THE AFTERLIFE OF AID: AN ETHNOGRAPHIC STUDY IN KWAZULU-NATAL, SOUTH AFRICA

by

Stephanie A. Peel

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<u>Abstract</u>

Global health community-based interventions are habitually time-limited. Given their temporal nature, it is imperative to understand how these interventions impact, affect and shape people's lives once these programs come to an end. Drawing on three months of ethnographic fieldwork in KwaZulu-Natal, South Africa after one global health intervention had ended, I argue that transient global health programs have lasting—often destabilizing—residual effects, especially impacting community social relations after they end. Specifically, by using anthropology's field methods, I illuminate feelings of abandonment that resulted because of broad inclusion criteria of past programs and subsequently how the contraction of these programs has had fracturing effects on the status of community workers and on the patron-client bonds between community workers and their clients. Although global health organizations continue to advocate for community-based care, the nature of their short-lived interventions are weakening the social relations they rely on in the afterlife of aid.

List of Abbreviations Used

AIDS: Acquired Immune Deficiency Syndrome

ART: Antiretroviral Treatment

ARV: Antiretroviral

CHW: Community Health Workers

DALY: Disability-Adjusted Life Year

DSD: Department of Social Development

GEAR: Growth, Employment and Redistribution

HIV: Human Immunodeficiency Virus

IMF: International Monetary Fund

KZN: KwaZulu-Natal

NGO: Non-governmental Organization

OVC: Orphans and Vulnerable Children

PEPFAR: President's Emergency Plan for AIDS Relief

PFN: PEPFAR-funded NGO

TCC: Themba Community Centre

WHO: World Health Organization

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Chapter One: Introduction

An Anthropological Account of the Afterlife of Aid in the 'Post-Crisis' Era

"[W]e can reveal how populations—patients, clinicians, service providers, policy-makers, activists—are coping with AIDS, not as it ends, but as it continues to unfold and evolve; we can use grassroots research to call attention to the forms of community-based expertise that exists in affected communities everywhere… [and additionally on their] ability to reinvent themselves, even in the face of immense structural constraints. Anthropological research may be better able to document this than almost any other discipline" (Kenworthy, Thomann & Parker, 2018, pg. 967).

The sun was shining, but there was a cool breeze that made me thankful I had brought my sweater. I had only been in Ndumo for a few days when I joined Mbali, the lead community worker of the Themba Community Centre (TCC)[1], one morning as she attended a meeting at the nearby community hall. The large rectangular cement building looked tired—dark, navy blue paint was peeling off in sections and visible cracks ran along the building's walls. Today was the day I was going to officially introduce myself to the many community workers that worked with the TCC as well as other "stakeholders" in Ndumo, such as representatives from the health clinic, library, grocery store, and other businesses in the area. We convened in the courtyard, inside the community hall, sitting on unsteady plastic chairs as *Induna* (traditional leader) addressed various community concerns. After a few hours, Mbali tapped me on the shoulder and said, "It's your turn now, you can go up and introduce yourself." Getting up from my chair, I walked to the front of the courtyard. Standing on a crumbling concrete step, glancing down at my notebook, I began, "First, I want to say thank you so much to everyone who has given me a very warm welcome. My name is Stephanie and I am a graduate student from Canada. I have come to Ndumo as part of my studies to learn about

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[1] The Themba Community Centre is a pseudonym for the outpost where I conducted my research.

your current local responses to HIV." Looking out at all the faces staring back at me, I tried to explain what I would be doing over the next three months; "I will be spending my days helping at the Themba Community Centre and hoping to speak with community health workers about their work." I regrettably spoke in English, feeling ashamed I could not piece together even a few sentences in Zulu. I tried to keep my introduction brief as we had all been sitting for hours, and I had felt the energy wane as the morning went on. "*Ngiyabonga*" (Thank you), I said as I finished, wanting to step down off the step and return to my chair in the first row. Before I could, one community worker exclaimed quizzically, "Why Ndumo? How did you find us?" At that moment, I realized I had addressed what my research interests were, but I had not explained why I had chosen Ndumo specifically.

On the surface the question seemed straightforward enough. Ndumo was a rural and remote place, located in KwaZulu-Natal (KZN), South Africa, sitting near the border of eSwatini (formally, Swaziland) and Mozambique. Since South Africa has the largest HIV epidemic in the world (UNAIDS, 2019a) and the province of KwaZulu-Natal bears the greatest burden of the disease with the country's highest HIV prevalence rate (27%) (HSRC, 2018), studying community responses to HIV in Ndumo made sense. But her question was more complicated than that. As I pieced together my response, *Induna* said to everyone, "We should be thankful she chose Ndumo." As I came to learn, international global health funding for HIV/AIDS had been withdrawn from Ndumo, leaving many individuals feeling abandoned and invisible to transnational donors and organizations. Little did I realize, I represented a thread of hope that someone from the West had noticed them.

The President's Emergency Plan for AIDS Relief (PEPFAR) enacted by President

George W. Bush in 2003 to "turn the tide against AIDS" celebrated its 15th anniversary in

2018. Since its inception, PEPFAR has committed more than USD $80 billion to HIV

and AIDS relief, and it has been celebrated as "one of the most significant and successful

global health initiatives ever undertaken" (Kaiser Family Foundation, 2019a, para five).

Its achievements have been distinguished as a far-reaching success story: PEPFAR has

supported antiretroviral treatment (ART) for over 13 million people around the globe;

provided over 85 million people with access to testing services; and, has provided support

and service programs for over 6.4 million 'orphans and vulnerable children' (OVC) and

their 'caregivers' (PEPFAR, 2018a). To date, South Africa has been one of PEPFAR's

largest recipients in Africa. Since PEPFAR began working in South Africa in 2004, the

country has received over US$6 billion in aid (PEPFAR, 2018b). Despite this, the future

of PEPFAR and HIV/AIDS investments more broadly, is uncertain.

Shortly after the global financial crisis of 2008, funding for HIV/AIDS began to

decline (Ingram, 2013; Kenworthy et al., 2018; Moyer, 2015; Simbaya & Moyer, 2013).

Specifically, for PEPFAR, the budget decreased between the years of 2010-2014 and has

since remained stagnant (Kaiser Family Foundation, 2019a). This plateau marked the

beginning of what anthropologists Kenworthy et al. (2018) call the "shift from 'scale-up'

to 'scale down'" (pg. 962). In the years following 2010, the HIV/AIDS epidemic was no

longer seen as an emergency in need of humanitarian aid, but rather a crisis which was

now over (Ingram, 2013; Moyer, 2015; Simbaya & Moyer, 2013). In an effort to

reinvigorate funding, global health organizations such as UNAIDS have turned their

attention to promoting an "end of AIDS" narrative, a successor to the previous

declarations that an AIDS free generation was within reach (Kenworthy et al., 2018; Sangaramoorthy, 2018). However, although the current and dominant "end of AIDS" rhetoric in global health circles was intended to re-establish funding for HIV/AIDS, Kenworthy et al. (2018) suggest the irony is that the "end of AIDS" talk may have the opposite desired effect and "elicit a complacency among donors and governments" (pg. 962). Unsurprisingly then, President Trump's 2020 fiscal budget requests drastic cuts to PEPFAR's funding.[2] If passed by Congress, this would mean close to a 30% reduction of the current budget—a decrease of USD $1.4 billion (Department of State USA, 2019).

To further add insult to injury, one of the main strategies of PEPFAR's recent plan, titled *Strategies for Accelerating HIV/AIDS Epidemic Control (2017-2020)*, is to streamline its focus to a subset of countries (see Kaiser Family Foundation, 2019a; PEPFAR, 2017), allowing them to align their objectives with UNAIDS' "end of AIDS" 90-90-90 targets (see UNAIDS, 2014). In doing so, PEPFAR's 2017-2020 plan narrows its focus and efforts to 13 countries that "show the greatest potential to achieve HIV/AIDS control" (Kaiser Family Foundation, 2019a, para 12). Of great concern, however, is that South Africa—which has the largest number of people living with HIV of any country in the world—is not included. To exclude the country that bears the greatest burden of the disease not only suggests that South Africa's epidemic is too great to achieve "HIV/AIDS control" under PEPFAR's recent agenda but also highlights that the "end of AIDS" in South Africa is not on the horizon. It begs the question: "where,

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[2] President Trump's 2018 and 2019 fiscal budgets also proposed major cuts to PEPFAR, which was rejected by Congress. However, funding has overall remained stagnant. For more information see Fidler (2018) expert brief entitled: PEPFAR's Impact on Global Health is Fading.

how, and for whom AIDS may be ending" (Benton, Sangaramoorthy & Kalofonos, 2017, pg. 474).

Despite this dramatic decline and stagnation of global health funds for HIV/AIDS programs, the impacts on-the-ground have been "woefully under-reported" (Kenworthy et al., 2018, pg. 962). After the 2008 global financial crisis, some concluded that the flat-lining of foreign aid caused delays in treatment and stalled access to testing in various African countries (see Geng et al., 2010; Kavanagh, 2014; Mugyenyi, 2009; Zarocostas, 2012). A more recent study, however, by Walensky et al. (2017), responded to the latest proposed gutting of PEPFAR under the Trump administration. Using mathematical modeling, Walensky et al. (2017) examined the clinical and epidemiological effects that foreign budget reductions would have on the lives of South Africans. As they aptly noted, "research on global financing for HIV prevention and care has focused on questions of scale-up and budget expansion. Little is known, however, about the effect of HIV program contraction" (pg. 618-619). Their study concluded that fiscal cut-backs would increase both HIV transmission and AIDS-related mortality and "have severe adverse clinical consequences" (Walensky et al., 2017, pg. 618). Less concerned about the modeling or metrics associated with program contraction in the Global South, I approach the effects of HIV program contraction and aid reduction from a different perspective.

My ethnographic study used anthropological methods to provide empirical evidence highlighting the nuanced ways in which the retraction of aid has impacted the lives of people on-the-ground. Rather than tending to particular global health interventions during their scale-up and implementation phases—which have been the foci of other critical medical anthropological studies (see, for example, Koch, 2013; McKay,

2018; Moran-Thomas, 2013; Reynolds, 2014a)—this ethnographic study tends to the time and space after an intervention had ended.

Situated ethnographic case studies allow for rich context-dependant analyses that when studied can contribute to broader discussions. Generally, case studies have four fundamental qualities; they are explorative, particularistic, descriptive, and inductive (Åkerlund, 2013). This ethnographic study has each of these four qualities. I explored the lived experiences of community workers whose daily work involved caring for those impacted and affected by HIV at a time when they were experiencing great financial constraints and a retraction of valuable material resources. As I learned while I was in Ndumo, a PEPFAR-funded NGO (PFN) and its programs had since departed and state funding from the South African government had been drastically reduced. Living with one of the community workers in Ndumo and spending time with others over a three-month period, I tried to attentively listen to and document their thoughts and perspectives, which I describe in this thesis. Paying close attention to recurring topics and on-going struggles as I analyzed my fieldnotes and interview transcripts enables me to provide a nuanced account of how people's lives and their work were impacted by the retraction of aid. In doing so, I hope to "relay the stories of African health workers…whose voices and wisdom is rarely appreciated by global health leaders" (Pfeiffer, 2013, pg. 181).

Given that South Africa has been one of the largest recipients of PEPFAR funding in Africa and that the province of KZN has the largest percentage of people living with HIV in South Africa, Ndumo was an ideal place to conduct research on the lasting micro-level effects of aid programs. Specifically, my primary question was: what

are some of the ways that transient aid impacts, affects, and shapes communities once their programs end? Based on my fieldwork in Ndumo from April until July 2018, I argue that even after health interventions and their programs depart, they continue to have an impact on individuals, specifically affecting social relations. Community-based health interventions both rely on and have the side effect of weakening social relationships—especially the patron-client bonds that are central to South African social life and personhood—in the afterlife of aid. Impacts on social relations may seem like a peripheral aspect to health and HIV-related programs, however, as Whyte and her colleagues (2014) remind us, even though sociality is "often beyond the purview of health-policy makers" these interactions "are essential strands of webs in which health rests" (pg.2).

In contextualizing the climate in Ndumo after aid was withdrawn, this study also aims to be "representative of a broader phenomenon…that can, in being studied and described, provide a ground for social critique" (Biehl & Petryna, 2013, pg. 13). In a broader sense, then, this study also contributes to a larger discussion highlighting that AIDS is in fact, not ending, despite the decline in funding and rhetoric that HIV/AIDS in the Global South is in a 'post-crisis' era. For those living with HIV/AIDS and providing care amidst structural violence (see Farmer, 2004), the chronic nature of the disease marks a lived, continual crisis. HIV in the Global South is still a disease characterized by "continuous uncertainty" (Moyer & Hardon, 2014, pg. 267) in people's daily lives, which is not 'ending' despite the arrival of ART but evolving as food insecurity and unemployment are still lived realities (see Kalofonos, 2010; Moyer, 2015; Moyer & Hardon, 2014; Sangaramoorthy, 2018; Whyte et al., 2014). Given the uncertainty of the

future of global health funding, anthropologists Kenworthy et al. (2018) argue "the potential contributions of critical social science research on HIV and AIDS, and global health more broadly, are especially important. Nuanced examinations of policies and their impacts — especially from scholars in the global South — is all the more important" (pg. 966).

The Afterlife of Aid: Recent Anthropological and Qualitative Accounts

Qualitative researchers have begun to examine the time and space after global health programs and interventions scale back or end—the *afterlife*. A recently published qualitative study, which took place in Zimbabwe, explored community workers' perceptions of "exiting" from households they were assigned to during a two-year global health intervention centered around HIV testing and children (Busza et al., 2018). They noted that "little attention has been paid to what happens at the end of time-limited CHW [community-health worker] interventions" (Busza et al., 2018, pg. 1). Busza et al. (2018) found that community workers did not "disengage" from the families they were seeing once the intervention had come to an end, as was expected, but rather all of the community workers they interviewed at their reflection meeting—11-months post-intervention—had maintained contact with the households they were assigned to during the intervention. In their concluding remarks, the researchers stated: "If [community health workers] do not disengage from interventions as planned…interventions will prove less sustainable… [and] threaten programme delivery" (Busza et al., 2018, pg.1). The fact that the community health workers did not "disengage" from the families they visited does not seem surprising. Just because an intervention protocol ends, the people contracted to deliver services and the people they sought to help remain. Their daily lives

continue to be plagued by poverty, ongoing uncertainty, and instability. Suggesting that community workers would make future interventions less sustainable and threaten program delivery due to their lack of "disengagement" fails to acknowledge the social worlds in which the interventions are taking place. More nuanced accounts tending to the time and space after interventions end are needed, as they can document the social dynamics and personal entanglements on-the-ground. After all, even after interventions and their resources are withdrawn, life continues.

Anthropologist Ramah McKay (2012a)[3] first developed the concept, "the afterlife of intervention" from her time spent in Mozambique where residents began to call on programs and interventions of the past to articulate the inadequacies of the current health programs they were receiving. More recently, medical anthropologist Amy Moran-Thomas (2015) reflected on the concept of the afterlife of intervention in relation to her work on guinea worm eradication efforts in Ghana. She drew attention to the physical and material artifacts that would be left behind after the intervention departed such as, but not limited to water filters, registration books, and even research study numbers written on homes. Morton-Thomas (2015) concluded that "as people engage or inhabit the roles, residues, ephemera and even ruins of the intervention, life unfolds on other intervals" (pg. 222).

While not specifically employing the concept of the afterlife of intervention, Kenworthy (2017) explored the afterlife of a public-private partnership in Lesotho that had previously funded antiretroviral treatment for garment workers. While the workers' transition into the publicly-funded treatment programs was fraught with difficulties and

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[3] In Ramah McKay's (2018) ethnography, *Medicine in the Meantime: The work of care in Mozambique,* chapter three entitled: *Afterlives*, also speaks about "the afterlife of intervention."

strain, Kenworthy (2017) remarked, "[a]s external partners depart from the local geographies of HIV care, they leave distinctive moral residues" (pg. 182). She questions the future of HIV care in the Global South more broadly as HIV aid is becoming "increasingly insecure" (Kenworthy, 2017, pg. 33).

In Kenya, Moyer & Igonya (2014) documented some of the realities of aid insecurity explaining how community-based care for HIV/AIDS has shifted with respect to funding reductions in the 'post crisis' era. In their field sites in eastern Africa, they found that many community organizations had to reinvent themselves as much of the money for home-based care and support groups had come from transnational donors whose support had recently ended. Similarly, anthropologist Alfred Montoya (2018) examined the ways in which HIV-related non-governmental organizations (NGOs) in Vietnam continue to develop new strategies amidst the decline of PEPFAR funding, in which they have, "…entered the afterlife of aid, a time of urgent scrambling" (pg. 412). This concept of the "afterlife of aid" (Montoya, 2018) aptly characterizes the climate in which I conducted my fieldwork.

While Montoya (2018) paid particular attention to NGOs and how they were adapting to the decrease of funding in the afterlife of aid, this ethnographic study focuses on another important global health actor: community workers. Community workers are local brokers who are often tasked with implementing various global health programs. Although they have little input on how funding should be allocated, or on how programs should be realised, I argue in this thesis that their lives, work, and interpersonal relations are altered after global health programs end and aid is withdrawn.

In this thesis, the term *aid* is used to explain both the financial and material resources given by transnational and national governments as well by NGOs to those in 'need.' The aid programs I critically examine were related to health and wellbeing and as such fit within what the World Health Organization defines as "Health Aid" (Gostin et al., 2010). Health Aid presumes an unbalanced relationship, where financial and material resources are given "in a donor-recipient relationship" (Gostin et al., 2010, pg. 12). One of the characteristics of the afterlife of aid is the "absence of material support" (Montoya 2018, pg. 410).

When I arrived in Ndumo, I spent a considerable amount of time at the TCC. As the HIV infection rate rapidly increased during the 1990s in South Africa, the residents of Ndumo worked with the nearest government funded public hospital to establish the centre in 2001. Its mandate has always been to "provide care for those infected and affected by HIV and AIDS." At the time of my fieldwork, the centre had lost both transnational funding from PEPFAR as well as funding from the South African government. In 2008, transnational funding was provided to the centre via a NGO[4] which was funded by PEPFAR. Prior to the arrival of the PEPFAR-funded NGO (PFN) in Ndumo, the TCC was receiving funding from the South African government. After PFN departed in 2014, funding from the South African government continued until 2015, at which time it was reduced by over fifty percent. The only funding that the centre was receiving during my fieldwork was the reduced budget from the South African Department of Social Development (DSD). In addition to the reduced budget, the community workers, who

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[4] PEPFAR-funding by design has always largely been given to non-governmental organizations rather than directly to the government or publicly-funded health clinics and organizations (see Pfeiffer, 2013). This is further explained in the next chapter, in the section titled: Global Health: PEPFAR, NGOs, the Development Doctrine.

worked with the TCC, continued to receive a small stipend from DSD of around R1800 per month (~Cdn$180) — albeit these remittances were always delayed. The absence of material support and lack of programs was felt and spoken about daily at the centre and among community workers. Thus, the afterlife of aid became the central focus of my study.

"Phantom Disengagement" in the Afterlife of Aid

HIV/AIDS global health aid is habitually time-limited and transient. Often funding is secured for a set period and programs are designed and executed with bench-marks to be met. While scale-up, implementation, budgets, and buzzwords are often predominant topics for both global health donors and researchers alike, what is often not mentioned is what happens after the funding time period has ended; in the time and space when donor priorities shift, funding is ceased, and implementing partners leave their field sites. As Kenworthy (2017) explains, "global health programs tend to be far more temporally bounded and incomplete than we think [of] them to be: as experienced by citizens in the Global South, HIV treatment scale-up and related health projects are full of gaps, disappearances, and departures" (pg. 184).

Paying attention to the effects these disappearances and departures can have on people's lives is critical in our understanding of global health practices and HIV/AIDS programing. It can also provide valuable insights into how aid is experienced and some of the lasting impacts it can have for people on-the-ground. Just as Kenworthy (2014) reminds us, "even well-intentioned global health efforts have far-reaching and unexpected consequences, leaving in their wake new debts, obligations, and forms of peonage for recipients" (pg. 81).

In this thesis, I turn my attention to the nuanced day-to-day realities after funding had been withdrawn from Ndumo, presenting an alternative narrative that does not simply explain that when aid is retracted jobs are lost and programs are relinquished, but rather, how life and work continues to evolve. It is an anthropological account that explores some of the unintended impacts of global health aid that are not outlined within program protocols and donors' agendas, but rather are experienced by community workers—the very people tasked to carry out these programs. While funding can end, life does not.

In many ways, this ethnographic study is a response to Ramah McKay's (2018) call for ethnographers to tend to the realities of the present, and "pay attention to work that happens in the meantime…in the space between the critical view of what could be and the pragmatic sense of what is" (pg. 198). While this study is particularly concerned with how past aid has impacted the work of community workers since it had been revoked, it was in tending to the present realities that enabled me to contrast how their work had changed over time. Without an understanding of the present, one could not appreciate how past aid has had a continual impact on the daily work at the TCC. When I do evaluate the now departed aid programs in Ndumo, I do so not as an evaluation of these programs specifically, but with the intention of providing context and demonstrating how some aspects of these programs have continued to impact life and work in Ndumo. My understanding of these past programs comes from my interlocutors as well as other anthropological accounts and program reports as I was not in Ndumo while they were ongoing.

Just as McKay (2018) urges other ethnographers to "pay attention to work that happens in the meantime" (pg. 198), her work illustrates the multiple ways transnational resources from NGOs can intersect with state-funded health posts allowing for alternative possibilities of care. Her primary focus was on their daily engagements and everyday practices of various state and non-state actors (McKay, 2018). As she notes, "attending to institutional multiplicity, rather than to eventual disengagement of the diverse institutions, is necessary to understanding the resources and possibilities available" (McKay, 2018, pg. 56). While McKay (2018) acknowledges that there will be an "eventual disengagement" between these various actors, my ethnographic study challenges this statement. Initially, there was a disengagement in Ndumo between the TCC and PFN. PFN was no longer working within Ndumo or with the TCC while I was there. Yet, while there was a physical disengagement as the NGO had departed and material resources were vastly reduced, there was, as I came to learn, a lingering presence of the NGO that was still very much felt. I argue that rather than a complete erasure, there was, what I call a "phantom disengagement."

Akin to phantom limb sensations where a person describes feeling as if their limb is still present after an amputation (see, for example, Katz & Melzack, 1990), I characterize the disengagement between the NGO and the community centre and workers in a similar way. Just as one may feel that their limb is still there even after it is removed and may experience associated phantom pain, in the afterlife of aid the NGO was physically missing but its presence was still very much felt. The NGO had left, but their disengagement was phantom-like. The community workers consciously acknowledged that the NGO had left and they lamented about the reduction of funding and material

goods, but in many ways they continued to act (or tried to act) as if PFN were still present. As I will show, the residual impacts of PFN continued to affect work and social relations in the community years after its departure.

Problematizing the Word Community and Its Central Importance in Global Health

Often global health organizations and those working in international development will use terms such as "the community" or "a community-based organization" when they speak of who is going to benefit from their program, or where and how they are going to implement their intervention. As a result, communities in the Global South have been, as Kenworthy (2017) argues, both "venerated and made acutely vulnerable" (pg. 32-33) during the scale-up of HIV programing.

Given its extensive usage in global health, it is critical to problematize the term "community" as it is often used in ways that portray a place or group of people as if they are one cohesive, pre-existing entity. This understanding can be problematic as the community in which an intervention takes place "can be 'artificial' in the sense that they are not expressions of endogenously occurring collectives, such as those organized by kinship relations" (Nguyen, 2004, pg. 129). This fraught casual application of the community is discussed in Whyte et al's (2014), *Second Chances.* The ethnography uses ethnographic vignettes to chronicle people's lives who are living with HIV/AIDS in Uganda, and notes that the participants "talk about their lives often in terms of help and hindrances offered by others: not 'the community', as development rhetoric has it, but specific relatives, friends, and acquaintances" (pg. 17). As Rose (2000) explains, a community must not be thought of only as "primarily a geographical space, a social space, a sociological space, or a space of service, although it may attach itself to any or

all spatializations… [but also as] a space of emotional relationships through which

individual identities are constructed" (pg. 1401). Seeing a community as a space that

allows for relationships to be made and even broken, helps to highlight how global health

interventions can facilitate the formation of 'new' communities on-the-ground (see

Nguyen, 2004) and how their presence can also have fracturing impacts on these

relationships.

Although I am critical of the over usage of the term, I use it throughout this thesis

as my interlocutors often used the term themselves. First, I call the centre where I based

my research the Themba Community Centre. Second, I refer to those I learned from as

community workers and finally, I argue, as mentioned above, that even after

interventions leave, they have lasting impacts on community social relations. By doing

so, I do not suggest that everyone who resided in Ndumo was part of this community, but

rather, since the creation of the centre in 2001, a community has been formed.

In South Africa and across the Global South, there are various names for

community workers. In South Africa, specifically, there are nine categories of community

workers including but not limited to: Community Caregivers, Community Health

Workers, and Community Youth and Child Care Workers (Schneider, Hlophe & van

Rensburg, 2008). Rather than use their separate designations, I have opted to use an

umbrella term, "community worker", in this thesis. I spent time and learned from more

than one type of community worker in Ndumo, however, their roles were similar to each

other and fit within the WHO's formal definition of a "community health worker:"

> Community health workers should be members of the communities in which they
> work, should be selected by the communities, should be answerable to the communities
> for their activities, should be supported by the health services but not necessarily a part of
> its organization, and have shorter training than professional workers. (WHO, 2007, pg. 1)

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All the community workers I met lived in Ndumo. Formally their day-to-day work was to

provide home-based care—"any form of care given to sick people in their homes"

(WHO, 2002, pg. 8)—as well as to visit children and youth affected by HIV/AIDS either

by being infected themselves or having lost a parent(s). Their work was primarily focused

on counselling and providing "psychosocial support," defined by the WHO (n.d) as

support which "addresses the ongoing psychological and social problems of HIV infected

individuals, their partners, families and caregivers" (para one). As I came to learn, the

scope of their work, and the work of the TCC, changed considerably after PFN departed

and state funding was cut, having lasting effects on their relationships in their

community.

A Paradox? Community Health Workers and the "End of AIDS"

After the Alma Ata Declaration of 1978[5], community health workers were

recognized as an integral part of providing primary care around the globe, particularly in

resource-challenged areas (Maes, Closser & Kalofonos, 2014). These lay workers

"occupy a front-line service provision role" (Schneider & Lehmann, 2010, pg. 61) in their

communities, shifting the care from formal clinics and hospitals to visiting people in

places where they live and work (Drobac et al., 2013; Mukherjee et al., 2016; Schneider

& Lehmann, 2010). Although community health workers' roles have shifted over the

course of the HIV epidemic becoming increasingly more biomedical and clinically

oriented (Kalofonos, 2014; Simbaya & Moyer, 2013), community health workers

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[5] The Declaration of Alma Ata took place at the 1978 International Conference of Primary Care in
Kazakhstan. In short, the declaration was a pledge to provide "health for all by 2020." It was not long after
the declaration that political climates and agendas shifted and as a result the goal of primary care for all was
supplanted with selective treatment health solutions (see for example, Basilico et al., 2013).

continue to engage in activities such as providing home-based care and counselling in the communities in which they reside (Campbell & Scott, 2011; Mottiar & Lodge, 2018; Schneider et al., 2008).

Community-based care carried out by community health workers continues to be a key pillar in HIV/AIDS programs around the globe, especially in South Africa, where they provide an "indispensable support" for the largest ART program in the world (Mottiar & Lodge, 2018). UNAIDS (2016) has recently accredited community-based models of care as a fundamental part of their "end of AIDS" talk, noting that "community responses will be key to ending the AIDS epidemic" (pg.2). Likewise, PEPFAR-funded studies continue to emphasize and advocate the need for "location-based approach[s]" to help curb infection rates (see, for example, Kharsany et al., 2018).

One of the key reported criteria for the success of community-based care models, is the ability for community health workers to develop relationships within their community and with the families they visit (Bhattacharyya et al., 2001; Campbell & Scott, 2011; Maes, 2015; Maes et al., 2014; Schneider et al., 2008). This "community embeddedness" (Schneider et al., 2008, pg. 180) of a community health worker is a foundational part of program success. As Bhattacharyya et al., (2001) concluded, "[i]n the end, the effectiveness of a CHW [community health worker] comes down to his or her relationship with the community. Programmes must do everything they can to strengthen and support this relationship" (pg. 36). Even though global health organizations acknowledge and recommend this model of care for "ending AIDS," I argue that their conventional transient global health interventions, such as the PEPFAR-funded one in Ndumo, have lasting—often destabilizing—effects on community social

relations after interventions leave. Paradoxically, these temporally-bounded interventions destabilize the very relationships that global health organizations advocate are necessary for "ending AIDS."

Outline

Following this introductory chapter, this thesis is composed of seven additional chapters. Chapter Two is a literature review that explores three areas of literature critical to this thesis: a brief historical overview of global health and PEPFAR; the anthropology of global health metrics and enumeration; and, the anthropology of patron-client relations and association in Africa. Chapter Three explores the social origins of HIV from a critical medical anthropology perspective, explaining how HIV emerged and spread in South Africa and ignited an unprecedented amount of funding soon after the turn of the millennium. Chapter Four examines ethnographic methodology. As ethnographic research progresses over a period of time, this chapter begins with a description of how I entered my field site and further explains the various methods that were used, the impact of language and working with a translator, as well as explaining how the data was analyzed and what ethical considerations were taken throughout the research process.

My field data and subsequent analysis and discussions are presented together in Chapters Five, Six, and Seven. Chapter Five explores how various inclusion and eligibility criteria of past health programs continue to impact the current work at the TCC. Specifically, it considers why community workers continue to visit families enrolled in previous programs and how the open inclusion criteria of these programs have produced feelings of abandonment in the afterlife of aid. Chapter Six focuses on past services that were available when aid was present in Ndumo and explores how the

retraction of some of these services has had a lasting impact on sociality in Ndumo. Specifically, it examines the impact of patron-client bonds between community health workers and their clients and the loss of patron status among community workers. Chapter Seven highlights some of the ways the community workers tried to informally provide care in the afterlife of aid climate. Each of these chapters collectively highlights a reoccurring theme: community-based care that the community workers provide rests on webs of social relations. Global health programs, knowingly or not, are inserted into social 'worlds'—often vastly different than the 'worlds' in which the programs were originally designed—and as such, when these programs depart, the social relations that were established while they were ongoing are impacted. While community-based health interventions rely on the social bonds made between community workers and their clients, they also have fracturing effects on these relationships in the afterlife of aid. Finally, a conclusion is provided in Chapter Eight.

Chapter Two: Critical Global Health Literature Review

  Medical anthropologists Vincanne Adams and João Biehl (2016) explain that critical global health "displaces our attention from the standard geographical markers and objectivity strategies of global health and returns us to questions about people [and] the politics of truth and accountability" (pg. 124). In exploring how transient global health programs impact, affect, and shape people's lives once programs end, this ethnographic study is situated in the growing field of critical global health studies, taking a people-centered approach in exploring the lasting impacts of global health aid. To contextualize this research, I draw on three areas of literature: a brief historical overview of global health and specifically, the President's Emergency Plan for AIDS Relief (PEPFAR); the anthropology of global health metrics and practices of enumeration; and, the anthropology of patron-client relations and association in Africa.

  First, I provide a brief history of global health and PEPFAR. This historical overview will help to build a foundational understanding of how global health programs are designed and implemented in both theory and in practice. Global health programs in many respects are intertwined with international development ideals. In understanding the logics and ideologies that underpin many global health initiatives, one can better understand how the retraction of these global health programs and protocols can impact the lives of people once aid is withdrawn. Second, I utilize literature on metrics, enumeration, and documentation to review how quantification and form-filling practices are materialized and to also highlight their limitations. These enumeration practices had a lasting impact on work and consequently, social relations, in the afterlife of aid in Ndumo. Third, I review the literature on patronage and clientelism and the micro politics

of association in Africa to better understand the social organization and networks in which community workers and their clients are enmeshed.

Global Health: PEPFAR, NGOs, and the Development Doctrine

Global health is a term that is widely used and yet it "defies simple delineation" (Janes & Corbett, 2009, pg. 168). Rather than try to hone in on a single definition, this section focuses on one of global health's defining characteristics, which highlights that global health is "a field of scholarship and practice that focuses on health issues that transcend the territorial boundaries of states" (Janes & Corbett, 2009, pg. 168). Given the transnational nature of global health practices which transcend nation states, there are a plethora of new actors who have come to play a direct role in financing, designing, and executing health programs across the globe (Brown, Cueto, Fee, 2006; Lock & Nguyen, 2010; Packard, 2016). One key actor is PEPFAR. Since its inception under President George. W. Bush in 2003, PEPFAR has undergone reauthorization in 2008, 2013, and 2018. Each of these phases have a distinct character, influenced by various political climates and agendas impacting how many global health programs are designed and implemented in practice. However, before I turn to a historical overview of PEPFAR, I first offer a brief history of global health practices more broadly.

Global health practices, which began to flourish in the 1990s, were largely influenced by the global political climate and dominant neoliberal ideologies that were propagated at that time (Packard, 2016). As a result of high oil prices in the 1970s, in the following decade many countries in the Global South were experiencing crippling debt. In an effort to provide loan and debt relief, the International Monetary Fund and the World Bank worked to create conditional debt repayment policies, known as structural

adjustment programs. Intended to stimulate economic growth and development, these structural adjustment programs were a mechanism for neoliberal practices: if a country wanted to be eligible to receive assistance, they had to reduce their public spending (see Pfeiffer & Chapman, 2010). In 1996, post-apartheid South Africa also embraced similar economic policies, cutting government spending on health, when the South African government introduced a similar laissez-faire policy known as GEAR (Growth, Employment and Redistribution) (Kahn, 2000; see also, Coovadia, 2009; Hunter, 2010). Consequently, these financial austerity measures which intended to foster development gutted many public health care systems across the continent (see Pfeiffer & Chapman, 2010; Pfeiffer, 2003; Rowden, 2009).

In addition, politicians and economists in the Global North expressed concern that money dedicated to international health programs in the past may have been ineffectively spent and lacked any accountability measures (Packard, 2016). These critical remarks about previous aid monies "flowed from neoliberal economists and politicians who sought to reduce the role of the government in the provision of health services for citizens" (Packard, 2016, pg. 276). In the words of anthropologist Salmaan Keshavjee (2014) there was an "untested belief that the private sector was a better mechanism for delivering services and that NGOs are more efficient than the government, especially providing services to [the] poor" (pg. 106; see also Matthews & Nqaba, 2017; Pfeiffer, 2003). As governments across sub-Saharan Africa began adopting dominant neoliberal ideologies in the 1980s and 1990s, they reduced their overall expenditures on social services. As a result, many non-governmental organizations came in to try to fill the gap (Rowden, 2009; see also, Matthews & Nqaba 2017; Packard, 2016; Pfeiffer et al., 2008).

Unsurprisingly, in the 1990s there was a proliferation of NGOs that emerged to provide a variety of services to people across Africa (Matthews & Nqaba, 2017; Pfeiffer et al., 2008). In fact, international NGOs across the globe exponentially increased from 6,000 to 26,000 during the 1990s (Pfeiffer et al., 2008); over 90% of international NGOs have been created after 1970 (Matthews & Nqaba, 2017). By 2005, there were an estimated 100,000 NGOs operating in South Africa alone (Packard, 2016).

Not only was there skepticism among critics in regards to past funding and state-inefficiencies in the Global South, the World Health Organization (WHO) was also under scrutiny in the 1990s. During the 1990s, funding sources had shifted within the organization which significantly impacted the WHO's leadership role in the international health arena (see Brown et al., 2006; Packard, 2016). For donors and politicians in the Global North, the "bureaucratic inefficiencies and internal politics of WHO had made it part of the problem…If the world was going to dedicate vast amounts of new financial resources to improving global health, different mechanisms had to be found" (Packard, 2016, pg. 277). Thus, the turn of the millennium saw many new health funding bodies enter the field of global health, such as the Global Fund to Fight AIDS, Tuberculous and Malaria, PEPFAR, and many public-private-partnerships such as the Bill and Melinda Gates Foundation (Packard, 2016).

The exponential increase of NGOs across the African continent enabled the multiplicity of new global health donors to use these non-governmental organizations as recipients of their funding rather than state governments (Packard, 2016; Pfeiffer, 2003; Pfeiffer et al., 2008; Pfeiffer, 2013; see also, Keshavjee, 2014). As the funding was "controlled by organizations closely linked to the propagation of the neoliberal vision"

(Keshavjee, 2014, pg. 141), NGOs were (and continue to be) seen as the best vehicle in which aid monies should flow. Through this ideology, NGOs are more efficient and effective in implementing programs and interventions than the state and can also allow for increased accountability measures (Packard, 2016; Pfeiffer, 2003; Pfeiffer et al., 2008). Consequently, most of PEPFAR's funding does not flow through the public-system, but rather through various non-governmental organizations (see, Pfeiffer, 2013). As anthropologist James Pfeiffer (2003) has argued, aid is "intimately bound up with neo-liberal emphasis on free-markets, privatization, and the development of an imagined 'civil society' necessary for 'sustainable development'" (pg. 725). In the end, the role of state governments in the age of global health has been significantly reduced. The turn of the millennium and the response to HIV/AIDS proved to be an archetype of "neoliberal developmentalism of the 2000s, with its concern with saving lives via partnerships, advocacy, leverage and empowerment" (Ingram, 2013, pg. 443).

PEPFAR I and PEPFAR II: Development and Sustainability

In the late 1990s HIV/AIDS emerged as a potential global threat to political and economic development (see Chapter 3). Not long after the turn of the millennium, unprecedented amounts of funding was funneled to HIV/AIDS relief in the Global South and cemented the idea that the AIDS industry had "become ever-more entangled with the development industry" (Nguyen, 2004, pg. 125). In many respects HIV/AIDS interventions share key characteristics with international development projects: they are both time-sensitive; driven by donor priorities; and implemented by non-governmental organizations (Benton et al., 2017). Moreover, many programs are designed and implemented based on western assumptions and neoliberal ideologies, favoring magic

bullet solutions to address complex problems (see Keshavjee, 2014; Kenworthy, 2017; Rowden, 2009; Sastry & Dutta, 2013). In fact, Kenworthy (2017) argues, "[m]any of the practices, ideologies, and approaches of development that were widely critiqued by scholars have seen a resurgence in global health projects" (pg. 52). One of the key underlining assumptions of many global health interventions is that health is an individual responsibility, and in line with neoliberal ideologies, all individuals are rational, autonomous agents regardless of their positionality—and if they are not, they should be (see Sastry & Dutta, 2013; Rowden, 2009). This outlook has had an impact on global health programs across the globe. As aid monies flowed into African countries soon after the turn of the millennium, through the hands of many non-governmental organizations, these neoliberal ideologies were disseminated in PEPFAR I-funded programs, but even more evidently in PEPFAR II.

In the early 2000s, HIV/AIDS was viewed as a global humanitarian emergency. In 2003, PEPFAR I (2003-2008) set out a five-year plan with lofty goals: support treatment for 2 million people; prevent infection in 7 million; and provide care for over 10 million individuals (PEPFAR, 2009). In addition to providing life-extending drugs for two million people, much of PEPFAR I's funding was centered on educating individuals about HIV transmission and advocating for behavioral change (see Epstein, 2007; Packard, 2016; Sastry & Dutta, 2013). Like with many types of aid, PEPFAR's funding had conditions, dictated by the USA administration. For example, in addition to buying antiretroviral treatment (ART), one-third of PEPFAR's prevention funding was directed at abstinence-only programs (Moss & Kates, 2019; Packard, 2016). Furthermore, during the initial years of PEPFAR most recipient organizations made use of the "ABC" strategy

(see Epstein, 2007; Packard, 2016; Sastry & Dutta, 2013). The ABC strategy is an acronym: Abstinence; Be Faithful; and use a Condom. Teaching the ABC strategy promoted behavioral change: advocating first and foremost for abstinence-until-marriage; followed by being faithful to one's partner; and lastly, educating Africans to "use a condom."

In 2008, PEPFAR celebrated its fifth anniversary. Per PEPFAR's Fifth Annual Fact Sheet presented to Congress, the first-five years were a success: 2.1 million people had received treatment and the funding had supported care for over 10.1 million people. Perhaps more astounding was their reported number of prevented infections. With an initial goal of preventing 7 million new infections in the first five years, PEPFAR reported to US Congress that they had exceeded that more than eight times over; they had "reached an estimated 58.3 million people through community outreach programs to prevent sexual transmission using the ABC approach" (PEPFAR, 2009, pg.2).

The number of people reached, however, does not necessarily directly correlate to infections prevented. According to global health researchers Lo, Lowe and Bendavid (2016) who recently studied the effectiveness of PEPFAR's abstinence and faithfulness programs across twenty-two sub-Saharan African countries, PEPFAR's abstinence prevention funding did not correlate to reducing "high-risk sexual behaviors" (pg. 860). In short, PEPFAR's USD $1.6 billion cumulative investment (2003-2014) into funding abstinence and faithfulness programs did not change people's behaviors and decrease HIV transmission (Lo, Lowe, & Bendavid, 2016). To medical anthropologists and like-minded scholars who have studied AIDS in sub-Saharan Africa, this conclusion would seem unsurprising (see for example, Epstein, 2007; Hunter, 2010; Smith, 2014).

Promoting abstinence not only obscures the social conditions propelling the disease, but centers the issue solely on an individual. Additionally, promoting condom use—the "C" in the ABC strategy—has also proven to be problematic.

In 2007, Helen Epstein wrote: "Perhaps many attempts to prevent the spread of HIV fail because those in charge of them don't recognize that decisions people make about sex are usually a matter of feeling, not calculation" (pg. 136). Although many relationships are driven by poverty and inequality, this does not displace love and affection within these "transactional" relations (see for example, Hunter, 2010; Fassin 2007). Women in South Africa told ethnographer Mark Hunter (2010) that they did not want to use a condom because they were in love. In parroting messages of safe-sex, many campaigns positioned the use of condoms as a last resort, as if the use of condoms reflects a casual sexual encounter. Furthermore, while many of these campaigns reduced prevention to an individual level, in many cases the messages they were disseminating about AIDS and HIV transmission associated the virus with 'risky' sexual behaviors (see Epstein, 2007; Hunter, 2010; Smith, 2014). As a result, while many people choose not to wear a condom because they are in love (Hunter, 2010), anthropologist Daniel Jordan Smith (2014) also found in Nigeria, "people eschew condoms, as they are so strongly associated with the kinds of sex immoral people have" (pg. 171). Therefore, not only do these individually-focused programs obscure the social conditions that perpetuate the disease, the messages in many prevention strategies are also largely ineffective. In a recent ethnography, *AIDS does not show its face,* Smith (2014) argues the moralizing tone in the messages promoted in many HIV-related prevention programs may in fact "have the unintended consequence of producing behavior among sexually active people

that actually *increases* their risk of infection" (pg 171, emphasis added). While many

HIV-prevention strategies have been misplaced and failed to address many of the social

roots of the disease, there is no doubt that the medications provided by PEPFAR I

extended the lives of millions of people in the Global South.

In 2008, PEPFAR was reauthorized. With even bigger targets, PEPFAR II (2008-

2013) aimed to treat at least 3 million people; prevent 12 million new infections; as well

as provide care for 12 million people (PEPFAR, 2009). However, just as PEPFAR II was

reauthorized political and economic climates were shifting. In the wake of the 2008

global financial crisis, PEPFAR's funding started to decline in 2010 (Kaiser Family

Foundation, 2019a). Consequently, the framing of HIV/AIDS also started to shift. A

decade had passed since the turn of the millennium and HIV/AIDS went from being

framed as an emergent crisis in need of humanitarian aid (see Ingram, 2013; Moyer,

2015; Simbaya & Moyer, 2013) to being "reintegrated into a health and development

paradigm premised upon scarcity" (Ingram, 2013, pg. 447). In this new climate

characterized by financial austerity, reforms were made to PEPFAR-funded programs.

Central to the reforms was a refocus and emphasis on monitoring and evaluation (Ingram,

2013; Reynolds, 2014a). If money was spent, there needed to be documented evidence of

its impact. As Allan Ingram (2013) argues, "the need for greater visibility, calculability

and attributability of all aspects of the response is intensified by a discourse of scarcity,

often rendered as 'sustainability'" (pg. 447). As a result, PEPFAR II was characterized by

a renewed focus on accountability but also on making sure the programs they funded

were 'sustainable.' This focus on sustainability intertwined PEPFAR's II efforts and

agendas even more so with those of the development industry.

Economist Amartya Sen (1999) defined development as "the removal of various types of unfreedoms that leave people with little choice and little opportunity of exercising their reasoned agency" (pg. xii). In this light, development is intrinsically tied to freedom of an individual (Sen, 1999). This ideology is often perceived to be universalistic, perhaps even commonsensical through a western lens. Through this world view, to achieve modernity and to progress through development, individuals must be self-reliant, free agents. Anthropologist James Ferguson (2013) refers to this outlook as the "emancipatory liberal mind" (pg. 225). Anything counter to this world view, such as dependence he explains, discomforts the "emancipatory liberal mind" (Ferguson, 2013, pg. 225). As dependence is viewed as the opposite of freedom, to "declare dependence…seems to be a wish for one's own devaluation and even dehumanization" (Ferguson, 2013, pg. 225).

In many respects, global health interventions have sought to increase an individual's 'freedom' and foster independence (see Smith, 2003; Swidler & Watkins, 2009; Watkins & Swidler, 2012). The end goal is to develop programs that can not only be accounted and whose impact can be measured but, importantly, to develop programs that can be sustained after aid is withdrawn. This ideal is what underscores the doctrine of sustainability. As the doctrine of sustainability suggests, "donors seek projects that (donors believe) recipients will be able to sustain after the donor — and the donor's funding — departs" (Swidler & Watkins, 2009, pg. 1184). Development then must not just foster independence and freedom, it must also be sustainable, even after funding ends. In this view, sustainability is similar to Sen's (1999) definition of development insofar that "the key contrast is thus between 'sustainability', with its connotations of

autonomy, self-reliance, and rationality, and 'dependence' with its taint of helplessness, passivity and irresponsibility" (Swidler & Watkins, 2009, pg. 1184).

Ideals of sustainable development are incorporated into many HIV programs around the globe: donors design programs hoping to foster community engagement, empower individuals and teach people in hopes they will achieve autonomy and freedom (see Scherz, 2014; Smith, 2003; Swidler & Watkins, 2009). It is no wonder that when HIV interventions came to center stage, "pro-poor" interventions, such as providing food decreased (see Kalofonos, 2010; McKay, 2018). Giving food or other material goods — often referred to as the "handout" — is not seen as sustainable as it could create dependencies. Thus—in line with the doctrine of sustainability— material aid should be avoided at all costs (see Kenwothy, 2017; Scherz, 2014; Swidler & Watkins, 2009).[6] Anthropologist China Scherz (2014) explains that "[w]ithin the ideal vision of sustainable development, one donation is enough, since if it is used property it will engender an endless string of benefits" (pg. 50).

Viewed in this way, funding must not go to programs that could potentially foster dependence but rather to programs that fit within the sustainable development model. One example that meets the criterion and continues to be present in almost all HIV programs is training and education (see Smith, 2003; Swidler & Watkins, 2009). Anthropologist Daniel Jordan Smith (2003) refers to this as the "workshop mentality" (pg 712). For donors, workshops provide a platform to teach and train under the rationality: "provide the target population with the 'right information' and people will make 'the

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[6] This is not to say that HIV programs do not give out any material goods. In fact, food parcels have been part of HIV treatment programs in southern Africa. However, they are usually given for a limited duration and in most cases, they are largely inadequate (see for example: McKay, 2018; Kenworthy, 2017; Kalofonos, 2010; Pfeiffer, 2013; Whyte et al., 2014).

right decisions'" (Smith, 2003, pg. 712). An example that fits this mentality would be to teach individuals to reduce their sexual partners and practice monogamy with the expectation that doing so will reduce their risk of HIV infection. In this way, donors are funding something that they imagine to be of help, while at the same time not fostering dependency. Across Africa HIV projects have taken on this similar form: "experts will teach people skills, or better yet, teach them to teach skills, which will provide all with the capacity to provide for their own needs" (Swidler & Watkins, 2009, pg. 1184). As Watkins and Swidler (2012) argue, although many HIV/AIDS projects designed in this way prove to be largely ineffective, they continue to be repeated because there is only a small subset of programs that meet the criteria set by the desired sustainability model.

While many global health programs continue to be designed and executed to meet the tenets of the sustainability doctrine, in practice, Kenworthy (2014) argues, these "dialogues of sustainability…often translate, at local levels, into unmet desires and obligatory sacrifices" (pg. 75). While teaching allows organizations to practice in the name of sustainability, not providing material aid can be seen at local levels as a form of abandonment as these material goods can foster forms of acknowledgement and create a sense of interdependency that local recipients long for (see Kenworthy, 2017; Scherz, 2014).

In sum, PEPFAR II was reauthorized in times of scarcity with a renewed focus on accountability, thus teaching and educating became key pillars of HIV global health programs. Although abstinence was the hallmark of PEPFAR I, PEPFAR II moved beyond promoting abstinence-only programs. In addition to HIV prevention the focus among many PEFAR-funded organizations was to focus on behavioral change and

provide educational workshops that also taught the importance of self-empowerment and care-taking (IOM, 2013). Training seminars had the benefit of providing various quantification measures for impact reports, but they also could — in theory — go on to have endless benefits. To donors, these workshops were a platform that allowed for the dissemination of valuable educational lessons that could ideally outlive the global health program and be of benefit long after funding ended and programs were withdrawn. Furthermore, focusing on programs that are centered around teaching and training not only allow for programs to meet 'sustainable' development goals while they are ongoing, but it also positions programs with an exit plan. As anthropologist China Scherz (2014) insists, sustainable development "is also posited as the end of aid" (Scherz, 2014, pg. 50)

PEPFAR III and PEPFAR IV: Pseudo-Partnerships and The End of AIDS?

While PEPFAR II had been influenced by fiscal austerity and refocused its efforts on creating sustainable programs, another theme that was emphasized during this phase was "health system strengthening" (Marchal, Cavalli & Kegals, 2009; Packard, 2016). In 2009, President Obama launched the Global Health Initiative. In many respects, the initiative echoed the sustainability doctrine as it focused on creating sustainable health systems in donor countries that would become self-sufficient. The intention of the Global Health Initiative was to help guide the investments made by the United States (and consequently, PEPFAR) "to support host country partners to plan, oversee, manage and deliver health programs that are responsive to the needs of their people" (SAG & USG, 2010, pg. 12). In theory, health system strengthening fits within the sustainable development framework. With building a sufficient health system, countries could 'take-

over' their own national HIV/AIDS related programs and, therefore, not rely on transnational aid; a true sustainability success. One such attempt was in South Africa.

In 2010, South Africa and the United States signed "The Partnership Framework in Support of South Africa's National HIV and AIDS and TB Response (2012/2013 – 2016/2017)" (SAG & USG, 2010). This highly politicized partnership between the two countries outlined that the United States would be "transitioning" out of providing direct HIV-related services within South Africa, passing the baton to the South African government, enabling South Africa to be the first country to "nationalize" their PEPFAR programs (SAG & USG, 2010; also see, Kaiser Family Foundation, 2012). The plan signed in 2010, was to be enforced over a five-year period beginning in 2012. PEPFAR's plan set to decrease its funding incrementally over the five-year transition, totaling a reduction of 48% in funding by 2017. This transition would leave the South African government responsible to fund and enforce its own national HIV program (SAG & USG, 2010).

This partnership agreement between the United States and South Africa was a complement to larger shifts within PEPFAR III (2013-2018). In 2014, PEPFAR implemented a five-year health-system-strengthening framework (Packard, 2016). Much of the health-system-strengthening framework, however, was concerned with planning, monitoring, and evaluating rather than focusing on pragmatic measures on how to strengthen public health systems. Randall Packard (2016) referred to this as a "classic example of 'development-speak' [which] made no mention of hard dollar contributions to building health infrastructure or providing medical training for health-care workers" (pg. 302). Health system strengthening had in many ways become the new buzzword among

global health actors, but as Marchal et al. (2009) suggested, it seemed to be more rhetoric than reality. This was evident in South Africa. Not long after South Africa began the transitional process of "nationalizing" PEPFAR's programs, thousands of patients were lost-to- follow ups at clinics, there were disruptions in medical treatment plans, and staff-shortages were reported (see Kavanagh, 2014; also, Kavanagh & Dubula-Majola, 2019). Michael Kavanagh (2014) argued that the transitional partnership was largely "driven by contract end dates rather than readiness of the public sector" (Kavanagh, 2014, pg. 249). The fact that the public health sector was not ready to absorb PEPFAR's programs is not surprising given that the hundreds of millions that had been invested into the country by transnational funders such as PEPFAR, had not gone directly into supporting South Africa's public health system.

By design PEPFAR's funding has evaded the public sector in many countries across Africa. Medical anthropologist James Pfeiffer, an incisive advocate for health system strengthening, is critical of PEPFAR's funding mechanisms, maintaining they are part of the problem (see Pfeiffer, 2013; also, Pfeiffer, 2003; Pfeiffer et al., 2008). There has been little investment made into public health systems as much of international aid has flowed through "implementing partners" (i.e. non-governmental organizations) rather than the state (Packard, 2016; Pfeiffer & Chapman, 2015; Pfeiffer, 2013). As a result, many HIV/AIDS programs funded by PEPFAR were not integrated into public health systems, but emerged as a vast "archipelago of autonomous care facilities dependent on external funding and existing independently beside a collapsing public-health sector" (Packard, 2016, pg. 301; also see Erikson, 2012; Kenworthy, 2017; McKay, 2018; Pfeiffer, 2013; Whyte et al., 2014). In many cases, complete avoidance of the public-

system, however, were not possible. Rather, NGOs, funded by international donors such as PEPFAR, often made use of state-funded outposts and publicly-funded workers to assist with their programs. This often resulted in publicly-funded clinics and community centres having to accommodate various, often parallel program agendas that uncomfortably imposed themselves on one another (see for example, Pfeiffer, 2013; also Kenworthy, 2017; McKay, 2018; Whyte et al., 2013).

Even though the goal of "The Partnership Framework in Support of South Africa's National HIV and AIDS and TB Response (2012/2013 – 2016/2017)" agreement intended to support South Africa and help the country in strengthening its own national health system, PEPFAR continued to rely heavily on their hundreds of "implementing partners" over the transition, only dedicating 10% of the overall budget to national departments (SAG & USG, 2010). Within a few years it became clear that even with South Africa's increased investment into their national HIV program and health system, the HIV-burden and challenges within the public sector impeded any progress. In 2016, in an effort aligned with UNAIDS 90-90-90 targets to bring an "end to AIDS" (see UNAIDS, 2014) PEPFAR forewent the proposed funding strategy outlined in their partnership agreement. Rather than see a decline in PEPFAR funding, as intended in their agreement, in 2016 PEPFAR committed over USD $ 400 million to go "towards the goal of achieving an AIDS-free generation" in South Africa (U.S Mission South Africa, 2016). With this 2016 policy shift, PEPFAR reverted to providing direct HIV-related services to the "front-lines" across South Africa, mainly through "human-resource support" (Kavanagh & Dubula-Majola, 2019). However, based on Kavanagh and Dubula-Majola's (2019) recent field research across South Africa, PEPFAR's efforts

were "not adequate or distributed based on the size of the HIV program, leaving notable gaps in outreach, defaulter tracing, and community service delivery" (pg. 1). In addition, much of the 2016 funding was directed at supporting selective interventions rather than improving the public health system. For example, part of PEPFAR's renewed 2016 investment in South Africa went to expanding "voluntary medical male circumcision" efforts, which intended to help lower HIV transmission, and directed funds to DREAMS, a public-private partnership educational program. DREAMS (Determined; Resilient; Empowerment; AIDS-free; Mentored; and Safe) was an educational program aimed at young women with the intent to reduce levels of HIV transmission, gender-based violence, and teenage pregnancies (U.S Mission South Africa, 2016). While focusing on health-system strengthening is a commendable goal and should be applauded, the program acted as more of a façade during PEPFAR III as biomedical-selective interventions, such as "voluntary medical male circumcision," were prioritized instead. Moreover, as medical anthropologists Nguyen et al. (2011) argue, the success of these magic bullet approaches are "unlikely to live up to their promise if social determinants of access to prevention and treatment are not addressed" (pg. 291) and if adequate public health systems are not in place to support them.

Soon after Donald Trump was elected President of the United States, PEPFAR was slated for reauthorization. Although President Donald Trump reauthorized PEPFAR in 2018, he has since proposed vast cuts to its overall budget (see Kaiser Family Foundation, 2019a). Congress has denied both the 2018 and 2019 requests to significantly reduce PEPFAR's IV (2018- 2023) budget, however, the recent 2020 Congressional Budget proposes even greater financial cutbacks compared to previous

years (Department of State USA, 2019; see also Rose & Madan Keller, 2019). Furthermore, as PEPFAR IV has adopted to accelerate and narrow its focus to only 13 countries as a part of its policy: *Strategies for Accelerating HIV/AIDS Epidemic Control (2017-2020)*, this has left several other "non-accelerated" countries, such as South Africa with less funding and support (Kaiser Family Foundation, 2019a; Webster, 2018).

South Africa's history with PEPFAR resembles that of a sinusoidal wave: while South Africa has been one of the largest recipients of PEPFAR-funding in Africa, the funding has also significantly fluctuated over the years with vast reductions. Within the last year, South Africa experienced yet another swell. In December 2018, despite previous proposed cuts to PEPFAR, it was announced that PEPFAR would provide South Africa with "surge" funding totaling USD $1.2 billion over the next two years. This "surge" was to "support South Africa's efforts to reach HIV epidemic control by 2020…fully aligned with UNAIDS 90-90-90 goals" (U.S Mission South Africa, 2018). Yet, within only a few weeks of the announcement, the U.S Global AIDS Coordinator, Deborah Birx, wrote that South Africa's treatment program was "grossly sub-optimal and insufficient to reach epidemic control" and proposed that funding should be cut (Kaiser Family Foundation, 2019b; also see Rose & Madden Keller, 2019; Rutter, 2019). Consequently, at the time of this writing, PEPFAR's proposed 2020 budget for South Africa outlines a 71% reduction in the country's funding; a complete divergence from the promised "surge" in late 2018 (Rose & Madden Keller, 2019).

If PEPFAR's history in South Africa is any indication of its future, ebbs and flows of funding will be part of the country's reality. While this history of PEPFAR

illustrates the magnitude of financial investments that have been made, one cannot lose

sight that funding, especially funding reduction, impacts the lives of ordinary people. For

many South Africans HIV is still a lived reality. As funding is cut and re-instated time

and time again, people's lives are impacted and many are left trying to navigate a

fragmented care landscape which is overwhelmed by daily instability and uncertainty. In

the words of South African HIV/AIDS activists, "with only a year until 2020—and the

deadline to reach the 90-90-90 targets—South Africa is dangerously off track" (People's

COP19, 2019, pg. 2).

Records and Recording: Quantitative Evidence and The Art of Belonging

As illustrated in the previous section, global health brought forth a surplus of new

actors and diminished the role of nation states providing direct health services to its

citizens. This surplus of new actors has had a direct influence on how global health

programs are implemented as explained previously, but also on how they are evaluated.

Thus, in an effort to evaluate interventions and increase accountability measures, global

health has brought to the forefront a reliance on certain types of evidence, notably,

quantitative metrics (see Adams, 2010; Adams, 2013; Adams, 2016; also Fan & Uretsky,

2017; Lorway, 2017). In the words of Vincanne Adams (2013) "for evidence to say

anything valid … it must speak the language of statistics or epidemiology" (pg. 57). The

underlying assumption is that metrics and the numbers they rely on are "indelibly

factual" (Adams, 2016, pg. 8) and offer valid, apolitical, objective results (Adams, 2016;

Adams, 2013; Biruk, 2012; Biruk, 2018; Merry, 2011; Merry, 2016). As Sally Merry

(2016) argues, simplifying social life to numerical data points is "seductive" as this

quantification allows for social complexity to be reduced to easily digestible facts.

Moreover, other forms of qualitative evidence that cannot be reduced to numerical data points are devalued and discredited in the process (Adams, 2013; Adams, 2016; Fan & Uretsky, 2017).

With the birth of global health in the 1990s, the World Bank overtook the WHO as a leader in the international health arena (see Brown et al., 2006; Packard, 2016). Along with the ascendance of the World Bank was the notion that health should be viewed like any other commodity and is evidently interwoven with market logic (Adams, 2016; Keshavjee, 2014). In addition, there was a seated belief at the time that money that had been spent on international health programs in the past lacked any accountability measures (Packard, 2016). Therefore, in a combined effort to increase both accountability and cost-effectiveness, the World Bank introduced the DALY (Disability-Affected Life Years). This metric, used to quantify disease burden in relation to productivity, was as Adams (2016) argues, developed because of a "crisis of data" (pg. 27; also see Merry, 2011). Thus, to measure overall disease burden and to help steer future health investments that could be grounded, objective, and true, DALYs were used. This reliance on an evidence-based metric, underscored the fundamental idea that 'proof' is in the numbers (Adams, 2016).

Other global health actors such as the Global Fund and PEPFAR have used evidence-based metrics to evaluate the programs they fund as well. Employing "performance-based financing" has allowed donor organization to tie their funding directly to the accomplishments of set targets by recipient organizations (see Fan, 2017; also, Inglis, 2018; Merry, 2011). As organizations employ performance-based financing to ensure numerical targets are met, this centres the focus squarely on "output[s], not the

processes" and reinforces the notion that "what counts are the targets, not how they are generated" (Fan, 2017, pg. 220). In practice, this implies that projects can be viewed as a success if they have good numbers even though the interventions may fail to improve health outcomes or help intended beneficiaries (Adams, 2013; Adams, 2010; Erikson, 2012; Fan, 2017; Fan & Uretsky, 2017).

In addition to the World Bank and other large multilateral donors that have been involved in the emergent field of global health, a plethora of other actors have also taken center stage. Now in global health, physicians and public health professionals are joined by bench scientists such as immunologists and virologists (Adams, 2010; also see Crane, 2013). This, in turn, has made global health research and interventions even more entrenched in "scientific rigor" where "[r]andomization, the use of controls, double blinds, power calculations, and the idea of using only statistics valid results" (Adams, 2010, pg. 43) are viewed as the best ways to measure efficacy and effectiveness. This shift in global health in the last decade has heightened the importance of numbers. While numbers are needed to ensure accountability, they are also required for rigorous scientific studies. Now, randomized control trials (as well as the enumeration techniques that are needed to collect good data for the trials) stand at the apex of all evidence (Adams, 2013; Adams, 2016; Fan & Uretsky, 2017). As Adams (2010) argues, what matters more than health outcomes are the power calculations and data collected from the studies as "lacking data may be even more tragic than lacking health" (Adams, 2016, pg. 44). This is even further complicated by public-private partnerships, which as Erikson (2012) argues, has turned global health into a global business.

Bringing private actors into the global health space has allowed for income generating programs to be linked with humanitarian good. Numbers then take on another role, becoming even more valued, as they bear the foundation for measuring financial investments (see Erikson, 2012; also Adams, 2016; Erikson, 2016). In such a context, "[w]hether statistics are accurate or enough to improve health is less important than whether statistics are performed and work to enable economic systems" (Erikson, 2012, pg. 372). Global health investments by private donors differ from other global health financing efforts. While funding from bilateral donors has "produced expectations of intervention in relation to health" investments made by private donors add another layer of complexity as "investors expect to make money" (Erikson, 2016, pg. 161).

With the World Bank ushering in the DALY in the 1990s to private organizations needing to measure risk and evaluate their financial investment, the field of global health has placed a high importance on evidence-based metrics, which are driven by collecting numbers and reducing people, places, and things to manageable data points. Medical anthropologists working in the field of global health have investigated the production of these numbers and their work has destabilized the notion that numbers provide valid, apolitical, objective truths. While medical anthropologist Vincanne Adams (2016) argues that using anthropological approaches to study the production of numbers "enables one to begin to see their solidity dissolve" (Adams, 2016, pg. 13), anthropologists Fan and Uretsky (2017) argue that these approaches also reveal that "the very process of evidence-making [is] both artificial and an artifice" (pg. 160). The remainder of this section is going to present recent anthropological research that interrogates the numerical techniques used in the field of global health to illustrate that both the collection and

dissemination of numbers are not produced in a vacuum and carry significant, albeit varied, importance to different actors. Moreover, it will also illustrate that quantified research, no matter how well designed, cannot truly capture the complexities in people's lives.

While data that is presented in numerical forms is often objectively presented as a fact (see for example, Adams, 2016; Biruk, 2018; Merry, 2011; Merry, 2016) analyzing the construction of such data shows that numbers can be politically complex (see for example, Adams, 2016, Biruk, 2018; Erikson, 2012; Merry, 2011; Oni-Orisan, 2016; Sangaramoorthy & Benton, 2012; Sullivan, 2017). Anthropologist Crystal Biruk (2012; 2018) has explored the social life of global health research projects across Malawi. In short, her research was an ethnographic study of "the production of quantitative data" (Biruk, 2018, pg. 3). Rather than assume that the numbers that appear in HIV-related reports are just simply tabulated "to covert or transform real-time snapshots of social reality" (Biruk, 2012, pg. 351), Biruk (2012; 2018) argues that the very act of collecting data is a sociocultural process. Furthermore, Biruk (2012; 2018) argues that the enumerative techniques used in global health are not as "clean" as they are presented to be, but rather the "numbers are the products of complex and messy negotiations, exchanges and relations" (Biruk, 2012, pg. 348). For example, in observing how surveys are written and how information is subsequently recorded, Biruk (2012) found that the demographers asked and "translated" questions in such a way to ensure they would prompt the most desired response.

Similarly, Oni-Orisan's (2016) work in Nigeria and Erikson's (2012) work in Sierra Leone and Germany, also point to the political weight that is tied to how numbers

are recorded for personal and professional gain. Their research reveals that maternal and infant mortality rates were carefully crafted (and sometimes not recorded at all) as the numerical statistics could have a profound impact on the future of physicians and politicians, alike (Oni-Orisan, 2016; Erikson, 2012). In Tanzania, Sullivan (2017) found that while many global health actors acknowledged the problematic nature of the numerical data, they worked to obscure the flaws of the data to pursue their own interests. Once the data was published, Sullivan (2017) argues, actors could "[p]erform 'progress' on an indicator" (pg.202) which was critical for deeming if the intervention was viewed a success or if it would be eligible for funding. In addition to having good numbers to ensure that their projects would receive funding, actors also knew that having good data could aid in personal gains such as a promotion (Sullivan, 2017). Notably, whether or not the data showed improved health outcomes was subsidiary to other political agendas (Erikson, 2012; Sullivan, 2017). Moreover, peer educators in Ghana, sometimes "cooked the data" in their monthly reports as a form of personal resistance to the low remittances they were receiving from their global health program (Inglis, 2018). As the aforementioned studies have shown, health statistics and the accounting practices that produce them are not "resistant to manipulation, adjustment, cooptation for personal or political agendas that may lie outside" of health-related concerns (Sangaramoorthy & Benton, 2012, pg. 289; also, see Erikson, 2012; Inglis, 2018; Sullivan, 2017).

While ethnographic accounts can reinforce the notion that numbers are far from apolitical artifacts, they also can shine a light on the idea that reducing life to numerical data points fails to acknowledge the complexity of social life. This reductionist approach can lead to "the disappearance of a subject" (Adams, 2013, pg. 85) and obscure the

unintended consequences that can result from the implementation of global health programs. To quote, Erikson (2012) there is a "hollowness in the numbers" as in many contexts, the numbers are "inaccurate or are too displaced from people's bodies, human complexities, or communities to be meaningful representations" (pg. 373; see also Merry, 2016). Often, as Merry (2011) explains, practices of enumeration have expanded into the domains of social life that are not easily quantifiable. For example, qualitative information, such as measuring "increased awareness of human rights" (Merry, 2011, pg.84) is difficult to reduce to data points. This, Merry (2011) argues, leaves organizations having to count "proxies" instead, such as how many human rights training sessions were provided. Anthropologist Lindsay Reynolds' (2014a) research on a PEPFAR-funded Orphan and Vulnerable Children (OVC) program in South Africa highlights the hollowness and implications of trying to reduce the complexities of social life to data points.

Soon after PEPFAR was mandated, it was decided that a portion of its funds (10%) should be directed towards OVC. PEPFAR's operational definition of "orphans and vulnerable children" focused solely on children who were orphaned and made vulnerable because of HIV/AIDS. Targeting children orphaned because of HIV/AIDS was problematic and left out other children who were equally in need of assistance (Reynolds, 2014a; also see Fassin, 2013). Although the operational definition was set in PEPFAR's guidelines, it was noted that communities should use their own judgement on which children should be included within OVC programs. Therefore, in practice, many PEPFAR-funded programs worked by reconfiguring the ambiguous eligibility category to meet their own needs on-the-ground (Reynolds, 2014a). On the anniversary of PEPFAR

I, OVC programs were deemed a success after reports indicated 2.4 million children had 'benefited' (Reynolds, 2014a). Though, this success was narrowly defined. Not only did the definition of OVC fail to encapsulate the complexity of social life for children across Africa, the success of the program was based solely on counting the number of children who were enrolled in OVC designated programs; such as counting how many children attended an after-school club (Reynolds, 2014a). As Reynolds (2014a) argues, "measures of programme success did not necessarily stand for effective programming but, rather, signalled the ability of actors to negotiate deeply contradictory mandates and fraught relationships across multiple levels of authority" (pg. 139). Nevertheless, the millions of children tabulated in reports deemed the OVC program a success and OVC funding was not only reinstated, but increased in PEPFAR II (Reynolds, 2014a). This example of enumerative practices as the sole means of measuring success is not isolated to PEPFAR-OVC programs. Numerical practices, such as counting how many vaccines were administered (see Graham, 2016) or how many people were tested for HIV (see Fan, 2017) as a measure of success plagues global health programs across the Global South.

In relation to her work on the implementation of a meningitis vaccine in Burkina Faso, medical anthropologist Janice Graham (2016) notes, "with success counted as numbers vaccinated… there was no need to build sustainable community engagements, health systems, or address social determinants" after all, "[t]here are no scorecards for these" (pg. 424). Similarly, anthropologist Elsa Fan's (2017) ethnographic research reveals that with success being measured by the number of people who underwent HIV-testing, HIV prevention efforts were undermined. Even though HIV prevention efforts may have had a greater impact on the lives of individuals than the intervention intended

to help, testing in and of itself, took precedence. If meeting targets is tied to funding (as it is in performance-based financing) and is doubly an effort to measure accountability, what matters then "is simply generating the numbers that meet those targets, not what they stand for" (Fan, 2017, pg. 225). As these studies illustrate, life is much more complex than counting children, vaccines, or HIV tests. Yet, this complexity is erased in pursuit of meeting targets, which are subsequently used to determine the intervention's success.

If there is in fact a "hollowness in the numbers" (pg. 373) as anthropologist Susan Erikson (2012) argues, she asks, who and what are they good for. According to Erikson (2012) numbers are good for donors, NGOs, and governments as they allow them to "engage in the performance of planning and evaluation at a distance, and to forecast, farcast, audit, and account for health monies and programming" (pg. 375). If, as Erikson (2012) argues, numbers are good for accountability, anthropologist Noelle Sullivan (2017) asks how accountability works in practice and for whom. Sullivan (2017) argues that accountability matters for bilateral donors (such as PEPFAR) as well as for their implementing partners (such as the NGOs that received their funding), but not so much for the people their programs are set to help.[7] In practice, there is a break in the chain of command; "[b]ilateral donors agencies are accountable to their governments, contractors are accountable to funding bilateral agencies, but neither is directly accountable to…those who are meant to benefit" (Sullivan, 2017, pg. 199). Not only are they not accountable to the people they are purported to help, as Sullivan (2017) maintains,

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[7] Kenworthy (2017) makes a similar argument from her work on the political impacts of HIV global health programs in Lesotho. She argued the state was accountable to their donors but not to the citizens of the country.

anthropologist Elsa Fan (2017) argues that accountability to communities is even undermined by these enumerative techniques. Drawing on her fieldwork from China, Fan (2017) found that many organizations had to adhere to the agendas of their donors over the needs of their communities, as she explains "in an effort to remain financially sustainable [organizations] must compromise to meet the needs of their donors at the expense of their communities" (pg. 225). Instead of focusing on health benefits or on even the desires of the individuals who are purported to benefit from many global health interventions, in many cases "what gets counted is not what actually counts or matters" (Fan & Uretsky, 2017, pg. 159) to the very people the programs intend to help.

Anthropologists have also noted that the increased demands for enumeration practices and the accompanied written documentation that is required by donors so programs can be monitored and evaluated, expand and reinstate forms of governance and sovereignty (see, Adams, 2016; Erikson, 2012; Inglis, 2018; Lorway, 2017; McKay, 2012b; Merry, 2011; Oni-Orisan, 2016). In efforts to monitor and evaluate programs within narrow confines, Erikson (2012) argues that governance "exerts power…along channels [of the] administrative apparatus" (pg. 380).

Robert Lorway's (2017) ethnographic study on the life history of one Gates-funded AIDS initiative illustrates the power held by and within required documenting practices. On one level, as quantitative metrics act as the gold standard against all other forms of evidence, this establishes what Lorway (2017) terms "evidentiary sovereignty" (pg. 178); global health actors use of enumerative practices reinforce the power of numbers over other forms of evidence. On another level, however, Lorway (2017) also argues that the documents and documenting processes to provide evidence also exert

"evidentiary sovereignty"; "hegemony is exerted by the documents" (pg. 178). In studying the social lives of the documents and the form-filling practices within one global health program in India, Lorway (2017) concludes that, "evidentiary sovereignty (re)produces a web of uneven and continually evolving power relationships…[where] the artifacts of evidence production themselves become the very site of politicization" (pg. 191).

Anthropologist Kathleen Inglis' (2018) research on monitoring and evaluation among HIV-related global health programs in Ghana also illustrates "evidentiary sovereignty" in practice. As peer-educators were required to fill out "the sheet" each month to indicate that they had reached their set targets, "the sheet" acted as a symbol "of literal and figurative distance between peer educators and donors" which reinforced that their relationship was "one of dominance and subordination" (Inglis, 2018,, pg. 251). Similarly, Adams (2016) argues that the efforts to "do metrics" (pg. 7) per global health's best practices are concerning as they are tied to forms of governance of the past; "these forms of counting ironically reproduce old forms seen under colonialism" (pg. 8). Anthropologist Crystal Biruk (2018), however, offers an alternative perspective. Biruk (2018) argues that even though enumerative practices and numbers were a part of governance in the colonial past and have resurfaced within recent global health programs, they can importantly also turn "uneventful suffering into aggregate suffering…making it visible" (pg. 26). Following Biruk's (2018) cue, I will now examine recent anthropological literature that has explored how enumerative techniques and the act of recording in global health can also at times have a positive impact on the lives of individuals who are being counted.

Medical anthropologist Thurka Sangaramoorthy (2012) has explored how people living with HIV/AIDS in Miami come to know themselves through enumeration and how these practices shape one's own subjectivity and identity. Not only does she argue that men and women have a direct role in the construction of the data, they also "come to know themselves and become known politically, socially, and medically through enumeration" (Sangaramoorthy, 2012, pg. 294). According to Sangaramoorthy (2012) enumeration practices do not act as oppressive mechanisms of governance, but rather, the numbers play a role in how "life is both imagined and lived…communicat[ing] ways of being and belonging" (pg. 293), in what she refers to as, "numerical subjectivities" (pg. 293). Drawing on her fieldwork in Sierra Leone, medical anthropologist Adia Benton (2012) similarly argues that HIV-positive individuals often made use of both enumeration and vernacular accounts to express their experiences of suffering.

Accounting measures and metrics in global health are interwoven with documentation, as data collection must be transcribed and disseminated to donors. As anthropologists Pigg, Erikson and Inglis (2018) describe, "audit and performance indicators elicit layers of documentation that lay out the terms, track measures, and demonstrate progress" (pg. 169). But the art of documentation, as Susan Whyte (2011) maintains, is much more complex than simply transferring numbers and words onto paper. Although documenting can act as a transfer of knowledge for donors, it can also be an act of acknowledgement for those being written about (Whyte, 2011). As such it is important to view documents as social objects, whereby "their very existence, form and use are generative ways of being and relating" (Pigg, Erikson, & Inglis, 2018, pg. 170). The very process of recording is based around relations between the person doing the

recording and the person providing the information to be recorded. Being able to write about people "has to do with being together, acknowledging one another, performing writing in the presence of the other, [as well as often] sharing and exchanging substances, including paper, food, words, and touch" (Whyte, 2011, pg. 30).

In many contexts, such as South Africa, writing can be a form of recognition (Reynolds, 2014b; also see, Biruk, 2018). Lindsay Reynolds (2014b) explains from her time in South Africa ethnographically investigating the implementation of a PEPFAR-funded OVC program, that the form-filling practices that were required by the program also allowed for other engagements between those recording and those being recorded, that went beyond what PEPFAR had envisioned. The forms, she argues, were a "façade of formality" as they also mediated the "construction of recognition, reciprocity, sympathy, solidarity, and obligation" between community workers and their families (Reynolds, 2014b, pg. 133). Being counted and documented in such contexts can act as a form of acknowledgment, can foster feelings of inclusivity, and as well, could lead to support which would be otherwise unavailable (Reynolds, 2014b; also see, Biruk, 2018, Whyte et al., 2013; Whyte, 2011).

In sum, anthropologists have shown that in many cases, enumeration and documentation across many health programs, overlooks many lived realities. Not only is the production of data a political process in and of itself, numbers alone cannot capture complexity. In an effort to count, sometimes what is counted misses what matters and as a result programs and interventions may be deemed more successful and effective than they are in practice. Moreover, often global health actors fail to realize that their programs and interventions impact human lives beyond what is outlined in their written

protocols. Although Biruk (2018) argues that global health research interventions see

exactly what they intend to, nevertheless, in the process of collecting metrics and

disseminating evidentiary documents, many actors in global health have been blind to

other social realities that influence, and often, impede good health. Rather than reduce

people and their lives to numerical data points, anthropologists and their ethnographic

methods help to reveal the complexity and nuance in people's lives. Their work

underscores that "context matters and individuals matter, as do the kinds of variation that

emerge within specific social encounters that vary from person to person, group to group,

context to context" (Adams, 2013, pg. 86). Without these alternative narratives, numbers

stand in as fact and many global health programs are left unchallenged. Medical

anthropologists give life to these numbers, questioning their validity, while offering to

contextualize the social space surrounding the data points.

"Currency of Association" in Sub-Saharan Africa: Patronage and Clientelism

In an attempt to better understand patronage and clientelism in practice across

Africa, sociologists and anthropologists have explored how non-governmental

organizations and their numerous programs centered around development, health, and

HIV/AIDS have inserted themselves into the everyday micro realities of neo-

patrimonialism on-the-ground. Sociologist Anne Swidler (2009) argues that "descriptions

of African political systems…give[s] us a basis to understand how external logics insert

themselves into African contexts" (pg. 199). While on one hand health and development

programs work (knowingly or not) within vital social patronage and clientelism systems

of support; on the other hand, these programs are implemented, monitored, and evaluated

by impersonal, rigid bureaucratic standards (see Whyte et al., 2013).

Social scientists draw on the work of Max Weber to understand these types of governance. Patrimonialism is a type of governance that is characterized as "systems in which political relationships are mediated through, and maintained by, personal connections between leaders and subjects or patrons and clients" (Pitcher, Moran & Johnson, 2009, pg. 129; also Weber, 1978). Patrimonialism fashions social bonds between individuals "through a reliance on trust, reciprocity, and material exchange" (Pitcher et al., 2009, pg.130; also Weber, 1978). Rooted in such a relationship is a mutual—albeit uneven—dependence between both patrons and clients (Pitcher et al., 2009; also Weber, 1978). Often patrimonialism is contrasted with another form of governance: "rational-legal authority" (Pitcher et al., 2009, pg.130; also Weber, 1978). Rational-legal authority privileges impersonal bureaucratic authority which is bounded by rules of law (Pitcher et al., 2009; also Weber, 1978). Many scholars of African governance, however, use the term neo-patrimonialism, to illustrate the hybridity that continues to co-exist between patrimonialism and rational-legal authority within African states following colonial rule (see Chabal & Daloz, 1999; Erdmann & Engel, 2007). For Chabal & Daloz (1999), however, the duality between the two types of governance in most African states is "no more than a décor, a pseudo-Western façade masking the realities of deeply personalized political relations…firmly embedded in the patrimonial practices of patrons and their networks" (pg. 16). Although, debates among scholars (see, for example, Erdmann & Engel, 2007; Pitcher et al., 2009) persist over the overall analytical definition of neo-patrimonialism, what is clear is that deeply personal forms of governance continue to be part of the macro and micro political reality in many African countries.

Within neo-patrimonialism, patronage and clientelism, are both foundational components (Erdmann & Engel, 2007). Erdmann and Engel (2007) distinguish patronage from clientelism by defining the former as "the relationship between an individual and a bigger group… [whereby there is a] collective benefit" (pg. 107) to many recipients. Clientelism, however, differs from patronage in that it implies "a dyadic and asymmetric relationship between a patron and client … [centered upon] individuals and, thus, is based on personal relations" (pg. 107) where there are relational benefits between the client and their patron (Erdmann & Engel, 2007). What underscores the need for clientelism is the instability and uncertainty in people's lives across Africa under neo-patrimonial governance. Establishing networks of patron-client relations allows for individuals to build up their web of associations which is central to gaining protection as well as having the potential to access resources and additional opportunities (Chabal, 2009; Chabal & Daloz, 1999; Erdmann & Engel, 2007; Wolf, 1966; for examples see Kaler & Watkins, 2001; Smith, 2003; Swidler, 2009).

While Suzanne Miers and Igor Kopytoff (1977) used the concept "wealth in people" to explain the underlying relations that were central to political life prior to colonization, some scholars of Africa argue that this concept continues to be relevant to contemporary life across the continent (see Chabal & Daloz, 1999; Ferguson, 2013; Scherz, 2014; Smith, 2003; Swidler, 2009). Anthropologist Daniel Jordan Smith (2003) has worked extensively in sub-Saharan Africa, particularly in Nigeria, and contends that "having people" (pg. 713) is still central to the lives of individuals. Having people fosters an interdependency between individuals, often structured within patron-client relationships, and is still critical for gaining access to opportunities and resources today

(Smith, 2003; see also, Chabal, 2009; Chabal & Daloz, 1999; Ferguson, 2013; Reynolds, 2014b; Scherz, 2014; Swidler, 2009; Whyte et al., 2014). Even though "having people" can be structured within patron-client relations, it is important to note, as Chabal & Daloz (1999) argue, they are still "inevitably based on personalized bonds of mutually beneficial reciprocity" (pg. 29).

Patron-client relations infer an imbalance between the patron and his/her client(s) in what Pitt-Rivers (1954) describes as a "lop-sided friendship" (pg. 140). As Eric Wolf (1966) explains, the exchange in patron-client bonds is not equal. Patrons provide their clients with "more immediately tangible" offerings, while the clients reciprocate "in more intangible offerings" (Wolf, 1966, pg. 16-17). In other words, patrons provide (or have the potential to provide) their clients with resources—which are often material that the clients would not otherwise have access to—in exchange for the clients' loyalty and support (Chabal, 2009; Chabal & Daloz, 1999; Erdmann & Engel, 2009; Wolf, 1966; for examples see, Kaler & Watkins, 2001; Whyte et al., 2013; Whyte et al., 2014). Patrons retain their status within their networks if they meet their clients' expectations and this establishes a valued interdependence on one another (Chabal & Daloz, 1999; Chabal, 2009; Smith, 2003).

While clientelism is based on personal relations between individuals, it is also this connection to others and "having people" (Smith, 2003) that is central to one's own selfhood across much of the continent. These connections with others help constitute oneself. In other words, one's own personhood is constituted by their relations with other people (Comaroff & Comaroff, 2001; also Chabal, 2009; Ferguson, 2013). Viewed in this way, persons are "nodes in systems of relationships" (Ferguson, 2013, pg. 226). One

popularized southern African philosophy, *Ubuntu,* which comes from the isiZulu phrase

Umuntu ngumuntu ngabantu (a person is a person through other people), illustrates the

inherent social nature of personhood in South Africa. As Mangena (2016) explains,

Ubuntu is a "way of life" (pg. 75). He provides the example that "in almost every

Southern African village children are socialized to value the interests and needs of the

group more than they would value their own individual interests. At a very early stage,

boys are taught to head cattle as a group as to foster the idea of a group or community"

(pg. 68). The defining characteristic of *Ubuntu*, Sambala, Copper and Manderson (2019)

maintain is the connection between the community and the individual, as "people exist

because of their interconnections, interdependence, and interrelationships" (pg. 6).

Based upon his decades of work in South Africa, anthropologist James Ferguson

(2013) has emphasised that dependency on others has been and continues to be central to

one's personhood. Although dependency on others has taken on various forms during

colonialization and apartheid, the contemporary focus he argues, should not be to

disallow or discourage dependency, but to find new ways in which dependency can be

meaningfully fostered (Ferguson, 2013; also see, Englund, 2008; Scherz, 2014). In the

contemporary era, Ferguson (2013) argues that "various forms of dependence (including

care-giving and care-receiving) must be recognized as building blocks of a healthy

society" (pg. 237). Ideas of dependency build on Patrick Chabal's (2009) work on

obligations and belonging in Africa. Chabal (2009) argues obligations between people are

woven into a value system central to one's belonging. These networks of obligations,

such as patron-client relations, act as a meaningful "currency of association" (Chabal,

2009, pg. 48). It is through personal relations of obligation and interdependency that

allow for individuals to belong to a rich social network as "[t]o have no obligation is not

to belong; it is not to be fully and socially human" (Chabal, 2009, pg. 48). According to

Chabal (2009), notions that people could or even should be autonomous individuals is

"not one that finds favour, or is even meaningful in Africa…the question is not whether

to be a party to a system of obligation or not but how to manage one's place in such a

system" (pg. 48).

Given the context of many HIV/AIDS interventions in sub-Saharan Africa, where

"having people" is tied to the possibility of accessing critical resources or further

opportunities, NGOs take on roles of being potential patrons (Swidler, 2009).

Furthermore, not only does the NGO act as a patron within the community where they are

located, local community workers who enter a patron-client relationship with the NGO,

are both clients to the NGO and also meaningful patrons to the families they visit.

One common example of a "patronage par excellence" (Smith, 2003, pg. 713)

within global health programs across the Global South is seen within workshops and

training seminars. Daniel Jordan Smith (2003) argues that workshops satisfy both

international funding bodies as well as local people for different reasons. While program

implementors and donor agencies see workshops as an opportunity to disseminate their

program's information, participants of these workshops also benefit from the materiality

provided by patrons, which can take on many forms including certifications, T-shirts,

food, or per-diems (Smith, 2003; also see, McKay, 2018). These workshops, Smith

(2003) explains are seen as "coveted opportunities…far from privileging some sort of

autonomous individual…workshops are valuable sites to develop [one's] social networks

of allies and supporters" (pg. 713).

Shifting from the focus of the patron specifically, Susan Whyte and colleagues (Whyte et al., 2013; Whyte et al., 2014) have explored how individuals in Uganda, who have been given a "second chance" since the arrival of ART in the early 2000s, continue to live their lives (Whyte et al., 2014). In an attempt to develop a term to conceptualize the landscape people must go through to navigate treatment, Whyte et al. (2013) co-opted the term "therapeutic clientship" (pg. 151). What is underscored by the term "therapeutic clientship" are the "relations between clients and their patrons or service providers" that are built upon and "can be analyzed in terms of exchange" (Whyte et al., 2014, pg. 62).

By using the term "therapeutic clientship" Whyte et al. (2013) could illustrate the multiple meanings of the word client and explore "the field of relationships through which people on ART find their ways" (pg. 151). The first meaning of client, through a public health lens, has neoliberal undertones, suggesting an individual is a user of a health service and has a direct role to play in the process (Whyte et al., 2014; also see, Mol, 2008). On the other hand, through a social science lens, clients are, as described above, in a lop-sided friendship with their patrons, depending on them for access to resources that would be otherwise unavailable. Therefore, in the multiplicity of meanings of the term client, Whyte et al. (2013) could illustrate both the "new service-mindedness in patient-health worker interaction… [as well as point to] the Ugandan world of personal interdependence" (pg. 151). Personal interdependency on others was critical for Ugandans to access their necessary medications as well as other material resources. In this sense, therapeutic clientship underscores that treatment programs are rooted in patterns of obligation, dependency and reciprocity where "vital resources are accessed

through enduring social relationships…with expectations by both parties about the morality of exchange" (Whyte et al. 2014, pg. 58).

Therapeutic clientship should not be conflated with another commonly used term by medical anthropologists, known as "therapeutic citizenship" (Nguyen, 2004, pg. 142). While Nguyen's (2004) "therapeutic citizenship" points to rights and demands made by individuals on the state based on their biological condition, Whyte et al. (2014) argue that the term is too abstract to illustrate the dyadic relationships she and her colleagues observed in Uganda between individuals (clients) and their health workers (patrons) (also see, Whyte et al., 2013). Furthermore, "therapeutic clientship" allows the focus to be centered on the interactions between individuals at an intimate level. These "nested levels of relationships" they argue, are foundational within the Ugandan health landscape (Whyte et al, 2013, pg. 163). Whyte and her colleagues (2013) found that "most HIV-positive people in Uganda are not so much claiming rights as hoping for help from a 'patron' with resources to distribute" (pg. 164). Whyte et al. (2014) suggest that "therapeutic clientship" better resembles what Nguyen (2004) refers to as "local-moral economies" in which "individuals call on networks of obligation and reciprocity to negotiate access to therapeutic resources" (Nguyen in Whyte et al., 2014, pg. 58). After all, Whyte et al. (2014) conclude most people on ART in Uganda, "were not talking about their rights and claims in the abstract sense" but rather, many were "worried about much more immediate entitlements, favors, and assistance from people they knew or wanted to know" (pg. 58).

Sociologists Amy Kaler and Susan Cotts Wakins (2001) have also used the concept of clientelism to better understand how community-based distributors involved in

family planning programs in Kenya have used these projects to meet their own personal needs. Given the insecurity of daily life in South Nyanza, Kenya, Kaler & Watkins (2001) argue that community-based distributors were acting as patrons, building their own social capital, and using their patron status as "a kind of insurance logic" (pg. 266). Although their role through the eyes of the intervention was to promote and distribute contraceptives, their work they argue was simultaneously "drawn into a local and historically rooted dynamic" (Kaler & Wakins, 2001, pg. 261). Although community based distributors across various global health programs are tasked with carrying out program protocols, they are also enmeshed within their social milieu, subject to interpersonal demands outside of their formal work (Kaler & Wakins, 2001).

Similarly, others have looked at how community health workers enter existing forms of social organization when they take part in home-based care (see Brown, 2014; Swidler, 2006). Ann Swidler (2006) argues that home-based care is one example which fits within, "existing patterns of African social life…most important among them are expectations of 'generalized reciprocity'" (pg. 276). In addition to providing in home-based care—an activity that is rooted in systems of obligations and reciprocity—some community workers also distribute material goods, such as contraceptives, medicines, or food. Whyte et al. (2014) refer to the goods that are exchanged in such relationships as the "transactables" (pg.58). The exchange of these "transactables" mediated by patron-client relations illustrate an interdependence that is established between unequal parties during global health interventions (see Brown 2014; Reynolds, 2014b; Swidler, 2006; Whyte et al., 2013; Whyte et al., 2014).

Sometimes the "transactables" that are exchanged within patron-client relationships in global health programs, however, refer to paper and documentation rather than actual material goods (see Reynolds, 2014b; Whyte et al., 2014; Whyte et al., 2013). For example, after extensive fieldwork in South Africa during the implementation of one PEPFAR-funded program, Reynolds (2014b) concluded that in addition to community workers filling out forms for accountability purposes, these encounters facilitated other forms of engagements which were "mediated by complex networks of patronage and dependence" (pg. 114). Form-filling practices has in some contexts also become a service of its own. In these cases, form-filling and the art of documentation act as symbolic tokens of the clientelism relationship, mediated through obligations and interdependency (Reynolds, 2014b; Whyte, 2014).

In addition to noting the dynamics of clientelism between the community workers and the families they visited, Reynolds (2014b) found that the community organization where she conducted her research also had a desire to "be supported, cared for, or even possessed" (pg. 135) by international donors and larger research centres. Through the eyes of her participants these globalized institutions were perceived as "wealthy patron[s] with riches to bestow on the people of the area" (Reynolds, 2014b, pg. 135). Reynolds (2014b) argues that these desires "call[ed] to mind much older forms of sovereignty and patronage, characterized by dependence on a chief or traditional leaders" (pg. 135) as the South Africans she spent time with were trying to "actively seek to construct relations of dependence with, and of recognition from, social actors who are perceived to have the capacity to provide and protect" (Reynolds, 2014b, pg. 136).

Similarly, Kenworthy (2017) heard a "nostalgia for patron-clientelism" (pg. 54) primarily among rural citizens in Lesotho, who wished to find a NGO to act as their patron.

Whether it be in organizing workshops, conducting home-based care or in the exchange of the "transactables" that occur within various health interventions, international global health programs are inserting themselves into micro realities of neo-patrimonial governance across sub-Saharan Africa. As anthropologist Lindsey Reynolds (2014b) has recently argued, "existing networks of power, patronage, and dependence are being reinvigorated and reshaped in important ways by the conduct of global health research and the implementation of programs" (pg. 137; see also Kenworthy, 2017). As such tending to these social realities can foster a greater understanding on how external projects insert themselves into the lives of individuals in the Global South. Often, global health programs have specific objectives and guidelines, but as Reynolds (2014b) suggests, social life has a profound impact on the execution of these programs, not only while they are ongoing but also after they depart.

Chapter Three: Setting the Scene

Macro and Micro Realities of HIV in South Africa

This chapter aims to explore both the macro and micro realities of HIV in South Africa, acting as a necessary backdrop for the following chapters. Through a critical medical anthropology framework and a historical lens, this chapter will first briefly explain some of the social and structural origins of HIV that have not only shaped and continue to divide South Africa, but have also had a profound impact on the distribution patterns and spread of the virus. A critical medical anthropology approach, also known as political economic medical anthropology, is a theoretical perspective that situates health at the interface between larger political and economic structures and socio-cultural factors that impact and influence one's overall health and wellbeing (Singer & Baer, 2018). To gain a holistic understanding of the social evolution of HIV/AIDS in sub-Saharan Africa a historical lens is also critical in understanding the influx of transnational humanitarian relief in the Global South. HIV has been argued to be the disease that ignited the field of global health and with it came an unprecedented amount of foreign aid (Brandt, 2013; Packard, 2016).

Shifting from a macro to micro lens, this chapter will then narrow its focus to my field site, Ndumo and surrounding area, using recent statistical data to exemplify the social inequalities, which continue to be everyday realities in KwaZulu-Natal (KZN). Finally, this chapter will close with a description of the Themba Community Centre (TCC), where my research was based, which was originally established in the early 2000s as a response to the increase of HIV/AIDS that was rampantly spreading across the country.

I have supplemented this chapter with maps to provide some geographical context as well as epidemiological data to illustrate many stark inequalities that are not only part of South Africa's history, but remain persistently in place today. The statistical data referenced in this chapter helps to illustrate the uneven distribution of this infectious disease and is sorted into four 'racial' categories: African, White, Indian/Asian, and Coloured.[8] I am aware of their problematic designations, however, for the purpose of this chapter rather than approaching 'race' and its designations as fixed, unambiguous categories, they ought to be viewed, as ethnographer Mark Hunter explains (2010), as a mix of "dynamic processes, ones always entangled with differences due to age, class, gender and much more" (pg. 26). Approaching 'race' as a static, stand-alone category as a basis to explain HIV rates in South Africa can "afford a false unity of the social history of AIDS" (Hunter, 2010, pg. 26). In sum, by exploring the multifaceted social history of HIV/AIDS, this chapter provides a holistic understanding of its social origin, moving beyond simple explanations that often are used to explain this complex—inherently social—infectious disease.

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[8] Even though apartheid formally ended in 1994, these 'racial' designations are still deployed by many South Africans.

South Africa and Its Most Eastern Province: KwaZulu-Natal

"AIDS has been described as a disease of poverty, but it might be more accurate to describe it as a disease of inequality, which settles along the lines of the ever-deepening chasm between rich and poor" (Epstein, 2007, pg. 101-102).

Figure 1: Above is a map of Southern Africa. Highlighted is the province of **KwaZulu-Natal (KZN)**, **South Africa**, where **Ndumo** is located.
Reprinted from Map Data 2019 Google. Retrieved from www.google.ca/maps

South Africa has the largest number of people living with HIV of any other country in the world; 21% of adults are infected with HIV (HSRC, 2018; UNAIDS, 2019a). However, the virus is not evenly distributed across the country. KwaZulu-Natal (KZN), South Africa's most eastern province has the highest HIV prevalence in the country, where close to one in three adults are infected with the virus (27%), and whereby arguably everyone is affected (HSRC, 2018). But this has not always been the case. In 1990 the HIV prevalence in South Africa among adults was less than 1%. Within one decade that number had risen to over 13% (UNAIDS, 2017). The number continued to rise; by 2010, the HIV prevalence had exceeded 18% (UNAIDS, 2017). In KZN the

numbers were more startling. HIV prevalence among adults was as high as 25% by 2008 and continued to rise to over 30% by 2012 (Shisana et al., 2014). To explain the unevenness of HIV in South Africa and how it came to spread so rapidly, one must examine the historical and social origins of this infectious disease, as anthropologist-physician, Paul Farmer (1999) has notably argued, "…poverty and other structural inequalities come to alter the disease distribution and sickness trajectories through innumerable and complicated mechanisms" (pg. 13).

By the 1990s, it became exceedingly clear that the spread of HIV in sub-Saharan Africa was not following the trajectory it had in the Global North. Both men and women in heterosexual relationships were becoming infected with the virus. HIV also was not only spreading at a rapid rate in Sub-Saharan Africa because of "high-risk" individuals (e.g. sex workers or migrants) having multiple sexual partners but rather was a result of multiple concurrent relationships—men and women having on-going sexual relations with a small number of other individuals—at the same time (Epstein, 2007; Hunter, 2010; Thornton, 2009). This created what Epstein (2007) calls a "giant web of sexual relationships" (pg. 55). Concurrent relationships, creating this giant web, are more critical than having multiple sexual partners in expediting the spread of HIV transmission as the viral load (the amount of HIV virus in the blood) is higher when someone is newly infected. Thus, as Hunter (2010) explains, "[in] dense sexual networks, everyone is linked to the newly infected person" (pg. 26). As a result of the rapid spread and trajectory of transmission for HIV in Africa, ignorant explanations arose from politicians and professionals in the Global North, largely blaming "culture" and "African promiscuity" as reasons for the exponential infection rates (Epstein, 2007; Hunter, 2010;

Fassin & Schneider, 2003; Packard, 2016). But this uncritical, superficial view obscured

the many structural reasons why concurrency was occurring in South Africa, as HIV

infection rates can "…only be understood by considering changes wrought by

colonialism, apartheid, and chronic unemployment" (Hunter, 2010, pg. 26).
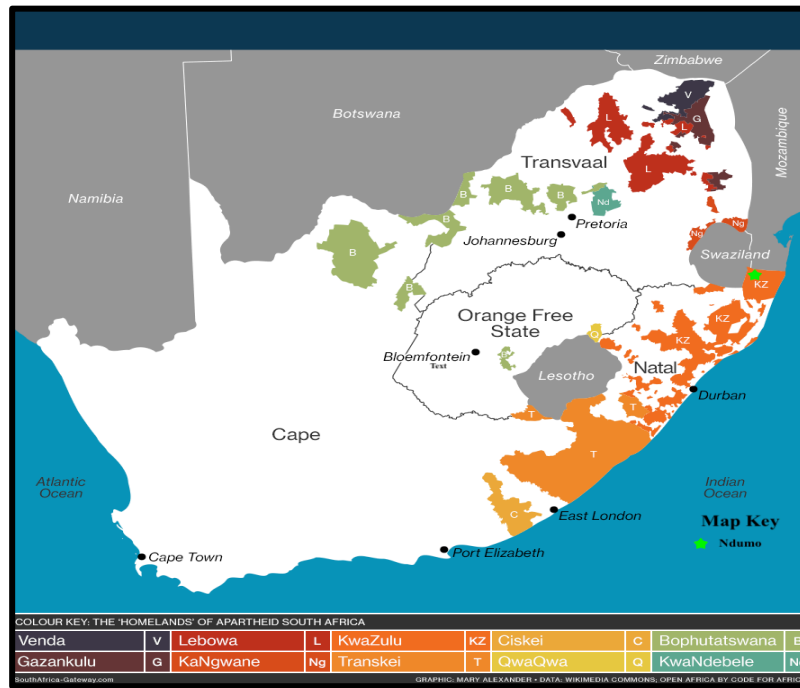
Figure 2: Above is an edited map, illustrating the "homeland" areas (in colour) as well as the former provinces of South Africa (in white) that were designated during apartheid. The province of Natal and the "homeland" KwaZulu united after apartheid had formally ended in 1994, forming one of nine new South African democratic provinces. This province is known as KwaZulu-Natal (KZN). Ndumo's relative location is depicted by a green star; formally part of the homeland of KwaZulu during apartheid. Photo reprinted and edited from South African Gateway 2019. Retrieved from https://southafrica-info.com/infographics/provinces-homelands-south-africa-1996/

South Africa has a long history of imposed racial segregation, social inequality,

land dispossession, and economic marginalization (see Coovadia et al., 2009; Fassin,

2007; Hunter, 2010; Lurie & Williams, 2014). South Africa was first colonized by the

Dutch (1652-1752 and 1803-1806) and later by the British (1795 – 1803 and 1806 -1961)

(Oliver & Oliver, 2017). During colonization, Black Africans were forced off fertile land

and subjected to live on rural designated "reserves." With imposed taxes, such as "hut taxes," men were forced into wage labour and left rural areas primarily to work on gold and diamond mines from the late 1800s onward (Coovadia et al., 2009; Epstein, 2007). Mining continued during the 20th century. Until 1961, South Africa was under British rule, however, from 1910 onward South Africa formed a Union, with its own independent government. The year of 1948 marked a critical moment in the country's history, as one of the country's political parties, the National Party, took office and marked the beginning of the apartheid government (Oliver & Oliver, 2017). From 1948 the South African apartheid government "consolidated the political exclusions, economic marginalization, social separation, and racial injustices of the preceding 300 years" (Coovadia, 2009 et al., pg. 819). By 1950, the Population Registration Act separated South Africans into "population groups" based on four 'racial' categories: African, White, Indian, and Coloured (Coovadia et al., 2009). These 'racial' designations dictated one's life: where one could work, whom one could marry, where one could live or go to school. Africans were denied South African citizenship and were again forced off land to designated rural "homelands" (bantustands). Families living in rural "homelands" commonly relied on income from other family members working as migrant labourers. By the 1980s in rural KZN remittances from migrant wage labour, made up over seventy five percent of household income (Lurie & Williams, 2014). Migrant labour also came from other countries in sub-Saharan Africa; by the late 1980s, over half the work force on the mines in South Africa came from neighbouring countries (Lurie & Williams, 2014). After their work permits were complete, they would most often return to their rural

homesteads, creating "circular oscillating migration" (pg. 39) across southern Africa between their work place and their home (Lurie & Williams, 2014).

Just as HIV was beginning to spread in South Africa in the 1990s, South Africa had its first democratic election in 1994, formally ending apartheid. Restrictions that were imposed during apartheid, such as where one could live and work were lifted, and migration for both men and women increased, expanding social networks and with it the spread of disease (Hunter, 2010; Lurie & Williams, 2014).

Migration for work continued after apartheid, separating men and women from their families in rural areas for months and even years at a time (Coovadia et al., 2009; Lurie & Williams, 2014). With more women entering the work force in the 1980s (a trend continuing into the 1990s and 2000s, with the post-apartheid government) there was a significant shift in the South African labour force from "…mostly men earning a living and supporting a wife to many men and women making a living in multifarious ways" (Hunter, 2010, pg. 5).

Although migration is certainly one of the most prominent arguments for explaining the spread of HIV across southern Africa through a critical medical anthropological framework, it leaves out other factors that must be considered, that were (and continue to be) significant driving forces in facilitating the spread. One of the goals of the anti-apartheid government was to address wealth disparities among South Africans, but within the first decade of democracy in South Africa, income inequality increased (Coovadia et al., 2009). This was due in part to new economic policies that the South African government had embraced. Just like some of its neighbours who had implemented structural adjustment policies enforced by the International Monetary Fund,

which favoured free market growth, reduction in government spending and increased

privatization, in 1996 the South African government implemented its own, similar macro-

economic laissez-faire policy known as GEAR (Kahn, 2000; also, Coovadia et al., 2009;

Hunter, 2010). In the words of anthropologist Jean Comaroff (2007) the onset of HIV in

South Africa was "uncanny: the disease appeared like a memento mori in a world high on

the hype of Reaganomics, deregulation, and the end of the Cold War" (pg. 197). In line

with the neoliberal political ideology, social spending in South Africa was reduced and as

a result income inequality grew. Along with the income gap widening and marriage rates

decreasing, the number of informal housing settlements and unemployment rates soared

(Coovadia et al., 2009; Decoteau, 2013; Hunter, 2010). By 2005, just over one decade

since the democratic election, unemployment rates increased "by 7 percentage points to

47% among women and by an equal amount to 31% among men" (Hunter, 2010, pg. 14).

Even though social inequalities could be found across South Africa, some

provinces suffered more than others, and consequently, the HIV prevalence was not

evenly distributed. KZN is the province that bears the greatest burden of the disease.

There are three reasons that are most commonly used to explain KZN's high HIV

prevalence. One dominant explanation is that because Durban, the most populous city in

KZN, is a large port city this increased social networks which helped to facilitate the

spread of the virus (Hunter, 2010). Another explanation places its focus on the low

circumcision rate. Some argue that given that KZN is predominantly Zulu, most isiZulu

speakers do not circumcise, and therefore are at greater risk of infection[9] (Hunter, 2010).

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[9] Male circumcision has become another selective treatment and technical fix to help curb the HIV
infection rates. The research that supports this argues that removing a man's foreskin helps with HIV
prevention (see for example: Jayathunge et al., 2014).

Finally, another common explanation focuses on KZN's long history of political violence brought to the region by competing political parties in the 1980s and 1990s which may have helped facilitate the high infection rates (Hunter, 2010). But as ethnographer Mark Hunter (2010) explains, there are two other explanations that highlight the history and social inequalities in the area. KwaZulu-Natal's geographical location in the country is where industrial decentralization during apartheid was the most successful. Additionally, the growth of informal housing grew more quickly in KZN than anywhere else in South Africa in the 1970s and 1980s (Hunter, 2010). Given these additional explanations it is clear, as Hunter (2010) explains, that "[b]oth histories left patterns of inequality and demographic shifts that are perhaps more extreme in this province than anywhere else" (pg. 28) in South Africa.

In recounting the historical past and economic climate during the period HIV began to spread in South Africa, it allows one to better understand the social origins underpinning the rapid spread of HIV, going beyond blaming "culture" or "African promiscuity" (Epstein, 2007; Fassin, 2007; Fassin & Schneider, 2003; Hunter, 2010; Thornton, 2009). Simply accepting that having multiple partners is synonymous with being an African man takes our focus away from understanding why these concurrent relationships occur in South Africa. Concurrent relationships are commonly formed between "boyfriends" and "girlfriends" and are often linked with the exchange of material commodities (e.g.: housing, clothes, school fees, food) (Hunter, 2010; Thornton, 2009). As such these types of relationships are termed as "transactional sex," or what Hunter (2010) calls the "materiality of everyday sex" (pg.6). Transactional sex relationships, however, involve "establishing relations of mutual assistance, protection,

and of course, affection" (Fassin, 2007, pg. 222) between couples, that evoke emotions and reciprocity, which differ from the commodification of sex that occur between a sex worker and client (Hunter, 2010). Concurrent relationships between multiple lovers must be viewed through, "the coming together of low marriage rates and wealth and poverty in such close proximity…[which influences] gender relations and material sexual relationships that fuel AIDS" (Hunter, 2010, pg. 6).

While the social conditions in the country help to facilitate the exponential spread of the virus in the 1990s and early 2000s, antiretroviral (ARV) medication (i.e management drugs used to slow the progression of the HIV virus) were not available in South Africa. Before 2004 in South Africa, AIDS was a death sentence, as there were no drugs available, despite their availability in the Global North since the mid 1990s (Brandt, 2013; Crane, 2013). Stereotypes that Africans were too poor or that they did not know how to tell time and thus could not take their medication in an appropriate fashion dominated discourses in the west in the 1990s (Crane, 2013; Messac & Prabhu, 2013; Packard, 2016). One person who is blamed for the slow arrival of ARV medications and the subsequent deaths of millions of South Africans, is former president Thabo Mbeki.

Mbeki, South Africa's president from 1999 to 2008, concluded that poverty was the cause of AIDS rather than the virulent agent HIV (Fassin, 2007; Fassin & Schneider, 2003; Hunter, 2010). During the beginning of his presidency, Mbeki not only questioned the cause of AIDS and the validity of western science and drugs, blocking the availability of a drug that would have reduced vertical transmission from mother to child, but he also supported a 'treatment' which was later proven to be nothing other than an industrial solvent (Epstein, 2007; Fassin & Schneider, 2003). His denial that HIV was the cause of

AIDS adversely impacted the lives of millions of South Africans. Moreover, Mbeki also

did not extend any explanation for the cause of AIDS beyond stating that poverty was

part of South Africa's colonial history (Hunter, 2010). As Mark Hunter (2010) explains,

"the tragedy of Mbeki's stance, therefore, was not only his 'denial' of AIDS science but

also his failure to pursue and address the links between poverty and AIDS" (Hunter,

2010, pg. 222).

While Mbeki questioned the validity of western science in the late 1990s and

early 2000s, political climates in South Africa and beyond its borders were shifting. Soon

after the millennium, discourses surrounding HIV began to change. As I will explain in

the next section, HIV went from being thought of as a disease that was too costly to treat

in resource-challenged countries to a disease that ignited unprecedented amounts of

foreign global health aid.

South Africa, HIV/AIDS, and Global Health

"The global response to HIV/AIDS, unlike responses to earlier disease threats,
was greatly influenced by interests and actions of people living with the disease"
(Packard, 2016, pg. 278).

As HIV rates were soaring in South Africa during the 1990s, AIDS activists

groups in South Africa began to form—such as the well-known Treatment Action

Campaign (TAC) in 1998—in response to the government's inaction to provide HIV

treatment and the patent laws which kept lifesaving drugs out of the hands of people who

needed them most (Epstein, 2007; Hunter, 2010; Ingram, 2013; Messac & Prabhu, 2013).

Activists played a major part in petitioning pharmaceutical companies with regards to

patent laws and put pressure on regulating authorities. They also took part in protesting at

global academic conferences, such as at the 13th International AIDS Conference in

Durban, South Africa in 2000, which was the first time the conference was held in Africa (Epstein, 2007; Hunter, 2010; Messac & Prabhu, 2013; Nguyen, 2010; Nguyen, 2004). Some AIDS activists across the Global South, evoked their "therapeutic citizenship" (Nguyen, 2004) of being infected with HIV as a form of "stateless citizenship whereby claims [were] made on global order on the basis of one's biomedical condition" (Nguyen, 2004, pg. 142). Indeed, as historian Randall Packard (2016) argues, HIV became the first disease whereby the actions of the people living with the virus had a tremendous impact on the global response. Although, activists had a profound impact on petitioning for the availability of ARVs, their efforts were coupled with the onset of dropping drug prices and shifts in a global political climate.

In 2000, at the time of the 13th International AIDS Conference in South Africa, the triple cocktail of ARV drugs, which had significantly reduced AIDS related mortality rates in the United States since they had been made available in the mid 1990s, were largely only available through pharmaceutical companies who controlled the patents for the drugs (Hoen et al., 2011; Packard, 2016). In a speech at the conference, Dr. Peter Mugyenyi famously stated, "the drugs are where the disease is not" (Gray & Gray, 2013). The triple cocktail came with a price tag of over USD $10,000 per person per year, an unattainable amount for the majority of people in the Global South (Hoen et al., 2011). These price points were a consequence of the World Trade Organization's (WTO) TRIPS agreement that was implemented in 1995, which required all members of the WTO to implement a standardized 20-year intellectual property protection on all technology, including pharmaceutical drugs (Hoen et al., 2011). In addition, these patent laws not

only prevented countries from producing their own generics but also prohibited them from importing the drugs as well (Gray & Gray, 2013; Hoen et al, 2011).

In India, however, generic production of ARVs was possible because of the Indian Patents Act, which exempted pharmaceutical products from having to obtain patents (and India was not required to do so by TRIPS until 2005) (Hoen et al., 2011). In 2001, Cipla, a generic pharmaceutical producer in India, garnered world-wide attention when it offered to produce and sell the generic version of triple cocktail of ARV drugs at a yearly cost of US $350 per person—less than one dollar per day. This dramatic drop in drug pricing was a watershed moment, making ARVs more attainable and "hammered the message home that many of the multinational drug companies were abusing their market monopoly in the face of a catastrophic human disaster" (Hoen et al., 2011, pg. 4).

Coupled with treatment activists and dropping drug prices, international agencies began to re-invigorate the arguments that diseases such as HIV were major threats to economic development, posed 'biosecurity' risks and could lead to political instability (Brandt, 2013; Crane, 2013; Ingram, 2013; Nguyen, 2004; Packard, 2016). This promoted the notion that AIDS in Africa was not just a continent-wide problem but rather a global one and helped to frame AIDS as a global emergency in need of humanitarian aid (Crane, 2013; Ingram, 2013; Packard, 2016).

Given this heightened global security threat and potential for loss of economic development, soon after the announcement that the generic cocktail of ARV drugs could be made available for less than one dollar a day, Kofi Annan, then-UN secretary called for the formation of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Gray & Gray, 2013; Ingram, 2013; Messac & Prabhu, 2013; Packard, 2016). Shortly thereafter, in

the 2003 State of the Union Address, President George W. Bush proposed another source of funding for HIV/AIDS in the Global South. Often known by its acronym PEPFAR— President's Emergency Plan for AIDS Relief—President Bush described the plan as "a work of mercy beyond all current international efforts to help the people of Africa…[to] treat at least 2 million people with life-extending drugs and provide humane care for millions of people suffering from AIDS" (Washington Post, 2003, para seventy three). In his address, he asked Congress to commit an unprecedented US $15 billion over the next five-year period to "turn the tide against AIDS in the most afflicted nations of Africa" (Washington Post, 2003, para seventy five).

Initially PEPFAR's legislation prevented any of the funds be used to purchase generic drugs, even though President Bush referred to buying generic ARVs in his speech when he said, "…drugs have dropped from $12,000 a year to under $300 a year, which places a tremendous possibility within our grasp" (Washington Post, 2003). Given that buying patented drugs would mean that fewer people would be able to receive treatment, there was push back from activists and other countries in the Global North, and the United States reversed its stance (Packard, 2016).

Prior to committing to fund life-extending drugs for AIDS, international and global health agencies had focused their efforts in the Global South on prevention. However, as this brief history of HIV in the Global South shows, the AIDS epidemic "disrupted the traditional boundaries between public health and clinical medicine, especially the divide between prevention and treatment" (Brandt, 2013, pg. 2149).

With PEPFAR's unprecedented allotted funds, its partners and programs have tried to make strides to "turn the tide against AIDS" (Washington Post, 2003, para

seventy five), but as described in the next section, even with this increased transnational donor activity in South Africa, many of the social origins of HIV—such as income inequality and unemployment—that contributed to the exponential spread in the first place are still very much a prevalent reality today.

uMkhanyakude, Jozini, and Ndumo

"ARVs have greatly reduced the number of AIDS deaths...[however] the social roots of this disease remain stubbornly in place" (Hunter, 2010, pg. 225).
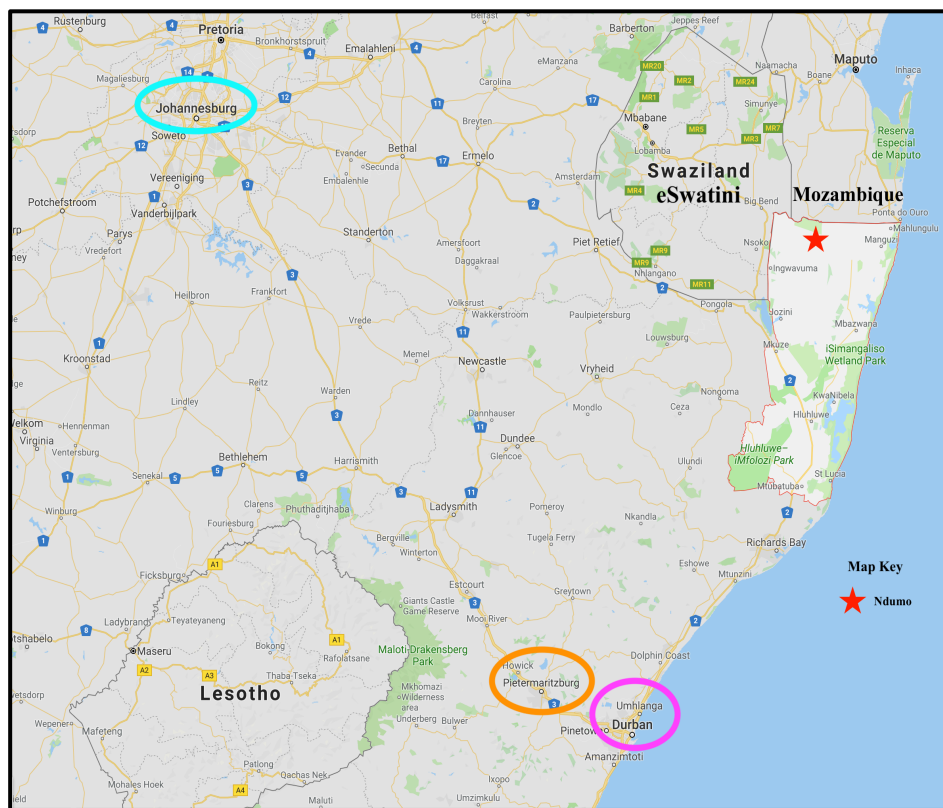
Figure 3: This map is a magnified version of the map in Figure 1. Ndumo's relative location is marked by a red star. **Ndumo** is in the northeast corner of the province of **KwaZulu-Natal**, in the provincial district of **uMkhanyakude** (outlined in red). Ndumo and its district of uMkhanyakude border both eSwatini (Swaziland) and Mozambique. Johannesburg, the most populous city in South Africa, circled in teal, is approximately 550 km or a 6.5-hour drive to Ndumo. Durban, the most populous city in the province of KZN, circled in pink, is approximately 400 km or a 4.5-hour drive to Ndumo. Pietermaritzburg, the capital of the province of KZN, circled in orange, is approximately 475 km or a 5.5-hour drive to Ndumo. Reprinted from Map Data 2019 Google. Retrieved from www.google.ca/maps
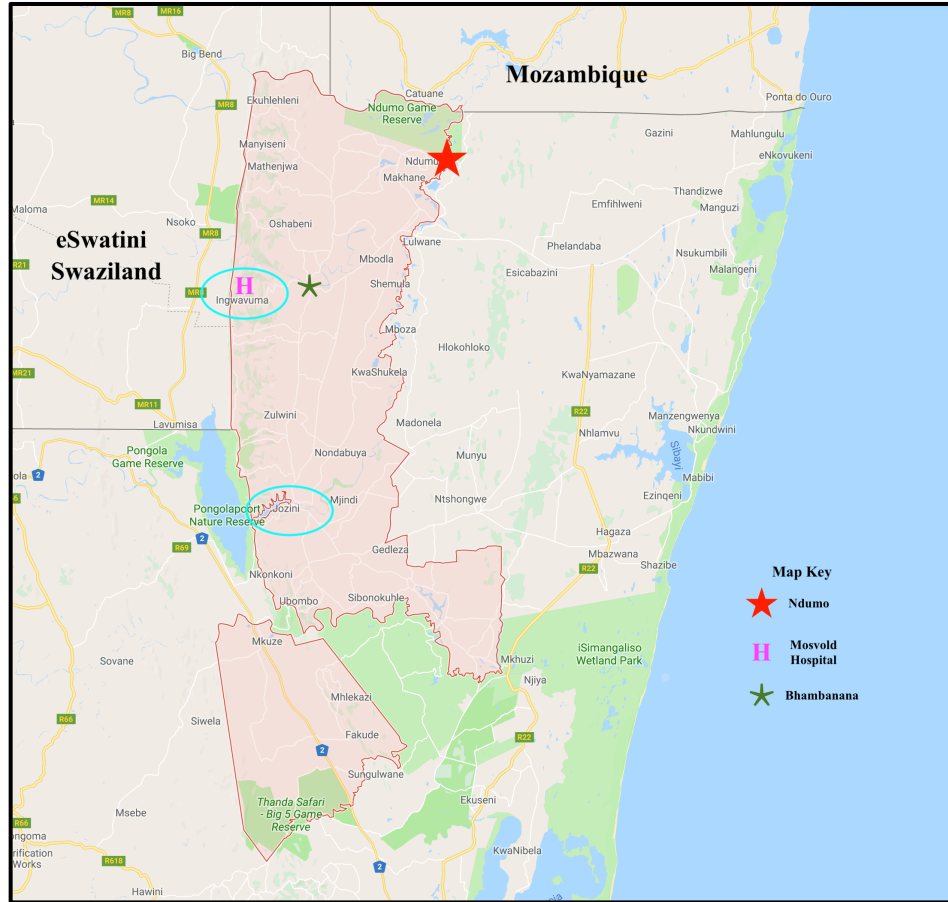
Figure 4: Above is a magnified version of the map in Figure 3. Ndumo's relative location is depicted by the red star. **Ndumo** is part of **Jozini Local Municipality** of the **uMkhanyakude District** in **KwaZulu-Natal**, **South Africa**.The Jozini Local Municipality is highlighted in red. The town of Jozini, circled in teal, is approximately 70 km from Ndumo and transportation costs by taxi are R90-100 (~$9.00 - $10.00 Cdn), for a one-way trip. Bhambanana, depicted on the map with a green star is a shopping area outside of Ndumo and home to the closest home affairs office. The distance from Ndumo to Bhambanana is approximately 35 km and taxi transportation costs R40 (~$4.00 Cdn), for a one-way trip. Depicted with a pink H and circled in teal is Ingwavuma, approximately 50 km from Ndumo and home to the closest hospital. To travel from Ndumo to Ingwavuma with a taxi costs R80 (~ $8.00 Cdn), one-way. Reprinted from Map Data 2019 Google. Retrieved from www.google.ca/maps

To illustrate the unevenness of HIV in South Africa, this section examines recent statistical data to exemplify how many of the social origins of the disease continue to be everyday realities to those living in KZN and certainly to those I met living in Ndumo. Through exploring race, income inequality, unemployment, and poverty in South Africa

today, one can better understand the social factors that facilitate the spread and how this disease disproportionally affects poor Black South Africans.

The province of KwaZulu-Natal is sub-divided into 11 districts. One of those is the uMkhanyakude district (see Figure 3). According to the last census in South Africa, KZN is the second most populous province in the country, with a population size of over 10 million, however, only 6% (~600 000) live in the uMkhanyakude district (Statistics South Africa, 2014). Within uMkhanyakude, there are smaller municipalities, one of those is Jozini municipality, where Ndumo is located (see Figure. 4).

The most recent South Africa National HIV Prevalence, Incidence and Behaviour Survey administered by South Africa's Human Sciences Research Council reported that 7.9 million people were living with HIV across the country (HSRC, 2018). However, HIV prevalence is not evenly distributed. According to the survey, HIV is unevenly distributed among various 'race' categories in South Africa. "Black Africans" had an overall HIV prevalence of 16.6 % (20.6% of females; 15.5% of males), while the designated "White" population group had an HIV prevalence of 1.1% (0.9% of females; 1.3% of males). But seeing race as a fixed category, fails to acknowledge other social, and economic factors that have also contributed to the trajectory of the virus. From this standpoint, I will use other statistical data to exemplify that the unevenness of HIV's distribution pattern runs much deeper than solely a 'racial' designation.

Not only is HIV prevalence unevenly distributed among 'racial' groups, it is also reported to be unevenly distributed among provinces. For example, KZN has the highest HIV prevalence rate in the country at 27%, whereas, the HIV prevalence rate in the Western Cape (another province in South Africa) is 12.6 % (HSRC, 2018). Perhaps

unsurprisingly, KZN has a higher percentage (87%) of "Black Africans" living in the province compared to the rest of the country (South African Statistics, 2014).

Income inequality still stands as a major problem for South Africa today. According to the World Bank, South Africa is ranked as the most unequal country in the world (Greenwood, 2018). As of 2015, Statistics South Africa reported that a "white-headed" household had an income that was 4.5 times higher than that of a "black-headed" household. Close to three-quarters of white South Africans are in the highest income quintile, while as close to 50% of black South Africans remain in the lowest two quintiles (Statistics South Africa, 2015). However, those statistics relate to those that are currently receiving state assistance or are employed. Unemployment rates remain extremely high in South Africa (30%). In KZN, one in three adults are unemployed (33%). Out of all the districts in KZN, uMkhanyakude, has the highest unemployment rate, where 42% of adults (over 34 years of age) and over 50% of youth (15-34 years) are unemployed. The municipality of Jozini has even higher unemployment rates than the uMkhanyakude district; 44% of adults and 53% of youth in Jozini are unemployed (Statistics South Africa, 2014). Although there are no exact percentages available for the unemployment rate in Ndumo specifically, the lack of employment opportunities as well as the precariousness of the jobs that were available infiltrated our daily conversations.

In addition to wealth disparities and unemployment rates in South Africa, according to an earlier version of the South Africa National HIV Prevalence, Incidence and Behaviour Survey, 57% of "Black Africans" live in informal areas whereas 99.6% of the "White" South African population live in formal areas (Shisana et al., 2014). The South African National HIV Prevalence, Incidence and Behaviour Survey defined

informal areas as places that are "under resourced and lack some basic necessities" and formal areas as "well-resourced in terms of basic infrastructure such as housing, water sanitation, and access to preventive health services" (Shisana et al., 2014, pg. 51). According to those definitions, Ndumo, Jozini municipality and much of the uMkhanyakude district would be designated as informal. While over 40% of homes in KZN are reported to have piped water inside, only 13% of homes in uMkhanyakude do, and a mere 11% in the Jozini municipality (Statistics South Africa, 2014). As for electricity, only 29% of homes in the Jozini municipality have electricity, which is much lower in comparison to percentages of homes across the district (38%), province (78%) and country (85%). In addition to lack of electricity in many homes in the Jozini municipality and the uMkhanyakude district overall, close to 1 in 4 people living in uMkhanyakude also do not have access to a toilet on their home's site, a very different statistic than for the rest of the country (Statistics South Africa, 2014).

This data illustrates that although great investments have been made from transnational donors such as PEPFAR, the social conditions that propelled the HIV epidemic in South Africa remain very much in place and most evidently in KZN. As sociologist, Claire Lauier Decoteau (2013) argued: "until abject desperation is no longer the everyday experience of millions of South Africans, the disease will continue to spread. The epidemic not only feeds off of but also *increases* socioeconomic vulnerability" (pg. 49).

In this next section, I move beyond percentage points to provide a description of Ndumo and the TCC. Nevertheless, the social inequalities that these numbers illustrate

were everyday realities in Ndumo and as such had a profound impact on health and social life.

Ndumo and the Themba Community Centre

Figure 5: Photograph of a road sign on the main tar road depicting the turn off to Ndumo. The heart of Ndumo, where the shops, market, and TCC are located is 17 km from the tar road. To travel to the various places indicated in Figure 3, such as Jozini, Bhambanana, or Ingwavuma you must first travel the 17km from Ndumo to the main road. The cost of traveling from Ndumo to the main road using a taxi is R25 (~$2.50 Cdn). Photograph taken July 2018 by author, Stephanie Peel.

Ndumo was described to me as a "deep rural place" by several people I met living there. The word "deep" accurately describes Ndumo's geographic positionality, as the drive into Ndumo's main square is well off the paved road.[10] Ndumo's winding road is a 17km long one where slowing down for roaming goats and cows is almost always certain. The soil is a deep rust, rich in iron, and the vistas change from open fields to dense, wet treed areas where the lime green barked uMkhanyakude trees grow. As you approach the center square of Ndumo, the market, health clinic, and petrol station are all

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[10] In the description for both Figure 4 and Figure 5 I have provided the costs of travel by mini-bus taxi (a common mode of transportation in Ndumo) to many places surrounding Ndumo, including the price to take a taxi from Ndumo's center to the main road. This was to help illustrate the restrictive costs of travel for many residing in Ndumo as well as the general remoteness of Ndumo from other places such as the hospital or a larger shopping centre.

located to the left of the road and if you continue driving for another minute, you will reach the TCC. A chipped and weathered white wooden sign, with black writing, and a painted red ribbon—a symbolic representation for HIV/AIDS solidarity—is located at the gates as you enter the TCC's site. The square site is fenced off with wire fencing, primarily to keep the animals out. To the left of the property's perimeter is the TCC, a white trailer, about 20 feet in length. Within the trailer, there are two main rooms. The smaller of the two rooms (less than 7 feet by 7 feet) is designated as the "office" where there are two desks along with a broken filing cabinet, which sits spilling out papers. The second, larger room is called the "boardroom." Plastic chairs are stacked off to the side and one large table sits in the middle. It was in the boardroom where meetings were held among community workers and often where community workers Mbali, Ulwazi and I used to work filing forms and completing reports. Stacks of coloured paper and other office supplies that were bought when the PEPFAR-funded NGO (PFN) was at the centre are still located in the back corner, daily physical reminders of the past. Two other smaller trailers also sit on the site: one acts as the kitchen for their feeding program and the other a resource centre filled with children's toys and educational posters. In addition to the three trailers, a small garden sits behind the centre, where we planted and harvested carrots, beet root, and cabbage. In the open space in the middle of the site there were several tire swings and a jungle gym, as well as a wooden picnic table located under a large tree providing shelter from the hot sun. We often retreated to the picnic table after the day's work was complete and many rich conversations and interviews took place there.

The TCC, as I came to understand, used to be a gathering place. Women and children would come, some would work in the garden, and children would play and have meals in the kitchen. Shaking her head and closing her eyes one afternoon, Mbali said to me pointing outside, "It used to be busy, and now you see." During my time at the centre no one really came. Since the NGO had left and state funding was reduced, I learned that this was the new normal for the centre. No one came to work in the garden, except the community workers themselves, and there would be several days in a row where no one—neither children nor adults—would come. Sometimes in the late afternoon, around 2 pm, a handful of children would come for food—if there was food available—but more often than not, the centre was quiet. With the decrease in state funding and the departure of PFN, programs were cut and resources were depleted. As a result, in the afterlife of aid, community social relations were changed.

Chapter Four: Methodology

Entering the Field and Ethnographic Serendipity

My path before entering the field was far from linear as I spent months corresponding with various on-the-ground actors in Southern Africa. My intention was to conduct an exploratory qualitative study on the lived realities of HIV self-testing kits that were being distributed through a large global health project known as STAR or Self-Testing AfRica. After months of email and skype conversations trying to enter the field from the top-down (through African research institutions involved with STAR), I re-evaluated and began to focus my energy on entering from the bottom-up. Through an established, extensive online health database in South Africa, I used their search engine in my quest to find an organization where I could at least begin my work. In my introductory emails, I explained my interests in HIV self-testing and was sure to note that I would be willing to volunteer and be of use however they saw fit. It was through this database, that I found and contacted the Themba Community Centre (TCC). Mbali, the lead community worker, welcomed my research and to my delight mentioned "there was much for me to learn" early in our initial correspondence. Soon after securing my field site, I departed to South Africa's most eastern province, KwaZulu-Natal. After 3 flights and a four-hour drive from a small secondary South African airport, I arrived in Ndumo, a remote area which sits near the border where South Africa meets eSwatini (formally, Swaziland) and Mozambique. It was not long after being in Ndumo that it was clear there were no HIV self-testing kits. When I used the term, "HIV self-testing" it was interpreted to mean, going to the clinic to voluntary self-test.

Any seasoned ethnographer understands that projects are bound to shift once in the field, and mine was no different. With no HIV self-testing kits in the area, I was left with a decision: leave Ndumo in search of finding HIV self-testing kits elsewhere in South Africa or stay and follow James Spradley's (1980) advice: "… to consult with informants to determine urgent research topics" (pg.18). I chose the latter, for both personal and pragmatic reasons. As this was my first fieldwork experience, I felt time would be better spent trying to improve my note taking, observational skills and interview techniques during those three-months rather than searching for a new field site. To reinforce this decision, my visa also had a three-month expiry.

With my original research proposal having no relevance to my field site, I spent my time engaged in daily work and life in Ndumo. I went to the centre every day, helped with daily administrative duties, took part in staff meetings, went to community gatherings and even lived in the same house as the lead community worker of the Themba Community Centre (TCC), Mbali. Anthropologist Alison Heller (2016) maintains that anthropology's most important method is the ability for the fieldworker to remain "intellectually agile" (para, 8). Despite fretting on a daily basis about my initial project's lack of relevance, I tried to remember Heller's advice. Casting a wide net, I wrote extensive field notes daily and listened and observed attentively. After all, it was my role as a fledgling anthropologist to document what people were telling me was important to them, their community, and their centre. It became clear after listening and engaging in daily work during my first few weeks and re-reading field notes as time went on, that various topics continued to re-appear as recurring points of contention primarily due to lack of funding. But it was not until one crisp morning that my project direction

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seemed to become clear. Through some ethnographic serendipity, one morning at the centre I came across hundreds of old patient files in broken, dusty binders we were trying to repurpose. As we were taking the sheets out of the binders and wiping off the red dust with an old ripped t-shirt, I asked, "What happened to all these people?" It was clear they were part of the now departed PEPFAR-funded program as each sheet was branded with the logo on the top right-hand corner. As mundane as taking pages out of binders may seem, it sparked a rich conversation that was a pivotal moment in my fieldwork and set me forward on this research project.

Effective Fieldwork

Often titled as the father of anthropological fieldwork, Bronislaw Malinowski had three secrets to effective fieldwork: to have scientific goals, to live with those you are studying, and to apply a variety of methods when collecting data (Malinowski, 1922/2012, pg. 47). Nearly a century later, this ethnographic study made use of his three secrets. In addition to having scientific goals, I spent my time living within Ndumo, and at the home of one of the community workers, Mbali. Living in Ndumo allowed for a deeper appreciation and understanding of what I was learning about daily. Most importantly, however, was the rapport I was able to establish because of living with Mbali. At the beginning of my fieldwork, many people in Ndumo would gasp and respond in astonishment, "*Howw*w," when I explained that I was living with Mbali. However, as time went on, few people stopped to ask questions, and no longer were there people stopping to stare or point when I was out in the yard fetching water or hanging laundry. During my initial meeting with *Induna* (traditional leader) and his community committee, when I explained why I had come and asked for their consent to carry out my

research, they expressed that they appreciated that I lived in Ndumo, saying "It is better for you to live here and see how we live, [and] not stay in some fancy hotel." Living in Ndumo allowed for a deeper connection with those from whom I was interested in learning from. Some of my most productive moments came from cooking dinner at night or sitting on the couch after a long day at work. It was here, in these intimate moments, that I was able to ask additional questions and talk at length.

Mbali had all the traits of a key informant; she was observant, reflexive and articulate (Bernard, 2006), but above all she was willing to share with me and had a tremendous understanding of the work at the centre and how it had changed over time. Bernard (2006) explains that good key informants are "…people whom you can talk to easily, who understand the information you need and who are glad to give it to you or get it for you" (pg. 196). Short and petite in stature, she had long dreadlocks that she always pulled back. Mbali walked with confidence and her head held high, with a warm bright smile. She lived alone in a small four room house she built in 2013. The cement exterior was painted an off white and it had a unique shape. Unlike the other rectangular houses in Ndumo, Mbali's was oval, "egg shaped" as she called it. Every morning before leaving for work, I always fed Mbali's chickens and took the opportunity to glance out into the vista below. The vista from our house was open and endless; brick-red soil and scattered small wooden and cement houses made up the landscape. Clothes hung from lines or on wire and wooden fences often swaying in the wind. Cows and goats roamed about. The view was quintessential rural South Africa.

Mbali explained to me early on in my fieldwork that she was "famous" in Ndumo because a lot of people knew her. Indeed, they did. Everywhere we went people stopped

to speak to Mbali and if we went into town nearly everyone would wave and greet us with a cheerful, "*Sanibonani"* (hello). One day, as we were leaving town, I was sitting in the back of a car with a community worker, Sizwe, when someone called out and wanted to get Mbali's attention. Sizwe and I laughed with affection as she jumped out of the front seat, and he turned to me saying, "She is famous here, now you see." However, as well-known as she was, Mbali expressed to me that even though people in Ndumo treated her with respect, being a Zulu woman who lived alone sometimes caused her to feel unsettled given the high rates of violence toward women.

Mbali was not born in Ndumo, she moved there for employment at the nearby Ndumo Game Reserve in 2008. She grew up in a small community about 45 km from Ndumo, where she had two sisters and a brother, "from her mother." At the age of 23, Mbali gave birth to her only daughter. Four years later and not yet married, her partner and the father of her daughter who had been saving cows for *lobola* (bridewealth), passed away in a motor vehicle accident. She never married. Mbali's true resilience shone through when she told the story of raising her daughter and the sacrifices she made to provide her with opportunities she herself never had. Pointing to the walls of the house, Mbali told me she saved all her earnings to build the modest four room cement structure for her daughter. Her daughter, now 18, attends post-secondary school in Durban, South Africa. Mbali's eyes glistened with pride as she told me.

In addition to living with those you are studying, I also made use of Malinowski's third and final secret to effective fieldwork: utilizing a variety of methods for data collection. I used qualitative methods during my fieldwork, primarily participant observation as well as both formal and informal interviews.

Eth-nog-ra-phy

Before I turn my attention to the methods I used, I want to make deliberate mention of the term I use continually in this thesis: ethnography. Because the term ethnography is so widely used, perhaps even overused (see Ingold, 2014), it may lose its meaningful significance. I wish to avoid this and highlight how ethnography underpins this study. It is not a method or solely a written product produced after a study is completed. To use the term requires a conceptual awareness and sensibility that is woven into how methods are applied and how results are written.

Doing ethnographic work and bringing forth ethnographic judgement to your analyses and elucidated written accounts begins with a sensibility that requires anthropologists to leave their assumptions at bay and start with "a conscious attitude of almost complete ignorance" (Spradley, 1980, pg. 4). Ethnographic work cannot be bound to set research guides or pre-determined questions as doing so goes against the heart of any ethnographic sensibility. Ethnographic sensibility encourages ethnographers to allow their informants to be their teachers. It requires us to listen attentively acknowledging our informants' points of view, and following down paths that they believe are important, even if that path is uneasy or a complete divergence to what you anticipated as salient. Through an attentiveness to their thoughts and commitment to their lived experiences, a camaraderie is established. As fieldwork progresses, fieldnotes are produced, commonly the result of extensive participant observation and interviews where ethnographers continually interpret their findings to help guide their study, in order to ask more suitable questions and gain a greater understanding. And after, the heart of ethnographic work continues when the ethnographer leaves the field and makes a written account. It is in the

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written results that we try to untangle our data and best describe alternative

understandings and realities, creating thick descriptions (Geetrz, 1973). But without our

ethnographic sensibilities—our commitment to learning from our informants, building

rapport, being open-minded to new possibilities and at times uncomfortable realities—

underpinning our methods and written descriptions, we lose the meaning of the word. To

use it requires our commitment to its sensibilities which help to guide our judgements

throughout the entirety of the research process.

Participant Observation

Participant observation, also known as deep hanging out (Geertz, 1998), or sitting

and doing (Pigg, 2013), is described by Bernard (2006) as "[g]oing out and staying out,

experiencing the lives of people you are studying as much as you can" (pg. 344). Each

day I conducted participant observation during my fieldwork in Ndumo. I was involved

in daily administrative duties at the TCC, such as helping to sort and file client forms and

filling out reports while also accompanying community workers to meetings and

attending community gatherings and events. Participant observation provided me with the

opportunity to engage in everyday activities at the TCC which allowed me to capitalize

on what Watkins and Swidler term, "hearsay ethnography." Hearsay ethnography

"captures spontaneous conversation rather than responses to researchers' questions or

probes" (Benton, 2015, pg. 33). Doing so enabled me to make notes on re-occurring

topics of conversation and points of contention.

Living in Ndumo also allowed me to experience daily life outside of working

hours. At night, as it was just Mbali and I at home, we had hours to sit and talk, either

while cooking dinner or while baking to fulfill an order for her subsidary business. We

often had visitors, whether it be neighbours coming by to say hello, or others calling or popping in to seek help from Mbali. These moments were invaluable for building trust and rapport and they often led to many in-depth discussions.

Participant observation is also what guided what I wrote in my fieldnotes. I wrote extensive fieldnotes daily, sometimes during the day at the TCC and additionally at night. My fieldnotes were not fixed or predetermined, but rather were guided by ethnographic sensibility and evolved throughout my time in the field. Researchers Emerson, Fretz & Shaw (2011) explain that fieldnotes are both intuitive and empathetic; "…[i]ntuitive, reflecting the ethnographer's changing sense of what might possibly be made interesting or important to future readers, and empathetic, reflecting the ethnographer's sense of what is interesting or important to the people he is observing" (pg. 14). Being attentive and recording, in what Pigg (2013) terms as, "the doing of sitting" (pg. 132), allowed me to attend to the social dynamics that were at play and the fine-grained details that made up day-to-day realities. Additionally, another reason why participant observation is such a valuable method in ethnographic research is that it allows the ethnographer to ask suitable and relevant questions (Spradley, 1980).

Participant observation is, however, labour intensive and requires at times formidable perseverance. In my case, many days were long, and sometimes I grew frustrated by the hours that would go by day after day where no one would come to the centre. As Bernard (2006) aptly acknowledges, participant observation is not for the impatient.

Interviews

A complementary method to participant observation is interviewing. Observations can lead to many questions, and it is in asking those germane questions that one can gain a deeper understanding. Just as anthropologist James Spradley (1980) notes, in ethnographic research "questions and answers must be discovered in the social situation being studied" (pg. 32). Interviewing, however, can take on multiple forms. I made use of both informal and formal interviews during my fieldwork, asking questions that were developed during my time in Ndumo.

Informal interviews often take place during participant observation, in the form of regular conversations. There is no set time or formal structure in these types of interviews; they are entirely unstructured (Bernard, 2006). I made use of informal interviews daily during my fieldwork. These informal conversations were in English.

In addition to my informal interviews, I used formal interviews, which were semi-structured in nature. The first language spoken by the community workers in Ndumo was isiZulu. While many community workers spoke little English, others were fluent. The 20 formal interviews that were conducted were in both English and/or isiZulu, with help from a translator.[11] Some of these interviews took place at the TCC, inside if the sun was too hot or outside at the picnic table. Others took place out in the community, mostly under large trees that provided some shelter, or in open flat fields where cows and goats roamed, but always close to where the community workers were working for the day.

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[11] The next section of this chapter, "Impacts of Language: Use of Interpreters and Data Sourcing" explains my use of a translator and the impacts of language on my research.

During my formal interviews, I primarily asked open-ended questions about their work to allow informants to steer the conversation and to take on a more unstructured natural form; but nevertheless, these interviews were more semi-structured given the general interview guide I tried to follow (Bernard, 2006). The focus of my interview guide was centered around asking about their work and if, and consequently, how it had changed after the NGO departed and state funding was significantly reduced. Throughout the interviews I prompted for examples, often asking, "can you explain to me how this was different than before" (i.e. when they had additional funding)?

My formal interviews, however, did not commence at the beginning of my fieldwork, as I wanted there to be significant time for me to first observe and gain rapport; just as ethnographer Mark Hunter (2010) explains, the "…fostering of friendships is inseparable from the work of collecting 'data'" (pg. 185). As my fieldwork progressed, I was introduced to several community workers. With Mbali's assistance, I asked community workers if they would like to speak with me about their experiences and how their work had changed over time. Not only had I met all the community workers before our formal interviews began, I had come to know some of them well and had numerous informal conversations. The community workers I spoke with and learned from during my fieldwork became my teachers, not just respondents or actors. As Spradley (1979) explains, "[e]thnographers adopt a particular stance toward people they work with…they say, I want to understand the world from your point of view…Will you become my teacher and help me understand? This frame of reference is a radical departure from treating people either as subjects, respondents or actors" (pg. 24). My mentioning that I had come to learn and that they were my teachers became a running

joke. Ulwazi, a community worker who took on a supervisory role at the TCC would often laugh and say, "Stef you are our student, I am your teacher, and Mbali is our principal."

In this thesis, I have called those I learned from in Ndumo, interlocutors, my teachers, or my informants. The latter two terms, teacher and informant were used in addition to interlocutor as they best explain the type of relationship we had: they taught and informed me about their lives, their community, and their centre. As anthropologists, McCurdy, Spradley and Shandy (2005) explain, the term informant has been contested by some, as "it resembles the word "informer", someone who is a snitch, or someone who shares information, and in doing so causes harm to others" (pg.11). However, they argue, some anthropologists, including themselves, continue to use the term because, "there is a lack of a better alternative" (McCurdy, Spradley & Shandy, 2005, pg. 11). I have chosen to continue to use the term informant as I feel it best resembles the type of relationship I had with those I learned from in Ndumo. They were not merely respondents responding to predetermined questions, subjects whom I watched, or participants participating under set research conditions, but rather, they were informing and teaching me throughout the entirety of my fieldwork.

Impacts of Language: Use of Interpreters and Data Sourcing

Learning the language of your informants is one of the many skills an anthropologist is assumed to master. If completing fieldwork is the rite of passage to becoming a social anthropologist, it could be said learning the language is one of its stages. Yet, although often presented as a simple dichotomy of either knowing the language or not, language competency does not fall within this binary framework, but

rather is better suited to be imagined on a continuum. In anthropological accounts of fieldwork however, language competency is often not discussed, nor is the use of interpreters (Borchgrevink, 2003; Gibb & Danero Iglesias, 2017; Tonkin, 1984). If learning the language is an assumed stage in the rite of passage of becoming an anthropologist, discussing one's lack of fluency or one's need for an interpreter may be seen as a taboo to the profession. As Tonkin (1984) explains, "[a]nthropologists are normally expected to 'learn the language', and while most of us try to do so, many of us feel we fail. Since this means failure to measure up to the publically required occupational definition, anthropologists have often taken refuge in silence" (pg. 178). Since Tonkin (1984) wrote about this silence in the 1980's, decades later there has been little headway made to continue this discussion. In a recently published, thoughtfully titled article, "Breaking the silence (again): on language learning and levels of fluency in ethnographic research" Gibb and Danero Iglesias (2017) evaluate the surprising scarcity of articles focused on language given its central importance to ethnographic work. They note: "…relatively few ethnographers have attempted to discuss in detail how their own knowledge (or lack of knowledge) of different languages and their decisions to use (or not to use) interpreters and/or translators during fieldwork have affected the research they have conducted" (Gibb & Danero Iglesias, 2017, pg. 135). To break my own personal silence and contribute to this dialogue, I have chosen to dedicate a section of this thesis reflecting on how language impacted my fieldwork, how I tried to make best use of a translator once I was able to work with one, and how language ultimately shaped where I sourced my data.

I am not fluent in isiZulu and upon entering the field I had a limited working knowledge of the language, despite a few words and phrases I had learned from working in South Africa in 2012. Before I turn to how I tried to make best use of an interpreter during my fieldwork, I must explain that my pathway to getting one was less than straightforward. Ironically, my status as a student is what provided me difficulties in obtaining a translator.

During my initial days in the field, Mbali and I discussed at length how she felt others would perceive me in Ndumo. Being white created an expectation that I had money. She assured me she would let everyone know I was a student and not wealthy like other white people. I was thankful for that status; just as ethnographer, Mark Hunter (2010) explained in his ethnography on AIDS in South Africa, that he was "… always grateful when Bongi [one of Hunter's key informants] told anyone who listened that I was a student who was not rich like other whites…with power comes vulnerability" (pg. 186). Like Hunter (2010), I was aware that my relationships in Ndumo were important for my safety as well as for my research.

Not long after arriving in Ndumo, Mbali and I attended a War Room meeting, a monthly meeting at the community hall where various community members and stakeholders came to address their various concerns. On this day, one community member asked if I would be using an interpreter for my research. Although I was not able to understand the comments that this question ignited, several people were shouting over one another in response. I understood by the climate of the room that this question stirred a heated discussion. Before Mbali could explain what everyone was saying, *Induna* called for silence. He announced in the community meeting that because I was a student

and was here to learn—just as I had explained to him when I arrived—I should *not* use an interpreter. Given that the community workers had learned some English he said, they should use their time with me to practice their English. Before I could interject, people nodded, agreeing with *Induna*, and the next concern of the day was addressed. On our way back to the centre that day, Mbali told me what people were saying at the meeting, expressing that they felt it would be unfair for someone to get paid to be my interpreter if I was not going to be paying the community workers as well. As she was telling me this, I felt my hands get clammy and my heart beat a little faster. I did not know isiZulu. How would I be able to ask for clarification or gather more in-depth data without an interpreter? As I sat and listened to Mbali recalling what others had said at the meeting, she mentioned she agreed with the *Induna*. Here my status of a student, which had previously been of benefit, hindered my access to a translator.

In the weeks that followed I met more community workers and had many informal conversations, but some of these interactions cemented the fact that I needed a translator if I were going to conduct more in-depth interviews. I proposed that as I was a student, perhaps it would be of benefit for another student to be tasked with the role of an interpreter; a student from Ndumo, interested in community health who would be able to converse in both English and isiZulu. I pleaded that it could be a mutual learning experience for the both of us—as students. Through various conversations, it was agreed that this would be the best solution and shortly thereafter, I was introduced to my translator, Amahle.

Given my limited ability to communicate in isiZulu, I had to make use of an interpreter during some of my formal interviews. My informants all had a basic

understanding of English, some much more extensive than others, but the use of a translator allowed for more detailed answers while also allowing me to check my understanding. Axel Borchgrevink's (2003) article, "Silencing Language of Anthropologists and Interpreters", suggests remedies to overcome problems associated with using interpreters during fieldwork, and he argues that " …working with interpreters also has clear advantages compared to struggling along with beginner's knowledge of a new language…for a short fieldwork stay, the advantages of having an interpreter may be the greatest" (pg. 113). Given my shorter, three-month fieldwork stay, I used some of the techniques suggested by Borchgrevink (2003) to mitigate some problems that can arise by using a translator in the field.

First, Borchgrevink (2003) suggests working with a local person. My translator, Amahle, was from Ndumo, and was fluent in English and isiZulu. When I met her she was back home from studying in Durban. Beyond aiding in translation, Amahle acted more as a field assistant. She helped me with transportation to and from our interview sites, *hiking* (flagging down a ride) along the road and communicating where we needed to go.

Second, Borchgrevink (2003) emphasizes the importance of training an interpreter and ensuring he or she understands the objectives of the anthropological inquiry. As such, I attempted as much as possible to explain my interests and objectives of the interviews. I stressed the importance of details within stories, my interests in hearing about different experiences and perspectives, and above all the avoidance of summaries. Not only did I explicitly stress this importance repetitively throughout the research, I also conducted role plays and skits, which inadvertently offered some humour. I would tell a story, and

then give a condensed version which consisted of similar thoughts but left out many details. In doing so I was able to show Amahle that although both of my stories may relay similar messages, details were lost in the summarized version. In addition, I also asked Amahle to come along to formal interviews that were conducted in English in case the interviewee wanted to express something in isiZulu. Unintentionally, this also allowed Amahle to see the type of interaction and environment I was interested in creating during the formal interviews. I distinctly remember one of my first formal interviews that I conducted in English. With the consent from my interviewee, Amahle also sat with us at the picnic table having juice and cookies. After the interview was complete and we were packing up, to my delight, Amahle smiled and said, "That was awesome." I smiled too, beaming in part because I had the same feeling, but also because I was pleased that she was able to experience the environment and structure that I had hoped all our interviews would resemble. Additionally, after each interview Amahle and I conducted together, we would debrief and discuss the intricacies of the interview. Sometimes I would offer suggestions we could work on.

Third, because I was not fluent in isiZulu, I was always diligent to continually double check my interpretations over the course of my fieldwork to ensure I had a solid understanding. This, Borchgrevink (2003) emphasizes, is critical when an anthropologist is not fluent in the spoken language.

Fourth, in my attempt to create a more relaxed environment, I made use of Borchgrevink's (2003) suggestion regarding seating arrangements and eye contact. I was careful about how the three of us sat and to whom I looked at and addressed my questions. The location of the interviews impacted our seating arrangements. Most often,

the three of us would sit in a circle, all facing one another. However, when we were at the picnic table, I would sit beside my informant, directing questions and looking at him or her (Borchgrevink, 2003). I tried to stress to both Amahle and my informants that I wanted to 'talk' and 'learn' from them, rather than use terms such as 'interview' or 'research' (Spradley, 1979; Bernard, 2006). In an additional attempt to reduce formalities I brought along cookies and juice to each interview. Lastly, during each interview I always tried to use greetings and phrases in isiZulu that I had learned (Borchgrevink, 2003), which helped with building of rapport.

Language was also central in deciding where I sourced my data. My interlocutors could speak English to varying degrees and as such day-to-day informal conversations and interviews were in English. My work with Amahle was restricted to my formal interviews. During my daily work at the centre or in the community, I was often around those who spoke English and many, especially Mbali, acted as translators when needed on a regular basis. My data was sourced from over 20 community workers that worked with the TCC over the three-month period. Each had either directly or indirectly worked with the now departed PEPFAR-funded program. Even though a translator was required for my formal interviews, which allowed me the opportunity to ask more follow up questions and clarify my understanding, each community worker had at least a grade 10 education, where they had been taught some English throughout their time in school.

In addition, as rapport is central to ethnographic fieldwork and data collection, I decided to focus my study learning from community workers and not solely on the intended beneficiaries of past aid. I had more interactions with the community workers on a day-to-day basis given my presence at the TCC. This allowed for a mutual familiarity, a

fostering of trust, and a building of friendships. Sociologists Susan Watkins and Ann

Swidler (2012) emphasize that little research has paid attention to the 'brokers'; "the

actual individuals and organizations that provide the critical link between the good deeds

imagined by the altruists and their imagined recipients in the village" (pg. 200). This

study aims to give a voice to the brokers. The community workers, who acted as brokers,

offered a dual perspective. On one hand, they had an emic, insider perspective as they

were from Ndumo and had intimate knowledge of the community. In fact, in addition to

their employment, some of their kin had directly benefited from being clients of the now

departed PEPFAR-funded program. On the other hand, because they were employed as

community workers, this gave them an alternative perspective. Thus, the community

workers had the experience of not only receiving aid but also delivering it.

Data Analysis

From my time in Ndumo, I had filled notebooks and had additional typed notes as

well as transcripts from my interviews, but I did not know how they would all come

together. As a fledgling anthropologist, I was unnerved; I knew I left South Africa with

many stories and countless experiences but I kept asking myself if what I had done was,

good enough (see Scheper-Hughes, 1992). Through my formal analysis of my notes and

interview transcripts, it became clear, however, that I did indeed have a greater

understanding of the work of the TCC and how it had changed over time with the

retraction of aid.

Upon returning from the field, I initially read and re-read my fieldnotes and the

transcripts I had made of my recorded interviews. Over the course of multiple readings, I

began to make memos on re-occurring topics and connected ideas. I then would re-read

them looking for examples relating to those topics. As Bernard (2006) notes, "nothing beats pawing and shuffling through your notes and thinking of them" (pg. 406). Eventually, I followed Emerson, Fretz and Shaw's (2011) suggestion of selecting and prioritizing themes that led to the most abundant amount of data that reflected re-occurring topics of concern mentioned over the course of the study. The three categorical themes by which I sorted my data (Who Counts and When; Valid Services; After-aid Exchanges) were driven by analytic codes as well as words and phrases my informants used, known as *in vivo* coding (Bernard, 2006). Although presented as distinct categorical themes, the three collectively illustrate the impact the withdrawal of aid has had on community social relations. Data analysis, however, in ethnographic research is a continual process, where, "analysis is less a matter of something emerging from the data, of simply finding what is there; rather, it is, more fundamentally, a process of creating what is there by constantly thinking about the importance of previously recorded events and meanings" (Emerson, Fretz & Shaw, 2011, pg. 199).

Ethical Considerations

Establishing my role in the field began on day one and continued throughout the research process. From the onset, I made it clear why I had come to Ndumo and what my objectives were. I asked for permission to take notes during my time in Ndumo. I explained, just as Emerson, Fretz and Shaw (2011) suggested, that my note taking was to ensure I did not miss anything and could record it accurately. There was no objection to this, in fact, there was a mutual understanding, as they viewed my documentation as an essential part of the process of providing evidence. Producing written evidence (for accountability purposes) was demanded of them by funding agencies with whom they

had worked. Throughout my research, sometimes community workers would tell me to make sure I wrote things down, and ask, on the rare occasion I did not have my notebook, to go get it so I could write, making sure I had "proof" of what they said. During the process of taking notes, as well as before any interviews, I was sure to tell my informants that everything was private and therefore I would not be using anyone's real name. Thus, for confidentiality and privacy I have used pseudonyms for each of my informants. I have chosen to do so even though several community workers said they had no issue if I used their real name, with one telling me after an interview, "I am free, Stef, you can use my name if you want." Given the precariousness of employment in Ndumo and in KwaZulu-Natal and South Africa more broadly, I feel it is best to provide each with confidentiality by using pseudonyms as I do not want anything to compromise their current or future employment endeavors.

During my time in Ndumo, I spent a considerable amount of time with my interlocutors, in addition to living with one of my key informants, Mbali. Given this close, continual contact, I took on, what Ken Wilson (1993) explains of many ethnographers, as a dual engagement between the personal and the professional. As Wilson (1993) suggests, I was mindful of explaining the purpose of my research throughout my fieldwork and asking for continual verbal consent. In the section on language, when I previously discussed why I chose to use less intimidating words when speaking with my informants, such as "learn from", or "talk with", rather than "research" and "interview", I was not suggesting that I concealed my intentions or what my role was in the field. The former phrases were better suited to the environment in which I was working. Given my close, continual contact terms such as 'research' and 'interview'

would have been too formal and out of place. An example of my time in the field best illustrates this point.

During my time in Ndumo I had the opportunity to observe South African government employees, such as those working for both the Department of Health and Department of Social Development, interview community workers and as well as, on one occasion, some individuals who were beneficiaries of the TCC. The anticipation of the upcoming interviews created a certain level of anxiousness and frenzy at the centre. Some community workers shared with me that they were nervous to have to speak in English. On one occasion, I was invited to observe during some of the interviews. In the room on the day of the interview, the air felt still, and the interviews were filled with various rigid formalities: the interviewee sat across from the interviewer, there was a three-page ethical consent form—written in English—handed out for the interviewee to sign, albeit no one ever read through the document, and the questions were asked in a robotic, sequential order. I use this example to illustrate why I was careful and chose phrases such as "talk with" and "learn from" rather than "research" or "interview" as I did not want to have my interviews provoke similar feelings or resemble the prescribed environment to those that I had witnessed. Fortunately, they did not.

I was also mindful of how I obtained consent before my interviews. Just as I had obtained consent to write notes during my time in the field, I also obtained verbal consent before my formal interviews. For each of the 20 interviews I formally conducted, verbal consent was sought after I reiterated the intention of my project, the purpose of our interview and what their role was. Furthermore, I explained Amahle's role as the translator, and made it clear that everything said would be private and confidential. Of the

20 formal interviews, 18 were audio recorded after receiving verbal consent from my interlocutors.

Overall, I believe my role as a student wanting to learn and their role as teachers was established and apparent. Over the course of my fieldwork, many thanked me for coming to Ndumo and some community workers even expressed gratitude for having the opportunity to talk with me about their work. I am equally grateful to each of them for sharing their individual experiences and insights with me and it is my intention to thoughtfully portray them and what they taught me respectfully throughout this thesis.

Chapter Five: Who Counts and When? Past and Present Aid Realities

Mundane Practices: Unforeseen Avenues of Exploration in the Field

Mbali and I had arrived at the Themba Community Centre (TCC) shortly after eight. The red soil was still damp with morning dew. Winter was approaching, leaving the nights and early mornings crisp and cool. The TCC, a 20 foot-long, white trailer, was located near Ndumo's main square and was not far from Mbali's house where I lived. Usually the square was filled and bustling about with people and animals alike, but as the mornings grew colder, the days' activities began starting later and later.

Not long after we arrived at the centre on this cool morning, Mbali set out to make some tea and I assumed my usual position at the large metal table, in the middle of the designated "boardroom." Community workers had brought in more registration forms the day before and I helped with sorting, documenting, and filing the forms. The metal legs wobbled as I wrote. One by one, I transferred names and South African identification numbers off the registration forms and logged them into a large black book. The black ledger book had red tape along its spine and painted white block letters that said "Admission Book" across the front. Page after page of the book was filled with names and ID numbers. I added to the growing list, one row at a time.

The pages were split into four columns. In the first left-hand column, was the running number, indicating a tally of how many were logged as beneficiaries of the TCC. After writing the subsequent tally number, I would transfer only the person's full name and South African identification number from the registration form. In the last column, I would jot the corresponding community worker's name next to the beneficiary. I logged this information, form by form, almost every day during my fieldwork. Names and

numbers mattered. The reason for recording the person's name was secondary and had no

place in the Admission Book. Nearly every registration form had boxes checked off

indicating the person "needs support" under headings such as Nutrition, Vital

Documents, Poverty Alleviation, and Treatment Support. What remained our focus,

however, was not the individuals' needs, but making sure every sheet was logged and that

reports were written.

Mbali had come back with our tea and Ulwazi, another community worker joined

us. I placed the forms aside. After sipping our tea, Mbali asked, as she pointed to the back

corner, if I could help them take papers out of some old binders. Eager to have a task

other than writing in the Admission Book, I was delighted. The green two-inch binders,

covered in dust, were filled with hundreds of plastic cover sheets. Each plastic cover

sheet had a registration form tucked inside. These forms, however, did not resemble the

current sheets I was used to looking at each day. They were yellow and pink, and in

another format, but what stood out was the logo in the top-right-hand corner. The

PEPFAR-logo, a globe with a symbolic AIDS ribbon on top, was embossed on every

sheet. I followed Ulwazi's lead, wiping the binders off with an old-ripped t-shirt, and

taking the old registration forms out of the plastic covers. Ulwazi and Mbali wanted to re-

purpose the binders and cover sheets so each community worker could have their own

binder with the current beneficiaries' registration forms. Papers and dust collected around

us, and the pink and yellow forms continued to pile up. Hundreds of intake forms littered

the table and piles were stacked on the floor. I could not help but ask what happened to

all of these people. It seemed to me there was a continual registration of people, and yet,

barely anyone came to the centre. I asked, "Are all these people still registered with the

centre?" Ulwazi, who had been working with the community centre since 2004 and had a wealth of knowledge to share, explained to me in between sorting papers, that "Some, but not all" of the people had been re-registered with the centre since the PEPFAR-funded NGO (PFN) had left Ndumo in 2014; it was "So painful" she explained when they left and "now it is not at all the same as before." Ulwazi, explained that the eligibility in the past was different than it was now. "With PEPFAR" she said "everyone qualified, they saw everyone in Ndumo as needy but now it is so different." As she opened another binder, she looked down and remarked, "Now we are abandoning people."

Ulwazi was one of the fortunate community workers who continued to receive a small stipend (R1800/month; ~ Cdn $180.00) from the South African government—although the remittances were always delayed—since PFN had left Ndumo. Others were let go. This was part of the trouble she explained. People who had been logged and a part of the previously funded program questioned why the community workers who continued to work in Ndumo after PFN departed were no longer visiting them. If they were still working and visiting others, why not them as well?

When I arrived in Ndumo in April 2018, I did not realize that the TCC had been a past recipient of transnational aid nor that my project would chart its course, learning about the impacts and effects this aid had on the lives of the individuals in the community. Though in true ethnographic fashion, this serendipitous event of pulling plastic cover sheets from binders, that cool winter morning, shaped this project.

This chapter explores the afterlife of aid climate in Ndumo that was revealed to me while I assisted with daily administrative duties at the TCC—filling out the Admission Book, filing forms, and writing reports. These mundane documentary

activities allowed me to ask relevant questions and helped me to better understand some of the frustrations the community workers were experiencing; frustrations that were heightened because of the reduction of aid the TCC had experienced. Form-filling practices were essential to the work of community workers in Ndumo and through these practices came rich conversations.

I begin this chapter with a general historical overview of the TCC, explaining when it was established and who has provided funding for the various programs the centre has accommodated over the past eighteen years. I then contrast the differences between various funding bodies and their programs. The chapter closes with a discussion of how various program eligibility criteria have had lasting impacts on the TCC , its community workers, and the social relations within.

Funding: Then and Now

In 2001 the TCC was established by residents of Ndumo and a neighbouring government hospital as a non-profit organization with a mandate to: "support those affected and infected by HIV." Since the inception of the TCC, the centre has been a recipient of state funding from the South African government. Funding, however, has significantly fluctuated over the years. In addition to government funding, in 2008 the TCC also received international aid through the President's Emergency Plan for AIDS Relief (PEPFAR). As PEPFAR's funding is funnelled through implementing partners (i.e. non-governmental organizations) the TCC did not directly receive PEPFAR's funding. PEPFAR's funding came through a large international NGO, whom I refer to as PFN.

In 2008, PFN began working at the TCC, rolling out their PEPFAR-funded Orphan and Vulnerable Children (OVC) programs. During the six-year period from 2008

to 2014, PFN ran their OVC programs at the TCC, parallel to the government-funded programs funded by the South African Department of Social Development. In order for PFN to carry out their various OVC programs throughout Ndumo, community workers were necessary. PFN's initial intention was to hire 25 community workers from Ndumo to implement their OVC programs. However, as I came to learn, there was push-back from the centre. The TCC already had 20 community workers who were at the time receiving a small stipend from the Department of Social Development (~R500/month; ~Cdn $50), to carry out existing community-based care programs (e.g. home visits; support groups) when the PFN arrived in 2008. The community centre leadership did not want PFN to hire an additional twenty-five workers, but instead, supplement the remunerations of the existing twenty community workers and hire only an additional five. "Imagine if they did hire an additional twenty-five people," Mbali told me one day, "they would be doing nothing now." When PFN left Ndumo in 2014 the additional five community workers who were hired when PFN arrived were let go. Of these five whose remunerations was paid for by PFN, Thadie, was the only one able to find work at the TCC as a "multi-skilled" worker after the PFN left. At the time of my fieldwork, the other four were unemployed.

When PFN departed in 2014 the TCC continued to receive funding from the South African Department of Social Development. However, in 2015 the South African Department of Social Development reduced its funding to the TCC by over fifty percent. Since 2015, funding has not increased nor has there been additional aid from international donors. The only funding the TCC was receiving during my fieldwork was the reduced budget from the South African Department of Social Development.

Taped on the vinyl wall of the TCC were past and current budget sheets from the Department of Social Development. I noticed these sheets early on in my fieldwork. Outlined on each yearly budget sheet was a breakdown of how funding was designated. The 2014-2015 TCC budget included funding for fifty food parcels per month; cooked meals for sixty children; money for school uniforms and transport; along with designated funds for training, income generating projects, support programs, and stipends for community workers. Taped next to the 2014-2015 budget sheet was the 2017-2018 re-aligned budget. Although the paper looked newer, with no ripped edges or pen-marks, the bottom column which outlined the overall total budget was strikingly different. The total budget for the TCC in 2017-2018[12] was 53% less than it was in 2014-2015. I glanced back and forth from each sheet, jotting down the differences. When Mbali came in I exclaimed, "The budget was really reduced" pointing to the sheets. There was no longer funding for food parcels and the cooked meals budget was also reduced, with funding to feed only ten children. Although stipends for community workers remained the same, all other programs had been reduced or cut altogether. Mbali was looking down, sorting paper, and continued to nod while I read the differences aloud, as if she was pleased I had noticed. After I was finished, Mbali looked up and said, "You now see [sic] how hard it is. There is no money." Although I nodded, as if I understood, in hindsight, at that point I understood little about what these reductions meant for the TCC and the community workers who continued to work each and every day.

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[12] The beginning of each financial year for the TCC is in April. When I arrived in Ndumo in April 2018, this marked the first month of the 2018-2019 financial year. The budget outline for 2018-2019 was not yet printed and taped to the wall but was identical to the 2017-2018 budget I refer to above.

During my fieldwork, I did ask if the centre had any budgetary outlines from PFN. Although they did not have any past documents that stipulated how much funding was provided to the centre by the NGO or any outlines on how the money should be spent, one community worker recalled, "Every time we needed anything [when PFN was here], we got it." To the community workers in Ndumo, whatever budget the NGO had from PEPFAR seemed irrelevant as PFN had an endless supply of resources to bestow.

While funding reduction meant that the TCC no longer had access to certain material goods, it also meant something greater: program contractions. When the NGO left in 2014, the programs they had initiated—holiday clubs, afterschool clubs, retreats, home visits—also stopped. This is not unique to Ndumo, but is a common reality in many communities across the Global South who are the recipients of transient global health interventions. While programs come to an end, the community workers who were key brokers in executing the programs locally remain. For many community workers across the Global South, the contraction of one program could mean their work comes to an end (see, for example, Moyer & Igonya, 2014) but it could also mean that they take up a new position working for the next program being rolled out (see, for example, Busza et al., 2018). In Ndumo, many of the community workers who worked for PFN also worked in Ndumo as community workers prior to the arrival of the NGO. Similarly, many continued to work as community workers after PFN departed.

Since the departure of PFN from the TCC, the PEPFAR-funded OVC programs have come to an end but some of the South African-funded programs have continued. Even though the TCC community workers continue to work in Ndumo fulfilling the requirements set by their current funder there have been significant changes to programs

at the centre since 2015 when funding was dramatically reduced. In this chapter, the

focus is not on the programs specifically, but rather about exploring who was included

and excluded within current and past funded-programs. While community workers have

always worked with residents of Ndumo, who they work with *on paper* is largely decided

by their funder. In the following sections, I will contextualize the differing inclusion

criteria set by the various aid programs at the TCC and further demonstrate how they

have had a lasting impact on community social relations.

Current Realities: Who Counts Now?

"We do [an] assessment [and] we look at the need of the family; what they need.
Then we intervene with and assess and help according [to] their needs. Like when they
are staying with their grannies we help them focus on education, then we help them to do
homework supervision…we focus to those [sic] that are at risk and vulnerable or those
that are orphans. My focus is on those [sic] that are using ARVs to help them, to remind
them [to take] their pills before they go to school and how [to] prepare food to eat before
they use [sic] their ARVs." – Unathi, community worker

The community workers at the TCC worked with both children and adults in

Ndumo who needed extra assistance. For example, adults who were unemployed,

individuals who were sick (e.g. HIV or TB), children who lived with grandparents or

other family[13] members. Lack of employment opportunities in the area resulted in abject

poverty and limited money was available for food and other basic necessities. Just as the

community worker quoted above told me she focused on those who were at risk and

vulnerable, others told me they worked with the "sick", "needy" or "poor people." Within

the current program, the assessments community workers conducted before enrolling a

family were holistic in nature. There were no rigid guidelines in the current program at

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[13] A Zulu family does not resemble a Western nuclear family. Often those that are called brothers, sisters,
aunts or uncles are not blood-kin.

the TCC dictating who could or could not be eligible, this was left to the judgement of the community workers. Many reminded me that it took time and it was not "check, check, check" on a sheet but rather getting to know a person and their family. Since the community workers lived in Ndumo, others would sometimes let them know of a family that was struggling and they would then conduct a home-visit assessment. While there was no "check, check, check" on a form that dictated who could be enrolled, the enrollment was dictated by strict target guidelines and one condition: the individual enrolled must possess a South African identification card. These targets and document guidelines were set by their current funder—The South African Department of Social Development.

Targets and IDs: Who Is Included Now?

"They have nothing to help the community, but they have big targets." – Nandi, community worker

Sixty. Sixty families in total. I asked the same question to every community worker I spoke to: "How many families do you have now?" There was never any hesitation from the community workers in answering this question and notably the answer was always the same: sixty. According to their current funder—The South African Department of Social Development—each community worker was required to have sixty families enrolled every year. As I was in Ndumo at the start of a new financial year, annual registration forms were circulating at the TCC on a daily basis. In reality, I learned these families rarely change year-to-year, as one community worker explained to me, "There are no new families because we can't do anything, we just keep registering the same people." However as per their funder's requirements, each year, families needed to be re-registered.

The registration forms asked for generic information such as name, date of birth, employment status, along with the needs of the individual. What was also required was a photocopy of each individual's South African ID. Under the funder's direction, every adult or child registered with the TCC also had to have a South African ID card.[14] The card had to be given to the community worker so it could be photocopied to accompany the registration forms that were logged at the TCC and then sent to a municipal office.

Given the geographical location of Ndumo, bordering eSwatini (formally, Swaziland) and Mozambique and the political-history of migration and violence in Southern Africa, many families who resided in Ndumo were not South African, and therefore many residents did not—and could not—obtain South African identification cards. Moreover, many South Africans in Ndumo who were formally eligible to receive an ID did not have one. The bureaucratic process of obtaining an ID was fraught with difficulties and costs associated were prohibitive for many residents in Ndumo (also see, Epstein, 2007; Decoteau, 2013). While this meant that those without "documents" were not eligible to be formally included in the TCC current programs, it also meant that these residents were not eligible to receive any government-funded financial grants (e.g. disability grant; old-age grant; foster-care grant). While each community worker in Ndumo knew the target number they had to meet, they were also well aware of the document conditionality.

One afternoon as we were finishing a monthly report in which we tallied how many individuals received assistance with the TCC in the past month, I asked Mbali and Ulwazi what would happen if the set targets were met but the condition of having an ID

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[14] Children could have birth certificates, however, for our purposes, I refer to all of the documents as South African ID cards.

was not. As I handed the next registration form over to Ulwazi, after I finished making a record in the Admission Book, I continued, "Would it have been a problem if you were only feeding 30 kids with IDs and the rest without, even if you had met the target?" Simultaneously, Mbali and Ulwazi shook their heads, "Yes!" Mbali exclaimed, "they would cut the money! They would cut the money because it would mean we have 30 [and] we don't have 60." Even if the TCC met the target number, having the appropriate documentation to accompany the target number was just as important. While targets mattered and were symbolic of the TCC's success, these targets had conditions; conditions that meant some people could not be included if they did not possess the appropriate documentation. If the targets or conditions were not met, as Mbali explained, funding would be cut.

To Mbali and other community workers in Ndumo the "neediest" people (i.e. those without documentation) were "left behind" under the current program guidelines set by their funder. While she always told me the TCC and community workers were "failing" she did not mean they were failing in the eyes of their funder—the TCC and community workers always met the set targets—they felt they were failing their community as they could do little for those truly in need.[15] As one community worker put it, "The very needy people are those [that do not] have document[s], and at the same time the department [does] not allow them to get the services; it is painful." This documentary condition was unique to their current funder and differed from when PFN was in Ndumo. I now turn to explaining PFN programs' conditionality and eligibility in the next section.

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[15] Given the opportunity for those with proper documents to access state-funded grants if they met certain criteria (i.e. they are of a certain age; cannot work due to disability; are care-givers of 'foster' child(ren)) not having an ID could mean that a family homestead is without any financial assistance at all.

PEPFAR-Funded OVC programs: Who Counted in the Past?

In 2005, two years after President George W. Bush established the President's

Emergency Plan for AIDS Relief (PEPFAR), the US Congress passed an additional piece

of legislation that mandated that 10% of PEPFAR's funding should be directed to

"Orphan and Vulnerable Children" programs (see Reynolds, 2014a). In 2006, a year after

the funding for OVC was mandated, the *2006 Orphans and Vulnerable Children*

Programming Guidance was released. This document was the first attempt at formally

defining the "OVC" categorisation. According to PEPFAR's 2006 Guidance an OVC is:

"A child, 0-17 years old, who is either orphaned or made more vulnerable *because of*

HIV/AIDS" (PEPFAR, 2006, pg. 2; emphasis added). By virtue of their definition, the

OVC funds were targeted at children who belonged to a specific, albeit narrow,

biomedical category. This limited focus, however, went against other dominant narratives

at the time set by other larger global organizations such as UNICEF and UNAIDS, which

stipulated that singling out children based on a biological condition should be avoided as

this could lead to further stigmatization and discrimination as well as exclude other

children who were also in need of extra care (see Reynolds, 2014a). Although PEPFAR's

2006 Guidance provided a formal definition of OVC, in the same publication it was

stated that: "the above operational definition identifies those [children who] are

potentially eligible for PEPFAR supported services…[f]or programmatic decisions, *each*

community will need to prioritize those children most vulnerable and in need of further

care" (PEPFAR, 2006, pg. 2; emphasis added).

Anthropologist Lindsay Reynolds (2014a), conducted field research during the

implementation of one PEPFAR-OVC program in northern KwaZulu-Natal in 2007-

2008. She found that who was ultimately included within PEPFAR-funded OVC programs was largely left to the various implementing partners on-the-ground. Reynolds (2014a) concluded that because of the "inherent ambiguity of the category and the clearly articulated 'flexibility' given to programmes in terms of implementation, organizations had a great deal of space in the end to adapt the provisions of PEPFAR policy to suit their needs" (pg. 133). Reynold's (2014a) finding is in line with the stories I heard in Ndumo. As I came to learn, from PFN's perspective, the ambiguity of the category of "OVC" meant that many children in Ndumo were eligible.

One afternoon, before leaving to attend a community meeting at the local library, Ulwazi, recalled PFN's prioritization of OVC while we sat on the broken, crumbling concrete step outside the centre. "You see the difference, Stef" she said to me, "with [PFN] they came here and saw all the children as needy." As Ndumo is a rural and remote area in KwaZulu-Natal—the province that bears the highest rates of HIV/AIDS in South Africa—it is unsurprising to learn that PFN, an international NGO, classified many of the children in Ndumo as 'OVC'. Given the ambiguous category, arguably everyone has been affected by HIV in the area given the prevalence of the virus, and therefore could be classified as being made more "vulnerable" because of HIV/AIDS.

Ulwazi and I had spent nearly every day together since I arrived in Ndumo. On this afternoon in late June, Ulwazi had seen me conduct several "formal" interviews with other community workers and while I arguably had conducted several informal interviews with her at this point, she stopped mid-conversation and said, "Maybe you should go get your recorder." Parts of our conversation that afternoon are quoted in full,

as Ulwazi explains some of the parameters of who was "counted" under the PEPFAR-

funded OVC program in Ndumo:

> Ulwazi (U): Even my child. I am working here [at TCC], but they [PFN] would take my child as their client as they believe that even my child need [sic] to play at the safe park as playing is the need [sic] of the child. You see the difference with DSD [Department of Social Development] now? DSD only enroll [sic] the needy children. That is why [PFN] end [sic] up having the BIG number[s]. They believe all children have different needs, even mine. When they supervise my clinic card [immunization record] for my child, they would encourage the one who is looking after my child to go to take the child [to the clinic]. They would count that as a service. If they come [sic] to my house, they could count it as a service, and say, show us your clinic card for that young one. They [would] count it as a service. If they say, come to the safe park and play, they [would] count it as a service, yes.

> Stef (S): So, they had big numbers …

> U: YES! That is why at the end we have [sic] big numbers. They say, prevention is better than cure. They say that.

> S: Prevention is better than cure.

> U: Yes. Like I told you before, if they encourage the person [sic] who is looking after my child to go to the clinic, they say it prevent drops of immunizations, you see, and they count it as a service. If they collect all the children and bring them to come and play here, they say that prevents children from going to strangers and stealing somebody's things, they believe [sic]. It all counts as a service…

> With PEPFAR there doesn't have to be [a] problem, they prevent those things …They are taking the routines of America in compared [sic] to South Africa routines, you see. Here, Stef, maybe here is an example: to raise a child as white is not the same as black, you see. Your child, usually they say you have to have his or her [sic] own bed, from, I am not sure. But ME, I have to sleep with my child maybe until three or four years. But you as white, you don't sleep with your child, your child has their own bed, you see what I am talking about. That [is why], PEPFAR see that [sic] so many things that are lacking on our children [and] that is why they take all children as needing [a] service. Even though the children may be getting [a] grant, or has [a] good parent, they include that child in their programs, that is why they have so many children…

> Even here, we eat food anytime. If I see this orange I have to eat [it], but through PEPFAR they say [we] have to have eating routines you see. On their forms, they ask you how many meals you get per day. You end up not knowing how to answer that question. Because here, anytime you need food you have to take it, but according to PEPFAR they have to have three or more meals per day, you see, there is a difference. That is why I say sometimes [they] compare our lives to their lives, yes. That is why they end up enrolling us.

> S: Ahhh I see, so by comparing your life to their life they thought there were more needs.

U: Yes!

S: Because it would be like, if I didn't eat at set meal times and someone asked me how many meals I ate yesterday, I may say umm one…

U: (laughs) Yes, you say one

S: But if they heard one, they would say oh no…

U: Yes! YES! (laughs) They [would] have to take you to malnutrition, what, what, what, (laughing) thought you were having malnutrition, you see.

S: But in reality, you were just eating whenever you wanted, no set meals

U: Yes, you see

S: Yeah, I see (laughs). Different ideas for eating and sleeping…

Ulwazi continued to outline the differences between what she termed "American" and "South African" ideas for raising a child. As her conversation with me outlines, through her eyes, PFN based their eligibility on "American" ideas of who was in need and therefore should be included. She found it comical that PFN would deem a family as "needy" and therefore include those children in their programs, even when that child had parents who were working—like she and her husband—and were well looked after. However, despite these differing perspectives, PFN's programs were underscored by the common HIV global health ideology, "prevention is better than cure." To program implementers in Ndumo, all the children living in rural KwaZulu-Natal, an area with the highest HIV prevalence rates in the world, were deemed to be "at risk" and therefore eligible to be included in their PEPFAR-funded OVC programs as they saw their programs as a prevention measure. Notably, just as Ulwazi explained, even if a child only came to afterschool club once a month or a community worker only visited a house to check for immunization records, these once off "services" were counted and thus added

to their overall number of children served by PEPFAR's OVC funding.[16] It is no wonder

they had "big numbers." Given this information, it is not surprising to learn that

PEPFAR-funded OVC programs in South African have reportedly served 1,270,567

children and their caregivers to date (PEPFAR, 2018b).

While the sheer number of children included in the now departed PEPFAR-

funded programs far exceeded the number of children and families receiving services

under the current state-funded program in Ndumo, there was another notable difference.

PFN worked with children and families regardless of whether they had South African ID

cards. As one community worker put it: "PEPFAR didn't care if a person had any

documents, they saw them as human beings that need care."

Clearly, PFN and the South African Department of Social Development, had

differing inclusion criteria. While all children and their families were seen as "needy"

under PFN, with the current programs, only a limited number of families can be

included—and only if they possess the appropriate documentation. Notably, as I came to

learn, as community workers in Ndumo and across the Global South are often enlisted to

carry out multiple programs, either concurrently or consecutively, the lived realities of

such work is fraught with ambiguities.

The next section will discuss the lasting impacts these ambiguous eligibility

criteria have had on the current work of community workers. While PFN's programs had

come to an end and the NGO had physically disengaged, I argue that rather than a

complete erasure, PFN's past programs were a phantom disengagement, as their presence

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[16] Reynolds (2014a) also reported similar recording and quantifying measures in the PEPFAR-funded
OVC program she oversaw in KwaZulu-Natal, South Africa.

was phantom-like and continued to have a lingering impact on the work of community workers, often inflicting moments of emotional pain.

Who Is Counting? Why There is Always "More Outside the Book"

"It was painful for the clients, because we [the community workers] do understand, they [the families] do not understand. They already see us working, but I am working to [sic] you, but I am not going to that other family. But I am still working, [do] you see that pain?" – Khanyisile, community worker

When PFN left Ndumo in 2014, not all the individuals who were included in their programs were transferred to the government-funded program, as Ulwazi and Mbali explained to me that cold morning while we were dusting off and re-purposing old binders. Not only were PFN's OVC programs larger than the current government-funded program, they had a broader eligibility criteria. Thus, there were hundreds of individuals in Ndumo who were included in the PEPFAR-funded program that were no longer enrolled as beneficiaries at the TCC. To Ulwazi and others, the individuals who were not transferred were those they referred to as being "abandoned." Given the size of the PEPFAR-funded program compared to the government-program, it was inevitable that many would not be able to be formally included within the government program. What proved to cause problems was not how PFN exited, but rather what remained after they left.

Many of the community workers who worked for PFN continued to work for the TCC after the NGO departed. They were, in many respects, continuing to work as they did before. Community workers continued going door-to-door conducting home visits with families, albeit the total number of families decreased significantly. This similarity between the past and current programs proved to be problematic as one community worker explained that the families she visited did not understand the difference between

the two programs. As she put it, "We were still working." In other words, the community workers' daily work still looked very much the same even though the programs and their funders had changed considerably. As one community worker explained, it was as if "they"—the community workers—were choosing to leave certain people behind. The varying programs and inclusion criteria, although clearly defined on paper proved to be problematic in practice.

It had been over four years since PFN had physically disengaged from Ndumo when I conducted my fieldwork, but their presence still lingered. While in theory program contraction suggests that the programs come to an end, the community workers who I spoke to in Ndumo did not experience such a clean break. I was speaking with Nonthlanhla, a community worker, one morning about her work and I asked the same question I asked everyone: "How many families do you work with now?" Although she, and everyone else, always said sixty, Nonthlanhla, also said something else: "Sixty in the book." Curious about what she meant when she said "in the book", I asked, "Do you have more outside the book?" She nodded, "*Yebo"* (yes) she said, and explained to me that because she already had sixty families, which met the target set by their current funder, she did not formally record the additional visits with other families. In addition to visiting the families enrolled in the current state-funded program, she would also visit additional families that were previously enrolled in past programs. Going forward I was sure to ask other community workers if they "had more outside the book" and each of them shared stories with me about visiting more than their set sixty families. Despite Nonthlanhla and other community workers in Ndumo meeting their targets and completing the work mandated by their current funder, they did more, *outside the book*. While the PEPFAR-

funded program formally had ended, the program had lingering effects as community workers continued to visit many of the families that had been included in the past—a phantom disengagement.

While the success of community-based care rests on the ability for community workers to establish trusting relations with the families they visit (see for example Bhattacharya et al., 2001) my research in Ndumo suggests that these relations cannot be withdrawn at the end of a time-limited intervention. Although the interventions are transient, the relations established during these programs are not. For community workers in Ndumo, to stop visiting families that they had been working with under previous funded programs felt like personal abandonment. Despite their efforts to continue to visit people who were enrolled in previous programs, given the sheer size of the previously PEPFAR-funded program, community workers did not feel their efforts were adequate, expressing that they felt "demotivated" and there were still people who were "abandoned."

This research finding is concomitant with the findings from a recent qualitative study conducted in Zimbabwe (Busza et al., 2018). Busza et al. (2018) sought to understand community health workers' experiences withdrawing from households they were assigned to during an 18-month research study concerning HIV testing and children. At a "reflection meeting" 11-months after the research study had ended, Busza et al. (2018) found that all the community health workers said that they had not "exited" from households they had been assigned to during the study, as was expected, but rather, they continued to have contact with the families. Moreover, just like the community workers I spoke with in Ndumo, the community health workers in Zimbabwe felt that ending all

contact with the families after the study finished felt like abandonment (Busza et al. 2018).

I argue that the reasons for understanding why Nonthlanhla and other community workers visited more families "outside the book" comes from a deeper understanding of their social milieu. Busza et al. (2018) speculated that the reason why the community workers did not disengage was because of their "community embeddedness" (Schneider et al., 2008, pg. 180). While the term suggests that community workers are physically embedded, living in the same community they are working in, being embedded also speaks to the social obligations that are intrinsic to belonging in such a community. Furthermore, without an appreciation of these dynamics, Busza et al. (2018) concluded that it would "prove more fruitful to proactively address the emergence of social bonds…working with CHWs [community health workers] to develop context-specific *strategies for creating personal boundaries*" (pg. 7, emphasis added). Teaching "strategies for creating personal boundaries" in sub-Saharan African countries fails to acknowledge the social worlds the community workers are living within. The very notion that individuals can create personal boundaries rests on seeing people as individual autonomous agents. This is a very Western-centric view of an individual. Personhood, however, is not universal or limited to this bounded-individualistic view, but rather, in many contexts, such as in southern Africa, people are constituted by their interpersonal relations with others (Chabal, 2009; Comaroff & Comaroff, 2001; also see Chabal & Daloz, 1999; Scherz, 2014; Smith, 2003).

While Busza et al. (2018) argue that social bonds need to be managed and boundaries need to be set, the fostering of social networks with others is fundamental to

one's sense of self and belonging in Africa, acting like a "currency of association" (Chabal, 2009, pg. 48). It seems unlikely that teaching community workers strategies to create artificial and foreign personal boundaries in these contexts would, in fact, have any real impact on changing their behaviour. The lack of disengagement was not a result of a knowledge gap that community workers could be taught but rather was a result of the relational social world in which they lived and worked. Just as Kaler & Watkins (2001) explain from their work on family planning programs in Kenya, we, as social scientists, must be attentive to "the multiple roles that providers play and the ways in which their status of providers can be intertwined with their extraprofessional lives [to]… help to explain anomalous results" (pg. 266).

Importantly, the process of tabulating and documenting, that is "having people in the book", is mediated by social interactions between those counting and those being counted (see Pigg, Erikson, & Inglis, 2017; also Reynolds, 2014b; Whyte et al., 2011). Social relationships were formed between community workers and families while PFN was present. Just as anthropologists Maes and Kalofonos (2013) found in Ethiopia and Mozambique, while there are a variety of reasons why people become community workers, many remain in their position because of the relationships they form with their clients. Having large enrollment under the previous PEPFAR-funded program created a further strain on community workers and their social relations, as once the aid was retracted, community workers felt that they had a personal obligation to keep visiting. Families would question why the community workers continued to visit other households but not themselves and as a result, many community workers in Ndumo continued to visit some families "outside of the book" long after the PEPFAR-funded programs were

withdrawn. This continued contact with families in the afterlife of aid can be better understood by unpacking these social relationships. In many ways, the relationships community workers formed with their clients also made up their own sense of self. In other words, the community workers' own personhood was constituted by these relationships with their clients (see Comaroff & Comaroff, 2001; also Chabal, 2009; Ferguson, 2013). Therefore, the lack of disengagement between community workers and their families is more complex and socially embedded and cannot simply be mitigated by teaching community workers how to forge "personal boundaries."

Further, in their concluding remarks, Busza et al. (2018) explained that "CHWs' [community health workers'] willingness and ability to forge enduring emotional bonds could threaten programme delivery" (pg. 7). Rather than place blame on the brokers who are tasked to carry out these short-lived interventions, it would be more productive to address the way in which fleeting global health interventions and studies insert themselves into communities across the Global South. These studies and programs may be short lived, but the people who were commissioned to carry out these programs remain after they end. Rather than focus on program delivery in its current form, global health interventions should be integrated into existing government programs, building local health systems that do not depart once time and money has elapsed.

The last section of this chapter returns us to the TCC on that cold morning when I was writing names into the Admission Book. While names were recorded into the Admission Book and registration forms were sorted, people were further reduced to numerical data points, tabulated on sheets within monthly reports. Form filling practices and tabulating numbers has always been central to the work of the community workers at

the TCC. The PEPFAR-funded programs and government-funded programs at the TCC both required that forms were completed and monthly reports were written, tabulating how many people received 'services' that month. The focus of the next section brings us back to critically examining the social life of documenting, asking why numbers matter and to whom? In addition, this section also explains the social realities that existed in Ndumo after PFN left, discussing the possible consequences of enrolling so many people.

What the Numbers From Ndumo Can (Not) Tell Us?

Numbers are at the center of evaluation measures within global health programs. Without a thorough understanding of how numbers are produced and processed, numbers come to be seen as objectively factual markers of success (see Adams, 2016; Merry, 2011). Rather than assume numbers represent a universal success story, my time in Ndumo destabilizes our confidence in attributing success to a number. While meeting targets and counting services on paper is often taken to be indicative of effective programing from the perspective of donors, to those on-the-ground in Ndumo, quantifying as a measure of success not only obscured the needs within the community but also inadvertently imposed more work on community workers, putting strain on their social relations after such programs ended. PFN had physically left in Ndumo but it was a phantom disengagement, as PFN's open inclusion criteria which inadvertently enrolled many people within their programs produced high levels of abandonment in the afterlife of aid. These feelings of abandonment, were phantom-like, acting as daily reminders of the past.

I asked Mbali while we were filling out a monthly report if the TCC always met their set targets. "Always", she said, "if not, funding would be cut." While there was

always talk among community workers at the TCC about the myriad of difficulties they were facing, such as lack of money for food or transport, the monthly reports, which tallied how many people received services at the TCC, lacked any mention of these daily concerns. Numbers appeared neatly in the columns. In Mbali's words, the reports are sent off "sealed, done, and dusted."

Forty-eight "indicators" were listed in the first left-hand column of the TCC's monthly reports. All the indicators began with the same phrasing: "the number of …" and varied from the "number of adults receiving antiretroviral support" to the "number of beneficiaries receiving psychosocial support services." In the columns to the right, the corresponding numbers followed. While the numbers were tallied and stood in as objectively factual markers (see Adams, 2016; Merry, 2016), quantifying the work that the community workers accomplished each month was a social process. Some indicators, such as how many adults were receiving medication were easily quantifiable, while other indicators, such as psychosocial support, were more ambiguous. As Merry (2011) explains, there is a push to also quantify qualitative markers. As such, in an attempt to quantify the psychosocial support provided to clients by community workers, proxies were used to help with counting: how many adults they referred to the clinic, or how many patients they counseled and taught about health and wellbeing. More significantly though, these numbers could not indicate the depth of care the individual received (see also Fan, 2017; Reynolds, 2014a) or what happened after the individual was referred. In Ndumo, the same people were usually reported month after month because there was little that could be done to assist them given the reduction of resources. However, as the targets were met, these numbers stood in as a sole means of success, regardless of

whether the 'service' had failed to help the individual (see, for examples, Adams, 2013; Fan 2017). While there were ongoing challenges behind those numbers tallied in monthly reports, meeting the targets meant, as Mbali explained that "Ndumo is okay."

Tying funding to set requirements is commonly referred to as "performance-based financing." This type of financing model is seen across various global health programs (see for example, Fan, 2017; Reynolds, 2014a). As Fan (2017) argues, as funding is tied to meeting set targets, what matters is generating sufficient numbers, not providing context to what these numbers actually mean. To Mbali and other community workers in Ndumo, they knew that they had to meet the targets and conditionality set by their funder or funding would be cut. While there were frustrations in regard to the limited care they could provide, there was no place for these details in their monthly reports. As Mbali explained, "For someone who is up there [in the government], they will say, 'Oh Ndumo is okay,' yet we are struggling. They push that we meet the targets. They don't care [about] the challenges." By looking at the monthly reports, it appeared as if "Ndumo [was] okay" as the monthly targets were met. However, there were various daily challenges, such as not being able to tend to the immediate, often material needs of those they were visiting, that could not be reduced to a number.

Even though numbers may fail to provide a full and complete picture, they are commonly needed in global health programs as they are accountability markers (see Erikson, 2012; also Adams, 2016). Whether it be governments, NGOs or private donors, numbers allow for "evaluation at a distance" (Erikson, 2012, pg. 375). While in practice, accountability measures, such as providing monthly reports, allow for the TCC to be accountable to their funder, their funder is not directly accountable to the individuals who

are tallied in their reports.[17] As one community worker explained, "They have nothing to help the community, but they have big targets." While there is no simple solution on how to measure accountability, anthropologist China Scherz (2014) presents a viable alternative. Scherz (2014) suggests that if donors and their implementing partners actually spent an extended period of time in the communities they are purporting to help, they may then be subjected to the demands of belonging in that community. In doing so, Scherz (2014) foresees that the potential relationships that might result from the prolonged stay would then prevent donors and organizations from moving from place to place. While this would mean less people could be counted and tabulated in reports, the exchange she suggests, would lead to actual improvements and change in people's lives (Scherz, 2014).

While Mbali shared her frustrations about their current monthly reporting practices, similar enumeration practices and reports were also required with PFN during the implementation the PEPFAR-funded OVC programs in Ndumo. As Ulwazi explained to me one day, shaking her head, "There was too much work, they always wanted proof." Ulwazi was comparing PFN's reporting criteria and documentary practices of the past to their current work. I learned that their current monthly reports paled in comparison to the forms and documentary practices they had to fill out in the past. In many ways the community workers were well socialized to the need of these documentary practices and "producing evidence" when PFN was present.

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[17] Sullivan (2017) made similar arguments from her work in Tanzania, where she found that while various actors in the health arena practice forms of accountability, they are not accountable to the citizens they are purporting to help.

One conditionality of PEPFAR's funding required recipient organizations to provide reports to the US Congress. Similar to the current reporting realities in Ndumo, the reports sent back to the US Congress compiled number counts of children who received "assistance" under their OVC programs (see Reynolds, 2014a). As is the case in performance-based-financing, PEPFAR's funding for implementing organizations was tied to the number of children they helped. In practice, as Reynolds (2014a) explains, this meant there was a "push for numbers [which] created even greater pressure and competition within and between organizations for children to count" (pg. 137).

According to PEPFAR's published reports, as of 2018, PEPFAR's OVC programs have reportedly provided support and services for over 6.4 million 'orphans and vulnerable children' and their 'caregivers' (PEPFAR, 2018a). Of the 6.4 million, over 1 million were located in South Africa alone (PEPFAR, 2018b). Importantly, targets that were mandated each time PEPFAR was re-authorized were often met and surpassed (see Reynolds, 2014a), celebrating PEPFAR and its programs as a triumph of success (see Kaiser Family Foundation, 2019a).

As Ulwazi explained, based on the realities of who was included within PEPFAR's OVC programs in Ndumo, it is no wonder that PFN considered "everyone as needy." Increasing the number of children enrolled was indicative of effective programing but it also could secure the NGO more funding. As Reynolds (2014a) cautions, in practice, there are uncertainties that arise when policy makers and their partners determine who is included within their funded programs. As a result, she argues that "there is a need for greater attention to the long-term efforts of such uncertainties on

the experiences of…the individuals tasked with delivering services" (Reynolds, 2014a, pg. 140).

From my time in Ndumo during the afterlife of aid, I illustrate a long-term unintended consequence of enrolling too many people. While on one hand, to PEPFAR and its NGO in Ndumo, having many children enrolled meant that many children had "benefited" from the aid, on the other hand, within the afterlife of aid context in Ndumo, it meant that many more children were "abandoned." These feelings of abandonment because of PFN's broad eligibility criteria are one of the ways aid has had an afterlife in people's lives.

To conclude, while the current monthly reporting practices in Ndumo illustrate that context is lost when people are tallied into columns on a page and cannot measure if, in fact, people's needs are met, enumeration practices of past programs have also had lasting effects in Ndumo. Counting more children allowed PFN to sustain their funding and was a marker of their success. However, for the community workers in Ndumo who implemented PFN's programs, not only did their counting make little sense while their programs were ongoing, but in the afterlife of the intervention, the community workers felt as if many were "abandoned" because of their open inclusion criteria. Anthropologist Joanna Crane (2013) refers to this as an "'uneasy symbiosis' of collaboration and discontent" (pg. 11). Rather than time-limited programs inserting themselves parallel to government systems, these programs must be integrated into local health-systems to ensure they adequately address the needs of individuals on-the-ground. Who should be "counted" should not be determined by individuals in boardrooms far removed from

those they are trying to help. As was experienced in Ndumo, counting too many people

can have lasting—destabilizing—impacts on social relations.

Chapter Six: The Afterlife of Aid: A Time of Loss and Longing

Current Services: "Just Talking, Encouraging but Not Valid"

Mbali sat at her desk, jotting notes on a scrap piece of pink paper, fretting about what she was going to say. On this particular day, community workers, Mbali, Ulwazi and I were invited to a "My life, My future" event at a local high school. In the written invitation that we received a week prior, the school requested that a representative from the Themba Community Centre (TCC) speak about some of the "social ills of society." While I was told "social ills" could mean we could discuss a variety of topics such as teenage pregnancy, HIV, or substance abuse, Mbali and Ulwazi agreed that the TCC should speak about teenage pregnancy. The topic was timely as at a community meeting a few weeks prior, the clinic announced that four teenage girls had given birth that month. Mbali exhaled and put down her pen, turning to Ulwazi and I, exasperated by her task, she remarked, "It's not like they don't know what we are going to say. They have all heard it before!"

Since the PEPFAR-funded NGO (PFN) departed Ndumo in 2014 and governmental funding had been greatly reduced in 2015, community workers' daily work involved teaching and counseling families they visited. Just as Mbali was frustrated about speaking about teenage pregnancy—one more time—other community workers shared similar displeasures that all they could do now was "talk", "educate", or "refer." Formally, the community workers were providing what is termed as "psychosocial support" to families in Ndumo. However, as I came to learn, community workers and the families they visited did not view "psychosocial support" as a "valid service."

This chapter explores some of the current realities of being a community worker in Ndumo in the afterlife of aid context. Spending time at the TCC each day and speaking with community workers, I was able to better understand the realities of their daily work. During informal conversations as well as in interviews, community workers shared some of the difficulties they were experiencing with the vast reduction of resources.

This chapter is divided into four sections. In the first, I explain some of the "services" that were no longer offered as a result of the funding freezes. Second, I discuss some of impacts that the loss of these "services" has had on patron-client bonds between community workers and their clients. Finally, this chapter closes with two discussions. One discussion is centered on the loss community workers felt in the afterlife of aid, as their perceived status as valued patrons diminished. The other discussion explores the necessity of food, viewing the commodity not only as a means of nourishment but also as a means of sociality.

Valid Services: What Makes a Service Count as "Valid"

Since PFN had left Ndumo and governmental funding for the centre was reduced by over fifty-percent, various material resources were no longer available. Food parcels and school uniforms, for example, were no longer available for community workers to distribute to the families that came to the centre or whom they visited at home. Support groups and community events were discontinued. As one community worker explained, "We can't bring people together and not provide a meal or some sort of food." Children were rarely brought to the TCC to play and there had been no events or retreats for children to attend since PFN left Ndumo in 2014. Additionally, in the past, the government allocated funds for a program at the centre to feed 60 children, however, the

current-reduced budget only formally provides funding to feed 10 children. While funding reduction meant that several material resources were no longer available for the beneficiaries of the TCC, the loss of funding also impacted the community workers themselves.

The TCC was quiet on most days. Despite community workers coming and going, rarely anyone else came to the centre. I had a difficult time at first understanding what happens when a person is actually enrolled with the centre. I logged registration form after registration form into the Admission Book that had check marks beside boxes indicating, for example, that a person "needs nutritional support" or "needs poverty alleviation." No one seemed to talk about the needs on the sheet of paper, however. Our energy was focused on making sure we logged the names and filed our reports. "If there are no resources, what is the TCC doing anyway?" I wrote in my field notebook early on in my fieldwork.

One day, while Sizwe, a community worker, and I sat in the boardroom, I pulled the next registration form from the stack beside me and I asked him: "What do we do if someone needs nutritional support?" pointing to the sheet, which had a check-mark in the appropriate box. "Nothing!" he quickly remarked. After a few seconds of silence, Sizwe, added, "Also counseling on home visits." Sizwe's perception that they were doing "nothing" was shared among other community workers as well.

As Ulwazi explained one day, "All we do now is talk, just talking… not valid services, like [giving] food parcels or school uniforms." Community workers visited families daily on home visits. What they could do or bring with them on these home visits had changed considerably over the years, as now they were restricted to only

offering psychosocial support. As such, much of what was offered in Ndumo was teaching and providing moral support to the families they visited. Topics community workers spoke about with the families varied but included information about HIV/TB and treatment support, importance of children attending school, proper nutrition. As Mbali explained to me, psychosocial support is made-up of counseling, prevention, and referring: "When I tell you it is not the end of your life living with HIV or to stick with treatment, or to condomize, that is all counseling and prevention and so it counts as psychosocial support." While there were no training seminars in Ndumo for community workers during my fieldwork, I learned that they had attended training in the past— provided by both the South African government as well as PFN—where they were taught various topics such as ways to counsel and encourage people to seek biomedical care and educate families on ways to prevent HIV transmission. In addition to lack of training seminars since the departure of PFN and the reduction in government funding, there was also nothing the community workers could physically bring to the families they visited. As one community worker explained, she is only able to bring "just the information I have to teach and refer them."

One afternoon, Busisiwe, one of the community workers in Ndumo, explained to me that if she has a family that needs nutritional support she must educate them; "We find that it is difficult but we educate mama to find a job or to sell something like in the market; some they are [sic] selling clothes, to make money [and we] teach them to make a garden." With a shrug of her shoulders, Busisiwe added, "Even though people tell me they have nothing to put in their garden." In other cases, community workers shared that they could only refer sick patients to the clinic, or refer to home affairs if they needed

help with grants or documentation, as they had no transport money to take them themselves. Just as Ulwazi explained that "talking" was not a valid service, Mbali explained the same sentiments in regard to referring people:

> Helping them is only a matter of referring them to home affairs. [We] do not help them by referring them to home affairs, they don't even have money to go to home affairs, they don't even have documents to provide to home affairs, so you are just telling them go, but you know exactly they won't even go. So, it doesn't help, not at all.

While the community workers continued to work visiting families and providing psychosocial support in the afterlife of aid, they were no longer able to provide "valid services." In the words of one of the community workers in Ndumo, providing families with valid services meant that, "When you see a problem you can tend to it immediately." Tending to the problem included providing something tangible such as a food parcel, a school uniform, or a ride to the clinic. Valid services were not "psychological" as Mbali explained, but "physical." The retraction of physical material goods, such as food parcels, that could be given from community workers to the families they visited resulted in community workers feeling that their work was no longer providing valid services. As I came to learn, this sentiment was also shared among the families they visited.

Fraught Difficulties: "What Are You Doing with My ID?"

"Now people are not getting anything, but I am still taking your ID. [Some people say that we are] going to ask [for] some help [with their] IDs but [we] don't give it to [them]. And then it means we have to explain and explain and explain so even though [we] can get them, it is not a matter of just asking, it is not easy, it is difficult. [They say] why now, [the community workers] are still here, why can't they help us, because they used to help us way back." – Zobule, community worker

Community worker, Zobule, shook her head. "Challenges" she said, "the ID cards, getting ID cards, that is [a] challenge." Zobule, Amahle and I were sitting on an abandoned soccer field, the metal goal posts were rusting beneath the chipped white paint

and cows and goats roamed in the open pasture next to us. I had taken a taxi with Amahle

that mid-June morning, riding in the bed of a pick-up, to come and speak to Zobule close

to where she was working for the day. We snacked on strawberry filled cream cookies

while I asked Zobule some questions about her work and how it had changed over time.

One of the questions I asked during the interview sought to better understand some of the

challenges she had as a community worker now that PFN had left and there had been a

reduction in government funding. ID documents became the focus of our interview that

day and many other community workers I spoke with in Ndumo shared similar

difficulties.

Zobule explained that although the community workers must continue to get ID

cards annually for the families they enroll in their current program, this was difficult.

"They think I am not doing my job, it is sad" she told me. Some families questioned why

they should give their ID cards as they did not feel the community workers were "doing

their job" as they were no longer providing the same "valid services" they had in the past.

Although the community workers continued to visit and provide psychosocial support to

the families, there were no longer any physical goods that were formally given. While the

exchange of materials in the past between community workers and those they visited was

uneven—the families gave their ID once a year to access tangible goods along with

psychosocial support—the removal of these valued material resources resulted in

community workers struggling to obtain ID cards.

The ID cards were also an important source of evidence for their current funder.

The cards, which were then photocopied and sent to the regional office with the monthly

reports, accompanied each registration form. Under their current funder's guidelines, each

formally enrolled family must provide an ID card as a means of evidence that "someone

was benefiting." While targets were met month-after-month in Ndumo, the process of

obtaining these documents, as Zobule explained, was fraught with difficulties.

While some families claimed that community workers were no longer working

because they were no longer providing valid services, another community worker

explained to me that some of the families claimed that the community workers were

getting paid "off their ID cards."[18] The statement, however, is not unsubstantiated.

Without the ID cards accompanying the registration forms, community workers and the

TCC would not meet target requirements and thus funding—along with the small

monthly remittances the community workers received—would be cut. In this regard,

while the community workers were personally benefiting from obtaining ID cards, as the

ID were a means to securing their 'stipend', many families in Ndumo expressed

frustrations as they did not feel as though they were receiving anything in return.

Previous aid provided tangible support (e.g. food parcels; school uniforms;

transportation; events and retreats with food), however, these were no longer available in

the afterlife of aid. While community workers had to continue to collect ID documents

per the requirements of their current funder, the removal of past "valid services" had

families questioning what they were getting in exchange for their IDs. As, Nozipho, one

community worked put it:

> It is very difficult because [we] have to get their IDs …sometimes the families
> would refuse because they are saying [we] are not giving them anything at the end
> of the day [that we] are just taking their IDs and everything for nothing.

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[18] In Lesotho, Kenworthy (2017) also found that sometimes community health workers were faced with
suspicion from patients who would voice concerns that they were "withholding or hoarding resources" (pg.
117). As a result, she argues, these dynamics had negative effects on their relationships with their clients.

While Ndumo was experiencing a retraction of valuable resources, these

reductions also had further implications that extended beyond loss of the material goods.

One implication of the removal of these physical resources was the strain it imposed on

the relationships between community workers and the families they visited. Removing

such "valid services" adversely impacted social relations between community workers

and the families they worked with. One community worker told me that the reduction in

resources put great strain on her and the family she visited and in one case, "It finished

our relationship because we started with the higher performance of service, but we try our

best." Similarly, as Zobule explained to me that morning on the soccer field, some

families used to call and want to have their community worker visit but in the afterlife of

aid context things have changed; "They no longer call because they know [we] will come

and teach them that is all." The exchange of providing something physical was

fundamental for the relationships between community workers and the families they

visited. Just as Mbali expressed:

> It really has made a bad relationship with the community. Yes, they know it is not us, we don't have funds, but the relationship now and way back is not the same, it is way changed [sic]. And whenever they see us they say, oh, we remember those times where you would help us, it was way better [sic]. We would know that even if you cannot provide us [with] everything [you would] at least would meet us half way rather than now [sic].

Although material resources and programs of past aid were no longer in

existence, aspects of these programs, such as not being able to provide material aid,

continued to have an impact on social relations, long after the aid had departed Ndumo.

Through the stories shared with me, it became apparent that past aid efforts had lingering

effects, resembling more of a phantom disengagement. What these effects were and why they matter is the focus of the discussion in the following two sections.

The first discussion focuses on the central importance of food both as a means of nourishment and sociality in Africa, critically examining what is exchanged in a "handout." The second discussion centers its focus on community workers, critically discussing the personal loss that many community workers felt in Ndumo in the afterlife of aid context.

Material Aid: An Alternative Perspective in an African Context

"It doesn't feel so well; it is a problem that [we] are just using their IDs but not giving them anything."– Jabulisile, community worker

One "valid service" that was no longer formally available in Ndumo since funding had been lost was the ability to provide material goods such as food parcels to beneficiaries of the TCC. In the past, food parcels were available at the centre for clients to pick up as well as given to families on home visits. Food was also a part of support group meetings, afterschool programs, and educational events that brought people together and to the centre. Moreover, the topic of food was central in explanations given to me about why clients never came to visit the centre, why events were no longer held, or why families were now hesitant to give their ID cards. In spending time in Ndumo, and listening to the challenges community workers were facing, I began to understand the importance of food and the multiplicity of meanings behind its significance. Food is not only an important means of nourishment but also of sociality.

Medical anthropologist James Pfeiffer (2013) argues that one of the greatest gaps in the response to the AIDS crisis in Africa was the inability to deal with the food insecurity. While an infection by a virulent agent, such as HIV, is biological, one's social environment largely impacts not only who is infected but also the progression of the

disease. Being malnourished is a co-factor in accelerating HIV pathogenicity and is further compounded by the fact that the virus also decreases one's appetite. Thus, in resource-challenged settings where food is scarce, HIV is more pathogenic and hastens one's progression to AIDS (Stillwagon, 2003). While the arrival of antiretroviral drugs in the Global South helped to slow the progression of the disease and prevented many AIDS-related deaths, the medication brought food─or the lack thereof—into focus (see Whyte et al., 2014; also, Pfeiffer, 2013).

Often, when patients begin antiretroviral treatment (ART), one of the side effects is that it causes people to feel exceptionally hungry (see Kalofonos, 2010; Pfeiffer, 2013). During his fieldwork in Mozambique, anthropologist-physician Ippolytos Kalofonos (2010) was confronted by patients who were conflicted; while the drugs allowed them to live they were "tormented by unrelenting hunger" (pg. 363). Having access to ART underscored one's social status, putting their poverty clearly into focus as many had lost their employment because of their illness and as such finding or accessing adequate sources of food was problematic (see Kalofonos, 2010; Pfeiffer, 2013; Whyte et al., 2014).

While food has been a small component of global health programs, the amounts given are often not adequate as it is primarily given to increase treatment adherence rather than to address hunger (see Kalofonos, 2010; Prince, 2012). In the current global health climate, providing life-saving drugs is celebrated but providing families with other basic life necessities such as food, is met with hesitation. Food aid is often presented as unsustainable with fear from donors that it could create dependency and as such is not encouraged. Teaching families who need nutritional support how to "plant a garden"─as

community workers told me they did in Ndumo—is preferred. According to the logic that underpins the sustainability doctrine, teaching people how to plant a garden, is a sustainability success story as it allows a family to become self-sufficient growing their own food (see, for example, Scherz, 2014; Swidler & Watkins, 2009).

One of the blind spots of this sustainability perspective, however, is the "continuous uncertainty" (Moyer & Hardon, 2014, pg. 267) and daily suffering in people's lives who are living with HIV in resource-challenged areas. HIV/AIDS is "interposed with moments of 'acute' intensity" (Sangaramoorthy, 2018, pg. 984) where the precariousness of daily life is often overwhelming. Although Busisiwe taught families to "plant a garden" in Ndumo, many families told her they had nothing to put in their garden. In other words, they did not have the resources to start a garden. Furthermore, even with the financial capital needed to begin and sustain a garden, the garden must also be watered and tended to. Given the on-going uncertainties of living with HIV in this context, these tasks may not always be possible due to lack of access to water, drought, and sickness. This outlook also does not address the immediacy of hunger that is experienced. Most notably, however, teaching skills to plant a garden, frames food only as a means of nourishment, obscuring the sociality that surrounds the sharing, receiving, and giving of food.

Medical anthropologists Ramah McKay (2018) and Susan Whyte et al. (2014) have found that while food aid in Mozambique and Uganda provided intermittent nourishment to HIV patients, social relations were also enacted and maintained through food support. In many ways, the very act of eating and obtaining food in these contexts is based on values of dependence and interdependence on others as "eating and feeding are

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about care as well as calories and quality as well as quantity, where quality stands for love and concern" (Whyte et al., 2014, pg. 207). Through this understanding of food and its close connection with care, Kenworthy (2017) proposes that "[t]his may be another significant reason why care from community health workers that is provided without the essential element of food is so often challenged or rejected" (pg. 204). Given the nature of community-based care, there are social bonds created between community workers and the families they visit that "engendered expectations of sharing" (Kenworthy, 2017, pg. 115) between them. Just as Mbali explained to me, community workers and families knew that the contents of their food parcels were not adequate to fulfill a balanced diet for one person, let alone a family, but the very act of giving the food parcel was viewed as "meet[ing] half way"—a means of fostering social relations based on African values of interdependence. Just as food can foster relations (McKay, 2018), the absence of food can destabilize social relations as it did between community workers and the families they visited in Ndumo.

While teaching how to plant a garden is often presented as superior to giving food in the eyes of Western donors, as the former allows for people to be independent and autonomous agents, this outlook fails to acknowledge what it means to be a relational person in many African contexts. Rather than seeking independence, many Africans seek to belong to social networks, rooted in a dependency on others (Chabal, 2009; Ferguson, 2013). In the words of Patrick Chabal (2009), "the question is not whether to be party to a system of obligation or not but how to manage one's place in such a system" (pg. 48). With an understanding of the inherent value of interdependency across Africa, one can better understand the impacts that the retraction of material goods has had in Ndumo.

While food and other material goods were no longer available, the retraction of these resources also meant that relations, rooted in interdependence on one another, were also disrupted. Moreover, food and material goods of past aid allowed community workers to provide their clients with "valid services"; fulfilling their roles as good patrons. When these material goods were no longer available in the afterlife of aid, community workers' abilities to act as good patrons were significantly altered. For the many families that received food in exchange for their loyalty and ID cards, the removal of food meant that the community workers were no longer able to engage and fulfill their role as a patron.

The social relationship between community workers and their families in Ndumo is best viewed as a "lop-sided friendship" (Pitt-Rivers, 1954, pg. 140); inferring a relationship built on an imbalance between patrons (community workers) and clients (families they visited). When aid was plentiful in Ndumo—when PFN was physically present and there was increased governmental funding—community workers acting as patrons could provide their clients with material resources (food; school uniforms; retreats; transport money) in exchange for their loyalty and ID cards when required. There was a reciprocity between patrons and clients that was established. In the afterlife of aid, however, community workers acting as patrons were losing their status within their networks, as they were no longer able to provide their clients with material "valid services." The relationship formed and rooted in a valued interdependency on one another were unsettled, as clients felt that their patrons were no longer fulfilling their roles and obligations. In Africa, Chabal (2009) argues, "the very texture of social relations is woven

from ties of obligation" (pg. 48). Thus, community worker patrons were no longer able to

meet their moral obligation of care which disrupted their social relations.

Chabal and Daloz (1999) argue "bad" patrons are those who do not distribute

goods to their clients. Community workers were receiving a small stipend from their

work, and yet they were not distributing anything physical. The psychosocial support that

was given in exchange for loyalty and ID cards did not satisfy families in Ndumo, thus

many were hesitant to hand over their ID cards for photocopying. Obligations—such as

community workers giving material support to families in exchange for their loyalty and

ID cards—that had been established when aid was present could no longer be met in the

afterlife of aid climate because of the removal of valuable tangible resources. Clients in

Ndumo did not view the psychosocial support given in exchange for their IDs as having

the same value as the material goods given in the past. Despite the overall changes in aid

provision they still saw the community workers benefiting more than themselves out of

their relationship. This resulted in a break-down of their "lop-sided friendship" in the

afterlife of aid.

The food parcel fostered a valued dependency between community workers and

local families. Yet, providing food parcels or other forms of material aid are often

discouraged within global health programs[19] as they are not seen as sustainable and could

foster dependency (see Kenworthy, 2017; Scherz et al., 2014). However, rather than

planning and implementing programs centered on meeting sustainable parameters and

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[19] There are of course exceptions to this. For example, one global health organization, Partners In Health, co-founded by anthropologist-physician, Paul Farmer, implements community-based care programs in the Global South informed by a "biosocial" approach to health. This means that in addition to providing medical care, their organization also addresses social factors that influence ill health; they provide food to patients, allocate money for school fees, and provide transport allowances to clinics (see Farmer et al., 2013; Mukherjee et al., 2016).

instilling neoliberal values of independence and autonomy, providing food parcels or other types of material aid in African contexts, are meaningfully significant as they mesh well with existing values of what it means to be a relational person (see Scherz et al., 2014). In many African countries, dependency, as Ferguson (2013) argues, is not seen as something that should be avoided, despite it unsettling common liberal ideas of freedom and independence. In fact, many people seek out ways to become dependent on others (see Ferguson, 2013). As Ferguson (2013) writes,

> … instead of waiting for some evolutionary logic to make people give up their 'backward' ideas, we should begin taking these ideas seriously, and recognizing that they address the very contemporary needs of care, moral connection, and responsible obligation in ways that the emancipatory liberal rights talk often does not (pg. 237).

Teaching and psychosocial support have always been central to the work of community workers in Ndumo, but it was in providing material aid that facilitated meaningful relations.

In resource-challenged areas in Africa, where community workers are foundational to community-based care models, providing families with a food parcel or other types of material aid do more than just provide families with goods. While food parcels provide nourishment, the exchange of the parcel is rooted in systems of reciprocity, interdependency, and acknowledgement (see for example, Kenworthy, 2017). As this case study suggests, although valued material resources were withdrawn in the afterlife of aid, the impacts of their loss are more significant than the materials themselves. The loss of material goods, such as food, has adverse impacts on sociality. While many scholars have concluded that the success of community-based care in the Global South rests on the ability for community workers to foster relationships with the families they visit (see Bhattacharyya et al., 2001; also, Campbell & Scott, 2011; Maes,

2015; Maes et al., 2014; Schneider et al., 2008) understanding ways in which these relationships can be affected and even unsettled is valuable. Moreover, rather than universally disregarding any form of material aid, with fears it would be unsustainable and foster a sense of dependency, providing tangible goods could be viewed as a supportive means that allows for the fostering of necessary relationships between community workers and their clients. Just as China Scherz (2014) explains from her work in Uganda, the very act of giving, "should not be rejected out of hand in places where interdependence and hierarchy carry a positive, or at least an ambivalent, moral valance" (pg. 142).

Symbolic Value of Workshops and T-shirts for Community Workers

At the beginning of every 'formal' interview with community workers I would ask for examples on how their work had changed over time. Although, I had several informal conversations with community workers about this topic, I noticed a significant pattern on how the question was answered in our interviews. In posing this question I had anticipated that community workers would share with me how there had been a change in programs and a reduction of resources since aid had departed, which had impacted the *families* they visited. However, the community workers notably, mostly always began with how their work had changed and impacted *themselves*.

I was walking back to the TCC one afternoon, gently scuffing the red dirt with my sandals, reflecting on the interviews I had that morning. I had conducted over 18 'formal' interviews by this time—three on this particular day—and I could not stop thinking about my overarching research question: what are some of the ways that transient aid impacts, affects, and shapes communities once programs end? Although I had developed the

question in the field, I came to realize one of the assumptions I made in its development. I naively assumed that much of the focus of my fieldwork would involve learning about the ways past aid programs had impacted and affected the very people they were designed to help. While this certainly did occur, community workers—interview after interview, conversation after conversation— also always spoke about the personal loss they felt since funding had been withdrawn. Certainly, on this day, all three shared with me that in the past they attended workshops and retreats for extra training; transport money was provided as was money for cell phone airtime. They were also given material goods, such as certificates, t-shirts, and bags. Pointing to the red and white polo shirt she was wearing, with a slight tear in the shoulder, Nonthantha said, "I now have to wear my own clothes, we no longer have uniforms, like shirts, bags and umbrellas that they [PFN] gave us." I stopped on the side of the road, reaching for my notebook in the bottom of my bag, to jot down my thoughts. I wrote the following note: "Although formal program agendas outline who their intended beneficiaries are for various aid programs, informally, community workers, those tasked with carrying out these programs, also benefit, in ways beyond receiving compensation." While the intended recipients of past global health programing in Ndumo were children and their families, past aid also positively impacted the community workers as well. As a result, while funding reduction meant valuable resources were reduced for the beneficiaries of the TCC, community workers also felt a personal loss.

Community workers in the Global South are often not paid (see, for example, Maes, 2015), however, community workers in Ndumo did receive remittances for their work. Prior to PFN's arrival in 2008, community workers were receiving ~R500 per

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month (~ Cdn $50). When PFN arrived in Ndumo in 2008, the NGO and the TCC agreed

that rather than PFN hiring 25 new community workers, they would increase the existing

community workers' monthly stipends. Importantly though, when PFN left Ndumo in

2014, the South African Department of Social Development continued to pay the

community workers the same monthly stipend. In other words, the amount of money

community workers received remained the same even after the NGO left. At the time of

my fieldwork the monthly stipend for a community worker was ~ R1800 per month (~

Cdn$180.00) ─ however, remittances were often delayed.[20] Although their

compensation did not change when the NGO departed Ndumo or when government

funding for the centre was reduced, past aid programs were salient in their lives beyond

the compensation they received. As I learned in Ndumo, what is lost after aid programs

depart, not only affects people who are enrolled in these transient aid programs but also

the community workers who are tasked with carrying out these programs. I argue, that to

better understand what was lost and why community workers felt "sad" and "demotivated"

in the afterlife of aid context, calls for an understanding of the social milieu in which they

live and work.

Sociologist Ann Swidler (2009) argues that one of the reasons that many

international NGOs are able to establish working relations within local communities in

the Global South is a result of the social fabric that exists across much of Africa. As

Scherz (2014) explains, persons' "strategies of self-making involve creating and using

networks (which are often hierarchical) to secure support (which is often material)"

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[20] Although community workers were paid by a governmental department, they were contract workers, not
fully incorporated into the public system. Thus, the precariousness of their work was a point of tension for
many; also see Mottiar & Lodge (2018).

(pg.2). Often these hierarchical networks are positioned in patron-client relations.

Although there is an inherent unevenness between patrons and clients, these relationships

are reciprocal in nature as both patrons and clients have an obligation to one another

(Chabal & Daloz, 1999). Moreover, having a large social network is critical for gaining

access to additional resources and opportunities that would otherwise be unavailable

(Chabal & Daloz, 1999; Smith 2003). It is in this light that Swidler (2009) argues that

international NGOs are able to establish working relations with local people, as they are

being integrated into these local forms of social support. Although the relationship is

uneven, it is the "possibility of relationships of exchange or of interdependence among

unequal partners [that] may account for the ease in which international NGOs…establish

working relationships with local communities" (Swidler, 2006, pg. 277). NGOs act as

patrons, while community workers simultaneously become clients to the NGO as well as

patrons to the families they work with. Working with NGOs as they implement their

programs allows community workers the opportunity to expand their personal social

networks and thus their social capital (see, for examples, Nguyen, 2004; McKay, 2018;

Smith, 2003; Swidler, 2009).

One such example of how NGOs provide opportunities for community workers to

expand their social network is through workshops and training seminars. Workshops,

according to anthropologist Daniel Jordan Smith (2003) are examples of "patronage par

excellence" (pg. 713). Although NGOs provide workshops and training programs as a

means to disseminate knowledge to community workers, workshops also allow for

community workers to broaden their social network with contacts in the international aid

community while also cultivating their own relationships within their own local

community (see McKay, 2018; Smith, 2003). Understanding what workshops can foster, beyond the information they expose, I argue is critical for understanding the feelings of discontent and loss community workers felt in the afterlife of aid. Moreover, the goods and material resources community workers received from the NGO at these workshops offered personal benefits, such as obtaining certificates and credentials, but they also allowed community workers to expand their client network. Given that personhood in much of Africa is inherently social and people's relations with others constitute their sense of self, it is no wonder many expressed they were "demotivated" in the afterlife of aid.

One's social capital is intrinsically tied to one's social network. As Nguyen (2004) explains, social capital is "the proximal network of social relations through which resources may be mobilized" (pg. 142). Thus, having access to transnational aid allowed community workers in Ndumo to rely on their proximal network to help mobilize resources for their work. Viewed in this way, the loss of aid severed community workers' relations with the transnational aid community, devaluing their social capital. The community workers in Ndumo no longer had access to mobilize resources for themselves or for the families they visited. Thus, the loss and lasting impact community workers were experiencing in the afterlife of aid climate was not just individual but also relational.

In addition to building and maintaining one's social network and social capital, access to transnational resources also provided community workers with the opportunity to help build one's symbolic capital (see McKay, 2018). Kaler and Watkins (2001) argue that one of the most important resources community workers have is their "personal

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prestige or standing in the community" (pg. 258). Anthropologists have shown that

transnational resources such as physical artifacts can also be taken up into local structures

of power (see Biehl & Petryna, 2013; McKay, 2018; Moran-Thomas, 2013). For

example, Moran-Thomas (2013) found that during the guinea worm eradication efforts in

Ghana, possessing a water filter allowed Ghanaian's to be affiliated with the USA, acting

as a symbol of status. In Ndumo, not only did the PFN's yellow polo t-shirts have the

NGO's logo on them, but they were also embroidered with PEPFAR's logo branded with

the American flag. When community workers spoke about the loss of these branded

shirts, it was not a longing for the physical artifacts per se, but for the symbolic capital

that came from wearing and possessing such materials. The community workers' feelings

of sadness and frustration since aid had left was intermixed with feeling that they were no

longer valued. As Zobule lamented, no one ever called her anymore. The perceived

respect and symbolic capital that community workers were able to establish when aid was

present deteriorated after aid was retracted. The community workers were experiencing a

loss of their patron status and position in their local social hierarchy.

　　This sense of loss that community workers felt in Ndumo was also similarly

expressed by community workers Kenworthy (2017) spent time with in Lesotho. One of

the community workers explained to Kenworthy (2017) that she was "poorer" now years

into the HIV global health scale-up than she was when transnational aid first arrived. As

Kenworthy (2017) explains, she was not just financially poor but also "poorer in terms of

her social position" arguing that "global health initiatives are reshaping citizens'

expectations, trust, and willingness to participate in future endeavors" (pg. 125). While

the community workers I spoke with shared these similar sentiments, if given the

opportunity, I am not convinced that they would be unwilling to participate in future programs. In fact, as I explain below, community workers expressed that they wished for the NGO to return.

At the end of each formal interview I had in Ndumo I often asked the community workers I was speaking with if they had a wish. Time and time again community workers would express that they wished for PFN or another funder to come back. Although, they saw flaws in the way PFN's programs were executed, these were outweighed by what transnational aid could provide. While funders provided additional resources, more importantly, the NGO was inserted into local systems of patronage. PFN acted as a patron and provided community workers and their clients with valuable resources. Furthermore, just as the NGO acted as a patron to community workers, their material and symbolic support allowed community workers to also become valued patrons themselves. The NGO's presence in Ndumo helped community workers build their own social networks as well as their social and symbolic capital, becoming respected patrons to the families they visited. As such, the loss community workers felt and their desire for another NGO to come to Ndumo was not a longing for workshops and clothing specifically, but rather the desire to belong to a social network that could also provide.

Just as community workers in Ndumo who wished for the NGO to return, anthropologist Lindsay Reynolds (2014b) also described that the local organizations she worked with in South Africa, wanted to be "supported, cared for, or even possessed" (pg. 135) by larger affluent aid organizations and research institutions. Reynolds (2014b) found that for the poor South Africans she met they "actively [sought] to construct relations of dependence with, and of recognition from, social actors who [were] perceived

to have the capacity to provide and protect" (pg. 135). While the NGO in Ndumo

provided community workers with material resources that could then be shared with

others, community workers' mere association with the NGO, as a potential provider of

resources in the future was also significant.

To conclude, as relational people, rooted in systems of interdependence, the loss

of the NGO not only affected the relationships between community workers and the

families they visited but also impacted them personally. Their extended social networks

were broken, and their status as valued patrons was diminished which shaped their social

and symbolic capital. Viewed in this way, the removal of past aid did more than retract

valued material resources, it had lasting disruptive impacts on patron-client relations on-

the-ground.

Chapter Seven: After-Aid Exchanges: Life and Work in the Afterlife of Aid

This chapter takes a step away from the formal work of the Themba Community Centre (TCC) and community workers. Rather than contrasting programs and services of the past and present, this chapter specifically focuses on the personal intimate acts of trying to provide care during restrictive times. In many respects, this chapter is a response to Ramah McKay's (2018) call for ethnographers to "pay attention to the work that happens in the meantime" (pg. 198). Much of my understanding in this chapter comes from my time spent "hanging-out" (see Geertz, 1998) in Ndumo and at the TCC as well as through spontaneous conversations I had with many community workers. I came to understand that the work and care community workers provided went beyond the psychosocial support they were enlisted to provide. Although many formally described their work as providing psychosocial support, I was attentive to some of the informal ways community workers personally provided care in the afterlife of aid climate. In many ways, community workers, as well as the TCC, took it upon themselves to provide families in their community with extra material goods that were no longer formally available since aid was withdrawn. I refer to these informal acts of giving as "after-aid exchanges."

This chapter is divided into two sections. In the first, I illustrate some of the after-aid exchanges that did occur in Ndumo despite a loss of funding. Next I propose an explanation as to why these informal exchanges were occurring and discuss some of the possibilities of what these after-aid exchanges represent.

After-Aid Exchanges: Informal Acts of Providing Care in Ndumo

Mbali and I were sitting next to each other looking over a monthly report, when two school-aged children appeared at the centre's side door. Both the boy and girl were carrying a copy of their South African birth card in their hands and extended their card towards us after our greeting. Although they spoke to Mbali in isiZulu, I had an idea as to why they had come. Both were dressed in school uniforms; the girl wore her grey kilt, the hem loose at the bottom and mismatched white and black socks with her black scuffed school dress shoes. Her shoes were too big as her heels popped out the back as she walked into the centre. The boy similarly wore his grey school dress pants, tied in the waist with a string with a grey sweater vest over his white button up. His knitted vest was ripping in the front where the stitching met in the V-like collar and had two small holes in the back. I sat and waited for Mbali to finish copying their ID documents. Mbali looked at me as they were leaving and she shook her head, "As much as we don't have, they deserve."

Despite the reduction of aid in Ndumo, the reduced budget from the South African Department of Social Development continued to allocate funds for a feeding program at the TCC. However, since their budget was re-aligned in 2015, the funding for the feeding program was reduced by seventy-five percent. The current funding for the feeding program at the TCC specifies support for one meal a day for ten children. Formally, one "balanced meal" is to be provided to ten children, Monday through Friday, and according to guidelines should consists of a starch (e.g. rice or pap/mielie-meal), a protein (e.g. beans or curry chicken), a fruit, and juice. In practice, however, what foods were bought and how many children were fed did not follow what was stipulated in the

outlined menu. As Mbali explained to me one day, "I can't just feed you and not Ulwazi."

She was pointing to the five 25 kg bags of maize mielie meal stacked on top of each other

at the back corner of the boardroom. Instead of buying fruit and juice as was outlined in

their "balanced meal" guidelines Mbali would buy more starch (rice and maize meal) and

beans to stretch their budget. Doing so allowed them to cook more food and thus feed

more than just ten children. The TCC already had over 10 children on their feeding

program when the boy and girl came to visit the centre that afternoon, but Mbali added

these two children to the program as well. As she explained, "It is not fair to say one can

eat and the other cannot. How can I do that?"

The TCC tried to stretch the funds that they did have from the government as

much as they could, however, at month-end, the centre would often run out of food and

no meals would be made. In addition, sometimes no food could be purchased for the

feeding program because funding was delayed. In June 2018, for example, while I was in

Ndumo, funding was delayed for weeks and as a result there were no cooked meals at the

TCC. This, however, did not stop Mbali and others from enrolling children or allowing

them to come when food was available.

In addition to the effort made at the TCC to feed more children and provide extra

meals by adjusting what types of food were purchased, many community workers told me

about some of their own personal acts of giving to families in need. Although community

workers lamented that they had nothing to give since aid had been lost and much material

support was no longer formally available, many were personally giving or arranging for

tangible goods to be given to the families they visited.

Monthly community meetings in Ndumo took place on the first Thursday of the month at a nearby community hall. In addition to community workers attending, other "stakeholders" from Ndumo such as representatives from the medical clinic, the manager of the grocery store, *Induna* and his committee also were in attendance. Many community workers took this as an opportunity to relay stories of some the difficulties the families they worked with were facing. During one meeting, community worker, Busisiwe shared that she had a family that needed to go to Home Affairs for documents but they could not afford the transportation costs. Busisiwe asked for others to let her know if anyone would be willing and have extra space for the mother to go with them, if they were headed in that direction. A few weeks later, when I was chatting with Busisiwe, she let me know that she had been able to arrange a ride for the mother to go to Home Affairs. Although it was just the beginning of a lengthy bureaucratic process, the very act of arranging a ride for the family allowed Busisiwe to feel as if she had provided something tangible and thus, valid to the family.

Similarly, another community worker expressed that even though their work was challenging because they were unable to formally provide goods such as food parcels, she has had to find other ways to help; "You know, a quarter of my stipend goes back, you end up giving them R100 or R50 to find something to eat, rather than saying, I have nothing to help you, bye-bye." In addition to providing money, other community workers shared stories of bringing families rice and other food staples such as canned pilchards; giving away their own personal lunch; buying chocolate for children; donating their own clothing. On one occasion, Nonthlatha, a community worker, shared that she went and

bought a family a broom because they were sweeping their floor with part of a tree branch.

Each of the examples above illustrates personal informal acts of giving, which allowed for community workers to provide something tangible—a meal; a bag of rice; a broom—to children who came to the TCC or to families they met on home visits. Although these after-aid exchanges were by no means adequate or given on a regular basis, they were still informal personal ways community workers continued to provide support that went beyond teaching, referring, and offering psychosocial support in the afterlife of aid. Nora Kenworthy (2017) also observed these types of exchanges from her time in Lesotho, where community health workers would personally provide material support to others, because they were "overwhelmed by the needs of their patients and their own sense of obligation to neighbors and friends" (pg.110).[21] For the community workers she worked with providing care meant "becoming embedded in new networks of obligation" (Kenworthy, 2017, pg. 116). Similarly, as I discuss below, the after-aid exchanges of trying to feed more children at the TCC or giving away personal lunches are intimate acts of trying to provide care in restrictive times but they also speak more broadly to community values of interdependence that are central to many across sub-Saharan Africa (see Chabal & Daloz, 1999; Ferguson, 2013; Scherz, 2014).

Benevolence or Moral Obligation? Understanding the After-Aid Exchanges

"It is always on your shoulders." – Xolisile, community worker

Some researchers in global health have explored how transnational aid organizations and their programs get inserted into local African systems of

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[21] Similarly, Kalofonos (2014) also observed community home-based care volunteers in Mozambique offering personal material goods such as food to the families they visited.

patrimonialism and clientelism (see Smith, 2003; Swidler, 2009; Reynolds, 2014b; Whyte et al., 2014). From her extensive fieldwork in South Africa, ethnographer Lindsay Reynolds (2014b) concluded that "existing networks of power, patronage, and dependence are being reinvigorated and reshaped in important ways by the conduct of global health research" (pg. 137; also see Kenworthy, 2017). By drawing on my observations in Ndumo, I do not intend to make grandiose proclamations, but rather, make a small contribution to the research regarding some of the unintended ways global health projects and programs come to alter "existing networks of power, patronage and dependence" (Reynolds, 2014b, pg. 137) on-the-ground.

Based on my empirical observations in Ndumo, I have highlighted in this ethnographic study some of the ways previous global health aid reshaped relations between community workers and their clients after aid was stopped. As discussed above, patron-client relations that were established between community workers and families when aid was present were unsettled in the afterlife of aid. The relationships between community workers and families, however, was not time-limited like the aid programs themselves. Rather than try to discontinue these relationships after programs ended, community workers in Ndumo continued to visit families and even personally tried to provide "valid" care during these restrictive times. In this chapter, I have argued that while these after-aid exchanges were intimate acts of trying to provide "valid" care, they were also attempts by the community workers to remediate their destabilized relations and re-establish their roles as valued patrons.

Anthropologists who work in Africa have found that personhood across much of the continent is relational. For relational people, relationships with others help constitute

oneself (Comaroff & Comaroff, 2001; Englund, 2008; Ferguson, 2013; Scherz, 2014; Smith, 2003). The popularized southern African adage *Ubuntu,* which comes from the isiZulu phrase *Umuntu ngumuntu ngabantu* (a person is a person through other people), is one illustration of what it means to be a relational person. Rather, than people being viewed as entirely independent, bounded, autonomous agents, one's personhood across much of the continent is achieved through others, establishing an interdependency with kin and kith (see Chabal, 2009). As Patrick Chabal (2009) argues, being an independent individual that could be "utterly detached from any community is not one that finds favour, or is even meaningful, in Africa" (pg.48). In her recent ethnography *Having People, Having Heart*, anthropologist China Scherz (2014) explains the tenets behind this valued interdependency:

> These ethics of interdependency… mean that people with resources stand to gain from their relationships with those that have less; that they have a moral obligation to take on clients; and that people with limited resources must actively try to attach themselves to others as dependents. (pg. 2)

Within such a system, as Scherz (2014) explains, a person's standing and ability to become a full person is not accomplished by being independent, but rather, through relations and dependency on others (see also Chabal, 2009; Ferguson, 2013).

Many social relations across Africa are often hierarchical, such as through patron-client ties. Though, Scherz (2014) proposes that "it is not inequality itself that is the problem, but what people do from their positions within the hierarchy" (pg. 94). Even with the inherent inequality within patron-client relations, patrons only retain their status if they can meet their clients' expectations (Chabal & Daloz, 1999). While patrons personally gain from taking on clients, in such a system, patrons are also morally

obligated to take on clients and redistribute to their dependents (see Chabal & Daloz, 1999; Scherz, 2014; Smith, 2003).

These values of interdependency within clientelism relations are linked to notions of a "moral economy." For my purpose, I use the term moral economy as anthropologist Newell (2006) did to describe "a system in which people often exchange for the purpose of maintaining and accumulating social relations, rather than merely for the purpose of maximizing their profits" (pg. 180). The notion of a moral economy helps us understand various types of exchanges that can occur between individuals. For example, in a review of patterns of giving in South Africa, Habib & Maharahji (2008) report that "giving is more common among the poor than the rich"; and that "giving processes…are conditioned by patterns of obligations rather than pure voluntarism" (pg. 38) critical for survival. In this light, to try and understand these giving processes among the poor in South Africa, a moral economy framework is helpful. As Habib & Maharahji (2008) note, the giving processes among the poor are drawn out from a sense of obligation, therefore, the act of giving is not a strict impersonal economic transaction but born out of a sense of moral sociality, enabling the poor to maintain and accumulate their social relations with friends and family.

An understanding of social systems of clientelism in which people live as well as moral economies of exchange provide critical frameworks for unpacking the after-aid exchanges that were informally occurring in Ndumo between community workers and their clients. In Ndumo, community workers continued to receive a small monthly stipend even after PFN departed and government funding was significantly reduced. The type of work and care community workers could provide, however, changed considerably as they

were no longer able to access material resources. As Mbali explained, with the withdrawal of aid, "there was nothing physical" that community workers could give. Many community workers explained that they did not view psychosocial support as a valid service. This understanding, as I came to learn, was also shared by the families they enrolled. In the afterlife of aid environment in which I experienced in Ndumo, there was a breakdown in the cultural code of interdependency.

As patrons, community workers were still receiving remittances for their work, but they were not formally redistributing anything to the families they were visiting (e.g. a ride to the clinic; a food parcel). Instead of redistributing valid services and providing tangible goods, their current formal work was only to provide psychosocial support. Clients began to question why they should provide their patrons with their loyalty and ID cards in exchange for something they did not value. And importantly, clients were aware that providing them with their IDs, meant that community workers would benefit by receiving their stipend. Their "lop-sided friendship" seemed to be markedly unbalanced.

Within clientelism relationships, however, patrons are restrained by their clients' expectations. Thus, these informal after-aid exchanges in Ndumo were not just community workers providing care in restrictive times, but patrons responding to their client's expectations. These informal acts of giving allowed community workers to provide something tangible and valid to their clients in exchange for their client's loyalty and ID card. As such, a bag of rice or small presentations of money was their way of re-establishing their role as a patron, redistributing to their families. On one hand, these exchanges can be viewed within a moral economy framework; the goods that were given from community workers were exchanged for the purpose of gaining symbolic capital

and maintaining social relations. On the other hand, these acts were also drawn out of a sense of moral obligation. Community workers, who had more than the families they enrolled, were under an obligation to give to their clients, who had less. By not redistributing their gains, community workers risked being viewed as "bad" patrons. Chabal (2009) explains that these kinds of obligations are not impositions as we often view them in the West, but rather, in much of Africa are, "a means of sustaining one's place in a network of belonging: the most vital attribute of humanity, sociality, and ultimately, being-in-the-world" (pg. 48). In a context where "having people" (Smith, 2003) and being interconnected to others is valued, community workers did not gain from just keeping their stipend for themselves as this disrupted their valued patron-client relations. Thus, these after-aid exchanges were attempts for community workers to help mediate their destabilized relations and re-establish their place in their social network and social hierarchy.

The after-aid exchanges I learned about in Ndumo are similar to anthropologist James Pfeiffer's (2004) observations among church groups in Mozambique. He found that many local church groups formed and flourished in Mozambique without additional foreign aid monies, fashioning their own social support systems. Like Busisiwe working with others in Ndumo to arrange transportation for a family, church group members in Mozambique often organized aid for their members as well, such as through gathering water or offering financial support to families who were in need (Pfeiffer, 2004). Pfeiffer (2004) cautions, however, "to acknowledge that the poor have fashioned a dynamic social support movement in these churches…is not to argue that they are in any way sufficient to meet the extreme material needs of their members" (pg. 369-70). Similarly, although I

observed these after-aid exchanges in Ndumo, they did not meet the critical material needs of many.

In the afterlife of aid, rather than international organizations or the public-sector providing families with valued material services, the responsibility was shifted to the community workers themselves. As one community worker said, "It's always on your shoulders." Even though aid was withdrawn, programs had ended, and vast valued resources were reduced, people were still in need of care and support. In the afterlife of aid, community workers did not stop providing care, but rather they worked tirelessly to personally try to fill the void.

<u>Chapter Eight: Conclusion</u>

"A critical ethnography of global health must attend to the granular ways in which interventions (multiple and fragmentary and tied to neoliberal principles and strategies) become part and parcel of public health landscapes and social relations" (Biehl & Petryna, 2013, pg. 133).

I sat in the front passenger seat of Mbali's white hatchback as she drove down the red dirt road to *Induna's* (traditional leader) house. It was my last full day in Ndumo and *Induna* called and wanted to see me before I left. I had become accustomed to looking for large pot holes and boulders as we were driving, letting Mbali know if she needed to slow down and veer to the left or right. The car was several years old and was notorious for breaking down. As we hit the bumps, water splashed out of the canister I was holding. We kept extra water in the car and poured it in the engine to act as a coolant if the engine was overheating. Mbali and I were unusually quiet, but the loud hum coming from the car seemed to fill the empty space. We soon arrived at *Induna*'s house and I waved as he was sitting outside at a plastic table.

"*Sawubona ubaba, unjani?"* (Hi father, how are you?), I said as I greeted him. Mbali and I took a seat the table and she and *Induna* spoke. Three empty beer bottles sat on the table and a radio played in the background while two young children chased a chicken around in circles. After a few minutes Mbali turned to me and said, "He wants you to know this is not goodbye. He knows we will see you again." I smiled, feeling my eyes tear up. She added, "He also says that you must not forget the poverty and poorness [sic] you saw here. If you have a funder, you must give him your report." I nodded, feeling a tinge of hopelessness. "*Hamba Kahle*, Stef" (Go well) he called as we were walking to the car, "*Sala Kahle*" (Stay well) I responded.

As we left *Induna's* house, leaving a cloud of red dust in our wake, Mbali asked

in her quizzical nature, "Stef, is there a cure for cancer in Canada?" I shook my head and

said no, watching the goats as they passed by my window. I felt deflated. Mbali let out a

sigh and said, "I hope that there will be a cure because we have lots of cancer in Ndumo.

HIV is a problem, but with HIV you have treatment, with cancer you have no hope." We

exchanged glances—two friends looking at each other, silently acknowledging the bleak

reality.

In July 2019 UNAIDS released a Global AIDS Update report, entitled

Communities at the Centre (UNAIDS, 2019b). With only one year left until the 2020

UNAIDS 90-90-90 deadline, the report addressed some notable gaps and proposed a way

forward. Although the initial "end of AIDS" narrative and subsequent 90-90-90 targets

were developed with the intention of increasing funding and resources for HIV/AIDS in

the Global South, ironically, just as anthropologists Kenworthy et al. (2018) predicted, it

"instead elicit[ed] a complacency among donors and governments" (pg. 962). From

2018-2019, funding for HIV responses in "low-and middle-income countries" decreased

by USD $900 million (UNAIDS, 2019b). The UNAIDS 2019 Global AIDS Update stated

that:

> This decline is a collective failure. Financial data reported to UNAIDS shows
> one-year declines across all sources of investment in HIV responses, including
> domestic resources, multilateral and bilateral donor programmes, philanthropic
> organizations and other international sources. (UNAIDS, 2019b, pg. 9).

In addition to highlighting the gap for HIV/AIDS funding, the report also highlighted that

the future of ending the global AIDS epidemic will depend on "community-led and

community-engaged programmes" (UNAIDS, 2019b, pg. 9). As UNAIDS Executive

Director Gunilla Carlsson wrote in her forward address: "Peer-to-peer counsellors,

community health workers, door-to-door service providers, grass-roots activists and networks of people living with or affected by HIV all have key roles to play in the response to HIV" (UNAIDS, 2019b, pg. 2). Thus, according to the report, for the "end of AIDS" to be realized robust financial investments must be coupled with community engagement (UNAIDS, 2019b).

While the future of global HIV/AIDS funding remains uncertain, as PEPFAR's proposed 2020 budget, for example, outlines a 30% reduction in funding (Kaiser Family Foundation, 2019a), what remains certain is the realization that community engagement is a critical component for HIV/AIDS programing (UNAIDS, 2019b; also see UNAIDS, 2016). One criterion that is essential for the success of community-based health programs is the ability for community health workers to foster meaningful relationships with the families they work with (Bhattacharyya et al., 2001; Campbell & Scott, 2011; Maes, 2015; Maes et al., 2014; Schneider et al., 2008). Given the temporal nature of these global health interventions, this ethnographic study illustrates that their conventional time-limited interventions are reconfiguring and at times destabilizing these social relations, once their programs end. Ironically, even though global health organizations and donors acknowledge the importance of community-based care, the very nature of their transient programs are having destabilizing impacts on community social relations.

The "end of AIDS" narrative cements the time-sensitive nature of global health interventions. With an exit in sight and targets to be met, what is obscured is how these programs impact people's lives outside of the program's protocol and timelines. As I have illustrated in this thesis, in the afterlife of aid, past global health programs, with their open and broad inclusion criteria produced high levels of "abandonment" among

people who were previously enrolled. As a result, this has had fracturing effects on the

relationships between community workers and the families they visited. The relationships

that were formed between community workers and the families they visited while

programs were ongoing were not time-limited like the programs themselves. Although

community workers tried to continue to visit families and maintain their relations long

after funding was withdrawn, their relationships were changed after programs ended.

While their lop-sided friendship was interdependent when aid was plentiful, in the

afterlife, with the reduction of resources, these relationships were destabilized.

Community workers lamented that they felt demotivated in the afterlife of aid as their

perceived social and symbolic capital were devalued. In an effort to continue to try and

provide care, many community workers often felt that it was their personal responsibly to

try and meet the needs of the families they visited without the additional external support.

Irrespective of UNAIDS "end of AIDS" goals, in the wake of these global health

programs, this ethnographic study illustrated that they have lasting impacts on people's

lives and social relations.

If the "end of AIDS" targets are met, I fear that they will be celebrated as a

success without acknowledging the plethora of other needs that plague people's lives.

And if the targets are not met, I hope that instead of blaming "communities" in the Global

South for the failure, we critically assess the social structures in which they live that are

crippling their ability to live a life where HIV/AIDS is not a reality. What remains

strikingly clear is that whether or not the "end of AIDS" goals are met, HIV/AIDS will

continue to impact people's daily lives—lives which are still marked by "continuous

uncertainty" (Moyer & Hardon, 2014, pg. 267). While ARVs are life-extending drugs

they do not "erase people's need for care and material support" (Moyer & Igonya, 2014, pg. 144). Whyte and her colleagues (2014) emphasize that although treatment provides someone with a "second chance" at life, "to realize the second chance, care must be given and taken continuously" (pg. 2). Often these biomedical redemption stories draw our focus away from other—often social—maladies that do not have simple, technical solutions. As Nora Kenworthy (2017) aptly explains:

> …we are easily enchanted by global health stories that offer a happy ending—a remarkable salvation. The scale-up of HIV treatment, with the transformative impacts it had on patients' lives, provided that narrative over and over. In doing so, it distracted us from the harder stories, the ones that do not have easy resolutions or bright futures (pg. 192).

While this ethnographic study does not offer any magic bullet solutions, it does highlight the unintended consequences that arise after global health programs end. Donor priorities may shift and programs may end, but they continue to have lasting impacts on people's lives and social relations long after—a phantom disengagement. We must be attentive to these narratives and not simply focus on the "inherent 'goodness' of initiatives" (Kenworthy, 2017, pg.184). Like other anthropologists who contextualize their particular cases, in paying attention to the day-to-day realities in the afterlife of aid in Ndumo this ethnographic study also helps to illustrate that HIV/AIDS is not ending in South Africa.

Just as my friends in Ndumo taught me, the precariousness of their lives is their everyday reality. The social drivers of HIV—chronic unemployment, inequality, poverty—are lived realities in Ndumo, KwaZulu-Natal, and South Africa more broadly. The "end of AIDS" narrative continues to focus on testing and treating individuals for HIV. In doing so, it inadvertently diverts our attention away from these social maladies,

the weakened public health systems, and other prevalent diseases like diabetes, tuberculosis, and cancer. While treatment is available, secure employment is not; food security is not. HIV/AIDS continues to impact and affect many lives in South Africa, but the singular focus on this disease distracts us from the others that are increasingly prevalent in the Global South. In Mbali's words, for those diseases, there is "no hope."

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