

Don't You See Our Shining Faces?

HAART's first decade in Namibia

There was a brief period in the 1990s when Namibians might have thought, however briefly, that they would escape the horrors of the new plague sweeping the continent. Richard Lee, the famous ethnographer of the Kalahari, recounts a chilling story of sitting under a tree with a group of San, listening as a visiting doctor anxiously tried to explain a perplexing new disease known in the big city as "AIDS." Those innocent days now lie on the far side of a complacent, slow, and at first ineffective response that allowed HIV to gain a foothold; by 2002 Namibia's rate had skyrocketed to 22%: the fifth-highest on earth.

There are several theories to explain why HIV hit Namibia so hard: low rates of circumcision, high rates of synergistic diseases like tuberculosis, busy shipping and trade routes; it also seems that the particular strain of HIV most common here is uniquely aggressive and contagious. Still, it is hard to avoid the conclusion that the government response allowed the epidemic to grow larger and deadlier than it should.

Fortunately, Namibia's subsequent response has been singularly effective: since 2003 the MOHSS and its international partners have extended life-saving anti-retroviral drugs to nearly all eligible patients. Indeed, Namibia today is matched only by Botswana and Rwanda, continent-wide, as an exemplar of a fast and efficient treatment rollout.

It is for this reason that Namibia offers a compelling glimpse of the future of HIV in Africa. After a decade of experience, this country's treatment program is a generation ahead of many others; the problems of Windhoek today are those of Lusaka next year, and Walvis Bay's challenges tomorrow will be those of Mombasa after that.

The lessons that Namibia holds, however, are surprising. It turns out that long-term, large-scale, public-sector drug rollout comes with many success and some challenges, but not the ones we might expect.

Inputs

Perhaps most surprising has been the emerging evidence that it is women who benefit most of all from HIV treatment. Along the 'HIV pipeline' from testing through care and treatment, men lag behind. My own research in Namibia confirms that women outnumber men in testing; even when accounting for differences in infection rates, women also outnumber men in treatment. In countless studies, the same findings have been reported across sub-Saharan Africa.

In my own research, I found that men were significantly more sick than women when they started treatment, with CD4 counts at least 40 points lower; this is, again, the case in other African countries.

Anecdotally, many doctors report that by the time some men finally arrive at the clinic, their disease is so advanced there is little to be done for them.

These anecdotal reports are supported by my research showing that men were over six times more likely than women to die after entering care, but before starting medication. This waiting period seems an especially dangerous one for men, and indicates some crucial stages in the pipeline that need extra attention.

One reason that women seem able to enter care sooner and more often is because of Namibia's maternity system: many women discover they are HIV-positive through routine antenatal blood tests, and are automatically streamed into the treatment system. Motherhood is so culturally valued and supported that maternity can be an ideal introduction to care. Men have no such entry point.

Women are still disadvantaged in many spheres of Namibian public and private life; it seems the clinic floor is not one of them. Men urgently need a shift in gender roles and a new, 'value-neutral' way to enter testing and treatment. Some years ago I sat with a veteran HIV expert in Windhoek to ask about this problem. Over a long cup of tea he explained with a sigh the frustrations he had experienced in trying to attract more men to participate in HIV programs.

The breakthrough, for him, came from recognizing the basic humanity of his target audience: just because they are unemployed, men shouldn't be expected to enjoy this fact or broadcast it to others, but this is exactly what many AIDS activities require. By respecting men's dignity and scheduling outreach sessions outside of work hours, my friend found that men turned out in droves: "you plan for 40," he said, "and you get 400."

Outcomes

When we consider treatment outcomes, the results are again unintuitive. In the early days of drug rollout, many observers were sceptical. As it turns out, several studies have proven programs across Africa are capable of excellent results; they also consistently show that men here have poorer outcomes than women.

In Walvis Bay, I found that men were about 1.7 times more likely than women to 'default' – that is, to fail to arrive for three months of follow-up appointments. This could be hiding further bad news: researchers in Mozambique and Malawi who tracked down treatment defaulters found that half of them had died. After testing and recruitment, retention is clearly a problem.

And at the end of that treatment pipeline? Men were just under 2 times more likely than women to die after starting treatment. Clearly, much of this is attributable to men's poorer health upon enrolment, and their higher rates of default. Still, this is unsatisfying: why have men consistently benefited less from what is clearly a well-run, well-publicized testing, care and treatment program?

There are no simple gender differences in physiology or drug metabolism that explain this disparity. The explanation is instead a complex socio-cultural and political-economic one that involves changing gender roles interacting with the health system. Diving into these complexities should be a priority.

The Next Generation

Recent anecdotal evidence suggests that Namibia may once again be ahead of the curve on two new challenges for the next generation of HIV treatment.

First, the slow and inevitable emergence of viruses resistant to antiretroviral drugs. Normally this problem is reduced through careful dosing, supporting adherence, and ultimately switching patients to different pills once they have 'burned out' their last combination. Eventually, however, the options are exhausted.

One doctor working in HIV in Walvis Bay recently described the problem to me: "Resistance," he said, "is going to be a big problem. Lately I've seen some patients that look like AIDS from the 1990s . . . they're drug-resistant now, and the old opportunistic infections are coming back." Without a solid back line of alternative drugs, this worrying development threatens to return us to the days when the best we could offer AIDS patients was prayers and painkillers.

The solutions here are not easy: Namibian clinics need an expanded capacity to test their patients' blood in-house. Currently, tests for resistance are sent to labs in South Africa. Further, there is an obvious need for more and better antiretroviral drugs to expand our arsenal. Without a domestic industry, however, Namibia will remain at the mercy of the major foreign pharmaceutical firms.

The second new development is a reported 'shadow' wave of infections among school-aged children. In interviews, several Namibian HIV professionals attributed this to various things, but simple math suggests that this is the coming of age of the first generation of children born during the 'boom years' of extremely high HIV prevalence in Namibia. These observations have been confirmed by the United Nations: they reported in 2013 that although deaths from HIV worldwide are down, deaths among children 10-19 years old had increased dramatically.

In some cases these children may have been born HIV-positive but not told of their status by anxious parents; there are indeed anecdotal reports of children believing their daily antiretroviral tablets were "just vitamins." It is not hard to sympathize with a parents' desire to shield their child from the stigma of HIV. But when these children become teens, their youthful romances could turn deadly.

Young people are notoriously difficult to reach with HIV messaging, and present a thorny tangle of legal issues around informed consent. This trend forces us to acknowledge that, as HIV treatment extends life expectancies, new and unimagined challenges will continuously emerge.

Conclusions

If truth is the first casualty of war, surely trust is the first casualty of AIDS. No amount of tablets can mend broken families, nor has the rollout been able to erase the heartbreaking stigma that patients still face daily. The offer of treatment is also, of course, cold comfort to those desperate for work or something to eat. Still, the power of antiretroviral therapy to transform HIV from a death sentence to a manageable chronic disease is little short of miraculous.

All we have learned so far suggests, though, that the cost of antiretroviral drugs will be eternal vigilance: years later, the virus still has the power to surprise us. The program does not need rescue or repair, but constant fine-tuning to ensure it delivers the greatest benefits to the greatest number. This fine-tuning will not be a question of logistics or pharmacy, but anthropology: we need to continue to learn about the complex world that lies between the laboratory and the hands of patients.

Above all, Namibia's first decade of treatment has been a remarkable success. The greatest testament to the rollout's efficacy is the patients themselves, who, if not for the introduction of treatment, would be long dead. Four years ago I sat in on a meeting with an HIV support group in Walvis Bay. I asked the patients if they thought the government's treatment plan was working. They shrugged, and looked at me as if I was a little foolish. 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?"

Mike Callaghan is a doctoral fellow at the University of Toronto. Learn more at <http://utoronto.academia.edu/MikeCallaghan>.