‘You Cannot Believe Your Eyes’: Gendered Dimensions of ART Anxiety in Rural Malawi

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ABSTRACT:

Access to antiretroviral treatment has transformed the lives of individuals and communities across Africa. Research on the social impact of ART pivots on questions of adherence and community acceptability of treatment programs. We examine unintended consequences of the scale-up of treatment in rural Malawi. Through thematic content analysis of over 150 observational field journals spanning 2010-2013, we focus on the ways young men, in a collection of rural villages in Malawi, talk about ART in everyday life. While official public health discourse urges people to get tested and treated, a parallel unofficial discourse about the hazards of scaled-up treatment has emerged, linking ART and new forms of gendered risk and danger: Particularly for men, the restorative capabilities of ART have confounded efforts to identify sexual partners who are HIV free. Ambivalence over the social impact of ART co-exists with individual demand for and appreciation of the benefits of treatment.

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Introduction

The treatment of HIV disease with anti-retroviral therapies (ART) is lauded as a modern miracle. The roll out of ART to countries with high HIV burdens, such as those in sub-Saharan Africa, reflects a commitment by donors and governments alike to saving individual lives and reversing the toll of death and despair that the epidemic has placed in countries hit hardest by the disease. But despite the obvious – that the drugs extend lives that were once condemned to an imminent death sentence, allowing those infected with HIV to resume “normal” lives – the widespread availability of the drugs poses unique sets of concerns. To be sure, ARVs are intrusive technologies: They must be taken every day for life, and they require people using them to become closely involved with clinics and the apparatus of biomedicine (Angotti et al. 2014). They also treat a condition – AIDS – one that carries powerful emotional connotations around the world.

In this paper we provide evidence of yet another concern: how the restorative capabilities of ART have confounded efforts to identify sexual partners who are HIV free. We focus on the ways young men in particular, in a collection of rural villages in Malawi, talk about ART in everyday life. Their conversations, we argue, are strategic, purposive and also, highly gendered: Since the appearance of health and “plumpness” conceals the truth of the body, young men in these communities perceive ART to be unsettling at best, and at times dangerous, and thus a subject of their gossip, speculation and observations about the women around them. Our findings thus point to what might be called a “perverse normalization of life”, that is, the unintended ways in which ART is being integrated into the social lives of communities experiencing the AIDS epidemic first-hand.

Talk about ART:

Most research on how people talk about ART is oriented by questions about whether attitudes towards ART encourage or discourage testing and treatment by individuals; and whether
these attitudes make life easier or more difficult for people on treatment. For example, Smith and Mbakwem (2007; 2010) argue that ART enables people who are HIV-positive to carry out personally meaningful “life projects”. These life projects include marrying and having children, mitigating their experience of being stigmatized and marked-out as sick or immoral because of their illness. Positive attitudes towards ART are part of the normalization of life with HIV.

Other studies of the way people talk about ART locate that talk within the broader context of shared beliefs, anxieties and aspirations, often connected to participation in social institutions. Asgary et al. (2014) describes how ART has become situated as the polar opposite of faith-based healing in Addis Ababa, with the result that ART is not understood simply as a form of medicine, but also as a refutation of religious teachings and faith. Leclerc-Madlala et al (2006) found a perverse relationship between ART programs and the South African government disability grant: successful treatment reduces viral load, which may actually disqualify people with HIV from the grant. Similarly, Mattes (2011) investigates the friction between the “ideal patient” implicitly figured in ART programs and the other imperatives, desires and norms shaping actual ART patients’ lives. Nguyen’s pioneering work on “therapeutic citizenship” (2010) also draws attention to the unintended consequences when a biomedical practice such as treatment meets co-existing social formations and subjectivities.

ART and masculinity

A trio of papers by Martin Skovdal and colleagues (Skovdal et al 2011, Skovdal et al. 2011a, Mburu et al. 2014) argue that local notions of masculinity pose a barrier to treatment and care for both men and women. Using the notion of hegemonic masculinity as a collection of highly valorized attitudes and practices, they argue that this version of masculinity intervenes between men and successful treatment. Hegemonic constructions of masculinity stress toughness, independence and aversion to feminized environments such as clinics and hospitals. Men are primed by their cultural context to deny, evade and reject the potential benefits of testing and
treatment. In particular, they write that men perceive an inverse relationship between the behaviors and attitudes associated with successful treatment adherence -- such as compliance with authority, deference to health workers, and abstention from recreational sex and drinking -- and the behaviors associated with hegemonic masculinity in the community. As a consequence, ART is set up in contradistinction to masculinity: it is not what men do (Skovdal et al. 2011).

These masculine norms are said to threaten women’s access to treatment as well, since men do not want their wives to be tested or treated because sickness in the household is considered a sign of weakness and belittles the male head (Skovdal et al. 2011a; also see Angotti, Dionne and Gaydosh 2011). When wives do test positive and start taking treatment, husbands are reluctant to come for their own tests and treatment because of intense antipathy to the health care system, associating it with femininity and passivity (ibid). Building on Skovdal et al., Mburu et al. (2014) argue that the “sick role” of being an HIV patient is antithetical to masculine ideals of independence and self-determination. Some of the time-hallowed aspects of AIDS prevention and treatment programs, such as the peer support group, were not well received by the men in Mburu et al’s Uganda study, who believed sitting around and talking was what women do, not what is fitting for men.

While these studies posit a lack of fit between treatment programs and hegemonic ideas of masculinity, other studies focusing on outcomes suggest that indeed treatment programs are not serving men as well as they serve women (Bila and Egrot 2009, Kipp et al. 2010, Lesia et al. 2012, Dovel et al. 2015, see also Nyamhanga et al. 2013 for a qualitative approach to the same question). Men appear to have lower rates of treatment uptake and poorer outcomes than women on treatment, including an increased risk of death, although the gender differences are often not large (Kipp et al. 2010).

Testing and treatment is clearly a gendered experience for men. Research on men and treatment has focused on masculine norms and expectations as roadblocks to treatment-seeking and adherence for individual men (and to a lesser extent, on the gendered outcomes of testing
services and policies that bypass men, such as antenatal testing). The most important outcome variables in these studies are uptake of treatment by individual men, or, in the case of Smith’s work on “life projects”, the experiences of people on ART.

In this paper, we follow the lead of these researchers. We depart, however, from their path in that we are not primarily interested in individual willingness to be tested or treated for HIV. In the communities of rural Malawi that are the focus of our study, ART is well accepted at an individual level. Although some people are doubtful about side effects and efficacy, in general willingness to be tested among men and women is high (see Angotti et al., 2009), as is the uptake of treatment.

ART and gendered risk

The uptake of testing and treatment by individuals coexists with collective skepticism, if not pessimism, about the negative impact of widespread availability of ART. Treatment may be good for oneself, one’s sister or one’s friend, but it is not necessarily good for “us”, the community. Attitudes towards treatment are thus more complex than approval versus disapproval, or support versus antipathy. Our work suggests that skepticism about ART is a gendered phenomenon. Fears about the noxious impacts of the ART rollout are concentrated among men, who face the dilemma of finding female sexual partners who are likely to be free from AIDS. Before ART became common, visual cues and biographic knowledge helped to distinguish “safe” women from those who were considered “risky” (Kaler 2004). However, ART has confounded that strategy, as healthy-looking women may in fact be HIV-positive. ART has thus scrambled men’s abilities to assess risk.

These fears about ART confounding assessment of potential sexual partners do not appear to be shared by most of the women in these communities, as we discuss below. While they marvel at the transformations wrought by ART, they do not perceive these transformations as deceptive or dangerous, presumably because they are not scanning their friends, acquaintances
and neighbors for potential sex partners (or if they are, they do not talk about this in public as the men do).

Skepticism about ART pivots on one crucial feature of the treatment regime: its capacity to restore an appearance of good health, replacing the wasting and weakness associated with AIDS disease. Zuch and Lurie (2012) observe that:

> as ART reconstitutes the immune systems of PLWHA [people living with HIV/AIDS], HIV/AIDS is transformed from what was once a “disfiguring and consumptive disease” into a manageable condition, largely invisible to the outside. (565, see also Castro and Farmer 2005)

The participants in Zuch and Lurie’s focus groups confirm the importance of the visible transformation, even to the extent that friends and family members do not believe they have AIDS because they do not look visibly ill. In our research, one of the strongest themes was the expression of disbelief or amazement that a particular individual could possibly have HIV, given his/her appearance of glowing good health.

But the transformative power of ART may also hold risk. For the person on treatment, becoming “invisible” as a sick person through the transformative power of ART may be a good thing, but for healthy people, ART disrupts the ability to determine who is or is not HIV positive, and by extension, who does or does not pose a threat of infection.

Previous research from the pre-ART era in these Malawian communities found that the visual cues such as thinness, discolored hair, or apparent weakness, coupled with knowledge of individual biographies, are a valued resource for determining who is or is not likely to be infected with HIV (Kaler 2003). However, these resources are undermined by ART, and old ways of “reading” the bodies of the potentially infected are rendered unreliable. The result is profound ambivalence about ART – it saves lives, but it also conceals information that people want to know about their neighbors and acquaintances.
Antecedents to ART

ART is one of the latest in a series of technologies introduced into rural Africa, a long line which includes childhood vaccinations, curative medications, prenatal care, and HIV testing. While these innovations have been intended as benign ways to improve life, they have not always been interpreted as such. Vaccines, for instance, have been interpreted as potential threats to fertility (Kaler 2010); HIV tests as the catalysts for suicidal depression and despair (Kaler and Watkins 2010). Local imagination about medical technology often exceeds the narrow meanings assigned to these technologies by their proponents or by those who make them available.

Among these innovations, the closest parallel to ART is hormonal birth control. Superficially, the two appear very similar – both are preventive measures that involve taking pills every day and keeping in contact with clinic personnel. Both are also connected to sexual activity, which creates (or at some point in the past created) the necessity for the pills.

The gendered symbolic and imaginative similarities between the two run even deeper. Both enable the recipient to manipulate the visible outward marks of sexual transgression. The birth control pill wards off the telltale pregnancy that might reveal that an unmarried woman or girl was having sex (or that a married woman was having sex while her husband was away), and ART conceals the consequences of the sexual activity that conferred HIV. With ART, the appearance of health and plumpness conceals the truth of the body, an effect that the members of these communities perceive as unsettling at best, and at times dangerous.

In this paper, we connect these new technologies of health with ideas about gender, sexuality and risk. We focus on the accounts of young, sexually active men (and to a lesser extent, the accounts of women), not all of whom are on treatment (or may ever need treatment). Nonetheless, their expectations and anxieties about sexuality are being altered by the existence of ART in the community, whether or not they are using the new medicines. We thus extend the study of the gendered impacts of ART beyond the clinical populations who use (or who may in future use) the drugs to the broader community in which ART programs have appeared.
ART availability

Between 1985 and 1990, researchers in the West identified antiretroviral agents that could be used to treat HIV (Bartlett 2006); in 1996, an international panel of the International AIDS Society-USA recommended antiretrovirals as a therapy for HIV infection (Carpenter et al 1996). Initially treatment was very expensive, up to $20,000 per person per year. UNAIDS began to work with pharmaceutical companies so that ART could be made available in resource-poor countries. In 1997, the UNAIDS Drug Access initiative was launched; the first patients received drugs in Uganda and Cote d’Ivoire in early 1998 (Vella et al 2012).

News that a treatment had been found slowly filtered into Malawi. Initially, rural Malawians were suspicious of the motives of the muzungu (white foreigners). The whites, it was said, are clever; they must have invented a cure but they did not want to share it with poor Africans. And just as the responses to the promotion of family planning in Malawi had been talk of it as a plot to make Malawians infertile (Kaler 2004), the news of a new drug for AIDS was greeted with suspicion. Subsequently, rural Malawians began to hear that treatment was available in the cities, but only for the rich who could buy it.

In 2004—nearly a decade after the International AIDS Society-USA had recommended the use of antiretroviral therapy--, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) provided funds to Malawi (and other high-prevalence countries) to enable the Ministry of Health to provide free ART to eligible recipients.² The country-wide ART rollout was featured prominently in national newspapers, radio, and TV. By 2006, a survey found that 95 percent of respondents had heard of ART and they knew that it would increase the likelihood of survival (Delavande and Kohler 2011). An analysis of longitudinal survey data collected from

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² Eligibility in principle was based on a CD-4 count. Not many facilities, however, had operational CD4 counting machines; thus, ART eligibility was based on symptoms.
three districts (one in Malawi’s northern region, one in the central region and one in the southern region), however, showed that access was limited (Baranov and Kohler 2009).

At the beginning of 2011, 421 facilities had now begun providing ART (Baranov and Kohler, MLSFH, Educ draft, p.51, TableD.2). The implication of the sparse availability of ART is that for many, distance is a substantial barrier. In 2006, the average distance of respondents in the survey was about 30 km; by 2010 it was about 10 km—much less, but still a long walk. Another study in Malawi tracked the decline in travel time from home to a facility with ART: as new clinics were added to the list of those that distributed ART, the number of people accessing ART increased dramatically (Houben et al 2012).

Description of site

Our study focuses on talk about ART in Malawi, a small country with many characteristics that facilitate dense social networks and interactions. The rural areas (about 85% of the population) are densely populated: most people live in compounds of extended family members in villages or small trading centers. Neighbors and relatives are geographically close: they often can see and/or hear their neighbors talking. Because roads are very poor, much interaction happens as village members walk together to a trading center or to their farms, while waiting in line to get water from a borehole, while attending a funeral, or hanging out at a bar.

The poorest depend on subsistence agriculture and small scale retail, as well as on borrowing and lending: ties of dependence, instantiated through patron-client relations, provide a cushion against unpredictable and threatening events, such as food shortages or the need to buy medicine for a sick relative.\(^3\) Although there is a strong ethic of redistribution and reciprocity, there is also jealousy of those who are wealthier and a fear of witchcraft, creating a context of

\(^3\) On transfers, see Anglewicz and Kohler 2009. On ties of dependence, see Swidler and Watkins 2007 and Scherz 2014.
spiritual insecurity. Minibuses and, more recently, mobile phones, connect relatives, friends, and patrons or clients who live at a distance, including neighboring Zimbabwe where many Malawians have relatives.

Methods

Our conversational data of talk about ART come from a unique longitudinal archive of field notes capturing conversations and interactions about AIDS occurring in everyday life collected by local participant observers (“journalists”). All the journalists live in one of the three sites of the Malawi Longitudinal Survey of Family and Health (MLSFH), a cohort study that began in 1998 and continues to the present day. The most prolific of the journalists live in villages in the southern site, the district of Balaka, a district with a relatively high HIV prevalence compared to other parts of Malawi.

We conducted thematic content analysis of over 150 journals spanning the years 2010 to 2013 utilizing methods of analytic deduction and induction (Timmermans and Tavory 2012): the journals were first coded deductively for all mentions of “anti-retroviral treatment” and then inductively for emerging themes of mentions of treatment. Our coding scheme captured three dimensions of ART circulating in everyday talk: as a “danger to the community”, “a danger to individuals”, and as “good for individuals”.

Because of the subject of this paper, male journalists are overrepresented in the data we present. In particular, we draw on the journals kept by younger male journalists who spend abundant time in the company of other young men, whether at work (most being intermittently employed), at leisure, passing through the area, or simply sitting around chatting and drinking beer. This demographic is one of the least visible in most studies of the uptake of ART – these are men, rather than women, they are young but not youths (in their 20s and 30s) and mainly

4 On redistribution and reciprocity, see Chabal 2009; on spiritual insecurity, see Ashforth 2005.
5 See http://investinknowledge.org/projects/research/malawian_journals_project for a description of the Malawi Journals Project. The journals are available on the site for public use.
unmarried, and they are not acknowledged leaders of the community such as religious figures or heads of community organizations. We do not claim that these somewhat footloose young men are entirely representative of their community, but we believe the ideas, concerns and priorities circulating in their homophilous social networks are probably circulating widely in rural Malawi.

In the section that follows, we draw out the themes emerging from conversations about ART, and that highlight questions of risk and danger. We describe the perceived ubiquity of ART in the study community, and the ways in which ART is reshaping the sexual landscape. The dangers that the widespread availability of ART is said to pose are most salient to young men, whose strategies for seeking sexual partners are confounded. These men and their strategies are the focus of this paper. Their talk of sexual risk implicates women as the embodiment of potential danger, but women themselves appear to regard ART in a more benign light, integrating it into “life projects” of reproduction and marriage (Smith 2010) and allowing them to remain continued providers for their children.

ART is everywhere

The benefits of ART are well-known in this community. Many people know stories about people who were HIV-positive and who have recovered strength and health thanks to treatment. This has made AIDS an episode in their lives, rather than the endpoint. In the old days, AIDS was considered a death sentence, but nowadays there is visible evidence that treatment saves lives. Although some people speak of side effects associated with treatment, or people for whom it has failed, most stories about people on treatment end with the patient’s return to health and functioning in the community.

AIDS was very dangerous in those old days when there were not these ARVs, but these days with the provision of the ARVs, AIDS is no longer dangerous … My friend N_____
here, she also lost her daughter who died of AIDS and it was in those days before these ARVs were being found so that if it was in these days, my friend couldn’t have lost that daughter because she could have been taking the ARVs. She was a very beautiful girl so that it pains us that if it was in these days when there are these ARVs, that girl wouldn’t have died. (George_111013)

In theory, information about who takes ART is confidential, shared only between the health worker and his or her patient. In practice, as these stories demonstrate, information about who is on treatment is a popular topic of conversation. ART is not something unattainable, reserved for a select few as it was in the past. Rather it is commonplace – so commonplace that people in the journals consistently overestimate how many people might be on treatment:

If a person has this virus and you tell your friend and the same friend whom you disclose [it] to [speaks to] others, rumours will be circulating. He said that he knows many, even 200, who receive ARVs in his village alone. (Bellos_110723)

I heard Mr. K___ saying that three quarters of women at Nkhadze area are on ARV treatment. (George_100920)

He [said] “not all people have kachirombo [HIV]”. N_____ said “Of course, but out of 100 people maybe only 20 have no kachirombo and 80 have [it] but [are] not easily noticed because of the nandolo [pills] that [they] are taking!” [W]e laughed. (Bellos_120206)
Although ART is perceived as omnipresent and effective, being on ART is not something that is openly acknowledged, at least by most of the men whose conversations appear in the journals. Certain clinics are known to offer testing and treatment, and people who are often seen in the vicinity of those clinics are suspected of being on ART, especially if they appear to have traveled a long distance to get there. One participant recounts a conversation with a friend who drives a taxi, who reports that:

G_____ was pointing at some of those women who do sell rice and they are on ARVs and he was saying, “Have you seen that woman there, that one is on ARVs.” He did this for about three women at that place alone. And after we passed that place, G_____ said “I have been here in Balaka for a long time and I know more about this town and its people and I do know more about some of these people who are on ARVs as we do find them at Dream Clinic at the place where they do gather to receive these ARVs when we have gone and drop some customers who do also go and receive these ARVs”

(George_110525)

People may seek privacy and anonymity in treatment, but neighbors note their movements to and from clinics. Strategies for avoiding notice can backfire, as everyone knows which clinics provide treatment, and indeed, some people can recite a list of local clinics known for ART, including the Dream clinic, Mikoke Mission, Ntcheu District Hospital, Machinga District Hospital, Malosa Mission Hospital and Zomba District Hospital.

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6 Testimonies to the value of ART and the merits of “living positively” with the virus are a staple of educational meetings, however.

7 This calculation of who might be on treatment is similar to the discussion noted in the pre-treatment era, when people speculated and debated who might be infected with HIV, based on behavioral signs or physical appearance (Kaler 2004). Estimates of AIDS prevalence were invariably higher than actual prevalence levels, and it is likely that once again, estimate of treatment prevalence exceed the number of people actually on treatment.
Crowds outside the clinics can also reveal that ART dispensing is going on. One journalist visiting the hospital spoke to a woman in the waiting area who was there for ART, who described how early she had to arrive:

She [said] “I always come here early in the morning at around 4:00 am for me to go back home in time as you have also see outside that there are many people who have come to receive the tablets”. Both Mrs. W____ and I we were surprised because we did not know that she meant the ART building. I told her that the clinic was not yet opened by this time and I am not sure that patients can be there at this time because it’s too early. She replied, “No sister, do you mean that you did not see many people outside as you were entering the gate? … I mean where most people come to buy their lives [receive their pills] near this building. It is impossible that there can’t be people around this time. A lot of people start arriving here at around 3:00 am. If you come this time or 6:30 am it means that you are very late on that day hence you shall go back to your home very late as well”.

(Sanudi_150120)

A_____ said, “Most of the people here in Balaka do prefer to go and get tested at Dream clinic because it is an outskirt place where most of the people who do go there to receive the ARVs know that they cannot be seen by those people who know them.” Then N_____ said “Not only at Dream clinic, some people who do go and receive the ARVs do even prefer to go to Mikoke Mission clinic that is in Ntcheu District so that they don’t get seen by those people who know them.” Then N_____ said, “Most of those people who are on ARVs here in Balaka, they don’t want to be known by the public that they are on ARVs and it is because of that reason that they do then prefer going and receive their ARVs from other hospitals which are out of Balaka Town”. (George_111118)
Such clinics are so closely identified with ART that the name of the clinic can serve as the punchline of a joke, as in the case of one man who recounted his decision not to marry a young woman who was thought to be promiscuous. His friends congratulated him on his good judgment, pointing out that if he had married that woman, “you would have now joined the Dream clinic ARVs team.” (George 111013)

In the excerpt below, one man asks a friend who sells pharmaceuticals in the market if it is possible to buy ART there, in order to avoid being seen at the local clinic, particularly by women:

Because L asks different kinds of tablets M asked him about ARVs drugs he said “Do you sell ARVs?”.

L said “No, I don’t sell. If you want ARVs why don’t you go at the Health Centre?”.

[M said] “I am just talking if I can be found with virus, I cannot allow to receive ARVs from our hospital”.

… L asked “Is it better to receive from the hospital of some [other]areas?”.

M answered, “Yes, it’s better”.

K asked “Why not here?”.

M answered “Because many people can discover fast that I have virus of AIDS. And some ladies can disagree with me so it can be painful in my everyday life” (Black_111215).

Another man eschews his local clinic, because the waiting area is shared by people who are

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Another likens ART to witchcraft, something people indulge in secretly. Rumors and suspicion may abound, but the telltale signs are obscured. One can say that ARV is like witchcraft. You can’t see a witch doing witchcraft. Even if you see him during the day that people say this one is a witch, but to see him doing witchcraft of flying at night - you can’t see him! (Bellos_110905)
looking for ART:

Those people who do go there for the ARVs supplementary, they do share the benches there and it happened that when we reached there, we found that there were some people waiting for different services there and all the officers there were busy and $T_	ext{____}$, said to me, “Let us leave this place because if we can stay at that place for a long time, some people who may see us here can think that we do come here to receive the ARVs.”

(George_120724)

$T_	ext{____}$’s concerns that he would be spotted by someone whom he did not want to see appears to be well-founded, as in this account of a woman who learned of her husband’s HIV by seeing him at the clinic:

It is difficult to ask as a man to go for a blood test, unless he is the one to tell you of going together to the hospital for blood test. The problem is that not many men who are mostly willing to go for testing. Most of them refuse that issue. Had it been that we [she and her husband] did not meet at the hospital to receive ARVs, we met somewhere and he never saw me at the hospital receiving the ARVs, I don’t think that he would have told me that he has the *kachilombo* and he is receiving the ARVs. He would have just proposed me to be his wife but he wouldn’t have told me that he has the *kachilombo*.

(Sanudi_101106)

“Strange beautiful women”

Although many of the accounts of ART in the journals involve anonymity and concealment, one group of people was described as “proud” to be taking ARVs, even to the extent that treatment has supposedly become a new fad or fashion. These people were young, independent women, identified as such by their male peers:
We saw a certain girl who put on a tight pair of trousers and she was heading to Balaka Town Center. And when we saw her T____ said, “That is a type of Balaka Town girls who are ready for any attack”. Then T____ said, “the bargirls and prostitutes of this town have also introduced their own slogan that is defending their business where they are now saying that, ”those who are not on ARVs they are not in fashion”. Then we all laughed. (George_110325)

These same women – young, unattached and presumably sexually active – were also described with confidence as all being on ART. In men’s barroom talk, the bar girls – waitresses, servers, and sometimes casual sex workers – were noted to be “100%” on treatment.

The men who do go for these bargirls do know that these bargirls are on ARVs but those men do still go for them. All the bargirls here do go and receive the ARVs, there is none of them who doesn’t take the ARVS. (George_111013)

In addition to women, “big men” from out of town, with expensive cars and ready cash, are also described as likely recipients of treatment: :

“All of the women who do sell beer inside this Chibuku Tavern are on ARVs except the old M___ M____.” Then the second man said, “100% of the bargirls here in Balaka are on ARVs.” And the fourth man said, “Not only bargirls that they are the ones who are on ARVs here in Balaka Town but even these well to do men whom we do see in town they are on ARVs so that when you go at Dream Clinic there, you see their vehicles on the car park and you see them coming from the ARVs Clinic and you do wonder in one’s mind to see that such well to do men whom we do see here in town they are on ARVs too. (George_110619)
The “big men” are conspicuous by their cars and wallets, although they may try to hide their presence at the clinics. Local women on treatment, by contrast, are both hypervisible and deceptively normal at the same time.

The hypervisibility of ART is suggested by one of the journalists’ friends, who could walk through the market, pointing out confidently which of the women selling rice were taking ART, and by another one’s take of how he had rebuffed the advances of a divorced woman in the neighborhood because everyone knew she was on ART. At the same time, ART disguises women, making them appear healthy, normal and safe when they really are not. It is to this feature of ART that we now turn.

Plumpness

In the earlier days of the AIDS pandemic, thinness was the hallmark of the disease. Earlier journals are replete with accounts of men and women grown thin and gaunt, whose appearance signified to everyone that they had AIDS and were not long for the world. It is thus not surprising that the most remarked-on effect of ART was the exact opposite of thinness – plumpness or fatness. People on ART could avert the tell-tale thinness, and become as plump as, or even plumper than, those who did not have HIV.

Many male friends and associates of the journalists remark on the attractiveness and amplitude of those on treatment. Sometimes the plumpness is described as unusual or odd-looking – a large potbelly, a prominent head – but most often, it is described as the sort of heft and healthy appearance that one would expect from a person who ate well and had never gotten sick. Sometimes the “plumpness” is associated with behavioral or psychological signs, including an increased appetite for sex, which make the plump individual even more likely to spread HIV. Once again, the discussion of treatment is gendered – the “plump” ART patients, who look just as
if they had never gotten the virus, are almost always female\(^9\).

Lots of people especially women have *kachirombo* that caused AIDS and by looking at them you can’t even know that because the ARVs are helping a lot for they are still looking plump. (Bellos_122226)

He said “If one see Mr X’s , [one] can’t also believe that she takes ARVs”.

“Why?” I asked, and he said that she is very plump and with her medium height and pale in complexion acculturated by her round face always in natural smart hairs and a bit oval eyes that really suits her everything in place really. She said she is beautiful and also works as [a village health worker] and receives money but her husband is the bad one because he is the one who gave her the *kachirombo* and because these ARVs helps, that’s why they are still alive today. They could have died long time ago had it been that they started taking the ARVs. (Bellos_110703)

Although this deceptive plumpness is considered a generic feature of ARV treatment, the stories about specific cases of “plumpness” were individualized, specific to particular women and contextualized within what the speaker knew of that person’s history. This suggests that the people knew of the effects of ART from direct observation, as distinct from distant rumor or gossip, or generalized truisms about treatment:

If you can see M___’s wife, you cannot believe your eyes that this is the same wife of Moses who had grown thin and being often sick, but this time around since she started taking the ARVs, she has now grown fat so that you cannot believe your eyes that this is

\(9\) In all the excerpts coded for this paper, only one referred to a man as having acquired plumpness through ART: “Not only women who are to be suspected that they are fat may be because of the ARV many men are also looking health the way you are and are taking the ARV like the malaria drug!” (Bellos_120617)
the very same wife of M____ who was about to die of Aids. (George_110715)

I met with the wife of Mr. T______ today, her health has highly improved after starting to take the ARVs so that if you can see her today, mother, you cannot believe your eyes that she is the same woman who had lost weight (George_110119).

It is clear from the journals that the plumpness is not believed to come from benign sources – women are becoming plump even when they don’t have the money for fattening foods or good diets. This plumpness is brought about by powerful drugs.

We laughed and C____ said that that’s why nowadays he doesn’t prefer rather admire ladies who are fat because the fatness of today is that of fake. We laughed as he continued saying that ladies nowadays are getting fat but looking back from two years they were extremely thin and he ask[s] himself as to what kind of food or relish they are taking in these days of money scarcity and hunger? (Bellos_120617)

Perhaps not surprisingly, the women whose weight gain is most remarked upon are not the respectable wives or upright pillars of the community, but the bargirls and single women – the same women who are described as having made a “fashion” out of ART. Young men warn each other against attractively plump potential sexual partners, providing biographical details to bolster their contention that the plumpness comes from ART, and by extension, is a sign of HIV.

This kind of biographical diagnosis of HIV risk is not new in these communities, but ART has added a new element to the work of figuring out who is infected (Kaler 2004). The men in these communities are clearly aware that times have changed, and remark on the difference between “then”, when a thin or skinny woman signified danger, and “now”, when a full-figured fat woman is cause for caution. In the following excerpt, the shift from the old ways of knowing –
thinness is a danger sign – to the new ways of knowing – plumpness is a sign of trouble – is clear:

Then K___ said, “But it is also possible to notice that this one has got AIDS because he/she does grow thin.” And T___ said, “You are lying, K____. It is very difficult to notice that this one has got AIDS or not and someone who has got AIDS can be looking fat and health as you are but whilst she/he is having AIDS while someone can be looking slim and in poor health while he/she is not having AIDS so that because of that, it is only after HIV tests where you can conclude that this is HIV positive or not?” then K____ laughed and said, “I agree with you.” (George_120313)

Times have changed: as one man says: “Nowadays this disease is found inside the one who looks plumpy [sic] and it’s better [to choose] the one who is slim, probably she gets thin because of hunger not plump because of drugs (thus meaning ARVS)” (Bellos_120804).

Other accounts stress the change from former days, when visible signs of sickness informed on who did or did not have AIDS, to the present time, when visual cues may be misleading and only biographical knowledge can be relied upon:

These days, you can’t see a person who is sick with AIDS like how people with AIDS were looking in those years. Because in those years, a person with AIDS was having pale hair, with persisten[t] diarrhea and highly losing weight. But these days you can just hear that this one has got kachilombo but you cannot see a person with kachilombo having those signs these days”. “Then N____ said, “That is true, you cannot see a person with AIDS [like we] were having in the past; this is due to the use of the ARVs”.(George_110109)
These miraculous return to plumpness offered by the new drugs means that biographical knowledge may be the only way to ascertain who is a risky sexual partner, short of a test at the clinic (an option that is not popular with most men). As a result, bargirls or prostitutes with AIDS can get a fresh start in a new community, because the signs of their illness are not apparent. Men tell stories of bargirls or prostitutes who leave their old places of work because they are suspected of having AIDS in favor of new bars or beer halls. They are able to make a fresh start, appealing to a new set of potential sexual partners who do not know their history, because the telltale signs of AIDS are masked by ART:

“Without those ARVs those bargirls would have died of AIDS because these ARVs are the ones who are helping those people who have got AIDS to live longer and healthy.”

Then Mr. C_____ after he said that statement, Mr. M_____ said, “What Mr. Chilenje has said is true because these ARVs are helping those people who have got AIDS to seem like that they don’t have AIDS”. (George_111013)

That girl she is about fifteen years old and … in the past few years, she was so sick that she lost weight and if you had seen how sick she was by that time and you see her this time, you cannot believe your eyes that this is the same girl. … But when she started taking these ARVs, she is now health[y] and beautiful and she has since not stopped her profession as a prostitute so that she is being found in some of the bottle stores here in Balaka Town and for a new person who doesn’t know her background, one cannot think that she is on ARVs. (George_110119)

These deceptively plump women are not generic or anonymous sex workers, but specific individuals who are thought to have multiple sex partners. Plumpness is not just a general
attribute of people who are on treatment; it is an observed property of specific women.

But the other thing which is the daughter of M____ M____ is that she started prostitution while she was here in Balaka and she was also used to going to S____ for the same business and it happened that she fell so sick and she had grown thin and after she was tested and found that she has AIDS, she started taking the ARVs so that this time around, she is back to normal health and she is now looking more beautiful than before.

(George_110715)

“That man who is talking with Y___ must be careful with Y___ because Y___ can just kill him because Y___ had grown thin in the past few months and because of her poor health, she was not marketable [as a sex worker], there at the tavern … but now that she is taking the ARVs, she has become fatter and healthier than before and she has since returned to her old business of selling beer and be going with men at the same time there.” (George_100822)

Mr. K____ said that woman was about to die so that she highly lost weight and she was having poor health and she thus stopped selling beer and she became a born again so that she then started selling some rice and after taking the ARVs, she started improving and she was a slim woman but this time she has become so fat so that you cannot believe that she has got AIDS. And after seeing that she has improved, she returned into the bar where she is still selling beer and she is having partners there. (George_110119)

Plumpness is not merely the return to health after AIDS-related illness: it is also a trap for the unwary, who might be tempted by the sight of a plump woman. Men warn each other of
particular women who are believed to be hiding their HIV infection with ART, as in the excerpts above.

In men’s accounts, ART has two faces: it restores their friends and family members to health, but it also threatens them. People on treatment – specifically, sexually available women – are dangerous because they confound the equation of risk with a sickly appearance.

Such strange beautiful women are very dangerous because most of them are becoming fat and beautiful like that because of taking the ARVs. (George_1206180)

[F____ said], “I do also hate that there are these ARVs because with the provision of these ARVs, it is difficult to notice the one who have got AIDS and the one who is not having AIDS.”

Then D____ said, “It is true that these days with the use of these ARVs, those who have got AIDS and those who don’t have AIDS they are just looking the same.”

[F said] … “But although those people who are having AIDS, they are not dying … These days you cannot be able to notice that this one has got AIDS and this one does not have AIDS because those people who have got AIDS are not different from those people who don’t have AIDS in their appearance due to the provision of the ARVs”.

(George_111118)

[My brother] said these ARVs are bad and it could have been better if stopped because they are making people [more] plump and beautiful than before they started taking the ARVs. He said since you know people especially we the Malawians, we admire someone being a healthy partner if she is plump and think she has no virus causing AIDS, yet a wise man suspects the one who is plump and knows that some plumpness is due to ARVs. He warned me to be careful on this. (Bellos_121226)
The actual dangers of having sex with someone on treatment are greatly exaggerated in these men’s accounts, because comprehensive treatment reduces viral loads to the point where transmission is extremely unlikely. However, it appears that this bit of information about treatment has not reached bottle stores and barrooms, so that plumpness is interpreted as a sign of high HIV risk, rather than a sign that it is being successfully treated. This overestimation of the danger of sex with someone on treatment is consistent with other overestimations, such as the claim that most people in the area are on ART, noted above, or overestimation of the probabilities of infection from sexual contact with an infected person.

Disinhibition and discovery

The advent of ART has complicated men’s sex lives in more ways than by simply deceiving them into thinking sick women look appealing. ART is also linked in narratives with disinhibition and an increase in risky sex; and with increased risk of extramarital affairs being discovered, through the presence of pills in the home or the presence of a spouse or sexual partner on line at the clinics.

ART is associated with a possible increase in AIDS prevalence because of concerns that people will have sex recklessly because they know they can be treated with ART should they be unfortunate enough to get AIDS. This disinhibiting effect of ART is ascribed generally to generic categories such as “youth” or “people these days”, unlike the masking effects of ART described above, in which “plumpness” was a feature of specific individuals known to the speaker.

He warned people that the ARV should not encourage people to do sexual intercourse with the heart of saying that there is ARV so when I get AIDS I will receive the ARV drugs and I will be fine. (Moloko_120405)
[S___ said], “These days when you have met with a beautiful girl like the one who has passed here, you just have to have sex with them without using condoms because you know that when you can catch AIDS, you can go and start receiving the ARV’s at the hospital there.”

And M____ said “You are right S____, these days with the provision of ARVs, people are not worried about catching kachirombo as it was in the past years when there was not these ARVs.” (George_110917)

He said that because of the ARVs people are not afraid of catching the virus because they know nowadays that if catching the virus today they are going to receive the ARVs and live longer life and never develop AIDS and people are not dying of AIDS nowadays as it was in the past. (Bellos_110508)

In addition to disinhibition, the existence of ART intervenes in extramarital affairs and marriages, providing evidence that one party is HIV-positive and is attempting to conceal this from a spouse or partners. The journals contain many stories about men who run into their wives and girlfriends while waiting in line for treatment, or about bottles of pills stashed in handbags which fall out at inconvenient times. In some cases, the revelation of ART has already happened; in others, it is presented as a risk to the partnership, as something that might become evident in the future and bring an end to the relationship.

In the most dramatic examples, the discovery of ART leads to confrontations amongst men, wives and girlfriends:

Then it happened that the wife of that man was tipped that her man is going with that girl and at the same time that man could sleep at the house of that girl, he was missing to take that particular day ARV dosage. But that man did not disclose to that girl that he is on
ARV’s. then after his wife heard that he does spend some night at that girl’s house, it happened that one day when her (that woman’s man) was at his workplace, that woman took the bottle of the ARVs of her husband by day time and went and drop them in the saloon of that girl while her friends were there and when that woman was dropping those ARVs, she said to that girl, “My husband is on ARVs so he is keeping on missing to take these ARVs when he is sleeping at your house. Here are his ARVs so that when he comes you tell him that I was here bringing his ARVs so that he should be taking them when at your house as we are both on ARVs”. (George_120412)

I went at Dream clinic today and what I have seen there is very difficult to understand. What has happened is that B_____ has got a certain extra-marital partner here in Balaka and B_____ went with his extra-marital partner at Dream clinic so that they should get tested and it happened that they got tested and should start receiving the ARVs as they have both been found HIV positive. But B_____ does already receive the ARVs with his wife from Balaka Main District hospital. So that he was going to Dream clinic with his extra-marital partner out of the knowledge of his wife. And it has happened that someone who knows B_____ came and [told] B_____’s wife here that B_____ and his extra-marital partner they had been at Dream clinic for AIDS and that they will be there again. What has made me wonder is that B_____ is already on ARVs and he already knows that he has got AIDS but he is also going with his extra-marital partner for AIDS at Dream clinic. (George_111003)

Women talking about ART

While men focus on the deceptive nature of ART, and the complications it poses for finding low-risk sexual partners, the view of the women in the journals appear to be much more consistent with standard public health messaging. They recount information they have been told
by health personnel, speculate on the effects of ART on pregnancy and childbirth, and tell stories of wives who navigate the complexities of husbands who refuse to get tested. In general, women’s accounts of ART are less ambivalent and disruptive than men’s, as ART is more smoothly woven into “life projects” of marriage, childbirth and domestic life (Smith 2010).

I was living with my aunt in Blantyre who is on ARV treatment who works at Standard Bank as bank managers, she has two cars and a big house … She has one child N who is a girl. Asking her why she only had N, she always replies by saying that she want to continue enjoying life with her negative child, she is afraid maybe the other child can be positive [i.e. would be born with HIV] and start taking ARVS at younger age. (Nsendema_120202)

“All things are right with you not so?” I ask R who with a smile replied “You have already heard that ARVs are now near, no need for going to Balaka. I have to make use of our hospital here! I will be fat[ter] than I am”. Today’s ARVs are making people grow fast fat. … . R is not on ARV treatment but the girl she was with (Z) is the one on treatment. R said “Tomorrow we are saving food, in the morning they will go for ARV clinic and in the afternoon attending a meeting. We will not go back home in the morning we will wait for Fanta and “obama” (buns) (Nsendema_120202)

Women are more likely to associate ART with experiences at clinics, generally positive ones of consultations, snacks, and solutions to health problems. While men’s stories of clinic-based treatment tend to focus on hiding the fact of clinic attendance, as in the stories of big men in cars who travel long distances to go to a clinic where no one will recognize them, women are more likely to mull over things they have been told at the clinics and test these bits of knowledge
against their own circumstances, speculating as to whether a newborn baby will become HIV-positive, or whether a husband should reveal to his wife that he is on treatment.

Both men and women ascribe this difference between the genders to women’s familiarity with the clinics through antenatal and pregnancy care, consistent with other research on men’s and women’s routes to accessing treatment (Dovel et al. 2015). Women spend more time in clinics more often, so their exposure to talk of treatment is more likely to come from the clinic than the beer hall.

That [getting on treatment] can mainly be practiced by women because women do have AIDS tests at the hospital whenever they are pregnant so that it is during that time when they do realize that they are HIV positive while most of the men do shun HIV tests so that it is difficult for such men to know whether they are HIV positive or not.

(George_120313)

While men’s presence at HIV testing and treatment sites is fraught with the possibility of being discovered, for women, attending for antenatal care is much more matter-of-fact. The link between antenatal care and treatment is strong enough that one man reportedly was relieved when his wife became pregnant, because now he would be able to access treatment through her antenatal visits:

He also told me that his wife is pregnant. He thinks that he is very lucky now because he will go to the hospital with her for the antenatal clinic. During that time his wife will be told to call her husband for blood test. Maybe that will be his chance to start the ARVs. But the problem that they have in their house is that a man is HIV positive while his wife is HIV negative. They had been going for the blood test together for several times but she is HIV negative. (Sanudi_120806)
Discussion

The most striking finding of this paper is the contrast between the life-saving benefits that ART offers to individuals (and by extension, to their families and communities) and the association between ART and new forms of gendered risk and danger. People are ambivalent about the drugs – on the one hand, ART saves lives; on the other hand, ART may actually endanger lives because it blurs the distinction between the healthy and the sick, putting one at risk when they cannot tell whether their sexual partner might have HIV. We document what might be called the perverse normalization of ART. It is being integrated into the evolving social lives of communities, becoming part of the landscape – but in a way that was certainly not intended by the organizations that have rolled out treatment programs.

This perverse normalization becomes clearer when we use gender as a lens to examine the incorporation of ART into everyday life. We treat gender not as a variable (male or female), as is standard in epidemiological studies, nor as a set of abstract norms and values to which people are said to adhere, such as the valorization of toughness, autonomy or strength among men. Instead, we examine gender in action – the “actions” of everyday conversations and chatting in a highly networked community with abundant opportunities for social interaction. The chats and discussions of the men here may appear to be simply filling time or shooting the breeze, but they may also be understood as part of men’s “life projects”.

These are not the large projects such as marriage, reproduction, parenting or career, such as those identified by Smith (2010). Rather, the men in this paper are engaged in the mundane conduct of everyday life -- gossiping, speculating and observing the community members that surround them. Their chats can be understood as life micro-projects – scoping out potential sexual partners, gathering and circulating information about their neighbors, and making sense out of the arrival of ART in their communities. Focusing on these gendered life micro-projects enables us to see casual conversation and chatting as strategic and purposive actions, even if the ultimate goal
or purpose of the actions is not always entirely clear. The complex impacts of ART are not always seen in major personal transformations such as surviving AIDS, but also in the ebbs and flows of daily life.
References


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