive, complex health problem that hits poorest patients the hardest, and places a heavy load on health systems.

*   *   *
Ultimately, the generalized HIV epidemic in Africa will defy easy solutions. No silver bullet will break the Gordian knot that ties together political-economic and socio-cultural strands of disparate communities in such complex ways. Even a vaccine or cure – both of which have remained elusive since 1983 – would not spell the end: tuberculosis has been readily curable with isoniazid since 1959, and rifampicin since 1967. Polio – which is not just cured but indeed vaccinated against, remains endemic in only four countries on earth, and is well on its way to being eradicated in the same manner as smallpox – re-emerged in Namibia in 2006. After 10 years without a single case, at least 19 people fell seriously ill and 7 died in a single winter (Sidley 2006). On balance, it seems wise to anticipate that HIV will be with us for a long while yet.

Of course, there is still much progress to be made on delivering basic primary health care, decades after the Alma-Ata. The poorest countries – and many of the wealthiest countries, too – need investment in health infrastructure, and the global community needs major new measures to ensure that health is more equitably distributed. But the fight against HIV appears to be one that must proceed in stepwise fashion, with minor victories and modest gains against frequent, frustrating setbacks. This includes the mission of delivering the best care currently available – whatever it may be – as equitably as possible to men and women alike. Exactly how to address the current gender inequities in HIV treatment is a difficult problem: given the consistent ineffectiveness of promotional activity\(^3\), and the concomitant disillusionment with the traditional “knowledge-attitudes-behavior” model, it hardly seems

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\(^3\) In 2007, Rachel Jewkes and colleagues (Jewkes et al 2007) reported on the findings of an educational intervention in South Africa to reduce risky behaviors and incidence of HIV and Herpes Simplex. Though the impact was modest (and not statistically significant to 5%), this was (at the time) described as the only behavioral HIV intervention program in Africa that had been tested in a controlled fashion and shown at all effective.
adequate to say that there haven’t been enough posters commissioned or radio adverts broadcast.

Nor was the problem in Walvis Bay simply one of money. Certainly Namibia is poor by developed-world standards and its citizens deserve to reap far more of the benefits of the modern world than they currently do. But Namibia has relatively low rates of absolute poverty compared with its neighbors, and has historically struggled more with inequality than poverty per se (Central Bureau of Statistics 2008). Further, the urban frame in Walvis Bay creates a unique set of subsistence challenges for patients that must be understood separately from the problems of rural poverty. The staff at the Walvis Bay HAART clinic were sometimes overworked and short-handed, and would have benefited greatly from more in-house capacity for lab work and counseling. But overall the clinic was a clean, modern, well-staffed and well-equipped place: it did not suffer chronic stockouts or staffing shortages or utilities failures that would discourage otherwise keen and compliant patients. During a series of meetings in Windhoek in 2003, I asked a group of foreign experts if a lack of funding was to blame for gender disparities in HAART. A Dutch doctor said, “not really. It’s hard to get men to come to the hospital in Amsterdam.” His German colleague laughed, “No, there’s more money for AIDS here than in Germany!”

Lessons from Walvis Bay

I am reluctant to make the conclusion of my thesis into a set of policy prescriptions; the world of HIV changes so quickly that most such efforts are rendered obsolete or redundant with
embarrassing speed¹. My goal from the outset has been to build knowledge about a phenomenon that remains under-explored, and I remain as convinced as ever that this is in itself a worthwhile endeavor. However, there was a great deal of suffering in Walvis Bay: many patients died there, and many others were consigned to lives so bereft of hope and comfort that no one should have to endure them. Having had the luxury of observing this problem from a safe distance, however close I stood, I feel some sort of responsibility to share four modest insights here with the hope that they may help shape our response to the epidemic.

First, the rollout of HAART is effective. Treatment was working well in Namibia, and both patients and caregivers were satisfied that the program was, by and large, meeting needs. This bears repeating particularly because in the early days of rollout, pessimism ran high. In 2001, Andrew Natsios, then director of USAID, notoriously suggested that HIV funding should be spent on prevention rather than wasted on treatment. HAART would not work in Africa, he said, because Africans “don’t know what Western time is. You have to take these drugs a certain number of hours each day, or they don't work. Many people in Africa have never seen a clock or a watch their entire lives. And if you say, one o'clock in the afternoon, they do not know what you are talking about.” (Herbert 2001) There were similar doubt about drugs being too expensive, about local supply chains not being able to handle the load, and a host of other socio-cultural, political-economic and logistical issues that were expected to interfere with treatment (Buse 2011).

¹ I have nonetheless included a more explicit set of policy suggestions that may improve the ability of Namibia’s health care system to test, treat and care for HIV patients more effectively. See Appendix One.
These concerns were for many put to rest by a landmark paper by Edward Mills and colleagues in 2006. Their large-scale meta-analysis (Mills et al 2006) of adherence in North America and Africa found that African programs – despite their myriad challenges – compared favorably to rich-country rollout. Substantial evidence from multiple sites showed that most patients in all settings are in some fundamental way capable of good adherence. Several studies have subsequently supported this (see Fox and Rosen 2010 for a systematic review) and turned the discussion away from whether rollout ‘works’ in poor settings, and toward fine-tuning rollout by considering the social and structural forces that shape treatment. Ware and colleagues (2009) advanced this quantitative literature with a multi-site ethnographic study that concludes that high levels of adherence in sub-Saharan Africa are the result of patients trying to fulfill social responsibilities and preserve social capital.

My own research clearly supports this. Mortality at the clinic was relatively low, and patients and providers were in the main satisfied that the program was working well. Time and again, when I asked patients about the hardest part of treatment they did not cite stockouts nor, pace Andrew Natsios, problems telling the time. I have identified some of the many challenges associated with living in Kuiebmond. But there were also some benefits: the urban frame brings with it a solid structure of counseling and outreach, and the population density of Walvis Bay and relocation of the HAART clinic from the CBD to the townships means that very few patients have an onerous commute for follow-ups and refills. Adherence proper was not a major problem, particularly in the ways once imagined by rollout skeptics. Instead, patients reported to me that they struggled to navigate new social structures in the city. They struggled, in this cold, lonely place, to find support and to build healthy relationships. They struggled, especially in the city’s fiercely competitive economy, to find work and to put food on the table.
HAART itself is not doomed to failure because of any sort of flaws or weaknesses inherent to African patients; instead, their health and health-seeking behaviors are, of course, enmeshed in the same political-ecological relationships as those of every human.

This finding also has important implications for the ‘Test and Treat’ or ‘Treatment as Prevention’ approaches\(^5\) discussed in Chapter 5. There is currently only a small body of research into how successful large-scale TasP programs could be in practice in sub-Saharan Africa (Bärnighausen et al 2012). The well-established evidence that adherence in the developing world can be strong – and that the factors that may impede adherence are knowable and amenable to intervention – should encourage efforts to roll out treatment more broadly.

The second lesson, which follows on from the first, is that rather than access or adherence, the problem facing rollout at the institutional level seems to be with points of entry and the timing of HAART initiation. I argue that we are starting to learn that the offer of treatment itself is only the beginning, even though the reach of a program may be wide and its capacities high. My study, and many others, found that men enter treatment later than women, with consistently lower CD4 counts, despite the fact that treatment is offered equally to all through a well-established and well-funded program with highly trained staff and a strong

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5 Test and Treat is a strategy in which patients initiate HAART immediately upon testing positive rather than waiting to reach a staging cutoff. Treatment as Prevention (TasP) is the idea that widespread uptake of HAART could, in high-prevalence areas, not only alleviate the suffering of those infected, but actually reduce transmission of new cases of HIV. That lowered viral load reduces contagion (enough to offset increased survival time) has been well established clinically (Attia et al 2009) and proven in models (Eaton et al 2012); Nguyen et al (2011) warn, however, that the eager embrace of TaSP carries the risk of replacing attention to the social, economic, and structural factors driving transmission with the ‘silver bullet’ of HAART.
supply chain. In other words, the future of rollout may be less about *access* or *adherence* than about *capture*.

One of the most striking results of my research was the finding that among patients who had entered care but not started treatment, men were 6.27 times more likely to die than women. This is probably the most worrying of the several breaks in the pipeline\(^6\), or at least the one with the most remarkable impact on mortality. There are of course many stages of care that my research was unable to examine, and the availability of more robust and more sophisticated research agendas and techniques will expand our understanding in the future. To date, one review from sub-Saharan Africa by Rosen and Fox (2011) has quantified the losses at each stage from testing through treatment, though their work is not disaggregated by gender.

In the meantime, it is worth considering how and why men were lost at these stages. The most obvious reason seems to be that women benefit from the ‘natural’ entry point of maternal health and PMTCT programs. Further, motherhood remains for women a guarantor of social esteem regardless of their HIV status, and is a reliable source of social and material support. Men lack an obvious (or socially ‘neutral’) treatment entry point\(^7\). Should Namibia institute some sort of ‘healthy man’ checkup, to parallel the ‘healthy mother/healthy baby’ programs already in place? As part of a general strengthening of primary care, it may be beneficial to move some of this programing out of the VCT and the HAART clinic: if HIV testing and counseling was part of a biennial checkup, or included in a standard

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\(^6\) This finding may also constitute a further argument for faster initiation, or even a Test and Treat approach: the space between diagnosis and initiation appears to be a particularly vulnerable one for men, and shortening it as much as possible might therefore reduce this excess mortality.

\(^7\) Men tended, in Kuisebmond, to enter care either through the VCT (a lonely, fraught avenue) or through tuberculosis care, which is already socially stigmatized.
workplace/government/military physical, might more men be captured and streamed into care sooner?

The question of social support is also important. My friend Michael Linke, a development professional working in several countries in sub-Saharan Africa, suggested a novel approach. During a discussion in Windhoek in 2010, he wondered if testing centers could capitalize on the massive local popularity of the World Cup (held, that year, in South Africa) to promote what he called ‘team testing.’ His idea was to incentivize groups of men – friends, coworkers, family – to test in ‘teams’ of five or six. This would ostensibly have the immediate benefit of driving up turnout, but more subtly would mean that men who tested positive might be able to rely on a built-in support network.

Many attributed Walvis Bay’s success (relative to the rest of Namibia) in attracting high proportions of men to HIV testing centers to the efforts of various workplace outreach programs. Bringing HIV education and testing into the workplace in thoughtful and effective ways can clearly be successful. As evidenced by the experience of the NGO in Windhoek organizing ‘after work’ barbeques (as discussed in Chapter 8), programs clearly need to work with men to create a framework around testing, treatment and teaching that is compatible with masculine gender roles. Finally, the presence of men in caregiving roles at various stages along the testing and treatment pipeline may also be important. Although men were well represented among medical doctors in Walvis Bay, many other cadres (especially at level of counselors and outreach educators) were predominantly female. A veteran Namibian activist once summed this up to me by saying, “The male-female HIV thing is a self-fulfilling prophecy. Women dominate the HIV agenda. They dominate in the clinics. They dominate the support groups, and on and on.”
The third lesson, which follows on from the latter aspects of the second, is that HAART must be understood as a bio-cultural phenomenon. This is to say that pills alone will not solve the problem of HIV, and that the concerns of rollout are not – and never truly were – purely logistical in nature. This may sound obvious, but only at a substantial remove of time and space: in the heat of the moment, and under intense pressures, HAART rollout almost invariably unfolds without the involvement of qualitative research that addresses the social determinants of health.

Anthropologists including Nguyen (2010) have been at the forefront of critiquing the ‘triage’ mentality of international HIV programs that has reframed the epidemic as a technical problem from the start. Petryna (2002) and others have similarly critiqued the creeping march of medicalization and large-scale state health interventions. These theorists share a concern with the totalizing logic of biopower, one that reduces complex issues of health to their barest ingredients and submits them to technical fixes in bureaucratic structures. In this scenario, health care and related resources – and ultimately life itself – are privileges granted by the state, and citizens must negotiate access to them through political structures.

I depart in some ways from these theorists; I prioritize the individual and ecological perspectives rather more than the political and theoretical, for a start. Nonetheless, we share a conviction that there can be no extra-cultural, supra-social rollout of antiretroviral drugs: all attempts to treat the disease must take in patients as social beings enmeshed in a web of relationships that have the power to help and hinder treatment. Of course, the corollary is also true: if pills alone will not be the solution to HIV, neither will social theory.

This is the traditional terrain of medical anthropology. Jennifer Hirsch (2007) has advocated for a stronger role for the social sciences in HIV programming, especially in addressing
gender disparities in testing, treatment, and care. She argues that the holistic and critical perspectives could help move HIV research beyond its emphasis on the merely technical to a more useful consideration of the interplay of personal and structural forces in health. Medical anthropologists should heed this call and make their voices heard: the discipline’s unique attention to the social and biological holds valuable insights for contemporary challenges of globalization and health in general, and infectious disease and HAART rollout in particular.

The fourth and final lesson is that HIV’s biggest challenges in the future will be ecological. As discussed in Chapter 10, the future of Africa will in all likelihood be one of continuing increases in the speed and intensity of migrations, flows of capital, and connections with the global market. During my first week in Walvis Bay, a local doctor said that he could sum up for me the biggest factor behind HIV and TB in the city, and the biggest obstacle to treatment: seated behind his expansive desk, he paused for dramatic effect, leaned back in his chair, and said: “movement.”

Looking ahead, it seems likely that we will continue to overcome the technical challenges in HAART rollout. New laboratory tests or a broader and deeper pharmacopeia for second-line, third-line, and salvage patients, would certainly help the staff in Kuisebmond; I am confident that those things will come along eventually and, given continued pressure from advocates and activists, will be accessible to patients in poor countries. But nothing could insulate the clinic from another massive failure of the coastal fisheries, or a rapid doubling of the township’s population in the wake of a mining boom. The overwhelming scale of the changes that global warming will bring to Walvis Bay, in fact, make those technical concerns seem minute in comparison.
An approach grounded in the ecological anthropology perspective in future research on HAART, especially in sub-Saharan Africa, will therefore be an extremely useful tool for understanding and anticipating changes. First, the population of Walvis Bay will continue to be volatile, quickly growing or shrinking in response to the local and global economy. More broadly, though, this population will continue to change its relationship with the urban environment as a place. Divorced from rural subsistence strategies and social structures, city dwellers will continue to forge new roles. This process will in turn continue to shape HIV transmission, testing and treatment.

Under an ecological analysis, HIV emerges not as the virus, but the symptom: a precipitate of epochal changes in the global system, unfolding before our eyes. It is important to combine this ecological view with the fine grain of ethnographic detail, to consider how these massive shifts will play out in the daily experiences of real human beings, and to ensure that this ethnography works in dialogue with reliable quantitative data.

The Future: HIV 3.0

In 2010, I left Namibia and went directly to the World AIDS conference in Vienna, Austria. I was there partly to present a poster (Callaghan et al 2010), but mostly to learn about new advances in research. One of the most prominent themes was the emergence of a new approach to HAART that came to be known as ‘Treatment 2.0.’ (Hirnschall and Schwartländer, 2011) Treatment 2.0 was to be the result of several concurrent developments: simplified and refined pill regimens and diagnostic procedures, continuing cost reductions and supply chain improvements, and the increasing impact of Treatment as Prevention. This is one of the primary reasons I chose Walvis Bay as a research site: the city has firmly moved out of the
'triage' stage and into a mature, stable rollout where long-term trends can now be considered. It is, in short, about as close to “Treatment 2.0” as anywhere in sub-Saharan Africa.

However, two interesting trends that arose in discussions with Namibian friends and colleagues after I left the field suggested that HIV 3.0 might in fact be closer than we realize: the slow and steady emergence of drug resistance, and the growth of a new, younger cohort of patients.

In 2013 I sat down for lunch with an old friend who worked as a doctor in Walvis Bay, and had a worrying conversation about the future. “Resistance,” he said, “is going to be a big problem. Lately I’ve seen some patients that look like AIDS from the ’90s . . . they’re drug-resistant now, and the OIs [opportunistic infections] are coming back.” He had been shocked out of the lull, however brief, brought about by a more stable pace at the clinic. The détente broken, patients were returning with symptoms that suggested that, after years of successful treatment, HAART was failing them. “We’re moving away from CD4 tests now, towards viral load tests,” the Doctor said. "Many patients might have okay CD4 counts, but high viral load because of resistance – they’re hiding under the surface. I think if we switched over to viral load, we might identify hundreds or thousands of resistant patients. Otherwise, we can only test resistance through labs in South Africa, and that’s a pain.”

Resistance is a natural eventuality of treatment, even under ideal circumstances: it is basic evolution in action. However, we should interrogate the socio-cultural and political-economic circumstances under which resistance emerges. In Tanzania, for instance, Ramhadani and colleagues (2007) found that the factor that most protected patients against virologic failure was disclosure of HIV status to friends and family; obviously, I found important gendered
dimensions to disclosure in Kuisebmond. However, clinical research shows that resistance to different classes of ARVs emerges at different levels of adherence (Bangsberg et al 2004), suggesting that addressing resistance will be a complex challenge.

The second looming problem seems to be generational in nature. In other conversations, several friends and colleagues in Namibia independently identified that HIV was rapidly rising among school-aged children. One suggestion was that this was the coming of age of children born to the first ‘boom’ generation of Namibian HIV patients in the late 1990s and early 2000s. Two friends who worked in HIV and education (one in Windhoek, and one in Walvis Bay) independently speculated that the problem stemmed from children born with HIV whose parents had never actually told their children the truth. These children might believe that the ARVs they take treat some other chronic condition (or are simply vitamins), if they’re told anything at all. As these children become adolescents, their sexual exploration unwittingly exposes their partners.

Both my informants offered anecdotal evidence of these exact scenarios playing out. This was also a common topic during my focus-group conversations at the church. One member volunteered such an anecdote, saying: “There’s a 12-year-old who has been on the tablets for 8 years! Now he doesn’t want to take his tablets any more, because his mother won’t tell him why! But how do you explain to a child why to take the tablets?” There was a great deal of concern and a certain sense of helplessness during these conversations; there was also a palpable degree of battle fatigue. Many members of the support group seemed to suggest that while adults might ultimately be left to their fates, children should always be spared.
Their observations were subsequently vindicated when reports started to emerge in late 2013 that HIV-related deaths among people aged 10-19 years had risen dramatically worldwide. Between 2005 and 2012, HIV-related deaths in that age group increased fully 50%, compared with a decrease of 30% among the general population during the same period (Ford 2013). This coincided with the release by the WHO of a new policy document called *HIV and Adolescents: Guidance for Counselling and Care and Testing for Adolescents Living with HIV* (2013). In addition to the demographic effects of a generation of HIV-positive babies coming of age, the report implicates as a cause of rising HIV deaths in this age group the lack of adolescent-friendly HIV services.

Could these trends be the harbingers of HIV’s future? On one hand, a chronic epidemic moving out of its stable, restive state and back into a high-care, high-cost stage requiring another set of new solutions; on the other, a ‘new wave’ of infections, after years of stable or declining incidence, in an age group that is notoriously difficult to reach with health messaging.

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**Men, Women, and HIV**

I began this chapter with Pliny the Elder’s epigram, “*ex Africa semper aliquid novi;*” it appeared many times in the books I was reading while in the field, and was frequently at the back of my mind. Both Dowden and Meredith start their monolithic modern histories of the continent with that quote. It is used in different ways by different authors – in some cases it seems a writer’s weary postscript to a litany of miseries, in others it reflects their optimism that
those African problems will generate African solutions. When I began to explore relationships in Walvis Bay, though, I was put in mind of another Roman expression, this one by Plautus: “homo homini lupus” – man is wolf to man.

If truth is the first casualty of war, the first casualty of HIV must surely be trust. Time and again I saw relationships wither under mutual mistrust, and heard countless stories of betrayal. Some of these were heart-rending and some bordered on farce, but taken together the picture was of a social vacuum created by HIV, into which swirled the wolves. Indeed, the reference to Martin Meredith’s (or Richard Dowden’s) history is particularly germane here; their now-canonical surveys of Africa since independence could roughly be summarized as histories of people treating one another badly: man’s inhumanity to man, writ large.

There is understandably a great appetite for technical fixes and social nudges of the sort I have suggested above, for a set of practical policies that will improve rollout for all patients in a straightforward way. But after several years spent thinking about this problem, I am not sure that I know how to fix whatever it is about HIV that makes it uniquely able to send relationships asunder; how does a virus turn husband against wife, parent against child, or neighbor against neighbor? Steinberg notes the same thing in the hills of Ithanga in *Three Letter Plague*, summing it up by saying “where there is AIDS, there is blame.” (Steinberg 2008; 6)

My own attempts at raising these questions with the support group tended to generate more heat than light; conversations were always lively but ultimately I do not think I have come closer to genuine understanding. One member explained the question of trust, and, really, set the tone for most subsequent discussions on the topic, by repeating a story about a couple who lie to one another about their status:
“Often people blame men, but women are just as bad! Men say they have TB – they hide the disease and say it’s blood pressure, diabetes, TB . . . then the girlfriend gets sick, goes to the clinic, and doesn’t tell her boyfriend. Then she starts asking why his pills match hers, and finds out! So she puts her tablets on the table next to his, and when he gets home, she asks him what and what. She says, ‘oh, I’ve got blood pressure medication.’ And he says, “Aye! So we’re both on blood pressure medication now!”

Given all this cynicism, I began to wonder whether relationships could ever be safe spaces for HIV patients. When once I earnestly asked the support group whether partners could be counted on to offer support, the room actually burst into laughter. “I got one month of support!” exclaimed one woman. One of the three men present said, “I had a partner before I joined [the support group] – she wasn’t helpful or supportive. She’s died, and now I get my support here in the group.” A pair of women sitting near me then started a debate about relationships: “it’s difficult to tell someone you’re positive when you first meet.”

“It’s not that difficult.”

“Sometimes, you insist on a condom the first time, but after 2 or 3 times they ask why. I don’t want to tell – I’m scared.”

“Are you afraid for your life?”

“No . . . some women are just scared to be alone.”

As they carried on, others around the room were still chuckling at my question about support. Slowly a discussion emerged about relationships, and people began to share their own stories. In truth, the laughing cynicism was peppered with some small amount of gratitude for supportive, caring partners.

“I’ve been single for 7 years. I have no thoughts of having a partner.”
“I went for testing with my partner. I was found positive but he’s still supportive. He encourages me to take my medication – he’s great. I’m really thankful.”

The two other men in the group shared contrasting stories: “I’ve got no problems with my partner – and she’s negative. She makes sure I take my tablets.”

“My partner died in 2005. I then went for testing. I got a new partner in 2007. We were together a long time without telling each other – so, we went for testing together. I told her I was positive and she wasn’t supportive. We started drifting apart. We broke up last year. I’d already accepted my status, so it didn’t bother me. We’re still friends.”

“My husband died in 2004. I’ve told my children, they’re a great source of support. The youngest is 10.

The youngest woman in the group said, “Sometimes I think I’m the only one with a problem. When I found out I was positive, first, I told my husband. But he’s not supportive. He drinks a lot, and won’t go to the doctor. We have a child together, but the child wasn’t planned. He didn’t want to use condoms.”

As other members chimed in, the conversation once again turned to mistrust and recrimination: “Men have more understanding of the virus, but they bring more diseases into the relationship!”

“You can’t get male partners to go for testing. And some women won’t go because the VCT staff will spread rumours!”

“You have the right to be seen by someone else! If the counselor slept with your husband, you won’t really listen – you’ll just want to kill her!”

At this the discussion tailed off into goading cries and scattered laughter; we left the topic for another day. But I remained unsettled by it: I was returning to some of the same
disturbing conclusions as my research on the PMTCT program in 2003, when it seemed that most women were participating despite a lack of support from their partners.

This background of secrecy and mistrust created a situation that was not only toxic for family, love, or working relationships, but for treatment as well. Surely, the support of a loving partner would be invaluable in building a successful treatment regime, but I found the opposite was also true: many of the patients I met were managing on HAART in spite of partners, lovers, neighbors and relatives who were not only indifferent but at times actively antagonistic to their treatment. In 2012, Schneider and colleagues reported that men attending ARV services in South Africa were more likely than women to be married. They further report that male patients rely greatly on their wives for support (leaving unemployed and single men most vulnerable), while women turn instead to friends and extended family.

Along with the erosion of rural lifeways and the massive political-economic upheavals since independence, the problem of trust seemed symptomatic less of a viral epidemic than a complete reshuffling of the social order. People in Walvis Bay are struggling toward entirely new ways of relating to and connecting with one another, and the implications for health are real. On this front, the role of multiple concurrent relationships in the epidemic in sub-Saharan Africa is by now well explored.

Lost in the epidemiology of these sexual networks, though, are the relationships between the humans in them. To say that ‘infidelity’ is common in Walvis Bay isn’t so much accurate as it is moot – logically speaking the statement takes for granted that fidelity is the natural state of local affairs, and that deviation from fidelity is noteworthy (and negatively so). In fact the opposite is closer to the truth: like quarter in a mortal duel, fidelity was usually
neither asked nor given. The incongruity between foreign and local ideas about fidelity, commitment, and sexual jealousy was always striking.

When once I returned to Namibia after a trip to South Africa, I sat for a welcome meal with a friend. Among the small-talk about time away, she asked, “so, did you have a girlfriend down there?” I was surprised – my friend knew that I was engaged to be married. In fact, she’d met my fiancé and they’d gotten on quite well. Her question was not posed conspiratorially, nor even with so much as a raised eyebrow. Instead it was a part of the routine questions for a returning traveler, along with weather reports and updates from mutual friends.

Her reactions, and mine, captured an important aspect of local relationships: I was as much at a loss to explain as she was to understand that, in my relationship, fidelity was obviously expected that it was almost taken for granted. In Walvis Bay, monogamous long-term relationships certainly existed, and many people demanded faithfulness from their partners too. But since all but the most flagrantly egregious infidelity was tolerated (and, as described elsewhere in this thesis, at times encouraged), and since monogamy itself didn’t carry any particular socio-cultural cachet (but at times, came at a real cost), well . . . why bother?

Here again, the assumption from the Namibian side wasn’t about ‘faithfulness’ to my partner at all; my actions while abroad would be completely separate from our relationship, and surely if the opportunity to have an affair presented itself I would say yes. I assured my friend that I had, as ever, remained faithful to my fiancé while in South Africa - she accepted my answer as nonchalantly as she’d posed the question. We then moved on to talking about her work: my friend, after all, held a management position for a nation-wide NGO doing HIV care and advocacy.
HIV and the Limits of Anthropological Understanding

I have explained that I myself became ill while in the field and was subsequently immunosuppressed through a long course of medication. This is probably as close as I will ever come to genuine participation in the daily experience of HIV-AIDS, but my brief experience was instructive. My illness and its course of treatment afforded no heroic narrative of struggle and success. Even once treatment was complete I would never ‘win’ against the condition, merely arrive at a lifelong stalemate whose wages were a constant reminder of my ultimate helplessness. I drew no particular strength or identity from my illness; it did not buttress my image of myself but rather clashed heavily with it – I became suddenly dependent, sickly, diminished, forever tied to the kind of pill box (blue plastic, with oversized letters and Braille marking the days of the week) that I associated with people at least twice my age. I didn’t enjoy the sick role and had no coherent illness narrative to construct around it, either.

I suppose the same seems true of my studies of HIV in Kuisebmond generally. I cannot entirely understand some of the things I witnessed in the field, nor do I believe any closer experience or greater first-hand knowledge would particularly help. I was confounded, as I mentioned above, by the breakdown of trust in so many of the relationships I examined in Walvis Bay. More than that, I remain profoundly troubled by my inability to truly understand the self-destructive impulses written into the code of masculinity there. Perhaps the closest I have come is to approach the problem metaphorically, remembering Ovid’s Metamorphosis: when the Greek elders decide that Ulysses rather than Ajax deserves the reward of Achilles’ arms for fighting most bravely at Troy, Ajax is despondent. Having lost his honour and seeing
no path forward, Ajax draws his sword and says, “this at least is mine. This I must employ against myself . . . lest any man but Ajax ever conquer Ajax.” (Simpson 2003)

This was the force I saw so often in Kuisebmond: a desperate, determined self-destruction. I could not entirely understand it, and am not sure I will.

The existential anthropology of Jackson (2012) suggests that this urge toward deconstruction misses the point, that the very need to understand through deconstruction is perhaps a selfish relic of post-Enlightenment empiricism. Rather than theorising human ‘actors’ in socio-historical contexts, Jackson argues (1998) that we should instead prioritize intersubjectivity: we need to understand one another in empathetic ways, to somehow come to embody knowledge of life and our shared experiences of it. I very much hope that anthropologists more skilled and more sensitive than I will someday be able to use this approach to bring to light the lived experiences of HIV and HAART.

Beyond this, it is perhaps worth mentioning one last time that the project that lies at the center of this and every other thesis – that of building human knowledge – remains an important one even in the face of an epidemic. Paul Farmer (2004) in particular has made the case that perhaps the most important role for anthropologists of HIV is to take daily life seriously, to faithfully record the struggles of individuals and communities who live with AIDS. For Farmer, the act of bearing witness is not merely the product of detached, passive objectivity, but something personal and passionate – a vital duty to faithfully document the lives we are fortunate enough to share.

It is also important to remember that the stories to be told here are not, of course, only stories of suffering. In A Farewell to Arms, Hemingway (1995) wrote that the world breaks
everyone; afterward, though, many are stronger at the broken places. And there is indeed a
great deal of resilience to be found amidst the suffering wrought by AIDS, and many survivors
among the infected and affected who have carved out successful pathways for themselves
against long odds. I hope that I have managed to convey some of their strength here.

Still, it seems natural to grasp at some larger purpose. In his ethnographic account of a
Dentan concludes by wondering,

. . . what's the point? Besides a technical exercise in presenting difficult data to a
small academic audience, what's the point? I guess, on some level, it's the same
as the point of the frightening cautionary tales Semai tell their children, to keep
the children safe. Pay attention to this, they say in essence. This is horrible. Be
afraid.

And so, perhaps, it goes with this study of one attempt at treating HIV in Namibia. The eerie
foreshadowing involved in a close study of the political ecology of HIV, and a survey of some of
the challenges of HAART rollout, are sobering. A bad thing happened there, quite simply, and
we should all of us pay attention. We should all of us be afraid. It is important for
anthropologists to record faithfully and compassionately the suffering of HIV patients, and the
efforts of the people who care for them. But I fear that final conclusions beyond this are
elusive. Whether the patients at the center of this study are “suspended in webs they
themselves have spun,” after Geertz, or are in fact “ravaged by what they float in,” per Wallace,
seems to be a matter of perspective.

*    *    *
I was born in late 1979, and am just young enough that I have never known a world without AIDS. I remember it from my childhood as a faint whisper, a power to fear, a distant and abstract but nonetheless menacing threat. Until I was personally confronted by the disease, it remained abstract, voices echoing in the dark. It was only when I traveled to southern Africa for the first time that I saw AIDS not as a symbol but as a terrifyingly malicious force in the bodies of so many people. Over time, I have increasingly come to think of AIDS as an absence more than a presence: the hollowness of sunken cheeks, the strange emptiness of eyes desperately staring from their sockets, the deafening silence of shame and remorse, and the paralyzing, empty-handed rage of those of us left behind.

I am haunted still by the absence of AIDS, by the loss. I am haunted too by my ultimate inability to fully understand it, and by a sense of withering helplessness in its shadow. The human face of this pandemic, to me, suggests the limits of anthropological understanding – there may after all be no final way to usefully theorize this disaster, no particularly enlightening conclusion to a deconstruction of the lives drained away and relationships wrenched apart. It is an important task for reasons that I hope the preceding pages have made clear, but one that in the end, I now believe, is doomed to be answered as cruelly and clearly as Primo Levi’s innocent questions of the absurd horrors of Auschwitz: Hier est kein Warum: here, there is no ‘why.’


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Below, I list several suggestions for policies that could improve some aspects of HIV testing, treatment and care in Walvis Bay. This list is neither authoritative nor exhaustive. I should emphasize once again that the HAART rollout there was successful. However, the program can be refined in ways that encourage more equity at all stages.

**One: New structures for Male Testing**

Walvis Bay enjoyed some success in attracting men for testing, though relative to the gender ratios in the population, men are still under-represented in testing. My research suggests that these three things may help to increase the numbers of men who test for HIV.

- First, the suggested concept of ‘team testing’ would have the benefit of both drawing more men overall into testing, and of providing those men with a ‘built-in’ support system.

- Second, the suggested incorporation of ‘after-work testing’ and men’s events (including barbeques and other social activities) could improve male turnout by respecting their social needs and creating a more positive, comfortable environment.
Third, many of my informants in Walvis Bay reported that the existing structures of workplace testing seem to be effective; this may be reflected in the city’s relatively high rates of male testing compared with other Namibian cities. Workplace programs should be supported and increased, where possible.

Two: Creating new pathways into care for Men

It seems clear that antenatal care offered a clear pathway for HIV-positive women into HAART. Men, however, lack a ‘natural’ pathway; the following three suggestions may provide such an avenue for men to enter care at an earlier stage of their disease:

· First, antenatal clinics should consider ‘matched’ maternal testing. This would mean that women, when possible, could be encouraged to present to antenatal care with their partners in order to participate together in a battery of health services (including, but not limited to, and HIV test).

· Second, the Ministry of Health and Social Services could alternatively (or additionally) create some sort of other ‘natural’ testing event, including an automatic “healthy man” checkup at regular milestones (for instance, on the 20th, 30th and 40th birthdays). This need not be exclusively for identifying HIV; again, men could be offered a battery of age-appropriate primary care including vaccinations and screening for chronic disease.

· Third, cooperation with the private sector could again be useful in creating a clearer pathway for men to move from workplace testing into treatment. Many – though by no means all – employed men in Namibia use private health care through workplace health insurance. The HAART program could capitalize on this by encouraging more regular workplace testing and counselling as a means of drawing men into care sooner.
Three: Balancing gender in Health Care Teams

The HIV/AIDS health care teams that I studied, including those involved in testing and counselling, were disproportionately female. Creating a clinic environment that makes males more comfortable may help to improve male outcomes. One useful approach may therefore be a concerted effort to recruit and retain men, particularly as nurses and counsellors, to work in HIV/AIDS treatment, testing and care, and offering men the option of being seen by a male professional if they so choose.

Four: Mainstream HAART into Daily Life

As rollout matures, it may become increasingly feasible – and efficient – to mainstream HAART into daily life. Fishermen who are in stable care, for instance, should have an easier time getting letters for long-term refills for trips to sea. The process to allow patients who move to another city to switch clinics should be streamlined, especially as more electronic records come online. The ‘vertical’ approach to treatment has been very successful in rapidly scaling-up treatment in Walvis Bay. In the long term, however, it may prove more efficient to ‘mainstream’ HAART by allowing for treatment of more patients (particularly those who do not suffer from complications) in decentralized models of ongoing care.

Five: Moving to a ‘Test and Treat’ Approach

The overall positive results seen at the Walvis Bay clinic should encourage a move toward the ‘Test and Treat’ approach of initiating HAART immediately upon testing positive rather than waiting until the patient reaches a given CD4 cutoff. This would increase the number of patient on HAART at the clinic, which would certainly require adequate preparations
and investments in staffing. However, it would also likely help to reduce mortality during the period between intake and initiation, when men seem particularly vulnerable. The rollout has been successful so far, and it seems reasonable to expect that an expanded rollout would be, too.

**Six: Actively Incorporate Social Science**

One of the lessons of this thesis is that as treatment rollouts mature, particularly in relatively stable and well-resourced contexts like Namibia, the challenges the program encounters and less logistical and more social. The insights of anthropology and allied social sciences will be crucial in anticipating and addressing the ways in which the complex socio-cultural and political-economic forces – impact on the lives of individual patients and interact with their treatment and care. This means moving beyond purely epidemiological research and instead devoting time to in-depth, qualitative research on the lived experience of HAART.