

## Acronyms

AIDS: Acquired Immune Deficiency Syndrome

ANC: African National Congress

ARV: Antiretroviral

DoH: Department of Health (South Africa)

ELM: Ethel Lucas Memorial Hospitals

HAART: Highly Active Antiretroviral Therapy

HIV: Human Immunodeficiency Virus

HSDU: Health Systems Development Unit

IPHC: International Pentecostal Holiness Church

MRC: Medical Research Council (South Africa)

NGO: Non-Governmental Organisation

NRCC: Nazarene Revival Crusade Church

OPD: Out Patients Department

PEPFAR: Presidential Emergency Funds for AIDS Relief

PHRU: Perinatal HIV Research Unit

RHRU: Reproductive Health and HIV Research Unit

PMTCT: Prevention of Mother To Child Transmission

SANT: South African Native Trust

STD/I: Sexually Transmitted Disease/Infection

TAC: Treatment Action Campaign

TB: Tuberculosis

TGME: Transvaal Gold Mining Estates

USAID: United States Agency for International Development

VCT: Voluntary Counselling and Testing

WHO: World Health Organisation

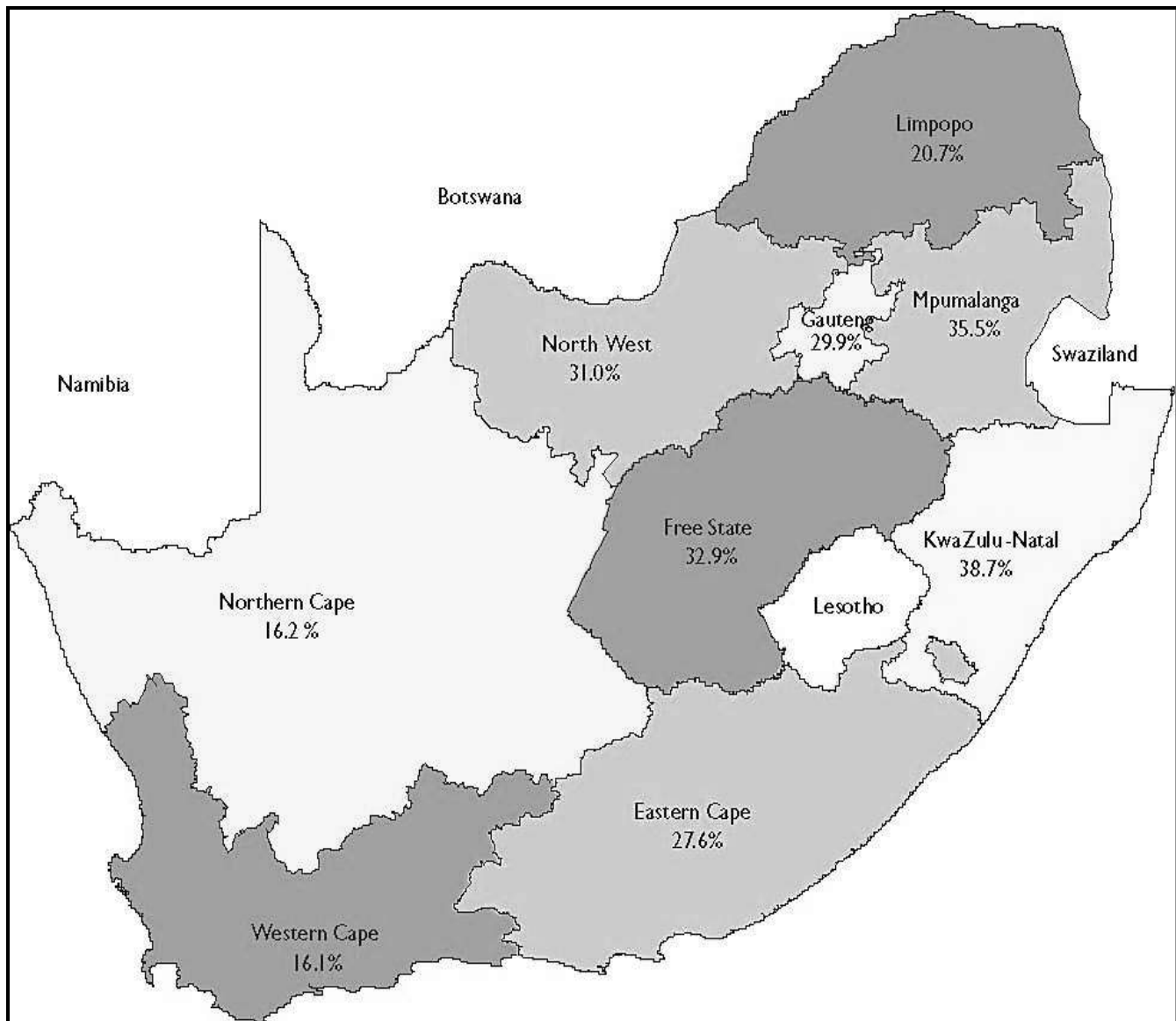
WRF: Wits Rural Facility

ZCC: Zion Christian Church

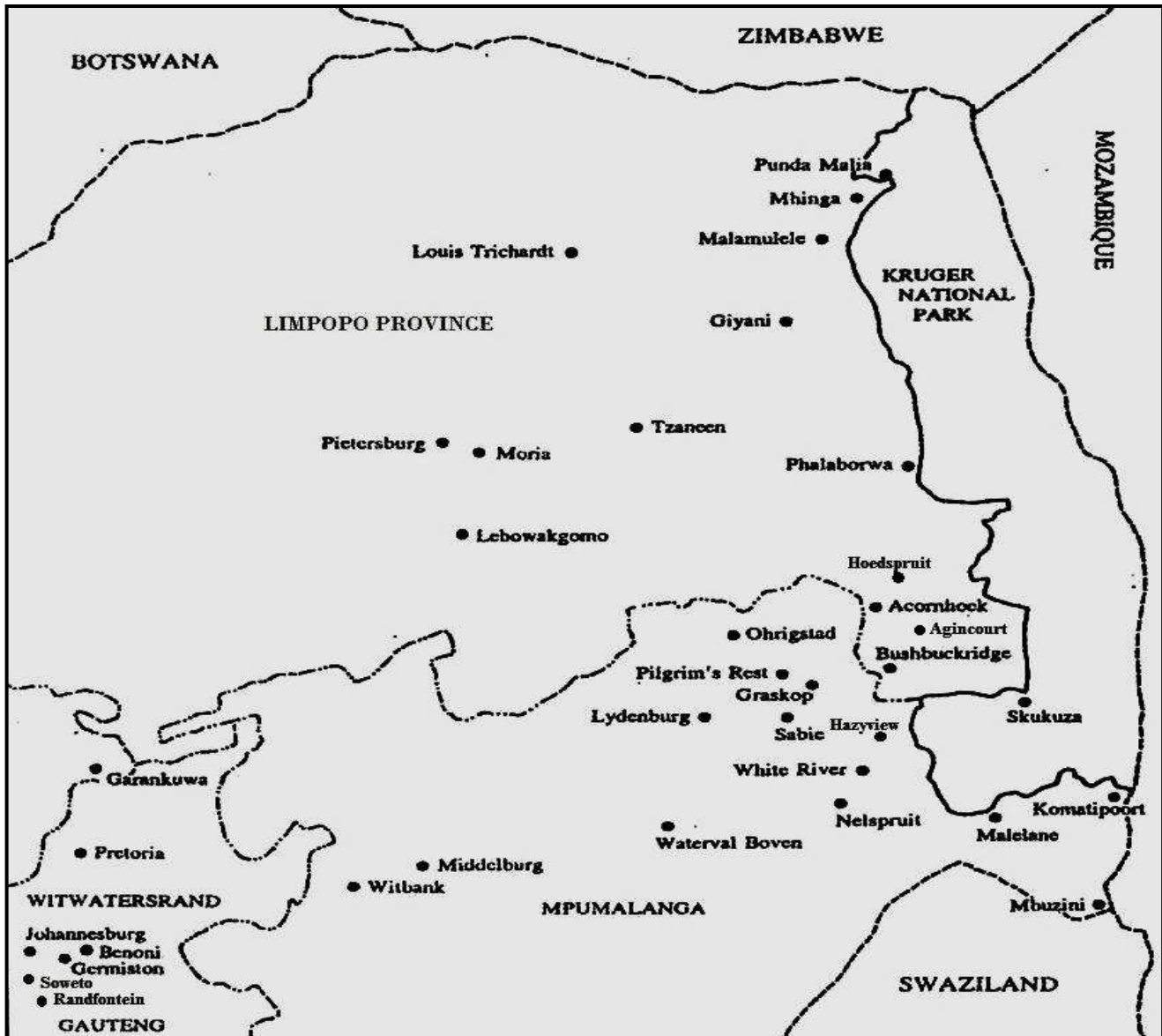
## MAPS



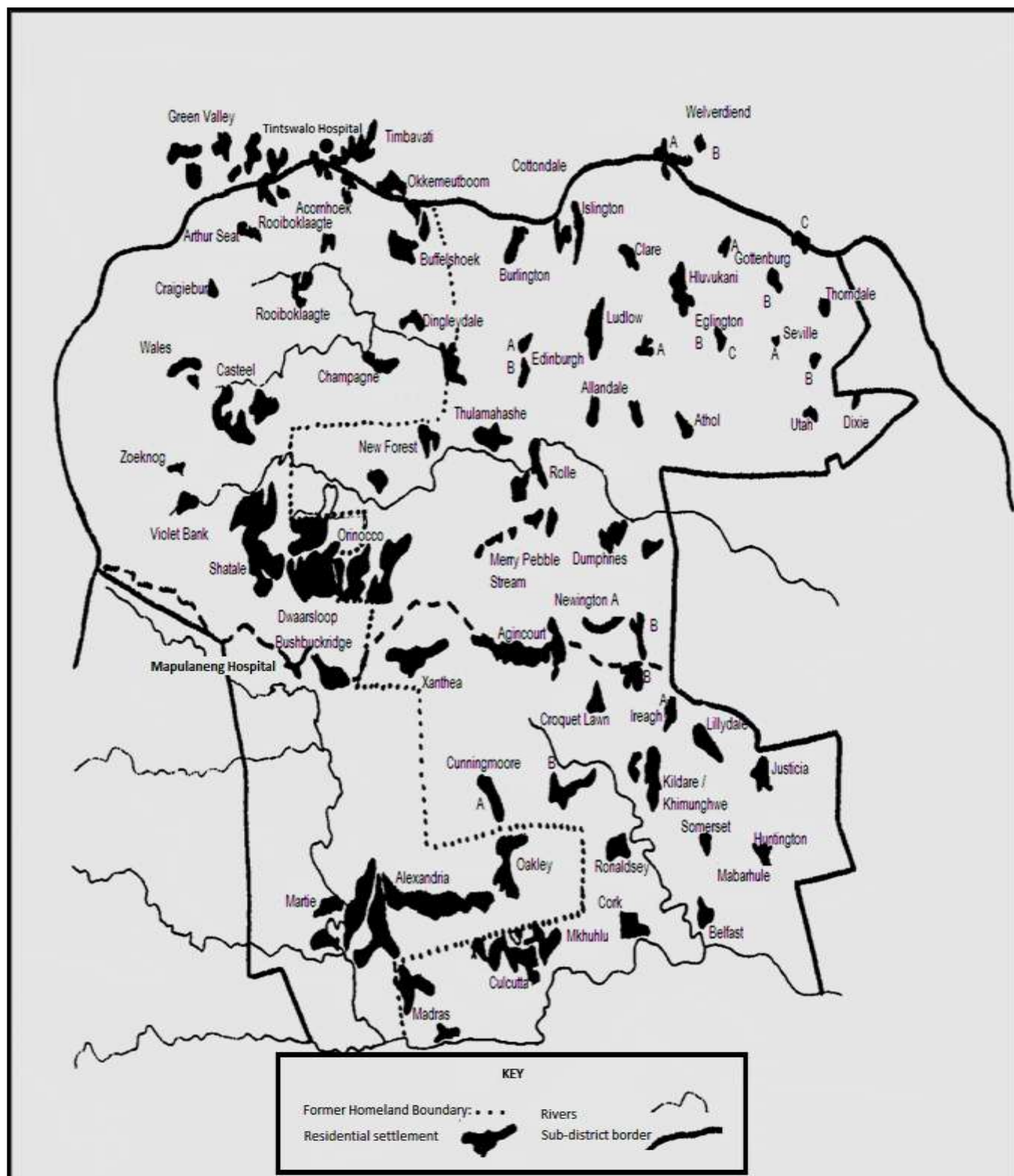
**Map 1: South Africa's Limpopo Province, showing Bushbuckridge**



**Map 2: HIV Prevalence Map of South Africa (Department of Health 2006)**



Map 3: Places referred to in the text



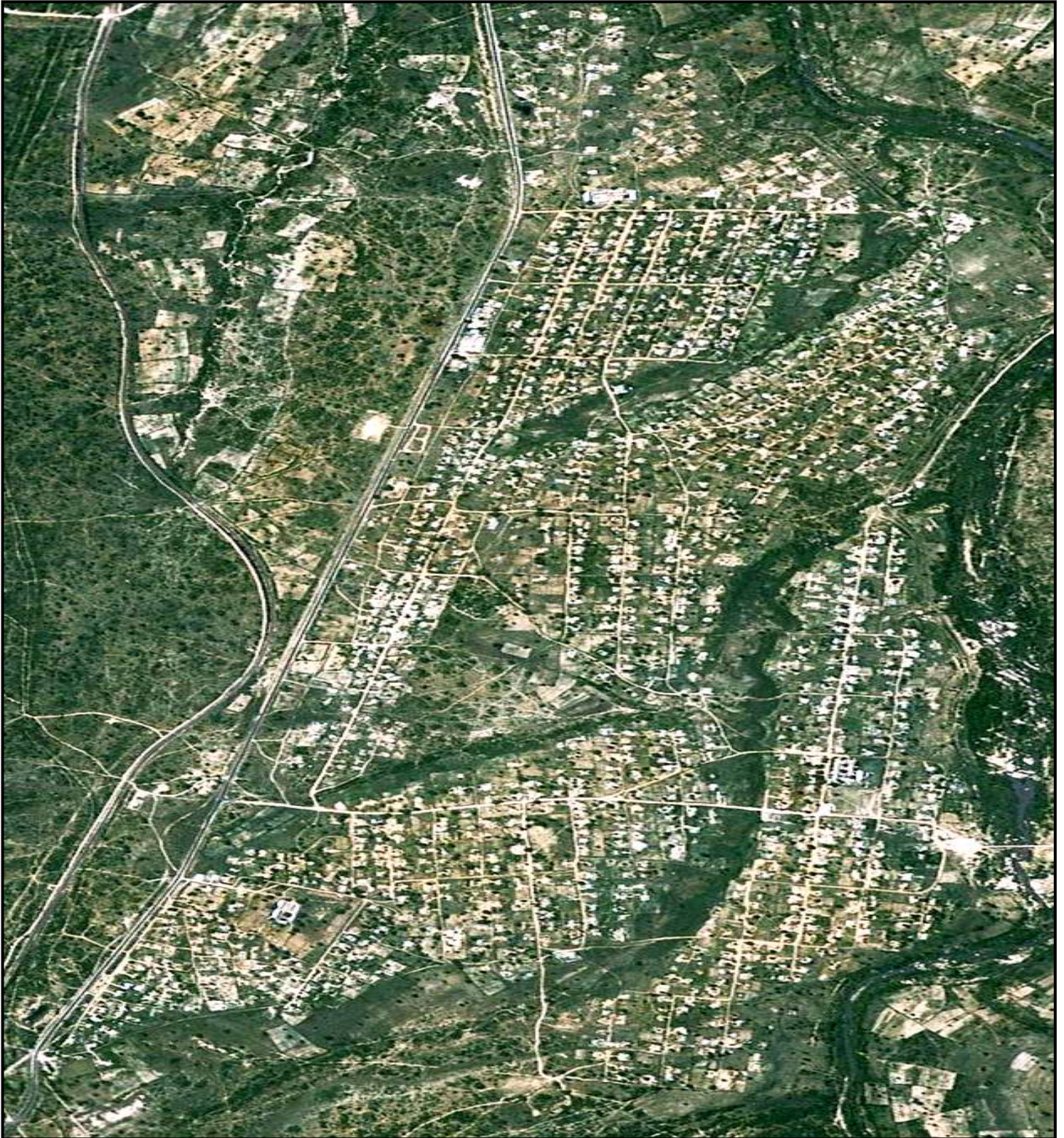
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**Figure 1: Cartoon on the death of ANC Youth League president Peter Mokaba (Shapiro 2002).**



## CHAPTER ONE

### INTRODUCTION

#### THREE FUNERALS AND A PARTY

SisMinah Khomani (58 years old) sat in her front yard holding her three-year old granddaughter in her arms, spoon-feeding her soft porridge. The infant was unwell and SisMinah was worried; the girl suffered persistently from diarrhoea and vomiting. Her constant illnesses affected her physical development; she was small for her age and could barely support herself on her puny limbs. The child's father had died shortly after she was born. Neither SisMinah nor Susan (the child's mother) attended his funeral nor did they visit his grave to pay their respects. Contrary to custom the family did not inform SisMinah of his death until after the funeral. SisMinah recalled that this had hurt her deeply; it was as if they blamed her for the death of their son. That day SisMinah confided to me in a whisper that Susan too was very ill but refused to seek care. Susan never spoke to me and usually hid away when I visited her mother. At SisMinah's request, Susan eventually agreed to come with me to a hospital located 20 kilometres from SisMinah's home<sup>1</sup>. Susan and her daughter were tested for HIV in the hospital clinic. After a long day of waiting in queues they were given an assortment of pills for herself and bottles of syrup for her daughter.

Soon after our trip to hospital, SisMinah's granddaughter died. Unable to afford a wooden coffin, SisMinah buried the tiny corpse in a cardboard box. A neighbour offered

her R100, and asked the other funeral attendees to donate money to buy a proper coffin. However, it was late and SisMinah was keen to complete the ceremony. The burial took place at the communal graveyard sited between the village and the open bush. When they returned to SisMinah's homestead, the small gathering ate bread with sweet black tea. By nine o' clock in the morning the funeral was over. Susan remained indoors the entire time.

These events occurred in January 2002, long before the widespread provision of antiretrovirals (ARV) to treat AIDS. About 18 months later I heard that SisMinah was ill. When I visited her she complained of aching legs and head pains. She started to make mistakes at her employer's house in Hoedspruit where she worked as a domestic assistant; she burnt the ironing and then ruined supper after she passed out at the stove. Her employer dismissed her without paying her wages.

The Khomani household depended on hand-outs from neighbours. Almost daily SisMinah crossed the road to ask for maize meal, sugar and tea from her neighbours. The family ate porridge with okra (*guxe*) and bitter spinach (*kaka*) that grew wild in her garden. Close to tears she described how her neighbours had loaned her food on so many occasions she feared that she had overstretched their generosity. She laughed bitterly as she recalled the R50 bridewealth (*ndzovolo*) her estranged husband had paid, and then left her to look after his four children. Her husband was an abusive man: once he stabbed SisMinah in the leg and punched her in the neck.

Over the next few weeks, SisMinah's illness steadily worsened. Eventually she retreated from her patch of shade under the tree in the yard to lie in her room. She complained of dizzy spells and aching bones which she attributed to 'high blood'

(hypertension) and ‘nerves’ because, as she put it, of ‘thinking too much’. She was admitted to hospital and placed on an intravenous drip for two days after a severe bout of vomiting and diarrhoea. The nurses confided to a neighbour who visited SisMinah: ‘we just want to tell you that your sister [friend] is HIV positive’. To me, SisMinah said:

I am dying. Since I became sick I will never become better again. I am just waiting for the day [I die]. I can’t eat beef, even chicken. I can only eat fish and *guxe* [okra]. Ha! They sent me to the AIDS people [clinic]. Agh! Even if people think I have AIDS I don’t care.

NwaSamuel, SisMinah’s neighbour, was indignant that SisMinah did not tell her that she had AIDS. Over the fence dividing the two properties NwaSamuel shouted in the direction of SisMinah’s room: ‘You don’t need to hide this disease. Hey you! Why were you hiding from me! This disease is not something you can hide. It will show itself and then you cannot hide anymore’

SisMinah’s closest friend, also a domestic worker, NwaMbembe confessed to me that she was terrified that she may also be infected. SisMinah and NwaMbembe occasionally had sex in exchange for beer with farm labourers, flush with cash after pay day, on the grassy pavement outside Wings, a tavern frequented by soldiers and working men in the small town of Hoedspruit. NwaMbembe recalled ‘Mr Jersey’ (*Manjezi*) the name given to a white railway employee who had sex with farm workers and domestic workers in exchange for jerseys worn by railway employees.

The evidence seemed to point toward SisMinah having acquired HIV from one of these sexual contacts. However, another woman speculated that it was possible that SisMinah acquired HIV from handling her granddaughter, accidentally coming into



contact with her bodily fluids. Either way, SisMinah's illness settled uneasily in the minds of her neighbours and friends.

A few months after these conversations I was surprised to see a party in full swing in SisMinah's front yard. Meat was roasting on a fire and a large pot of porridge (*pap*) was on the boil. The party was for Dudu, SisMinah's youngest daughter, who had turned 21. The birthday girl was dressed in high heels, a black mini dress and wore multi-coloured hair extensions. Loudspeakers were pumping *kwaito* music<sup>2</sup> and youths were jiving, holding ciders and beers and plates of food, chanting 'yes, yes, yes'. SisMinah made a brief showing at the party. Her daughters dressed her in a clean white blouse, blue pleated skirt and matching hat, and positioned her on a chair, under the shade of a tree.

SisMinah's neighbours were shocked by her daughter's behaviour in the presence of their mother's suffering. Earlier that day, two neighbours suggested to Dudu that it was disrespectful to hold the celebration. Dudu rebuked them and said she was 'happy her mother was dying' because she would no longer have to bear the humiliation of seeing SisMinah begging food from her neighbours. She even accused her neighbours of jealousy, insinuating that they wanted to bewitch her, and more ominously, that they had bewitched SisMinah. I shared in the older women's indignation at this insensitive display.

Later, I realised the significance of the party and its juxtaposition with the terrible predicament of SisMinah's small household. The consumption of feast food countered the image of SisMinah going from house to house with an empty tin begging for maize meal. The dancing and celebrations erased the memory of the pathetic cardboard-box funeral held for SisMinah's granddaughter. The party was a rebellion against suffering and poverty, a refusal to accept this fate, to be defined as 'the poorest of the poor'. Dudu

had (as the slogan goes) ‘declared war on poverty’, and the disease that was destroying the family.

In the months following the party SisMinah hid away and died a slow and painful death. She was buried by her children. In Johannesburg, a while after my final visit, I heard that SisMinah’s daughter, Susan had also died. She was taking antiretroviral (ARV) tablets sponsored by the United States Agency for International Development (USAID) but apparently ‘threw her pills away’<sup>3</sup>. According to my informant, Susan did not see any point in continuing to live. She no longer had a child to support. Her funeral was described as ‘decent’. Susan used a portion of her state welfare disability grant to contribute towards membership of a burial society.

This account of three generations of AIDS death reveals the horrendous and destructive impact of the epidemic. Over a period of about two years almost half the membership of the Khomani household died from the same disease. At the same time, the responses to illness and death, as vigorously asserted by Dudu’s party, articulated in the words of SisMinah, and perhaps in Susan’s refusal to take her ARVs, actively resisted and redefined their suffering. In essence, the act of forgetting illness and death allowed life to proceed.

In thinking about this tragedy and the reactions of household members, neighbours and friends, I am reminded of Scheper-Hughes’ accounts of premature death in North Eastern Brazil. In the following vignette she writes about the death of an infant juxtaposed with a child’s birthday party:

The cake was baked and decorated, a few balloons purchased, coca-colas were lined up and ready. The infant in its cardboard box was prompted up on the table

next to these party favours, and the birthday well-wishers came and celebrated Patricia's birthday while barely noting the dead baby as the counter-centrepiece to the birthday cake (2008, 44).

Scheper-Hughes argues that actions such as this reveal the normalisation of suffering and peoples' resilience to extreme adversity. She concludes:

...while theories of human vulnerability and trauma acknowledge the weight of the world on the lives of the poor, the excluded, and the oppressed, human frailty is matched by a possibly even bio-evolutionarily derived, certainly historically situated, and culturally elaborated capacity for resilience. While for many years searching in the nooks and crannies of oppressed and excluded communities for political mobilizations and organized resistance in the face of terror as usual, I found, instead, forms of everyday resilience (2008, 52).

Similarly, I am drawn to understanding peoples' responses to suffering in the midst of a devastating epidemic, of debilitating illness and death. The history of AIDS in South Africa is one marked by fierce opposition to state policy that withheld lifesaving drugs to treat AIDS. Although the story of the prominent political struggle between AIDS activists such as the Treatment Action Campaign (TAC) and the South African state are worthy of social analysis, I am more concerned with ordinary peoples' quotidian struggle for survival.

In Bushbuckridge where my research took place, AIDS is ubiquitous yet concealed and censored in public: the bodies of the AIDS ill, and talk about the disease are hidden. The public silences deny the reality of the horrendous illnesses, deaths, and the implications this has for the living. This has significant public health implications for diagnosis, prevention, treatment, and community mobilisation.

This thesis chronicles what the silence and concealment of AIDS means for HIV spread, illness and death. I argue that despite the silence and concealment surrounding AIDS, subaltern forms of social discourse such as gossip, rumour and witchcraft beliefs are strategies employed to manage the effects of the epidemic, albeit not always successfully. These strategies and their deployment reveal the agency of the most vulnerable.

In the following I explore social responses to AIDS in the anthropological and public health literature, describe the research context and end with an account of the research process, stressing the value of the ethnographic perspective in AIDS research.

## **THE PARADOX OF AIDS IN SOUTH AFRICA: DENIAL, FATALISM AND CULTURE**

The end of apartheid was a historic and momentous moment in the life of South Africa. But our suffering has not ended. Just as we were bringing to a close a terrible chapter in our history, another crisis was just beginning. Back in the 1980s, in the midst of our struggle against apartheid who could have foreseen that another tragedy that of HIV/AIDS was just starting to unfold? (Desmond Tutu, Archbishop Emeritus, July 2003, Cape Town cited in: Kauffman & Lindauer 2004)

(...) in developing countries this silence [about HIV] is even more oppressive because it is mixed up with the pathologies of poverty and deprivation: gender inequality, illiteracy, violence against women, acquiescence to undemocratic powers of chiefs and unelected rulers. Further, people whose poverty often means that they are already beset by disease make an easier accommodation with a new disease, even HIV. For the poor, the aetiology of a disease may be irrelevant if the symptoms and causes are much the same (Heywood 2004, No page numbers).

At the same time as South Africa achieved political liberation in 1994, the country has been consumed by the spread of HIV and death from AIDS. An estimated 5.4 million

people out of 48 million are infected with HIV (Dorrington et al. 2006). Furthermore, the forces that were engaged so successfully in the struggle against apartheid have not mobilised around the battle against AIDS (Karim & Karim 2002, 40). Instead, the optimism surrounding the birth of the new democratic South Africa has been steadily worn away by the AIDS epidemic (Fassin 2003). As Fassin notes: ‘the spectacular spread of the epidemic in the past decade, runs in terrible counterpoint to the happy narrative of national reconstruction’ (Fassin 2007, xvi). Although apartheid is no longer, the AIDS epidemic reveals the resilience of social inequalities; the indigent experience worsening poverty resulting from AIDS illness and death and new forms of discrimination emerge, directed at people infected and affected by AIDS. ‘AIDS is the new apartheid’ declared Archbishop Desmond Tutu (Independent Online 2001).

In 2003, twenty years into the AIDS epidemic the response of the South African government to this crisis was completely inadequate, marked by public denial, conflict, and delays in implementing prevention and treatment. This resulted in thousands of preventable deaths. These failures are largely attributed to South African AIDS policy under the government of Thabo Mbeki, the former president of South Africa. Yet, apart from vocal opposition from AIDS activist movements such as the Treatment Action Campaign (TAC), the massive threat that AIDS poses has not engendered widespread public action at the local level. Indeed, despite the overwhelming visibility of AIDS, South Africa ‘has been produced as a site of secrecy, silence and denial’ (Reid & Walker 2003, 85). Only in 2004, South African AIDS policy underwent a complete transformation: antiretroviral drugs to treat AIDS began to be rolled out in the public



sector and provided for free to patients. AIDS was recognised as a disability and government sponsored cash grants were provided to patients meeting the requirements.

### **Silence as denial**

Denial is seen to underlie the partial and incomplete silences and veiled communication about dreaded and incurable diseases. This is often inferred from speech that avoids direct mention of the disease. For example, cancer is seldom mentioned by name but by euphemisms such as the big ‘C’ (Balshem 1991; Sontag 2001). In South Africa, AIDS is referred to as ‘the three letter disease’, ‘three numbers plus bonus’ (a winning score in the lotto), a BMW Z3, OMO (a brand of washing powder), House In Vereeniging (spells out the acronym HIV) (Stadler 2003a).

These verbal avoidances are mirrored in performances of suffering; AIDS sufferers are concealed in homes, hidden from the public view, and alienated from society (cf. Nzioka 2000). This is also reflected in society’s attitudes toward people living with AIDS. For example, in a survey published in 1992, 38% of those interviewed expressed the opinion that people living with HIV/AIDS should be separated from society (Stadler 2003b).

Denial of the biomedical reality of HIV has special significance for public health and disease control, as is apparent from the uptake of HIV testing. For instance, in a survey of 2 500 residents in the mining town of Carletonville, respondents were offered free and anonymous HIV testing but not a single person volunteered (Ashforth 2002). Denial also impacts on disclosure of status. In a survey of 726 HIV positive patients, 92% had not told anyone of their status (Pawinski & Lalloo 2001). Patients often opt out of

receiving results of their tests, seriously undermining the effectiveness of treatment programs (Doherty et al. 2005). Ironically, health policy and medical practice actually reinforce secrecy. In South Africa, AIDS is still not a notifiable condition, despite various attempts to implement notification (Sidley 1999)<sup>4</sup>.

The maintenance of secrecy has had a direct impact on the effectiveness of providing treatment to prevent the transmission of HIV from mother to child (PMTCT). Pregnant women who test positive for HIV during antenatal care visits are scheduled to enter the PMTCT programme. Their clinic cards contain vital information relating to their pregnancy, including HIV status encrypted using an alphabetical code that uses the first name of their maternal grandmother as the key to unlock the code. This is not a fail-safe system and results in many pregnant women being miss-identified<sup>5</sup>.

Kubler-Ross (1970) classified 'denial' as the first of five psychological stages that individuals experience when faced with extreme trauma and knowledge of impending death. Denial prevents one from thinking about reality and therefore reduces stress and anxiety; it acts as a mental 'buffer' (cf. Brandt 2008, 14). This is thought to have a direct bearing on individual behaviours. A person may be aware of the dangers that a particular behaviour poses, but chooses to expose themselves to these dangers due to their being 'in denial'. Therefore, the concept of denial is able to explain the apparently irrational behaviour of individuals who knowingly have unsafe sex. The widespread nature of denial is explained by its manifestation as 'collective denial'. This occurs when a threat such as AIDS is highly prevalent, or where stigma is strongly associated with the threat (Parker & Aggleton 2003).

However, to assume that the absence of explicit discussion about HIV/AIDS is denial can be misleading (Wood & Lambert 2008). Moreover, denial may be better explained, not only as personal disbelief, but due to social and economic context. Sobo (1995) explores the political and economic ‘logic of denial’. Her research amongst inner city women in the US focussed on the social and economic context of women’s everyday lives in understanding their denial of personal HIV risk and their resistance to condom use. Risk denial is actually encouraged by AIDS education messages that recommend condom use in the context of ‘multiple partners’, ‘casual sex’ or ‘unfaithful lovers’. Women invest in a ‘monogamy narrative’ characterised by love and trust, in terms of which condoms are inimical.

What is classified as denial may constitute resistance against the stigmatising character of biomedical categories that promote blame; for example Haitian conspiracy theories of AIDS are counter discourses against US categorisations of Haitians as the dangerous other (Farmer 2005). Similarly, Mbeki’s questioning of the causal link between AIDS and HIV can be seen as attempts not to deny but to actively *resist* the allocation of blame on black<sup>6</sup> South Africans. In particular, Mbeki sought to resist the idea that Black South Africans spread AIDS because of uncontrollable sexuality (Schneider & Fassin 2002).

Furthermore, the interpretation of public silences literally as denial ignores the social and cultural meanings of silence. For example, McNeil (2009) argues that the reading of public silences of AIDS as collective denial risks simplifying a far more complex issue. The silence surrounding AIDS reflects conventions of silence that

surround death in general. In this sense, McNeil suggests, silence is a protestation of innocence of personal culpability.

### **Silence as fatalism**

A related concept that is used to explain why people fail to react to the threat of AIDS is that of fatalism, hence the use of the term ‘AIDS fatalism’ in the literature. As a cognitive-behavioural construct, fatalism is linked to hopelessness, and a lack of self-efficacy to change and conceptualise a future. A South African study found that 30% of respondents aged 18 years and over who reported fatalistic views about AIDS also ‘lacked self-efficacy’ and expressed hopelessness (Meyer-Weitz 2005). Fatalism is seen to predispose individuals against behaviour change (cf. Hess & McKinney 2007), limiting an individual’s ability to act on personal intentions (Paiva 2000). In public health discourse, fatalism is opposed to the adoption of ‘healthy lifestyles’. This is articulated as a struggle between modern rational knowledge and ‘an atavistic culture of “fatalism”’ that must be destroyed and replaced by a lifestyle approach to health (Davison et al. 1992, 676).

Caldwell *et al.* (1992) propose a cultural basis to fatalism. They argue that according to African beliefs in witchcraft and the ancestors, destiny is predetermined, and ‘outside the control of individuals’ (Caldwell et al. 1992, 1175). Therefore, the ‘extraordinary stoicism about death’ in African societies needs to be understood in the context of a belief in ancestral spirits and ‘survival after death in one form or another’ (Caldwell et al. 1992, 1178). Similar ideas appear in various guises in other writings. Kaler’s Malawian male informants define fatalism as inevitability: death is ordained from

God or witchcraft or vengeful spirits (2004, 290-291). Liddell *et al.* (2005) argue that beliefs in malevolent forces such as witchcraft shape a fatalistic outlook.

Fatalistic world-views are particularly manifest in societies that are oriented around the 'image of limited good' following Foster's (1965) formulations. Everything good is seen to exist in limited quantities, and 'God's will' determines individual fate; one person's good fortune represents another's loss. This outlook is thought to result in a lack of progress and change. Applying this idea to health, Nations & Rebhun (1988) surmise, 'this cognitive orientation leads to a resignation toward sickness, a view of it as a punishment from God, and a consequent lack of whole-hearted attempts to treat it'. Scheper-Hughes (1992) argues that fatalism underlies maternal neglect of weak infants; extreme poverty compels mothers to selectively neglect their children, nurturing those who are seen to be likely to survive and neglecting those who they believe will die. Scheper-Hughes' perspective has attracted criticism, largely because it ignores the material barriers to care seeking as well as the extent to which women will go to try to save their children's lives (Nations & Monte 1996; Nations & Rebhun 1988).

The concept of fatalism has been drawn on to understand peoples' apparent lack of will to mobilise against the AIDS epidemic. For instance, Leclerc-Madlala (2005) suggests that South Africans are highly fatalistic as a nation. She argues that fatalism is

Inevitable in societies beset by daunting and uncontrollable forces. Fatalistic attitudes coupled with a careless and reckless approach to life and the desire of some people not to "die alone" which further adds to the spread of AIDS' (Leclerc-Madlala 2005, 855-856).



Campbell (2003) suggests similarly that fatalism is related to peoples' sense that they lack control over their lives. Fatalism, she suggests

... may be particularly common among people who are persistently faced with difficult life situations over which they have little control, or who have had few experiences of situations in which they have succeeded in meeting their hopes or achieving their aspirations (2003, 183)

Therefore, the life experiences of men and women of desperate poverty, disempowerment and exploitation engender world views of limited control over the self.

The material circumstances of sexual relations may also cause fatalistic attitudes. Unprotected sex in exchange for material support may be the only means for women's survival (cf. Preston-Whyte et al. 2000). For men, multiple sexual relationships are the sole means through which they are able to assert their masculinity (Campbell 1997). In situations of extreme poverty and dire need, AIDS becomes secondary to the more pressing demands of simply surviving day-to-day life. For example, boys who live on the streets in Mwanza, Tanzania regard HIV/AIDS as a distant threat in comparison to the more immediate threat of starvation and violence and will therefore risk HIV infection through commercial sex (Lockhart 2002, 2008).

The idea of 'AIDS fatalism' is derived from the 'culture of poverty' model, according to which structural impediments form barriers to people being able to change their lives or even wanting to change. AIDS is experienced as yet another hardship endured by the poor and oppressed against which they are powerless. And, impoverished people do not invest in their health because they have so little to lose (Oster 2006).

A critical failing of the ways the concept of fatalism has been applied lies in the underlying assumption of cultural conservatism. To paraphrase Herzfeld (1982) who writes on modern Greek society, fatalism is regarded as a 'passive resignation to the future dictates of chance'. This suggests a certain backward looking-ness, 'the worst kind of inefficiency' that stands against progress. It is a 'rigid barrier' to the 'practical', implying that people are caught up in culture and tradition, or 'cultural sclerosis' (Herzfeld 1982, 644). In contrast to these orientations Herzfeld proposes that statements about fate and destiny may reflect the incorporation of new ideas and experiences into already existing and familiar ways of seeing the world. Furthermore, rather than asking how fatalistic statements about life shapes social and personal action, the question is how such 'declarations about fate constitute a form of action' which Herzfeld calls the 'performative action of excuses'. These are performances that 'invoke the idea of fate through oblique allusion' (Herzfeld 1982, 657).

Statements that allude to fatalism do not necessarily reflect a fatalistic attitude or disposition, or indeed predict behaviour. For example Balshem (1991) points out that the apparently fatalistic statements about cancer in working class American society can be interpreted as 'purposeful acts in a discourse of resistance' (Balshem 1991, 153):

...the community view is tied to strong feelings about access to power in society. Community members are disinclined to accept their assigned position as "targets" of a health education campaign. They have seen themselves labelled sick and they have turned this around to label their social and material environment sick. They have considered blaming themselves as victims, and they have rejected the notion. Scientific authority, clearly, does not consider their interpretations of experience valid. So they use rhetoric about fate as a shield, and charge the scientists with hubris (Balshem 1991, 165)

Statements about fate may be regarded as irrational and conservative, yet can be employed as rhetoric in contestations between Western biomedicine and ‘local’ knowledge. Implicit in this is a particular use of the concept of culture, often employed in public health and anthropological writings on AIDS.

### **Culture, AIDS and blame**

Culture often features in explanations for the apparent lack of change of sexual behaviours in sub-Saharan African society in response to AIDS and the continued high prevalence of HIV infections in the sub-continent (Marshall 2005, 2520). For example, researchers have focussed on witchcraft (Mshana et al. 2006; van Dyk 2001; Yamba 1997), and traditional healing (Green 1994; Peltzer et al. 2006). Sexual behaviours are also believed to be strongly influenced by traditions such as widow cleansing by having sexual intercourse (Campbell & Kelly 1995; Chipfakacha 1997), the levirate and sororate (Sow & Gueye 1998), polygamy (Cleland & Ferry 1995), bridewealth transactions (Wojcicki et al. 2010), and sexual promiscuity (Caldwell et al. 1989). Therefore the failures of disease prevention are conceptualised as African cultural failures to respond to prevention messages (Heald 2006, 30).

This analysis influences policy, directing resources toward combating cultural practices and traditions. For instance a recent report published by the United Nations Economic Commission for Africa asserts that culture plays a ‘major role’ in ‘gender inequalities’, ‘wife inheritance and widow cleansing’, ‘polygamy’, ‘domestic violence including marital rape’, and ‘harmful practices like female genital mutilations’ (Commission on HIV/AIDS and Governance in Africa 2008, 18-20). The report

specifically focuses on risky sexual practices, their link to culture, and the need to change cultural practices to reduce the spread of HIV on the continent.

Culture is further thought to promote unsafe sex. ‘Dry sex’ which causes vaginal lesions creates an entry point for HIV is believed to be a cultural preference of men in Africa (Brown et al. 1993; Brown & Brown 2000; Runganga & Kasule 1995; Van de Wijgert et al. 2001). And as a result of patriarchy and male dominance, women are seen to be unable to insist on condom use (Campbell 1995). A strong link is made in the literature on AIDS in South Africa between culture and the risk of HIV acquisition. For example, Leclerc-Madlala (2001, 41) writes that ‘Zulu sexual culture’ is characterized by:

...gender inequity, transaction sex, the socio-cultural *isoka* [masculine] ideal of multiple sexual partnerships, lack of discussion on matters of sexuality in the home and between sexual partners, the conditioning of both men and women to accept sexual violence as “normal” masculine behaviour along with the ‘right’ of men to control sexual encounters, and the existence of increasingly discordant and contested gender scripts.

Anthropologists have questioned and critiqued the exclusive focus on culture in explaining the spread of AIDS (Gausset 2001) and discuss social, economic, political (Farmer 1992; Parker 2001; Schoepf 1995) and biological factors (Stillwaggon 2002, 2003). The adoption of ‘culture’ as a variable detracts away from examining how political, economic and social processes influence the ways in which a disease spreads and the response to the disease (Parker & Harper 2006); a failure to recognise the political economy of AIDS (Farmer 1992; Schoepf 1995; Setel 1999), and the social contexts in which HIV transmission occurs (Deliuss & Walker 2002).

Perceiving the spread of HIV as a problem of culture effectively de-politicises the AIDS epidemic. Blame is directed toward local cultural knowledge and practices. And, by insisting that biomedical knowledge and technologies can alone provide the answers the focus shifts away from peoples' everyday struggles.

The thesis provides an alternative reading of the social response to the AIDS epidemic by exploring the social meanings of silence and censorship, avoidance and concealment of AIDS. Although these discourses appear to deny and suppress the reality of AIDS, I suggest that they are active attempts to deal with the AIDS crisis: gossip and rumour allocate blame and construct a local epidemiology through which the epidemic can be monitored; interpreting AIDS as witchcraft creates the possibility of avenging death. These discursive forms are critical in informing individual and social responses to the AIDS epidemic. While the absence of public acknowledgement of AIDS as a cause of illness and death suggests denial and fatalism and appears to limit public action, subaltern discourses create shared secrets to manage the AIDS epidemic at the local level. Furthermore, these discourses may constitute a form of resistance against biomedical models of causality.

### **AIDS IN BUSHBUCKRIDGE**

The effect of the AIDS epidemic in Bushbuckridge is visible even to the most disinterested observer. By the early 2000s, the impact of the disease was particularly evident in the growth of a local AIDS industry. Newly established funeral homes and mortuaries jostled for space near hospitals and shopping centres. A prominent businessman and also a (somewhat distasteful) medical doctor established a massive



mortuary where there once was an open field. Such growth was also evident in the mushrooming of organisations with complicated acronyms geared toward AIDS care and treatment and HIV prevention. The Bushbuckridge Health and Social Services Consortium (BHSSC) provided counselling and condoms, loveLife erected billboards and walk-in youth centres, the Health System Development Unit (HSDU) conducted intervention research projects. Numerous village-based organisations were established with funding from the Department of Health and Welfare to generate incomes for those households infected and affected by the AIDS epidemic.

Funeral processions choked the roads on Friday afternoons delivering bodies to all night vigils. Burials occurred daily even on Christmas and New Year's Day. The scene was comparable to the aftermath of the terrible tsunami of 2004, yet the effects of AIDS were far more far-reaching. I was told about shocking scenes in state mortuaries with bodies stacked on top of each other; and of a funeral home that resorted to hanging corpses on meat hooks to save space. The health services were unprepared to cope with the rising numbers of patients. The sick were often sent home from clinics with little more than 'Panados' (headache tablets). Hospitals were 'places to die'<sup>7</sup>. Nursing staff were rumoured to be in league with mortuary owners; to boost profits they suffocated or poisoned the terminally ill to hasten their deaths<sup>8</sup>. The ill and the dying were neglected and alienated by their own kin who appropriated and squandered their inheritances. Attempts to prevent the spread of HIV were perceived as futile: condoms were believed to be contaminated with HIV; infected persons purposefully spread the virus so 'not to die alone'; there was no guarantee that sexual partners would remain faithful; rape was

commonplace. The picture of AIDS in Bushbuckridge was of a ‘hopeless epidemic’ (cf. Smith 2003), one of passive resignation and acquiescence to the most extreme suffering.

What was most striking was that AIDS was not even spoken about publically as a threat to public health or well-being. Suffering was performed in secret and the sick and dying withdrew from the social world, becoming ‘living corpses’ (cf. Niehaus 2007). Actual mention of AIDS was carefully avoided, expressed through metaphor, and buried within rumour and neighbourhood gossip (Stadler 2003a). The silencing of AIDS created considerable barriers to public action against the epidemic. Despite efforts to educate and inform, the image of coherence that is so often projected in biomedical and epidemiological constructions of the epidemic was not shared at the local level. AIDS was imbued with multiple, contradictory meanings. The silences and ambivalences that surrounded AIDS challenged biomedical sureties and epidemiological confidences (Setel 1999, 184).

The reaction to the AIDS epidemic is puzzling in the light of a recent history of community mobilisation in response to other social injustices and crises amongst residents of Bushbuckridge. Political activism in the area was relatively low-key in comparison to other areas of the country up until the mid-1980s and early 1990s. In this period, witch-hunts occurred sporadically throughout this period as groups of self-identified ‘comrades’ sought to purge the communities of witchcraft (Niehaus 2001). Their actions gained popularity in the face of rising tensions, unexplained misfortune, illnesses and death. In some parts of Bushbuckridge, vigilantes patrolled the streets to protect residents against thugs and rapists as a response to the failure of the authorities to effectively protect residents (Ritchken 1995). On the eve of political liberation, school

children revolted against the use of corporal punishment in schools and called for an end to the repressive 'Homeland' government (Stadler 1995). Political activism did not fade after the 1994 elections; in 1997 residents of Bushbuckridge led violent protests against their incorporation into the Limpopo Province (Niehaus 2002b; Ramutsindela & Simon 1999) .

In contrast to these instances of activism, the public response to the AIDS epidemic is little more than a murmur. Unlike the deaths associated with the struggle against apartheid, deaths from AIDS are devoid of meaning; they occupy spaces external to the body politic. For example, former anti-apartheid activists are recognised by the naming of public spaces; for example Matsikitsane View in Green Valley<sup>9</sup>, the Merriam Mogakane Hall, and the Matthews Thibela branch of the African National Congress. The 'fallen heroes' of the anti-apartheid struggle are also resurrected in political speeches. In his public address, the Mayor of Bushbuckridge, Miton Morema listed those 'cadres who died in action' and asked that 'their revolutionary spirit continue to bless the unity of the people of Bushbuckridge for sustainable service delivery and development'. In contrast, Morema mentioned AIDS only fleetingly, tagged onto a public service announcement about drink driving:

Please always arrive alive. Don't drink and drive and speed kills. Always apply ABC as HIV/AIDS is still a monstrous killer. Let us test to know our HIV status and be counseled (Morema 2011).

The obfuscation of AIDS is particularly poignant in the silences in the numerous funerals of young men and women who embody the promise for the future survival of households, and in whom huge investments have been made. Funerals are public rituals,

well attended sometimes by thousands of people. This stands in stark contrast to the hasty and almost hidden funerals such as those held for SisMinah's granddaughter.

It is this contradiction between the high visibility of AIDS, its omnipresence and at the same time, its public censorship that shaped the contours of my research and lies at the heart of this thesis.

The reasons for these responses can be analysed from many different perspectives. Biologically, HIV is an invisible infection. Although the mode of HIV acquisition is commonly recognised as sexual, the paths of HIV infection are seldom visible. HIV infections only become realised when individuals test or when infections manifest as illness and death. Yet, the point of infection and illness are events separated in time; 'the epidemic silently creeps through the population', only later manifesting itself years later as actual illness and death (Whiteside et al. 2002, 1). Personal risk of infection is therefore seldom self-evident; it is hidden from view and lies outside the immediacy of personal sexual relations. Therefore, despite epidemiological sureties (Setel 1999), the delinking of infection from illness and asymptomatic carriers creates the space and indeed the need for alternative interpretations of the illness and deaths that result from AIDS.

Second, the diagnosis of AIDS has massive implications for social relations among the living. As the account of the Khomani family shows, AIDS does not only infect individuals, but affects relationships between spouses, lovers, parents and children, and neighbours. Revealing HIV and AIDS threatens to expose the failure of intimate relations, kinship and good neighbourliness. Concealment is therefore also a strategy to avoid the potential conflicts that can arise from a HIV positive diagnosis. Yet, acts of

concealment also generate suspicion and tension, and ultimately reveal that which is supposed to be secret.

Third, because AIDS is concealed and unmentionable, it is impossible to deal with the threat it poses. To accuse another of infecting oneself or others with HIV is to confess to have been infected, and to experience shame and social death. This presents a conundrum: how can one know about something that is not even acknowledged? And how can one act against a threat that is rendered invisible?

As I found out quite soon into my fieldwork, the silence and concealment of AIDS also poses particular challenges to doing research.

### **DOING ETHNOGRAPHY IN AN EPIDEMIC**

Several years ago, the anthropologist, Ralph Bolton (1995) charged anthropology with an inadequate response to AIDS. To a certain extent his criticism holds true today. Despite the massive literature on AIDS in the social sciences, very few full length ethnographic studies of AIDS have been produced<sup>10</sup>. Initially, the absence of anthropology from the AIDS research field may have something to do with an anthropological disinterest in researching sexuality. Anthropological research focussed on the observance of public behaviour; sex as a private behaviour was hidden from view, and lay outside of the observational gaze. Despite the apparently open nature with which anthropology dealt with conventionally taboo topics (Lindenbaum 1991; Vance 1991), surprisingly few shared Malinowski and Mead's enthusiasm (For example: Malinowski 1929; Mead 1928) for researching sexuality (Sanday 1996)<sup>11</sup>.



While anthropology was initially slow to respond to the challenge of research on AIDS in the early 1980s, this changed rapidly with a growing interest within biomedical research on sexual behaviours and meanings between different ‘cultural groups’ (Marshall & Bennett 1990). This research has produced an agenda that, as Fassin (2007, 25) bluntly states, focuses on the ‘customs of the natives’ that promote the spread of AIDS and anthropological knowledge tends to be exoticized. Farmer (1997, 517) agrees:

The Scenario most commonly evoked was one in which ethnographers, steeped in local lore after years of participant-observation, afforded epidemiologists and public health authorities detailed information about sexual behaviour, childbearing, and beliefs about blood and blood contact. This knowledge transfer was held to be indispensable for determining which "behaviours" put individuals and communities at risk for HIV infection.

Mimicking these international trends, South Africa has produced very few anthropological studies of AIDS, and even at the height of the epidemic displayed a disinterest in studying the epidemic. In 2003, at the conference for the Association for Anthropology in Southern Africa (AASA), only two presentations based on original research were about AIDS<sup>12</sup>. This situation has since changed, perhaps in response to the availability of funding for AIDS research in the social sciences, but also since the topic has become more topical.

South African writings on AIDS have tended to focus on the public and political contestations between the Treatment Action Campaign (TAC) and the state (For example: Fassin & Schneider 2003; Hoad 2005; Robins 2006; Schneider 2002). This body of research is important, yet tends to exclude the experiences of ordinary peoples’ everyday

lives, the ‘ordinary experiences of AIDS, the most personal, intimate suffering’ (Fassin 2007, 276-277).

AIDS research tends on the whole to favour epidemiological and behavioural approaches. Anthropological methods and approaches do not always suit the AIDS research agenda that is preoccupied with an urgent need to find solutions. Short-term consultancy research typically employs knowledge, attitudes, and sexual practices (KAP) surveys to provide quick answers. Yet, there is growing recognition of the limitations of surveys. Surveys often fail to reveal why ‘practices’ seem to contradict ‘knowledge’, as these methods lack insight into the context of knowledge and action. Qualitative methods such as focus groups and structured interviews are employed to fill this gap. However, these methodologies construct artificial settings for the research (cf: Heald 2006, 31). Consequently, the data that results often reflects the perceptions of the researchers rather than the experiences of the research participants.

In contrast to these rapid methodologies, ethnographic research is long-term and takes place in natural settings. Ethnography strives to locate the actions of individuals within the cultural context that gives them meaning and that of the political and economic setting that structures everyday life experience.

Moreover, insights into suffering and the daily struggles of life are possible only from the researcher’s personal involvement in the ‘quotidian life - the humble, familiar, and mundane aspects of everyday experience’ (Green 1998, 3). Anthropological research is an attempt to articulate the complexities and the contradictions of peoples’ lives and by doing so anthropologists become part of the lives that they are researching. Upon return from the ‘field’ we have two languages: the language of theory and also the ‘language of

peoples' practices' (Green 1998, 6). The challenge is to try to make linkages between these two perspectives.

Anthropology also stresses reflection and introspection. The research process is an extremely personal experience, influenced by who we are and our own histories. This shapes the questions we ask and influences the way we make sense of what people say (Clifford & Marcus 1986; Marcus & Cushman 1982).

The personal account of my research begins in 1990 when I first came to the Bushbuckridge area as a post-graduate student in anthropology. Over a two-year period I spent eight months conducting research on generational relationships. My research was concerned with youth participation in popular resistance against apartheid and the impact this had on domestic relationships, intergenerational struggles and negotiations over authority. I was particularly interested in the use of tradition in contestations over generational authority within the public and domestic spheres of life (Stadler 1995).

When I completed my research I worked for the Witwatersrand University Rural Facility (WRF), located a short distance from the village where I had done my research. The WRF aimed to create a learning environment for students from the university and thereby encourage professionals to work in the area on community development projects. However, by 1995 when I left WRF, I was disillusioned with the idea of 'community development'. The research and development agendas promoted by the projects implemented by WRF seldom directly addressed the basic needs of the villagers who were targeted by their projects. For example, using biogas (from fermenting cattle dung) as an alternative energy source ignored the realities of imminent electrification in the area and the paucity of livestock (necessary to produce the dung).

In 1995, I began work as a researcher for the Health Systems Development Unit (HSDU), based at Tintswalo Hospital in Acornhoek. At this time national and international public health concerns focussed on teenage pregnancy and the social and health issues this engendered. The US-based Henry J Kaiser Family Foundation funded research to establish ‘adolescent friendly’ services in three villages. Sexual and reproductive health was a neglected area particularly for adolescents; hostile nursing staff and adult oriented services alienated adolescent patients and were unable to address their complex needs. At this time AIDS was lurking on the horizon but was an unimaginable threat. I left Bushbuckridge in 1998 having spent five years living in the area.

In 2000, I returned to Bushbuckridge, this time working on an evaluation of loveLife, a national program that aimed to reduce HIV infection in adolescents by 50%. The intervention included the establishment of youth centres (*Y-Centres*), one of which was built in Acornhoek in Bushbuckridge. Talking to people in the area about the AIDS epidemic I became aware of the absence of local knowledge and contextual understandings of the epidemic in the formulation of the loveLife intervention. For example, attempts to introduce local cultural practices into the Y-Centre activities were frowned upon by the donor. At the Acornhoek Y centre, the portraits of Ramahlodi (Premier of the Limpopo province) and Thabo Mbeki (South African President) hanging on the wall were hastily removed when Washington DC-based representatives of the donor organisation paid a visit. It was clear who controlled the ‘loveLife brand’. Community conversations reflected a growing awareness of mortality from AIDS. Many expressed disbelief and confusion regarding the cause of death, disputing the validity of stories of AIDS in the media. Public health propaganda that urged condom use,

monogamy and abstinence was also regarded with scepticism. I was frequently challenged by youth who expressed disbelief that there indeed was an AIDS epidemic. Although the number of ill and dying were steadily increasing the sense of the unreal pervaded.

These experiences inspired me to begin research toward a PhD. Between 2002 and 2005 I completed 12 months of fieldwork in a village settlement I call KwaBomba<sup>13</sup>, located near a site where I had worked several years before (Shackleton et al. 1995).

The project is a culmination of several years of involvement in Bushbuckridge, on and off over 15 years, as a student, as a part time resident, and as a member of a large extended family through my marriage to Conny whose family are from the area. Over the years I have developed a strong sense of identity with the area. At times I feel like a migrant worker; earning a living in the city and returning home to rekindle social relations by participating in funerals and other rituals. I also experience guilt when I do not visit my 'home'. My wife spent her childhood years in the Bushbuckridge area and many of her kinsfolk live there. She continues to regard Bushbuckridge as home; my feelings are more conflicted.

White South Africans, particularly of the anglicised middle-classes such as my own seldom have much to do with their kin. We may celebrate Christmas or Easter together and keep in contact through email and telephone calls. As by way of example, my paternal grandmother's funeral was a small affair attended by only close family members; enough to fit around the dining room table. In comparison, funerals are *the* chief ritual in Bushbuckridge.

As an in-law of family from Bushbuckridge I am part of a large and complex kinship network. The network spans across the villages of the lowveld and into the urban settings of Johannesburg, the East Rand and beyond. Kinship operates as an inclusive system, assimilating members rather than defining those who do not belong. Thus, depending on who I meet, I can be a grandfather (*kokwane*), a grandson (*ntukulu*), brother (*buti*), uncle (*malume*), father (*bava*), cousin (*mzala*). With these kinship categories come responsibilities and expectations. I attend family rituals, participate in family discussions, and contribute financially and in other ways toward the welfare of my kinsfolk.

This ‘insider identity’ has distinct advantages for research but also poses challenges. During my fieldwork, my in-laws (*vakonwana*) involved me in everyday and ritual life. I attended funerals, ritual cleansings, bridewealth payments, and ancestral rituals (*ti mhamba*) as a kinsman. I also participated in the more mundane aspects of running a household and dealing with family issues, debates and feuds. This occasionally involved suspicions and accusations of witchcraft. For example, at the funeral of my wife’s step-brother an emergency meeting was held to discuss the lack of funds for the burial. The family did not belong to a burial society and it was up to the salaried members of the family to make up the difference. At the same time, on the side-lines of these discussions were insinuations of witchcraft that identified a family member. My inclusion in the practical discussions about finances and my willingness to assist meant that I was included in these more private discussions. Therefore I observed and participated in both the mundane and the magical aspects of everyday life.

Yet, as a white, middle-class English-speaking South African, and as a researcher, my position was often tenuous. I experienced a sense of ambivalence and at times



schizophrenia in ‘doing research’ on the one hand, and participating in rituals and everyday life as a kinsman on the other; a process captured well in the phrase ‘stepping in and out of society’ (cf. Powdermaker 1966). To do anthropology seemed disloyal to my position as an in-law as it suggested a hidden agenda. But, failing to collect information and record what I heard and saw meant failure as a student of anthropology. At family gatherings I longed to take out pen and notebook to record an interesting comment or conversation. When I did so, comments were made about me ‘being on duty’ (at work). Clearly ‘doing ethnography’ did not always mix well with ‘doing kinship’. However, the ambivalence and the contradictions regarding my identity encouraged greater reflection, born from a sense of distance and intimacy at the same time (cf. van der Waal 1992).

I am not suggesting that kinship is solely a means to gaining insider knowledge; nor am I suggesting that my personal circumstances provided me with better access. Indeed, my personal circumstances meant that I was bound by the same etiquette and rules of censorship when it came to discussions about AIDS and associated death as other villagers. My status as a local meant that I had little excuses to make mistakes. However, ethnographic fieldwork demands a level of intimacy and personal involvement that other forms of research do not usually require. There are many different ways in which an insider view can be developed. Furthermore, my position as an insider also meant that I had to exercise my own form censorship when sharing life stories with my informants.

My research experiences pose ethical questions, particularly from the perspective of the field of bioethics that centres on the process of informed consent. In biomedical research each interaction with research participants is mediated through an informed consent procedure; the aims and procedures of research are explained and a signed or

verbal agreement is made. In more formal interviews this is possible and desirable. Yet ethnographic research makes it extremely difficult to make a clean distinction between research and normal interaction in daily life. Informed consent in the context of participant observation poses ludicrous expectations on the part of the anthropologist and those with whom he or she is interacting (cf. Fassin 2006). The formal contract of the informed consent procedures is at odds with the nature of the social interaction required in building relationships of trust and respect (Oxlund 2009). I am aware that research on a topic such as AIDS creates sensitivities; I have to the best of my abilities protected the identities of those who I quote in this thesis by replacing informants' real names with pseudonyms and a fictitious name for the village where my fieldwork took place.

The more formal or structured process of my research occurred in three stages. I began by gathering sexual life histories, experiences and perceptions of AIDS through interviews with young men and women. I hung out with a group of younger men who were involved in HIV prevention activities in the village and used their personal networks to identify other informants. I was interested in understanding peoples' personal histories of AIDS and the implications the epidemic had had for their sexual relations. Young men's sexual biographies were easier to collect than women's, although access to women's experiences was facilitated through key informants. At the same time I collected oral histories from older men and women (Table 1).

**Table 1: Interviews conducted in KwaBomba, 2003-2005**

<i>Number of interviews</i>	<i>Description</i>
10	Sexual biographies of males / older youth / young adolescents
5	Young men life histories
6	Older women life histories
4	Older men life histories
7	Young women life histories
4	Teachers (including one high school principle)
3	Nurses
2	Medical doctors
3	Pastors
6	Traditional Healers
3	Faith healers
63	

Quite soon into my fieldwork I started attending funeral rituals. I remembered from the early 1990s that these are important events that are well attended. Those who fail to attend funerals face a lonely burial when they die. The AIDS funerals that I attended were markedly different from what I remembered from previous years. Funerals in the 1990s started in the mid-morning and lasted well into the afternoon, feasting on beer and beef. During my fieldwork, I attended funerals that were brief, almost hastily conducted events. On some days up to five burials occurred in the village. Feasting was restricted to kin and friends and those from afar. This apparently was in response to a directive from the local headman (*nduna*). Funerals were bankrupting families who had limited funds and who were not members of burial societies. Moreover, it was rumoured that witches were killing people in order to benefit from the feasts provided at the

funerals. Indeed, funerals were an important opportunity to eat meat. People joked that some attendees even brought salt, pepper and packets of chilli powder to flavour the rather bland funeral food.

Although funerals are silent about the cause of death, accounts of suspected AIDS death were voiced ‘in the corners’ these gatherings once the deceased was buried. Due to my visible presence at funerals I was privy to the secretive conversations during which gossip about the cause of death was expressed. I explored these whispered accounts in more detailed interviews with neighbours, friends and kin. These investigations form the basis of the material presented on AIDS mortality and secrecy.

In addition to funerals, I also participated in other social events such as weddings (I attended one), children’s birthday parties and ancestral rituals. Traditional dance (*muchongolo*) contests are held weekly in Bushbuckridge. I attended these whenever they were held in KwaBomba, interviewed the song writers and recorded several of the songs about AIDS (see Appendix A).

At this point in my research I had not met anyone who was open about their HIV status. AIDS was a subject that people wanted to avoid. Although people ‘talked’ about AIDS, this was usually in very general terms or as rumour and gossip. My informants seldom made specific references in their accounts of the AIDS epidemic. Instead they pointed to general characteristics of people who were thought to be infected or have died from AIDS. While this frustrated my objective of gathering information about the epidemic and its impact at the local level, secrecy and concealment emerge as major themes in the thesis.

I noted too, that there was a distinction between public and private accounts of death. In public accounts, AIDS death was insinuated through euphemism. This response was a way of avoiding talking about dangerous topics. Private conversations with people close to the deceased revealed a different set of concerns. Although my informants admitted AIDS to be the cause of death, they also expressed uncertainty and the suspicion of witchcraft.

Hanging around at peoples' homes and listening to gossip was an important component of my fieldwork. NwaAbraham – who I visited almost daily – always had visitors at her home. The midday meal attracted children and friends from the neighbourhood. Neighbours often stopped to have a chat. Because of her status as a respected and kindly woman, many villagers treated NwaAbraham as a confidant and sought her advice for their personal problems. Illness and the circumstances surrounding death were often reported to her. I recorded these conversations as best I could and pursued the issues they raised in my interviews.

In the final phase of my research I gained insights into the experiences of suffering. I was approached by individuals asking for practical assistance with access to disability grants, Unemployment Insurance Funds, unfair dismissal, and mysterious illnesses. Word also spread that I was interested in AIDS and that I was a resource that could be used to access care and support. I was also identified as a medical doctor. This resulted in my involvement in individual struggles to seek care. It led me to meet Pinkie and Solomon, Sizwe, Khayellhle, SisMinah, MaKwaMary-Jane, and Robert. Their stories provide insights into the everyday struggles to deal with a terminal illness and the social suffering that it engenders.

Doing fieldwork in an epidemic as devastating as AIDS is in South Africa calls into question whether as observers we are able to comprehend and understand the experience of suffering. Autobiographical accounts of AIDS provide authoritative voices on the experience of suffering from AIDS, although these are often from privileged positions (For example, Cameron 2005). To what extent is it possible for anthropologists to comprehend suffering without having first-hand experience of this? The anthropologist, Renato Rosaldo could only comprehend the anger and desire for revenge expressed by Ilongot head hunters once he experienced the personal tragedy of the death of his brother and his wife (Rosaldo 2004). Sontag's struggle with cancer led her to write from personal experience and later extended this to her analysis of AIDS (Sontag 2001). Some anthropologists write about AIDS from the intimate perspective of having lost friends, lovers and companions (E.g.: Bolton 1995).

Because of the nature of the anthropological enquiry, anthropologists are bound to deal with the immediacy of the suffering of others. This can be emotionally draining and extremely stressful. Emily Frank wrote about her fieldwork on AIDS in Zambia:

It is too difficult to work with people who are dying or who have just lost someone. It is frightening to work with illness and death. It is hard to talk about and difficult to become emotionally involved with people who will not be around when you return the following year for fieldwork. (Frank 2005)

During my fieldwork I witnessed the illnesses and deaths of people I had grown to know and with whom I felt that I had established a relationship. In some cases I faced the dilemma of recognising signs of infection and illness in a person I knew and not knowing how to express my fears that they were possibly infected. A young man I had interviewed



several times approached me complaining of a skin rash and diarrhoea. I feared the worst and offered to take him to consult at the hospital. Yet, I could see that he shared my suspicions and was not prepared to admit to what was obvious to both of us. I did accompany several individuals to hospital. The experience was wearisome and depressing. I often felt in these circumstances a ‘social and political impotence’ (Schoepf 1995, 346), due to the callous and unsympathetic medical staff.

I believe that the intimacy of the ethnographic perspective promotes a moral obligation to communicate the experience of suffering. Research in an epidemic cannot be regarded as a neutral act (cf. Castro 2004). For example, Shao (2006, 536) has this to say about his fieldwork conducted in the ‘AIDS villages’ of Henan, China:

As ethnographers, we cannot avoid taking a position within the very social worlds in which we carry out our research. No matter what position is taken, it is implicitly or explicitly political and has political consequences

I feel strongly that there is a moral imperative to expose and lay bare the realities of suffering from AIDS. Writing about suffering from an ethnographic perspective is distinct from epidemiological and biomedical discourses that tend to reproduce the official discourses of disease and death<sup>14</sup>. Irving (2007, 204) points to the invisibility of people in scientific writings on AIDS:

For a literature concerning a blood-borne disease, much of it is surprisingly bloodless; the person’s thinking, emotions and dilemmas, their very flesh and being, are reduced to statistics, the biological body or social structures. Surprisingly few *people* inhabit these texts (...) [original emphasis]

Absent in these accounts are the intimate details of human suffering which are so important if we are to start to comprehend the impact of the AIDS epidemic. Without this perspective, the suffering of others is obscured. Furthermore, this legitimises and reinforces indifference to suffering by rejecting our common humanity and by denying identity (Herzfeld 1992, 1).

Recognising the limitations of the epidemiological ‘official’ data on infant mortality in Brazil, Nations remarks on her research:

I resolved to come to grips with the human face of infant death. To get down to the flesh, blood, and souls to understand it, to live it in the households of impoverished parents who suffer its tragic consequences’ (Nations & Amaral 1991, 205).

Sharing in the personal tragedies of the AIDS epidemic was a critical component of my fieldwork. This involved escorting sick people to hospital, waiting in queues, sometimes late at night, only to be told that there were no beds available, no treatment for ‘this disease’, and witnessing first-hand the effects of AIDS. One specific instance that stands out in my fieldwork was the death of a young woman, Pinkie Mnisi, whose story I recount in detail here.

### **Pinkie’s story**

Pinkie Mnisi, a young woman who I return to later in the thesis (Chapter Seven), died from bronchial pneumonia early in 2006. Her husband, Solomon died the same year from tuberculosis. Both were HIV positive. When I first met Pinkie in 2005 she was emaciated and weak, an unbelievably small figure hunched under blankets. There was no

one to care for her except her husband who was also extremely ill. At this initial meeting I was shocked that so little was being done for them and that their family seemed so resigned to her illness and death. A day before Christmas, 2005, I accompanied the young couple to the hospital in Acornhoek to fill a prescription of medication and vitamin supplements. My field notes recorded the following:

We arrived very early (8:30 am) at Tintswalo Hospital on the day before Christmas and still the queues at OPD [Out Patients Department] were very long. Pinkie and Solomon went to the Rixile [AIDS] clinic. However, the clinic was closed from the 24<sup>th</sup> until after New Year. There was a sister on duty at Rixile. She explained that she was only doing VCT [voluntary counselling and testing]. She had no clients but several patients seeking medication found their way to the clinic. They were also turned away. Eventually she closed the clinic because she said she was tired of sending people away without really helping them. She suggested we return to the OPD to seek assistance. Here we were referred to a consultant who was running a hypertension and diabetes clinic. But when we arrived we found the nurse was mistaken. The doctor was not in. Instead we found a dentist who was running a dental clinic. We went to the pharmacy. They told us to go back to OPD and get a new file for Solomon and Pinkie. We returned to OPD. The desk nurse looked at us and asked her colleagues ‘what do these people want?’ [*U lava yini*]. This phrase is usually reserved to talking to a nagging child. I asked if we could fill Pinkie and Solomon’s scripts. They insisted that the only way was to wait for OPD to open a new file. I was worried as Pinkie was really tired and Solomon’s feet were hurting. It was cool outside but the OPD was stuffy and sweaty. An old man was wheeled in. A young woman limped in on crutches. A victim of a car accident was brought in on a stretcher.

My friend who had accompanied us tried to push in the queue. She begged the other patients to let Solomon and Pinkie in. A woman complained saying that she was also sick and also needed to see the doctor. To us it seemed like the doctors were hiding in their cubicles to avoid the patients. A poster on the wall depicted a baby with pellagra. Someone had drawn a speech bubble coming from the baby saying ‘Feed me’ to which was added ‘Help - I have AIDS’. Defacing this shocking image created a distance between people and the horror of disease and death.

Outside I talked to a senior administrative clerk who remembered me from the time when I worked at the hospital. I remarked on the signs of beautification at

the hospital. Attractive new plants and water features and ornate concrete benches had been set up on the grounds presumably for patients and visitors. He told me that the hospital had insufficient funds to rebuild the decrepit paediatric ward, but the hospital did not want to report an under-spend to the provincial government. So the hospital administration decided to use the money to beautify the grounds. He also pointed out the new ornate wall clock for the sisters' station in OPD. My old friend told me that it is important for the hospital to appear like a place where healing happens. I wonder if he saw the irony in this.

A few nights later I was awoken by a phone call from Pinkie's aunt. Pinkie was seriously dehydrated and was unable to hold down solids or fluids for two days. I drove to her home and picked her up to take her to hospital. The young female community service doctor examined Pinkie. She scolded me for bringing Pinkie in at such a late hour and told me that it was a waste of time to put Pinkie on a saline drip and that we could have simply given her an energy drink. Nonetheless she eventually agreed to admit Pinkie for that evening and to monitor her progress.

The long queues, the hostile responses of the medical staff, the obvious wastage of funding on frills, the scolding doctors are inimical to the needs of the ill and dying. It is in the microcosm of the hospital waiting rooms and consultation booths where one can start to understand peoples' reluctances to access care until extreme desperation sends them there<sup>15</sup>.

Over the next few months I continued to follow Solomon and Pinkie on their journeys to the hospital, clinics and 'traditional healers'. On the day she died Pinkie awoke before anyone else and assembled her sister, grandmother and aunts and led them in hymn. Later, her grandmother told me that this was Pinkie's way of saying goodbye to her family, 'because she knew she would not be returning'. I arrived soon after this intimate family gathering to take Pinkie and her husband to hospital.

The journey over the bumpy roads to the hospital was extremely painful for Pinkie sprawled on the back seat of my car. She was so thin the veins had atrophied leaving dark bruises on her almost translucent skin. When we entered the hospital grounds she groaned and begged me to take her home, crying that she could not go back to hospital again. The doctor met us in the car park, took one look at Pinkie and said ‘Jonathan she is going, she is going’ and urged me to get to the emergency ward. I drove fast braking hard at the entrance to the emergency ward. I opened the car doors and lifted Pinkie up, but I was already too late. As her eyes rolled back in her head she let out a few last gasps struggling to breath and died in my arms. Shaken, I placed her on the back seat. Curious onlookers cast frightened glances at me and after peering in the window looked away hastily. I covered the body with a blanket and waited.

I returned with Solomon to Pinkie’s grandmother’s homestead in absolute silence. To my dismay I was called upon to explain to the family what had happened at the hospital. I had barely opened my mouth to say the words ‘I am sorry to tell you ...’ when I was silenced by one of the most terrifying displays of grief and anger, and one of the most moving experiences of my adult life. Pinkie’s sisters and aunts screeched and cried, beating their fists against their heads, hurling themselves on the cement floor of Pinkie’s room, tearing out hair and ripping off their clothing in an orgy of grief. Solomon sat and sobbed holding his son in his arms rocking back and forth. I sat numb, unable to move or express anything.

This lasted for what seemed an hour although it was probably only a few minutes followed by absolute calm. Pinkie’s sister was pregnant at the time and had injured herself by throwing herself on the floor and required immediate care. The older women

set to brewing tea and sending the children out for loaves of bread and bottles of cold drink. Phone calls were made to close relatives in the area to arrange to meet the hearse that would be transporting the body to the mortuary. I was soon outside the house sharing a smoke and having a light-hearted chat with Pinkie's uncle. The calm and efficiency at which people dealt with the immediate practical needs of organizing a large funeral were a dramatic contrast with the chaos and disorder I had witnessed only moments previously.

## ORGANIZATION OF THE THESIS

The thesis is divided into two parts: the first tells the story of the rapid spread of AIDS in Bushbuckridge and locates this within social history and contemporary sexual relationships; the second part explores public concealment and censorship of the epidemic in the public domain, and discusses the implications this has for individual suffering.

**Chapter 2** 'Origins' is a social history of the AIDS epidemic in Bushbuckridge and documents, through the lens of my fieldwork in KwaBomba, the dramatic spread of the disease, its impact, and official responses. By the turn of the 20<sup>th</sup> Century, political and economic transformations had disrupted social, gender, and generational relationships, and created the ideal conditions for epidemic spread. This is reflected in the demographics of reported AIDS deaths amongst predominantly young unemployed women and older employed men. Official responses to the AIDS epidemic in Bushbuckridge promoted awareness of the disease, yet failed to create an open public discourse and address the underlying social and economic foundations of the epidemic.



**Chapter 3**, ‘Infections’, continues to explore the spread of AIDS, by examining the social structure of contemporary sexual relationships. I argue that a broad spectrum of forms of sexual relationship create opportunities for overlapping, multiple sexual relationships that shapes the structure of sexual networks. Because these networks are largely invisible, spread over a wide geographical area and are socially undifferentiated, the potential for HIV transmission within them is extremely high.

Although AIDS is a widely known affliction, its existence is often disputed and seldom discussed in public. Questions about the verbal and visual avoidance of AIDS are addressed in **Chapter 4**, ‘Secrets’. Here I argue that AIDS is subjected to cultural censorship in everyday public speech, while suffering is hidden from public view. Censorship is explained in relation to fears associated with the power of the spoken word and the idea of dangerous knowledge. The concealment of the AIDS body is a reaction to anxieties about what the sick body reveals about social relations. Yet at the same time, concealment and censorship are never absolute and contain the potential to reveal.

Given the censorship and concealment of AIDS, **Chapter 5** ‘Evidence’ asks how it is possible for proof of the epidemic to be generated at the local level. I argue that the oral performative genres of gossip and rumour are instrumental in this process of assimilating ‘data’ about the epidemic. Yet, at the same time, gossip and rumour are also moral texts about peoples’ behaviour and are attempts to attribute blame. These texts have the power to mobilise and catalyse social action, yet ultimately fail to do so.

In **Chapter 6**, ‘Revenge’, I continue to show how AIDS is made local through witchcraft. I argue that witchcraft beliefs create the possibility for avenging AIDS as well as offering protection by recasting AIDS through the idiom of witchcraft beliefs. The

chapter explores the analogical parallels between AIDS and witchcraft: although AIDS is not believed to be sent by witches, beliefs about AIDS and beliefs in witchcraft share distinct similarities. Witches are also believed to send an affliction that is similar to AIDS. By interpreting AIDS as witchcraft people are able to exert a form of control over the epidemic. Witchcraft therefore can be seen as a therapeutic resource. It allows for open talk of illness and death and vengeance for death.

In **Chapter 7** ‘Suffering’, the final ethnographic chapter, I document in semi-biographical style the experiences of living with and dying from AIDS. The chapter revolves around extended case studies of two men and follows their accounts of infection, illness and ultimately their deaths. Their experiences illustrate the ways in which the concealment and silences surrounding AIDS are played out in peoples’ experiences of suffering. In particular, the chapter reveals the consequences of AIDS for men’s capacity to perform masculinities.

My conclusions in **Chapter 8** are concerned with exploring the significance of the material presented in the thesis in the context of recent changes in AIDS policies to provide antiretroviral (ARV) drugs to people living with HIV. ARVs offer the promise of a regeneration of life, by visibly reversing the effects of the disease. Yet, the optimism and hope surrounding AIDS treatment tends to obfuscate and effectively silences dissenting voices, and brings to the fore the inequalities in health care provision that continue into the ‘treatment era’.

## END NOTES

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- <sup>1</sup> There are two large public hospitals in Bushbuckridge: Tintswalo (450 beds) and Mapulaneng (350 beds), as well as Sekororo (100 beds) and a public-private Life Care facility, Matikwana (150 beds). There are 45 Primary Health Care (PHC) clinics in the district, including two health centres.
- <sup>2</sup> *Kwaito* music is a uniquely South African blend of hip hop and gangster rap popular amongst youth.
- <sup>3</sup> The Johannesburg based Perinatal HIV Research Unit (PHRU) was awarded Presidential Emergency Funds for AIDS Relief (PEPFAR) funds through the United States Agency for International Development (USAID) to run an ARV clinic (called *Rixile*) based at Tintswalo Hospital.
- <sup>4</sup> This is not unique to AIDS or to South Africa. In Italy, a cancer prognosis is often withheld to spare the patient and their family members the stress of knowing (Gordon & Paci 1997).
- <sup>5</sup> Personal communication: Dr Vivian Black, Faculty of Medicine, Witwatersrand University.
- <sup>6</sup> The words ‘black’ and ‘white’ are used mainly in the emic sense and are therefore not capitalised.
- <sup>7</sup> The roll out of antiretroviral treatment (ARV) for AIDS started in late 2003. By 2004 only 50 patients were on ARV at the only distribution site in Bushbuckridge, Mapulaneng Hospital and three years later one of the distribution sites was seeing 1200 patients per month, of which 500 were on ARV (Lurie et al. 2008).
- <sup>8</sup> Tintswalo hospital had an extremely negative reputation and was referred to by some as ‘Acornhoek Dogs’ (Acornhoek *Njanja*). An informant reported that she overheard a nurse saying ‘I haven’t managed to get all my cattle today’ which meant that she had failed to collect enough corpses to earn her commission from the funeral parlour.
- <sup>9</sup> In the 1950s, Matsikitsane and Segopela Mashile led tenant struggles against the use of child labour by white farmers and joined the ANC (Niehaus 2006b, 529).
- <sup>10</sup> There are a few notable exceptions to this (Farmer 1992; Fassin 2007; Hyde 2007; Setel 1999).
- <sup>11</sup> See Herdt’s (1981) ethnography of ritualised homosexuality.
- <sup>12</sup> A student from Malawi and I presented our papers to a tiny audience in a parallel session.
- <sup>13</sup> KwaBomba literally translated means the ‘place of swaggering’. This name was suggested to me by my young friend who described his daily routine of walking around the neighbourhood where he lives as ‘to swagger’ (*ku bomba*).

- <sup>14</sup> The focus on predicting outcomes creates distance from suffering. ‘Predicting outcomes is a legitimate sociological pursuit, yet its effect in terms of language use and in terms of a framing of time is one of distancing’ (Henderson 2004, 48).
- <sup>15</sup> Unlike the ‘emotional labour’ that receptionists and health personnel perform in mediating conflicts in waiting rooms in medical clinics in the US (Strathmann & Hay 2009), health staff at Tintswalo Hospital often simply ignored the predicament of patients arriving at the casualty ward.

## CHAPTER TWO

### ORIGINS: A SOCIAL HISTORY OF THE AIDS EPIDEMIC

Okay, today, young men do not work anymore – I want to tell you the truth about this – it is women working nowadays. They [men] go around and steal and they arrest them and take them to jail, huh? Huh? Huh? Okay, in the olden days we didn't sell this person [the vagina]. God says you must sit down with your partner and eat your food [have sex]<sup>1</sup>. So you people go around and sell this 'little person' [the vagina] and end up getting *doropa* [syphilis]. In the olden days they just went and paid *ndzovolo* [bride wealth] and you would find a girl who has not had sex, she would be ready to get married. I want to say it is women who are working nowadays. Nowadays we are running after *xilungu* [the way of the whites]. Why are people doing that? Because they are eating eggs and chicken; when they start feeling their tummies are rumbling they cannot control themselves. They shit here in the street. It is because you young people are eating eggs. It tastes nice and good all the while it is ruining your tummies. And you see these young people they feel their tummy rumbling they will pick up their dress and just shit even if someone is looking at them. They can't control themselves. Today, we people are from all over; there are people coming from overseas and coming down here to give us this disease [AIDS] did you hear me it is the people from Persia and America. Okay, you women wearing pants; you will be sitting with your father and you will open your legs. Do you think it is good? And they will be sitting in a group looking at the book [for sex education] and pointing did you see, did you see here, she is giving birth, here they are having sex<sup>2</sup> [My inserts, emphasis in original].

Madimbi Mathebula, an elderly man, delivered this impromptu monologue one day as I sat chatting to NwaMbembe and her grown-up children under the maroela tree in her yard. As he rambled on, my host and I did not interrupt, only sniggering occasionally at his choice of words. As soon as he finished, Madimbi left abruptly, not even having sat down. We shook our heads and dismissed his monologue as typical of an old man's rant performed, I suspect, largely for my benefit.

Madimbi's speech resonated strongly with local constructs of AIDS, even though he failed to mention the disease by name. Locally, AIDS is constructed as symptomatic

of a moral decline; a result of the erosion of tradition and its replacement with modern ways; an outcome of the reversal of gender roles; the uncontrollable bodies of the young and their appetite for luxuries and sexual mixing with foreigners; young peoples' disrespect toward traditional rules of behaviour (cf. Heald 2002). Madimbi's narrative conjured an image of the world gone wrong, a 'protracted failure, real or imagined, that carries with it the spectre of *degeneration*: of a future stillborn' (Comaroff & Comaroff 2004, 336). As oral historical accounts usually do, Madimbi portrayed the past in glowing terms as a critique of the present. The opposition between past and present, tradition and modernity is a popular narrative in Bushbuckridge and is invoked in daily conversations and in rituals. For example, *muchongolo* dances that are performed weekly display the contestation between traditional ways of life (*xintu*) and those of the whites (*xilungu*) (Niehaus & Stadler 2004).

This oppositional discourse is especially interesting because it contrasts so starkly with the public health narrative that attributes the rapid spread of HIV in Africa to culture and the tenacity of tradition (see Chapter One). Particular traditions such as the levirate and 'dry sex' and traditional values, such as patriarchy, are believed to be behind the spread of HIV in African societies (cf. Gausset 2001; Saethre & Stadler 2009). As I show later in the chapter, this is dramatized in AIDS rituals. Madimbi's oratory refutes this and argues instead that modernity and the untrammelled desires that it creates drive the AIDS epidemic. His monologue is replete with images of immoral consumption, a metaphor for uncontrolled sexuality, which he blames on modern ways of life. His narrative constitutes a counter-discourse against the blame directed toward local traditions and culture.



This chapter situates this polemic in the context of a social history of the AIDS epidemic. I begin with an overview of historical writings on AIDS and then, through the lens of my fieldwork, sketch out a history of the epidemic in Bushbuckridge. This history spans the time when Shangaan settlers first arrived in the lowveld region in the late 19<sup>th</sup> Century up to the period of fieldwork in the early 2000s and the first reported cases of AIDS.

In the chapter I argue that political and economic transformations disrupted gender and generational relationships, and created the ideal conditions for epidemic spread, enhancing the vulnerability of especially young, unemployed, mobile women and ‘affluent’ older men to HIV infection. Official responses to the AIDS epidemic in Bushbuckridge were articulated through public awareness campaigns, yet failed to create an open public discourse about the disease. Instead, these programs reinforced social divisions, alienating certain sectors of the population rather than galvanising popular support.

## **A TALE OF TWO EPIDEMICS**

The first case of AIDS in South Africa is thought to be that of a white homosexual air steward who died of *pneumocystis carinii* in 1982. In 1983, 32 out of 200 homosexual men in Johannesburg tested positive for HIV. Despite the relatively low numbers of infections, the media hysterically coined AIDS a ‘gay plague’. Yet, by 1990 the epidemic amongst homosexuals was ‘levelling off’ and a decade later only 207 homosexual men were reported to be infected with AIDS in South Africa (Iliffe 2006, 43).

The story of the spread of AIDS amongst predominantly white homosexual men stands in stark contrast to the epidemic amongst (assumed) predominantly heterosexual black South Africans. In 1986, 130 Malawian mine workers employed by Rand Mines tested HIV positive. They were identified as the first heterosexual cases of HIV in South Africa (Phillips 2004)<sup>3</sup>. By 12 February 1990, 353 cases of AIDS had been reported (Zwi & Bachmayer 1990). From this point onward HIV infections increased dramatically. Prevalence levels amongst pregnant women tested in government clinics were below one per cent in the early 1990s. These figures grew rapidly to almost 30 per cent by the mid-2000s. By the turn of the century the South African AIDS epidemic had reached catastrophic proportions; HIV prevalence amongst pregnant women increased from 1% in 1990 to 29% in 2005. With an estimated 5.4 million of 48 million (11%) of South Africans infected with HIV (Dorrington et al. 2006), South Africa is regarded as having the highest rate of HIV infection globally.

This tale of two epidemics with sharply contrasting trajectories raises questions about what drives HIV infections and why efforts to prevent the spread of HIV were unsuccessful.

Theories about the rapid spread of HIV/AIDS in southern and South Africa are often based on the idea of a unique ‘African system of sexuality’ characterised by sexual permissiveness (Caldwell & Caldwell 1987; Caldwell et al. 1989; Caldwell et al. 1992). As I pointed out earlier, cultural practices and beliefs are seen to underlie behaviours that place individuals at risk of infection. This view underwrites public health models and tends to ignore historical processes (Hunter 2007, 690). I agree with Fee and Krieger (1993, 1481-1482) who argue that public health is:

...profoundly a-historical...it contains within itself a dichotomy between the biological individual and the social community, and then it ignores the latter. Reflecting an ideological commitment to individualism, the only preventive actions seriously suggested are those that can be implemented by individuals. Intended or not, these attitudes variously implicitly accept social inequalities in health and fail to challenge the social production of disease (Fee and Krieger, 1993, pp. 1481-1482).

Social historians, seeking to understand the explosive spread of HIV in southern Africa are concerned with viewing the AIDS epidemic as a 'sequence' of events shaped by social and economic change (Iliffe 2006, 1-2). The roots of the AIDS epidemic can be found in its 'pre-history' (Berridge 1993; Iliffe 2006).

The historical analyses of the South African epidemic focus attention on the pre-apartheid era in explaining contemporary vulnerabilities to HIV. In terms of this approach, the AIDS epidemic was 'waiting to happen' (Marks 2002) embedded in the political economy of apartheid, the creation of the Bantustans and a result of 'disordered development' (cf. Setel 1999).

Similar to the rapid spread of syphilis that reached epidemic proportions in the 1940s and 1950s (Jochelson 2001), HIV is assumed to travel along the same pathways as these earlier epidemics of sexual diseases. (Delius & Glaser 2002; Jochelson et al. 1991; Setel et al. 1999) However, there are limitations to the 'male migrant as vector' model. As Hunter notes, this has become 'something of a cliché in explaining sexually transmitted diseases and in framing scholars' understandings of the political economy of sex' (Hunter 2007, 690). For instance, wives of male migrants may infect their husbands having acquired HIV from relationships with local men (Lurie et al. 2003). Moreover, the focus on male migrants ignores the increasing numbers of women who oscillate between rural and urban settings (Hunter 2007).

It is also important that the focus on the injustices of apartheid do not eclipse the social, political and economic transformations that took place in the early post-apartheid era. Indeed, not without a certain irony, epidemic growth coincided squarely with political liberation in the mid-1990s. This specific moment in history was a time of intense social, economic and political turmoil, characterised by high unemployment, a mushrooming of informal settlements, declines in marriage and migratory movement of women (Hunter 2007). Political liberation signified the freeing up of sexualities and the emergence of new sexual economies (Donham 1998; Niehaus 2000). Posel (2005, 131-132) argues that the era of political liberation signalled the ‘eroticisation of liberation’. Sex, in this context, is the sphere ‘within which newfound freedoms are vigorously asserted’.

From the perspective of national health policy, the response to AIDS was marred by significant set-backs. On the eve of the establishment of the first democratic elections, the South African government was already late in responding to the looming crisis. In the early 1980s AIDS was perceived as affecting only gay men and intravenous drug users and therefore posed a limited risk to the heterosexual population. This initial complacency continued until the late 1980s when heterosexual cases of HIV infection started to be reported. The government responded with AIDS awareness programs, but by 1992 AIDS was still not regarded as a critical issue by the department of health (Grundlingh 2001).

In the period leading up to the first democratic elections an ‘AIDS plan’ was drafted. However, post-1994 the new ANC-led government was tasked with extensive restructuring that distracted attention away from dealing with the epidemic. Since then

the state's response to AIDS has been beleaguered by controversy and contestation pitting AIDS activists such as the Treatment Action Campaign (TAC) against the department of health, and the South African president (For varied and detailed treatments see: Fassin 2003; Mbali 2001; Robins 2004, 2006; Schneider 2002; Schneider & Fassin 2002).

From the mid-1990s, one debacle after the other undermined relations between state, non-governmental organizations, academics and health workers. For example, the state's support for Virodene (a failed experimental AIDS drug) and allegations of corruption surrounding the AIDS-awareness play *Sarafina II* (Fassin 2007). Prior to the state roll-out of antiretroviral treatment in 2003-4, direct confrontations over access to treatment took place inside and outside the courtrooms between the TAC and the departments of health (Fassin 2007).

One of the arenas in which contestations were enacted was over the evidence for the AIDS epidemic. Assembling the evidence for AIDS is not unproblematic. AIDS is a complex and contested field, scientifically and politically, and its measurement and evidence 'unleashed an extraordinary amount of political heat, controversy and contestation' (Robins 2004, 652).

The Department of Health had a particularly uneasy relationship with the scientific community. When data from the Medical Research Council (MRC) on AIDS mortality was presented, the Department of Health (DoH) publicly rejected these in an article published in the *Sunday Times*, and claimed that AIDS could not be the major cause of death. They accused the authors of the report of being engaged in a 'witch hunt' against the South African president (Tshabalala-Msimang et al. 2001). High profile AIDS

deaths such as that of the presidential spokesperson Parks Mankhalana were also denied, although this was later revealed (Anon 2002).

The anti-scientific stance of the state president was well articulated in a document, penned by Peter Mokaba and released by the ANC during 2002 entitled *Castro Mnisi, Caravans, Cats, Geese, Foot and Mouth and Statistics*. It argues that AIDS is not simply a scientific biomedical problem but a threat to the new African identity:

[This monograph] rejects the assertion that, as Africans, we are prone to rape and abuse of women and that we uphold a value system that belongs to the world of wild animals, and that this accounts for the alleged “high incidence” of “HIV infection” in our country (Mokaba 2002).

The counter-discourse of racism and poverty resisted biomedical models of risk that associate AIDS with the dangerous ‘anti-social other’ (Leap 1995, 229) which sees people as vectors of disease, as guilty bearers of misfortune rather than as people requiring compassion and support.

The schisms and public spats between state and the scientific community resulted in considerable confusion about AIDS in the public imagination (Mills 2008). The South African state’s position on AIDS is also believed to contribute toward the widespread denial and secrecy that surrounds the disease. Yet, the response of the state toward the AIDS epidemic cannot solely account for the continued rise in infections and ‘prevention failure’. Indeed, despite the position of the Department of Health and the state president toward HIV and AIDS, massive funding and resources have been allocated to HIV prevention over the years (Fassin 2007).

In the absence of a cure for AIDS, the main focus of HIV policy is prevention. Yet, prevention programs have had limited success in reducing HIV infections (Campbell

2003). Social analysis of the failures of prevention campaigns point to a poor understanding of the local political, cultural and social context, and how messages are received and interpreted (Jeeves & Jolly 2009). For example, Heald (2002) argues that the failure of AIDS education messages in Botswana in the 1990s was because these are purely biomedical and ignore local conceptualisations of disease. Similar criticisms can be made of South African approaches to prevention. Campbell's ethnography of HIV prevention in a South African gold mining community points to the failure of educators to take everyday life concerns of miners into account (Campbell 2003). In both these cases, HIV prevention is constructed as a matter of individual behaviour divorced from local social, economic and historical context. It is toward this local historical context of the AIDS epidemic that the discussion now turns.

### **THE RESEARCH SETTING: BUSHBUCKRIDGE**

The municipality of Bushbuckridge lies on the border of the Kruger National Park in the East and in the west borders on the Klein Drakensburg mountains, in a geographical region known as the *lowveld* (lit. low bush). To the south of Bushbuckridge is the commercial and administrative city of Nelspruit and to the north, the mining town of Phalaborwa. The climate is semi-arid with cycles of drought and flooding<sup>4</sup>. The area is surrounded by rugged beauty, game farms and conservation areas and is a major attraction for national and international tourism. Yet, with quintessential South African irony, it is also one of the poorest areas in the country.

Most of Bushbuckridge is defined as 'rural', an official category that is contradicted by the vast residential settlements and population densities that are similar to



urban settings (approximately 255 persons/sq. km) (Freeman 2002). The population is estimated at over half a million people (Statistics South Africa 2008). Economically, the area is extremely poor. Over 85% of the population lives below the poverty line, earning less than R19 200.00 per annum and 14% of residents between the ages of 15 and 65 years are 'economically active'. Many residents are unemployed work seekers and at least 10% of households are dependent on old age pensions (Freeman 2002). Local employment opportunities are narrow and limited to poorly paid unskilled labour on the citrus and game farms surrounding Bushbuckridge or civil service employment for the educated elite, for example in the police, health and education sectors. As a result, many men and women migrate in search of work in the urban and industrial centres (Collinson, Wolff, et al. 2006).

The high levels of unemployment and poverty evident in Bushbuckridge are rooted in the policies of separate development imposed by the Nationalist Government since the early 1960s. Prior to the elections of 1994, Bushbuckridge was divided into two districts of two Bantustans: Mhala of Gazankulu and Mapulaneng of Lebowa. Officially these were the 'Homelands' for the Shangaan / Tsonga and Mapulana respectively. The Bantustans were the outcome of the process of creating an industrial labour force. In terms of official state discourses, the labour reserves were legitimised, as 'healthy reserves', unlike the urban slum dwellings that were associated with disease and poverty (Packard 1989). However, as early as the 1940s, Africans faced poverty and starvation. Forced relocation and resettlement undermined agricultural subsistence and increased dependency on migrant remittances. The creation of the Gazankulu and Lebowa 'Homelands' in the 1970s, resulted in the division of resources, along ethnic lines

between residents of Mhala and Mapulaneng. Educational and health services were most affected, as hospitals and schools refused to provide services based on ethnic identity and residence (Niehaus 2002b).

In 1994, Bushbuckridge was reincorporated into the newly formed Limpopo Province (formally the Northern Province). Residents' material circumstances did not necessarily improve. Increasing unemployment, declining standards of health care delivery, increased crime and rising cost of living are the main challenges that Bushbuckridge residents face. Moreover, the political transformations of the mid 1990s were accompanied by the growth of the AIDS epidemic. This era was also characterised by repeated political indecision and inaction regarding the AIDS epidemic. Paradoxically, the current governing party the African National Congress (ANC) continues to receive the vast majority of votes (89% in the 2004 national elections) (Niehaus 2006b).

Partly because of its status as a border district and a labour sending area, Bushbuckridge has been particularly hard hit by the AIDS epidemic. The area lies in the path of the Mozambique Development Corridor, designed to create linkages between the port of Maputo in Mozambique and the Gauteng Province in South Africa. This creates pathways for the spread of HIV in and out of Bushbuckridge through truckers, migrants and sex workers. A highly differentiated employment market and high rates of unemployment has also created the social circumstances for HIV spread.

HIV was present in Bushbuckridge in the early 1990s, but because of its long incubation period, there was little evidence to support its presence in the public eye. In 1990, Tintswalo Hospital in Acornhoek reported incidence rates amongst patients of between 0.2% and 0.3% (Taylor et al. 1992). From the mid-to-late 1990s, the picture

changed dramatically. A longitudinal census conducted in the Agincourt sub-district of Bushbuckridge collected verbal autopsies. Between 1992-1993, 15 males and five females accounted for deaths from AIDS, TB and chronic diarrhoea, in comparison to 1994 to 1995, when 33 males and 21 females died (Tollman et al. 1999). The 2000s were a definitive turning point. The death rate increased from 5 (per 1000 person years) in 1992 to 10.9 in 2004 leading to a reversal in fertility trends. By the late 2000s, AIDS was identified as the leading cause of adult mortality in Bushbuckridge (Garenne et al. 2007). Based on anonymous testing in government health facilities HIV prevalence was approximately 30% in 2007 (Lurie et al. 2008)<sup>5</sup>.

This shocking rise in infections can best be comprehended from the perspective of transformations in sexual economy, at two critical moments in its history. The first begins in the early 1900s and lasts until the early 1960s. During this period, the social regulation of sexuality was intricately related to household production. A strict order of age and exogamy supported elders control over pre-marital sexuality and the marital ambitions of their juniors. Ideologies of sexual health reflected and reinforced this system of regulating sexual activity. However, the decline of the agricultural subsistence economy created a crisis in elders' authority over fertility decisions and sexuality. In the second period from the early 1960s, forced resettlements and increasing dependence on wage labour led to the emergence of new sexual economies based on individual survival. As marriage declined, women moved between village and city seeking ways to support their children.

These historical dynamics are explored from the perspective of material collected in KwaBomba, the village where I conducted my fieldwork. The village lies north to south along a main tarred road that also forms the western border of the village, while the

NwaNdlumari River borders the village in the east. The village is divided into six sections, containing approximately 108 blocks that consist of up to 12 residential stands each, totalling 1300 stands for the settlement. Reliable population data for KwaBomba are not available; the Department of Water Affairs and Forestry give an estimate of 3, 827 residents<sup>6</sup>. My impression is that this is a gross underestimate; based on the number of residential stands, there could be more than 10, 000 residents.

Each stand consists of one or several buildings. Housing types range from large red brick tiled roof ranch-style homes to small huts with thatched roofs. A few residents still cultivate large gardens on the outskirts of the village. Only a handful of residents keep cattle and goats, mainly for ritual purposes.

There are two primary schools, a secondary school and one crèche in KwaBomba. The nearest health centre is ten kilometres away along the tarred road. The regional hospital is situated 30 kilometres away near Bushbuckridge town in the south, and a district hospital, in Acornhoek, is 21 kilometres to the north.

A transport network of busses, trains and taxis connect KwaBomba to nearby towns and villages. City to City buses and commuter taxis collect passengers in Bushbuckridge town destined for Johannesburg. The least favoured but also the cheapest form of transport is a third class berth on the Maputo to Johannesburg train which one can board at the KwaBomba railway siding across the main road to the village.

### **SEXUALITY IN THE ERA OF AGRICULTURE (1913-1960)**

KwaBomba (then ‘Edinburgh Farm’) forms part of residential land under the Nxumalo Chieftaincy Native Trust. The Nxumalo clan arrived in the lowveld from

Portuguese East Africa (Mozambique) towards the end of the 19<sup>th</sup> century, fleeing the ravages of the Luzo – Gaza civil war. Several thousands of Shangaan speakers moved to the lowveld after Ngungunyana Nxumalo was defeated by the Portuguese. They were led by Mpisane Nxumalo, Ngungunyana's uncle. The refugees were granted permission by Setlhare, the Pulana chief to settle in the unoccupied areas to the east of Bushbuckridge (Niehaus 2001, 18). Other settlers were also drawn from Portuguese East Africa into the mining estates established by the Transvaal Gold Mining Estates in Pilgrims Rest (Bonner & Shapiro 1993).

By 1913, most Africans in Bushbuckridge and surrounding areas lived on the land belonging to mining corporations such as the Transvaal Gold Mining Estates (TGME), on Crown Land as rent payers, or as labour tenants on white-owned farms. Labour tenants had access to ploughing and grazing land and worked for three to six months per year in exchange for grazing, agricultural and residential rights. On company owned land, rent was levied in exchange for the right to settle and to graze cattle.

In this setting, the social organisation of sexuality focussed on the reproduction of the household, the primary unit of social organisation. The household (*muti*) was a large co-residential group of male agnates, their wives, and offspring. Huts were sited in rows, each surrounding their own courtyards. Boys (*vafana*) and girls (*vanwana*) had separate living areas – the *lawu* for boys and young men (*majaha*) and the *n'anga* for unmarried girls (*tintombi*). Gendered spatial divisions controlled the potentially polluting bodies of young men and women (Hammond-Tooke 1981; Junod 1962 [1912], 189; Niehaus 2002a).

Each member of the *muti* cooperated in agricultural activities. Parents allocated a small plot of land to young children to cultivate for half the day. Young children guarded the crops against foraging baboons and birds. Pre-menarche girls herded goats and cattle, collected firewood and water. When not in the fields, girls assisted in cooking the household meals<sup>7</sup>. Once girls started to menstruate their movements were restricted to the homestead owing to concerns of the polluting effect of menstrual blood on the fertility of livestock. Young boys and young men looked after cattle and goats and hunted small buck (duiker) with hunting dogs. A wide range of crops such as sorghum, millet, maize and legumes (*tinawa*, *tindluwa*, *timwembe*) were cultivated. A variety of wild fruits such as the monkey orange (*mkwakwa* / *Strychnos pungens*) and wild herbs were gathered from the bush.

Households were largely reliant on local resources. For example, large households in the nearby Setlhare Chieftaincy gathered sufficient maize and sorghum to cater for their needs (Niehaus 2001, 20). Hut walls were built using soil dug from termite mounds; wooden beams were cut from the forest and thatch and reeds and grass were used as roofing materials. Villagers dug water wells and stored the water in clay pots.

Oral accounts highlight the significance of the size, and status of household members. The presence of a senior man defined the household as a *muti*. An elderly woman commented on the absence of material goods:

There was nothing; a grass mat and a blanket. There was nothing else at all; no table, no radio, and no bicycle. We only had a mat to sleep on and some pots. The *muti* only needed a *hloko ya muti* [male household head] to make it a *muti*

As she suggests, to be respected as a *muti* required a senior man (*wanuna*) of good standing. Such men were good providers and had many wives and children who were all well fed and healthy. Senior women also desired large households; as an elderly woman told me ‘we women wanted big families’. As soon as her sons married, a senior woman could command several daughters-in-law (sing. *makothi* pl. *vakothi*). A new wife lived with her mother-in-law (*mamazala*) for six months prior to moving into her husband’s dwelling.

Men engaged in agricultural work and to a lesser extent in wage labour. The establishment of mines in Pilgrims Rest, the Lydenburg mines and the Maputo – Lydenburg Railway line provided numerous employment opportunities. However, men were seldom employed on long-term contracts. Mining concerns, such as the Witbank coal mines and the gold mining estates in Pilgrims Rest (TGME) struggled to attract labour from the Bushbuckridge area (Bonner & Shapiro 1993). Men usually invested their earnings with the intention of purchasing cattle for bridewealth, or used it to pay annual rental or hut taxes, taxes on dogs, bicycles, and dipping fees for livestock (Stadler 1995, 55)<sup>8</sup>.

Families that faced starvation borrowed (*tekela*) from relatives who had stores of surplus maize and dried meat. In return, they laboured on their relative’s fields. People travelled from KwaBomba to settlements bordering the Kruger National Park where their relatives resided, returning home with an ox-drawn sled (*xileyi*) piled high with maize flour, dried maize and dried meat. The end to the ‘borrowing’ (*ku tekela*) was celebrated by sacrificing a goat or a cow. Sharing the meat demonstrated ‘love’ between kin.



All productive activities such as wage labour, fertility and kinship contributed to the production and reproduction of the *muti*. My informants referred to this as ‘gathering’ (*ka hanza*). ‘Gathering’ implied survival through hard work, leaving the homestead with empty hands but returning with your hands full. As one of my older female informants described it, this was production ‘through sweat’.

The reproduction of the household was managed by senior male household heads who regulated marriage (Stadler 1995, 60), and pre-marital sexuality (cf. Delius & Glaser 2002). The capacity to build and retain a large, productive labour force was critical for survival. Control over the ‘means of reproduction’ (in this case women’s procreative capacity) was critical for household reproduction (cf. Meillassoux 1972).

The focus was on reproductive sex within marriage, while sexual pleasure was sanctioned so long as this did not result in pregnancy (cf. Hunter 2004). Procreative sex was regulated and controlled through an ideology of age, marriage proposals (*ku gangisa*), and payments in exchange for brides (*ku dzovola*). The birth right of first born sons was to marry and have children prior to younger brothers. The last born son married last but inherited property and cared for his aged parents (cf. James 1988).

Women who were deemed to be physically fit and able to ably carry out domestic roles were approved as wives (Stadler 1995). Payment of bridewealth (*ndzovolo*) legitimised pregnancy and child birth, granting the husband rights to the reproductive potential of the wife (cf. Jeffreys 1951; Stadler 1993). Bridewealth also tied young men into bonds of dependency on their elders who provided the cattle (cf. Harries 1994; Jochelson 2001, 113-114).

Marriage did not contain all sexual experience (Delius & Glaser 2004). A wife was permitted to seek a temporary lover outside of the homestead to impregnate her, if her husband was infertile. In the same fashion as productive activities, this was called ‘gathering’ (*ka hanza*). Even though the wife was said to have ‘stolen’ outside (had sexual relations outside of marriage) *ka hanza* was not considered immoral as it was an act that contributed towards the growth of the household by increasing the pool of productive labour.

The sexuality of adolescents was recognised and sexual experimentation was permitted, within certain bounds. As Delius and Glaser (2002, 31) note:

Communities attempted to negotiate the tricky terrain between acknowledged adolescent sexuality and the risk of pre-marital pregnancy through establishing limited forms of sexual release and effective forms of sexual monitoring and management

My older informants recalled sexual play as young children. As a young girl, NwaSamuel played with boys<sup>9</sup>: ‘We would play with the boys and they would touch our breasts, but we would not have sex’.

Male and female adolescents met under relatively controlled circumstances. One of these was a dance (*xingombela*) held on Friday nights on the eve of a *muchongolo* dance to celebrate a wedding. At the dance, boys and girls danced in rows facing each other, singing: ‘We will be alone in the house’ (*Hi ta helela malawini*) (Stadler 1995). This song laments the solitary man or woman who never marries. Another song communicated the physical need to experience sex: ‘If you hide something it will become rotten’ (*dudlu ntombi xa ku veka xa bola*). Older youth (*tensini*) supervised the *xingombela* and instructed the boys and girls in non-penetrative sex<sup>10</sup>. Sexual play was

important for the sexual socialisation of adolescents. These provided an opportunity to experiment with sex through play.

### **A crisis in authority**

This vision of gerontocratic governance over the sexual and reproductive decisions of the young belies evidence of the growing brittleness of the authority of elders (cf. Harries 1994). In the early part of the 20<sup>th</sup> century, declining prospects for agricultural subsistence, the steady increase in mission influence and the increasing dependency on wage labour threatened the hold of senior men and women over the young.

The 1913 Land Act restricted the borders of the African reserves and ‘facilitated the demise of the independent African peasantry’ (Jochelson 2001, 99). By the early 1920s the economies of the South African countryside were under attack. Previously, hunting, gold exploration, transport riding had dominated commercial ventures in the lowveld. After World War One, the building of a new rail link made farming a far more attractive prospect for white farmers. Moreover, the government provided ex-servicemen with concessions to own Crown Land<sup>11</sup>. Increasing numbers of white farmers started growing citrus, ranching cattle and forestry. Former African farmers entered into labour tenant agreements with these new land owners.

Many areas of the lowveld became labour sending areas on a large scale (Harries 1994). In 1936, the passing of the Bantu Authorities Act led to company, crown land and several white-owned farms being purchased by the South African Native Trust (SANT) and reserved for African occupation. Conditions on these farms began to change as they started to experience an influx of people removed from other white-owned farms and

forestry areas. By 1948, all farms in the area had been purchased by the SANT<sup>12</sup>. By the 1950s 'agricultural production declined to such an extent that it became a mere supplement to migrant wages' (Niehaus 2001, 121). Restrictions on cattle ownership and farming land led to greater dependencies on migrant earnings.

The crisis in agricultural production and the real threat of starvation is well illustrated by letters written from the lowveld (Cited in: Burns 2000, 17). In November 1942 Mr E. H. Wittingstall (the farm manager of Acornhoek) wrote to Mr M Petyt of Johannesburg:

Dear Mr Petyt. All the storekeepers are experiencing difficulty in keeping stocks. We have now been out of stock for more than two weeks both of meal and mealies, and the Natives will soon be starving (...).

In November 27 1942, Wambazi Makukule a resident in Newington in Bushbuckridge wrote to Wilson Maekere Mathebule at Daggafontein Mine on the Reef:

As you are in Johannesburg have you forgotten of the great famine prevailing in this territory this year? The people are falling on top of each other in the stores owing to the shortage of maize - please hurry up sending seeds.

Farm stores and shops implemented rations: at the general dealership in KwaBomba maize meal was restricted to two scoops per customer. Villagers queued for hours and sometimes returned home empty handed. One man, an employee on the railways, transported sacks of maize flour from Johannesburg to Bushbuckridge each month for his family.

Contra to the image of large productive and healthy households, life was extremely hard. Those who came of age during this period expressed negative sentiments

about their early upbringings. One woman described her childhood as ‘slavery’. Her parents beat her severely if she did not work hard at home. NwaEphraim, an elderly traditional healer, recalled that she slept on reed mats and wore rags instead of clothes. She and her siblings suffered constantly from infestations of lice. Food shortages were a constant problem and many meals consisted of wild fruits such as monkey oranges (*masala*), wild berries (*timbulwa*) and jackelberries (*tinsanguri*) and water. This diet caused diarrhoea and abdominal bloating.

Larger households struggled to feed and support their members. Selinah married into the Mamabolo family in 1951. The six Mamabolo brothers each married several wives. The entire household of more than 20 people ate from one huge pot, and two people shared the cooking. ‘If you didn’t eat quickly you would die of hunger’ recalled Selinah. She was the third wife of Gaza Mamabolo, a worker in a construction company in Johannesburg. Gaza seldom visited his family and stopped remitting his wages home to his wives. For some months Gaza’s brothers ensured that Selinah and her co-wives were taken care of. Yet, the household eventually broke up and Selinah was forced to earn a living by brewing and selling sorghum beer (*mgodwana*). One litre of beer sold for one tikkie. Selinah was often harassed by the police and was imprisoned for two months for the illegal production and sale of liquor.

Like many others, Selinah Mamabolo was placed in a precarious position because of the dereliction of men from their responsibilities as wage earners and supporters and the dwindling capacity of the *muti* to support its members. Ironically, migrant labour was necessary for the survival of the household, but enforced the alienation of men from the rural household, destroying its integrity (cf. Murray 1981).

Under these circumstances, senior male figures were more often absent from the home. Joseph Seerane's father married two wives and spent most of the year in Daveyton, a township on the East Rand close to where he worked for a large paper production firm. Joseph remembers that the two wives would take turns visiting his father in Daveyton. Occasionally Joseph would accompany his mother; life was good in the township for Joseph because of the abundance of tinned food and other commodities. Other children were less fortunate and only saw their fathers four times a year.

In the context of steadily worsening living conditions, fathers experienced a diminished capacity to control their sons' marital ambitions. A reflection of this is the increasing numbers of young men and women who deserted the village for urban life.

Children ran away 'because they were afraid to work hard' as an informant claimed; 'many ran away and died in Johannesburg'. NwaEphraim recalled that her neighbour's son, Twoboy Machavi left for Johannesburg and never returned. 'We don't even know where he is buried' she commented<sup>13</sup>. By the late 1950s the desertion of young women became a major concern for village elders. Discussions at the headman's (*ndhuna's*) court (*bhandla*) complained of the increasing number of young women who never married who had left their homes. Women who left home for Johannesburg were labelled prostitutes (*mageligelis*<sup>14</sup>). Others were discovered years later to have established second families. A man recalled that his mother's younger sister disappeared for several years, to be found again in Barberton, having assumed a new identity<sup>15</sup>.

The desertion of young women threatened the growth of the household as it removed the reproductive potential of future wives, and the income generated by bridewealth cattle. In some cases violent sanctions were exerted against women who

followed this path. NwaBoyi was allegedly raped and murdered by her four former lovers. Another woman from KwaBomba was found hacked to death in a hut on a farm near the town of Tzaneen.

Missionary interventions also undermined the household economy<sup>16</sup>. The initial response to missionaries was antagonistic; men beat drums next to the church hoping to disrupt the services and drive the missionaries away. Adult men resisted missionary influence mainly because of their temperance policy; not surprisingly, the majority of converts to the Swiss Mission were initially women (Nkuna 1986). Missionary influence posed a challenge to the hold that elders had over the younger generation: Mission schools distracted children from their productive activities; Mission clinics and hospitals introduced modern family planning to adult women. Missionary propaganda was highly critical of local tradition and culture. Ultimately this removed the responsibility of the social organisation of sexuality from the hands of the elders to the clinic and the school.

By 1931, ten mission schools had been established in Bushbuckridge, although initially these were not well attended (Ndlovu 2003), and reported high rates of drop-out (Nkuna 1986, 134). This was due to competing demands between the *muti* and the school over children's labour (Stadler 1995). Mission schools threatened children's productive activities in the household.

Mission teachings also challenged modes of sexual socialisation. The missionaries left a 'moralistic legacy on the nature and administration of Black education' (Nkuna 1986, 136). Christian converts were warned against sexual impropriety and instructed to dress in such a way that would not evoke strong feelings of desire (Nkuna 1986, 174).



The following extract is from the Report on the Commission of Native Education 1949-1951:

The following sins are strictly forbidden and heavily penalised in school: Theft, vain oaths, lies, unlawful copying, insulting, love affairs between boys and girls...it is strictly forbidden that boys and girls play together...all pupils must be clean in body and clothing (Nkuna 1986, 122)

During the era of Bantu Education, strict rules of conduct were sustained; the first generation of local teachers had been educated in the mission schools (Niehaus 2000).

Pregnant school girls faced total expulsion from school. Educators complained that pregnant women were a bad influence on other learners. School children discovered with love letters in their possession were disciplined. Hand holding and other signs of affection were also discouraged (cf. Niehaus 2000). The school committees censored the syllabus, pointing out that teaching human anatomy and reproduction encouraged children to experiment sexually. Schooling also undermined the traditional forms of sexual socialisation and the role of the youth peer groups (*tensini*). Without these forms of control over adolescent sexual experimentation, pre-marital pregnancies increased (cf. Ahlberg 1994; Delius & Glaser 2002)

The health work performed by the missions promoted Christian morals and ideals, and envisaged the eradication of 'traditional superstitions and beliefs' such as witchcraft. Local nurses were trained and employed by the mission who saw them as the 'torch bearers for Christianity and models of progress and modern womanhood, responsible for the reformation of their communities' (Marks 1999).

The diminished surveillance of younger men and women's sexual relationships was regarded as a reason for disease spread at the time. Ideally, procreative sex was

regulated and controlled through birth order, marriage proposals (*ku gangisa*) and bride wealth (*ku dzovola*). The birth-right of first born sons was to marry and have children prior to younger brothers. Essentially this meant that a man was expected to wait before his older brother had paid bride wealth. Breaking this 'law' or taboo (*milawu*) meant that the household would experience bad fortune (*xinyama*). Unsanctioned sexual contact also caused 'illnesses of the mat' (*tindzaka*). For example an older sibling who has sex in a younger sibling's house caused the older sibling to experience permanent paralysis of the lower body, an affliction called *vukulu*. Sex before menses resulted in *richilane*, an affliction of retarded physical development. Ritual sexual cleansing following death is supposed to follow a strict birth order; failure to do so causes a terrible affliction similar to tuberculosis. Child birth before bride wealth is paid results in pollution caused by symbolic heat (*hisa*) that requires chyme from the gall of a goat to cool it down. 'Cross a river' (*ku wela*) is a fatal affliction, resulting from absorption of a woman's polluted blood following an abortion.

The local aetiology of sexual diseases reflected concerns with labour migration as a source of infections. Older men and women talked about the increased mixing with people of 'other nations' (*xaka*), as a cause of the increase in disease burden. The affliction known as *doropa* (possibly derived from '*dorp*' the Afrikaans word for town) or 'white person's sickness' (*vu vabye wa xilungu*) was identified as a venereal disease spread through migrant contacts in the towns. Older men who were migrants recalled contracting *doropa* and described painful urination, penile discharge and genital ulcers. Treatment was often ineffective; an older man recalled a man who was castrated due to incurable infections. My informants also described a disease they called 'little fishes'

(*swihlampfu*) or ‘maggots’ (*swivungu*); these developed inside the vaginal tract and consumed the body from within. The affliction was thought to be spread through sexual contact with Asian traders who sold their wares in the villages to local women. *Chovela* was similarly acquired through contact with foreigners and caused genital sores<sup>17</sup>. As we see later, the descriptions of early sexually transmitted diseases and ideas about pollution form the basis for contemporary understandings of HIV and AIDS.

### **RESETTLEMENT, WAGE LABOUR AND POVERTY (1960-1994)**

By the 1960s, the last vestiges of agricultural subsistence had been destroyed. The period that followed was marked by increasing poverty and the alienation of household members. Increasingly, households depended exclusively on the earnings of migrant men. Migrant labour undermined conjugal bonds and resulted in the impoverishment of households left without a source of income. Women, placed in dire situations migrated out of the village to seek a means to support themselves and their children.

From 1968 the Bushbuckridge area was carved into two separate districts of Mhala (Gazankulu) and Mapulaneng (Lebowa). Households were resettled into residential stands in areas defined as villages. This alienated domestic units from their arable and grazing lands, leading to the complete destruction of subsistence agriculture. Women and children lost their productive role in the household and became completely dependent on men’s migrant earnings. Food insecurities intensified. A woman remarked ‘There was hunger when we were removed. People started to starve. They couldn’t get what they needed’.

An agricultural development program was implemented in KwaBomba. Individual farmers paid rent for land use, rented tractors, purchased manure and pesticides. They grew cash crops such as wheat and white maize that were susceptible to infestation by boring worms. Members of the farming project seldom made a profit and experienced a decline in quality of life. A woman complained that she worked the scheme for ten years and only reaped 'a few onions and some small change'. As a result many small farmers simply gave up, although some farmed smaller 'secret fields' in which they grew 'traditional crops' such as ground nuts, maize and root vegetables.

The officer responsible for the removals was despised and villagers nicknamed him '*Munguluve*' literally 'White Pig'. 'If I were to hear that he is dead I will dance for joy' remarked NwaEphraim. '*Munguluve* played with people. When you left to work on your field in the morning it was like going to a [white-owned] farm'. She continued: 'He scrapped our bodies because we really cannot plough anymore. Nowadays we buy everything. We eat [chicken] heads and feet but we never see the chickens!'<sup>18</sup>

Villagization impacted negatively on inter-household relationships. Relations between neighbours became flashpoints of suspicion, accusation and violence. Disputes between neighbours focussed on accusations of theft and witchcraft (cf. Niehaus 2001; Stadler 1996). Social differentiation became overt and pernicious. Members of poorer households worked for more affluent villagers. They dug termite mounds to collect soil to make bricks and smeared floors with cow dung, in return for a few scoops of maize meal. A woman remarked on the changes from the reciprocal relations of the agricultural era to the exploitative practices after relocation:

At this time [it was as if] we worked for the whites – we got paid in money. Those with bad hearts would just look at you like you were *chaka* [shit] and won't give you anything

An elderly man who witnessed the changes during the 1970s commented on how this negatively affected inter-household, gender and sexual relations:

We have started to hate each other. We don't like each other. There is the next door neighbour next to each other, to each other, so we can't breathe properly. That is why we end up marrying each other, brother to sister ...

Although the 1970s and early 1980s were a time of industrial growth and increased access to employment this was short lived. By the 1990s, massive job losses occurred due to deindustrialisation<sup>19</sup>. Permanent and stable jobs were replaced by casual contract work (cf. Slater 2001). Men's failure to remit wages and support families was also a constant source of tension. In 1992, after months of receiving no income from her migrant husband NwaMakathshwe threatened to murder her children rather than let them starve to death.

By the late 1990s, it was apparent that the conditions in the former Bantustans had deteriorated. Deindustrialisation cut into the stability of full time employment, rendering thousands of men unemployed. In the place of full time work came casual 'contract' work which resulted in long periods of joblessness and financial insecurity. Aaron, a 45 year old unemployed man described the changing face of employment:

In the past we had *dompas* [pass books<sup>20</sup>]. In the past the firms would come and recruit people here. Now we have IDs [identity documents] and we are allowed to move around. There are so many in Johannesburg who are looking for work. In 1988 until 1990 things started to get worse. They closed the TEBA [The Employment Bureau of Africa, the recruitment agency for Anglo American

Mining Corporation] offices in Bushbuckridge. Since then it is hard to get work. Before we could just go to the TEBA offices and wait there.

Political change for men such as Aaron was therefore highly ambivalent: an unemployed workforce that has freedom to move, but no work.

Disputes between co-wives intensified due to competition over household resources. Fights over food, particularly meat and tinned goods are recurring themes. A 40-year-old woman recalled that when her mother was away from home she and her siblings went hungry as the first wife refused to feed them. After relocation many polygamous households broke up. Men built houses for their wives on separate stands to avoid conflict. Women's life histories highlighted the growing tensions between husbands and wives. Joyce Mathebula's marriage lasted for fifteen years until she decided to leave her husband after his fists left her in hospital with broken ribs, a cracked jaw and several missing teeth.

## **THE EARLY 1990S: YOUTH AND SEXUAL LIBERATION**

An integral aspect of the history of sexuality and disease in Bushbuckridge was the introduction of schooling and clinical services. The growth of these institutions and transformations within them impacted on the capacity of the senior generation to exercise control over the youth and introduced alternative forms of socialisation and medical knowledge located outside of the influence of the household.

In the period prior to the early 1990s, access to reproductive health was restricted and mediated by official and unofficial policy. Although facilities for the provision of family planning or contraception were available in about 1974, clinics were often

criticised and even attacked for trying to issue women with contraception (cf. Marks & Andersson 1987). It was only in the mid to late 1980s that family planning services were more widely available (Garenne et al. 2001). Up to 28% of women in the former Gazankulu 'Homeland' reported using contraception (Kaufman 1998).

However, even then, in terms of common law, contraception could only be issued to a woman with written permission from her husband<sup>21</sup>. Nurses resisted providing contraceptive services to unmarried women and adolescent girls (Kaufman 1998). Even after contraceptive policies had been rescinded nurses continued to restrict family planning services to adult married women. Nursing staff scolded young girls who sought contraception, threatened to inform their parents, and were particularly heavy handed when administering contraceptive injections. They told teenage girls who requested contraception 'come back and show me the baby' and demanded to see used sanitary pads to prove that they were menstruating. Adolescents cite nurse attitudes as the main reason why they hesitated to access family planning services (Stadler et al. 1996; cf. Wood & Jewkes 2006).

In schools, despite the strong emphasis on Christian values regarding premarital sex, in practice this was highly ambivalent. School teachers did not practice the same restraint expected of learners in their sexual conduct (cf. Mathabatha 2005). Scores of young girls were impregnated by their (usually) married teachers. Teachers also drank beer and socialised with school children in village drinking houses (*shebeens*). Affairs between married teachers were public knowledge. A young man remembered the conduct of his primary school teachers when he was in primary school in the early 1990s: 'They



were too playful. All of them were married but they all had affairs'. He described romantic liaisons between teachers during school trips and even in the school classroom:

Teacher Skweni had an affair with Mr Khosa. They drank alcohol and lost control and kissed each other and touched each other in front of the whole school. Our teacher used to kiss the other teacher behind the door while we kids were in the classroom

In the early 1990s, the youth publically contested the authority of state, of the school and of their elders (Stadler 1995). During a school children's uprising of 1990-91, learners rebelled against the use of capital punishment in schools, formed Student Representative Councils (SRCs) and in some cases demanded the sacking of teachers and principals. In events reminiscent of the 1976 Soweto uprising, school buildings were burnt and violent attacks were made on school authority figures. The school boycotts carried on for several months in 1990 (Stadler 1995). Later, youth in the villages of Bushbuckridge mobilised into groups of witch-hunters, promising to rid their communities of known witches (Niehaus 2001; Stadler 1996).

These events had significance for the expression of youth sexuality. In the years following the uprisings, school authority was constantly defied and challenged. Eric, a young teacher at KwaBomba High School saw a distinct change from when he went to school:

In 1994 I saw the change because all kids who were 18 [voting age in South Africa] were saying 'I am old enough I can go and vote I have a right'. But at 18 you are still young; you have a long way to go ... it gave them freedom from 1994

Political liberation of the 1990s was experienced as sexual liberation (cf. Niehaus 2000). Whereas previously sexual relations between youth were secretive, youth defied

the repression of sexuality through public display. This challenged the rules (*milawu*) of respect (*hlonipa/xavisa*). The school principle at KwaBomba High remarked:

You used to hide yourself, but now you see a boy and girl hugging each other in school in the street. In previous years it was done in secret. But they were told ‘you have the right!’ Even at school they can do what they want because there is no punishment. Before 1994 there was punishment at school. The students would respect the teachers. You would be punished for coming late to school, for hitting other learners or using impolite words. But now if a student does sex at school then you only talk to them, you cannot punish for that issue. What I can remember when I was at school, if a learner forged the signature of his teacher that teacher could hit him with his fist, and if the learners fought then you could hit them.

### **THE ARRIVAL OF AIDS (1990 – 2005)**

Official data on HIV infections and mortality at the village level are not available. Nonetheless, the increased incidence of AIDS illness and death in the early 2000s is reflected in local narratives. By then the AIDS body was well recognised and AIDS was identifiable as a cause of death by ordinary residents (See Chapter 5). I asked informants to record all deaths that were suspected to be related to AIDS, noting the age, sex, occupation and a brief description of the symptoms. Whenever it was possible to identify a relative or neighbour who knew the deceased an interview was conducted to collect a history of the illness. Relying on these accounts I recorded 52 cases of death identified by my informants as AIDS. The majority of deaths that I recorded took place during the 2000s (See Table 2), particularly in 2002, perhaps reflecting both an increase in mortality, but also the increased awareness and knowledge of AIDS symptoms.

**Table 2: Reported AIDS deaths according to the year of death**

<i>Year of death</i>	<i>Male</i>	<i>Female</i>	<i>Total</i>
1989	-	1	1
1993	-	1	1
1999	1	1	2
2000	3	6	9
2001	1	4	5
2002	12	14	26
2003	-	-	-
2004	-	-	-
2005	-	-	-
2006	2	2	4
Total	19	29	48

According to this data, women account for the majority of cases (29 of 48 or 61%) and men for 39 per cent<sup>22</sup>. The mean age of the women is 27 years, and their ages range between 17 to 54 years. The men are on average ten years older, with a mean age of 39, and their ages range between 20 and 65 years. Only four women (13%) had access to an income and three of these were formally employed. Six of the women were scholars. In contrast, more than two thirds of the men (68%) had access to incomes. Most of these men are formally employed; some were teachers and others in local government, while others are migrants (See: Table 3 and Table 4).

**Table 3: Reported AIDS deaths according to gender, age, occupation and year of death**

<i>Male</i>			<i>Female</i>		
<i>Year of death</i>	<i>Age</i>	<i>Occupation</i>	<i>Year of death</i>	<i>Age</i>	<i>Occupation</i>
1999	36	School teacher	1989	30	Unemployed
2000	47	Migrant worker	1993	30	Domestic worker
2000	20	Not known	1999	30	School teacher
2000	58	Unemployed	2000	32	School teacher
2001	50	School teacher	2000	32	Unemployed
2002	45	Labourer	2000	30	Unemployed
2002	39	Not known	2000	50	Unemployed
2002	38	Miner	2000	22	Unemployed
2002	40	Not known	2000	21	Scholar
2002	30	School teacher	2001	17	Scholar
2002	35	Truck driver	2001	18	Scholar
2002	34	Migrant	2001	29	Domestic worker
2002	65	Pensioner	2001	54	Unemployed
2002	30	Not known	2002	19	Scholar
2002	31	Migrant	2002	19	Scholar
2002	40	Labourer	2002	30	Vegetable seller
2002	35	Security guard	2002	30	Vegetable seller
2006	35	Employed	2002	30	Not known
2006	42	Employed	2002	20	Unemployed
			2002	32	Unemployed
			2002	16	Scholar
			2002	27	Unemployed
			2002	30	Unemployed
			2002	25	Unemployed
			2002	21	Unemployed
			2002	19	Unemployed
			2002	40	Unemployed
			2006	30	Unemployed
			2006	45	Unemployed

**Table 4: Summary table of the demographics of reported AIDS deaths**

	<i>Male</i>	<i>Female</i>	<b>Total</b>
Number (Per cent)	19 (39%)	29 (61%)	48
Average Age	39	27	33
Age Range	20-65	17-54	17-65
Employed	13 (68%)	4 (13%)	17

These records of AIDS mortality tell the story of rapidly increasing rates of HIV infection and AIDS death over the period of little more than ten years. The demographic features of those identified reveal the structural underpinnings of the AIDS epidemic, in terms of gender, generation and economic class. Local accounts made sense of these patterns by drawing attention to changing political economy of sexual relationships. Specifically, my informants' narratives pointed to the increasing mobility especially of younger women, and material inequalities between those with incomes and those without.

Of particular significance to understanding the spread of HIV is the increasing mobility of young women. In 1997, the number of women from Bushbuckridge who migrated to Gauteng increased from 15% to 25% amongst older women (aged 35 to 54) while younger adult women (aged 15 to 34) increased from 5% to 20%. In 2003, 24% of older adult women and 19% of younger adult women were absent for the majority of the year (Collinson, Kok, et al. 2006).

In KwaBomba, a group of women commuted regularly to Randfontein, a mining settlement in the North West Province. The regular commute to Randfontein began in the mid-1980s when a few older, separated and/or widowed women sought to support their children by selling produce in urban settlements. One of the first, Jemima Mabunda struggled to support her three children with the paltry R30 monthly wage she received as

a farm labourer in Barberton. In 1984, Jemima commuted to Soweto by train to sell fruits purchased from white farmers in lowveld. However, frequent police harassment and township violence drove her away. In Randfontein she found a market amongst the men employed on the mines that were keen to buy fresh produce. Jemima was able to substantially increase her income. ‘I would pay school fees, buy a bag of maize meal, buy clothes’ she said, remarking on the ease at which she earned this extra income.

Sarah Dzhambukeri, Jemima’s neighbour, was an unemployed divorcee. Jemima and Sarah travelled to Randfontein together, although Sarah made more permanent roots in Randfontein. She settled down with a Mozambican man who worked on the mines and together they rented a house near Randfontein in Mohlakeng Township. Sarah invited her sisters and friends from KwaBomba to visit her there. In 1989, Flora (Sarah’s sister), divorced her first husband and joined the others in Randfontein. She set up a small informal trading store (*spaza*) and by 1993 she was renting out one-room corrugated iron shacks (*mukukus* lit. chicken coops) on the borders of Mohlakeng<sup>23</sup>.

In the early 1990s the pathways to Randfontein that had been established by women of Sarah and Jemima’s generation were followed by a younger generation of women. Lindiwe (Flora’s eldest daughter) and Xolani (her neighbour) visited Randfontein in the early 1990s. They sold fake gold jewellery and formed relationships with working men who supported them financially. Xolani eventually gave up on selling jewellery and only visited Randfontein when she needed money from her boyfriend. Lindiwe recalled that when she asked her mother for money, she told her to ‘go and find a man to help you’.

An older woman reflected on the role that poverty plays in driving epidemic spread:

It is poverty that makes women sleep around with men...I know because I used to do that. Yes I know life. I will never know what will happen after having sex with those men; maybe those men were HIV positive I do not know. And you will never know that time I was sleeping around whether this disease was around or not. Where I was working I realised that they do not pay me enough that is why I was running around with men...if I was working on this farm they gave me two rand or three rand, so I realised that if I find a man who is working for the firms they will give me bread, other men gave me sugar, those kids I left at home they will be able to have something to eat. And they [the men] don't give you this stuff for nothing. Others want you to bend others want your head to face down and have sex with you like that... [Laughter] and that time it is like I am working and after that they pay me something. The time you leave work and come to stay at home you are not able to do anything. So that time they are bending you and doing this to you it is the time the disease just gets into you...so that is why I do not know if I am HIV positive because today I will say oh my head the next day I will say oh my tummy...and all that time the disease is eating me [laughs]

The relationships that Xolani and Lindiwe formed with men in contexts such as that of the settlements around Randfontein undoubtedly exposed them to HIV. By 2005, Lindiwe was a candidate for antiretroviral treatment and Xolani was critically ill with AIDS. Their movement between village and mining town created a pathway for HIV to enter the village and permeate local sexual networks<sup>24</sup>.

While poverty shapes women's vulnerability to HIV infection, relative wealth and material inequalities shapes that of older men's. Only one of the men identified as having died from AIDS was unemployed. The remainder had access to disposable incomes, drove cars, built modern houses, and cash to purchase alcohol and luxury food. Three of the men who died of AIDS between 1999 and 2003 were teachers, and more were rumoured to be infected. A local physician once remarked that he found it surprising that most of his AIDS patients were the 'educated ones' such as teachers and policemen and



not those ‘who are deep in the bush’, by which he meant the uneducated and unemployed. Yet, even those men who simply had permanent jobs or access to some form of income were vulnerable to HIV infection.

Other important developments that took place during the early 1990s were also seen to underpin the spread of HIV. My informants identified the construction of the main road that passes by the village and links it to Acornhoek in the north and Bushbuckridge in the south as an important turning point in the local epidemic. The road ultimately created a connection between the world of the village and the increasingly busy development corridor between Johannesburg and Maputo. Older residents were unhappy when the road was built as it was believed to only benefit the educated elite. This is reflected in a song performed at the *muchongolo* dances when the road was being built:

Gijimani miya byela	Run away and tell
Jojo Malamule	Jojo Malamule <sup>25</sup>
Leswaku xikantiri	About the tarred road.
Xihi heta milenge	It destroys our legs
Hitler uhi kombe mihlolo	Hitler he showed us a miracle
Byela byela	Tell, tell
Hoyo hoyo hoyo	Welcome, welcome

The song urges people to complain to Jojo Malumele (the former minister of road transport in Gazankulu) about the road's hard surface that hurts the unshod feet.

Metaphorically it alludes to the suffering that accompanies development. The song had prophetic vision. The geographical location of settlements, particularly in relation to truck stops and major highways is an important factor in the epidemiology of AIDS (Webb 1997, 99-101). The new road created a new locale for transactional sex. AIDS was seen to literally 'travel' this road from the major centres of Gauteng. Streets and roads feature prominently in local discourses about AIDS. Young girls are warned about the dangers of 'lingering' on the streets, and AIDS is seen to attack those who 'play in the street' (*famba tlangeni xitrateni*). Sexual liaisons formed on the street are hidden from the gaze of parents, are socially unsanctioned and dangerous. In a speech at a public ceremony a health official stated: 'Most people think that when they are on the streets having secret love they are safe. They can hide from people but they can't hide from AIDS'.

NwaMbembe walked past a notorious pick up spot on the main road every evening on her way home from the bus stop. She commented on the young women who hung around:

Aaai there are many you can't even count them...even those kids at school there at KwaBomba High there is not one that can say I am only having one boyfriend. Because today you pass her on the way she will be standing with this boy the next day with some other boy. It is just difficult even when she becomes pregnant you want to know who made her pregnant – you won't know. The time you ask her 'who made you pregnant' she will count ten boys because she doesn't know who made her pregnant. So you will never know where you got AIDS that time. You will never know!

Road construction and commuting to Randfontein were raised as the reasons for Anna's death, a 27 year-old woman who died of AIDS in 1999. A male relative provided this account:

She started to become thin and not eating well, vomiting and she had diarrhoea. It happened like that – it took three years. She went to Bushbuckridge hospital and they told her and her mother that she was HIV positive. She slept with many men without a condom. It was her behaviour that made her to become infected. She had many partners. She was always trying to catch men. I was angry with her for becoming sick because she ignored that lesson from the nurse from Tintswalo [Hospital]. Many people were talking about her, saying 'this girl – she will get AIDS because if there is a road contract [construction] she will be there as well. She never stayed at home. She would visit Randfontein. When she became sick at first they sent her home. She would go to where people were camping [at the road construction sites]

### **EXPERIENCING AIDS AWARENESS**

The public health response to AIDS took place through education and awareness programs promoted by schools, provincial and local government, NGOs and clinics. These activities, rituals and symbols are arenas in which public health discourses of the causes of the epidemic are articulated and disseminated.

Post-1994, 'Life Orientation' of which sex education formed a part was introduced as a compulsory subject in schools. AIDS education was adopted into the school syllabus in 1998. This represented a significant shift in approaches toward sexuality for teachers and students. Teachers, accepting that adolescents were sexually active and vulnerable to HIV infection, ceased attempts to stifle sexual expression amongst adolescents through punishment. In theory, sex education stressed open discourses of sexuality, with the aim of arming learners with knowledge to enable them to make the right choices regarding the onset of sex, condom use and contraception.

The extent to which this promoted an open discourse about sexuality and HIV was limited. Sex education tended to focus on the negative outcomes of sex and thereby judged adolescent sexuality. The moralising discourses of missionary and Bantu Education teachings were replaced with a biomedical discourse of risk, disease and hygiene. Danger was associated with disease to motivate learners to take up ‘responsible behaviours’ (cf. Macleod 2009). Moreover, despite the attempts to promote a liberal approach to sexuality, there was a notable hesitancy to talk openly about AIDS at schools, even in sex education classes (cf. Morrell 2003). Teachers were often poorly trained and ill-equipped to deal with the issues that sex education raised.

Teacher Sibuyi, a young mathematics teacher and devout Christian, was trained in sexuality education. Although Sibuyi felt it was his duty to remind learners of the consequences of unsafe sex he struggled to communicate these issues to learners. My interview with him revealed his personal difficulties in communicating with his pupils:

The children laugh when I advise them, because it is interesting [amusing] for them. But the time this disease catches them they won’t laugh. This is the time to tell kids the truth. Maybe I tell them what you call private parts but I don’t say exactly that name so they laugh for that ... the word I am using for the eh [penis] ... instead of saying that word sometimes I say it is a stick [penis] or...but they know even if you don’t say exactly, they laugh. Some laugh because they are still young. Some have a difference of one year with me so they laugh; others have children so they question me, what [do] I know, because I don’t even have a wife.

As is clear from this extract, Teacher Sibuyi struggled to communicate with his students. He was far too embarrassed to verbalise the facts and lacked the status required to gain the respect of his students.

One of the limitations of current approaches to awareness and education about AIDS is that the messages are unappealing to young people due to their reliance on

negative outcomes approaches. Young people also report being bored and irritated with being bombarded with messaging about AIDS. Many of my young informants switched channels on the television when public service announcements about AIDS were made.

The large national NGO loveLife (their spelling), operating on an annual budget of 200 million rand, was launched in 1999 (Parker 2003). Recognising limitations of previous approaches their campaigns are based on ‘motivational optimism’ in contrast to the heavy-handed, finger wagging, scare tactics of the national ABC (Abstain, Be faithful, use Condoms) campaign (Jeeves & Jolly 2009). The campaigns centres on promoting ‘positive sexuality’ via a ‘lifestyle brand’ ‘that combines communication about sex and sexuality with the promotion of consumption of fashion items, music, film and branded goods’ (Parker 2003, 7). It includes an awareness campaign that used billboards, a telephone helpline, events (*‘love tours’*, *‘love train’* and loveLife Games) youth centres (*‘Y-Centre’*) and peer education (*‘Groundbreakers’*).

In 2001, loveLife established a youth centre in Acornhoek, a half hour taxi’s drive from KwaBomba. The centre is housed in a circular building (previously a tavern), painted garish purple. The Y-Centre approach to HIV prevention is to emphasise alternatives to sex through recreational and educational opportunities. Children learn about computers, ballroom dancing, self-defence, radio broadcasting, and play basketball. The clinic called a ‘Wellness Centre’ based at the centre offers counselling and there is a chill room where children can read loveLife publications and talk (see Picture 1).

The Y-Centre is extremely popular and attracts hundreds of young people every day (see Picture 2). However, loveLife is also regarded as exclusive and elitist. It targets youth between 13 and 21 years of age. As a consequence older youth tend to stay away

from the Y-Centre. This seems odd given the high rates of infection amongst older youth. A centre volunteer remarked: ‘The problem is that the old people who we believe are infected as well, they do not go to loveLife – like those of 21 years they say it is the place for kids’.

Access to the centre is also mediated by social class (Hunter 2010, 207). The children who attend the centre are regarded as affluent and trendy youth. Although the youth and staff at the centre communicate in XiTsonga, the printed and audio visual materials and workshops are all in English. LoveLife consciously promotes American fashion, styles, and attendees adopt American accents and slang. During a workshop I observed, children learnt to sing the ‘Pizza Song’<sup>26</sup>. Motivational speakers invited to present at the centre are usually US based such as Miles and Associates, an organisation that links basketball to youth development. The promotion of basketball itself was criticised by local youth and parents who favoured soccer and netball. In response, the centre allowed girls to use the court for netball as well.

The focus on American consumer culture is attractive to many youth but also tends to alienate those who struggle to afford the fashion or identify with American fashions, music and sports. The following extracts from interviews conducted with youth about loveLife drew attention to the elitist image projected by the Y Centre:

LoveLife is like a competition. A competition of clothing, you see? ‘Oh, I can go to loveLife’, or ‘Oh, I’m a member of loveLife’, you see? ... So you become proud (Boy, 21)

Boys look for girls there, girls look for boys. They are promoting condoms, not talking about abstaining. They should teach about AIDS. They think they are better than you, they’re like models (Boy, 17)

I don't know whether you have to speak English, I mean... maybe...they want intelligent people to... take part [at the Y-Centre] (Girl, 19)

A boy of 17 used a black marker pen to draw the *Nike* symbol on his otherwise plain tennis shoes:

I love basketball, but [if] you don't have a load of money, or... wearing the stuff, maybe you are wearing *takkies* [tennis shoes] and they are ugly, so you're an embarrassment. So they are just laughing... They are wearing *Nike*, *Adidas* and those things

As a demonstration of LoveLife's power and wealth, a massive yacht was driven on a trailer into Acornhoek and parked outside the Y Centre. The exercise was to celebrate a voyage to Antarctica to raise awareness of the AIDS epidemic (Picture 5). The professional film crew that accompanied the boat also erected portable toilets at the centre, despite the availability of flush toilets. The irony of the spectacle of a boat standing on a trailer in the middle of a town in the semi-arid lowveld did not go unnoticed by passers-by. For many it was yet another example of the disjuncture between the affluent foreigners who commanded the centre and local realities of poverty.

Awareness and education for HIV prevention also takes place through AIDS rituals such as World AIDS Day. These rituals are dramaturgical devices (cf: Goffman 1959) that display and reinforce the global reach of the AIDS industry<sup>27</sup>. I attended World AIDS Days in Bushbuckridge from 1996 to 2003. In 2002, the main event was held at Puledi High School (Picture 6). On the sports field the organisers had erected three gaily striped marquees. One marquee was reserved for VIP guests from the department of Health and the Bushbuckridge municipality. It was decorated with flowers and traditional artefacts such as woven baskets, kudu horns, spears, and wooden porridge spoons<sup>28</sup>. In



the other tent a display of boxes of condoms arranged to form a pyramid was closely guarded by male and female nurses also offering pamphlets (see Picture 4). A good distance from the arena, a few school children, old women and old men gathered on the embankment. Further beyond food and drink sellers had set up stalls and a few young men stood around.

The day's program consisted of speeches (the mayor of Bushbuckridge and local representatives from the Department of Health and Welfare) and cultural performances. A group acted out a scene from the Broadway musical *Sarafina* about the Soweto school children's uprising of 1976; young boys dressed as soldiers held wooden AK 47s (see Picture 3) gave a display of military marching; a group of older women performed a traditional Sotho *kiba* dance; two young men performed impressions of Thabo Mbeki and Nelson Mandela. These items were punctuated by hymns and songs. After the displays, dignitaries and special guests were invited to the main tent to a sit down lunch of chicken, beef, salads and porridge, while beef stew and porridge was on offer to the spectators.

Mandla Ndlovu and Riot Mathonsi, two young men from KwaBomba who had accompanied me to the event, hastened me to my car before the feasting could begin. When I protested (I was hungry and curious), Mandla said: 'I am really not interested in standing in a queue for food. That is for poor people'. This was somewhat ironic: Mandla and Riot were unemployed and from very poor households and both depended on welfare grants; Mandla's mother was an alcoholic and Riot's father abandoned his family many years previously. The two young men were the quintessential 'community members' targeted by the AIDS awareness event held that day.

I was curious about Mandla's reaction and interpretation of the day's events. He was an organizer of AIDS awareness activities in KwaBomba and participated in many AIDS awareness programs as a youth representative of the village. Mandla was therefore in a good position to comment on AIDS awareness interventions. He reckoned that AIDS awareness activities such as the World AIDS Days were mostly failures. According to him, these rituals promoted divisions within communities by celebrating the status of the affluent and powerful while marginalizing the poor. Ironically, the World AIDS Day event reinforced the social inequalities that lie at the foundations of the AIDS epidemic itself. This was especially a feature of the feasting. Mandla said:

The World AIDS Day is an exclusive event. You have to be invited as an organization and the main attraction is the catering that is provided. If your name is on the list of VIPs then you get to eat in a special area for VIPs – if not then you have to stand in a queue with everyone else.

Those who end up at the end of the queue face the humiliation of not getting anything to eat. For Mandla and Riot to eat at these events was to accept a position of inferiority, to become in the eyes of those around you, an impoverished person. The ritual served as a reminder of their status as commoners.

While the World AIDS Day event seemed to promote these social divisions between rich and poor, another ceremony I attended portrayed the superiority of modern biomedicine over traditional healing. At a home-based care-giver graduation ceremony held in Thulamahanshe, the graduates put on a short play. The plot revolved around an older married man sick with tuberculosis. The first scene opens with the man drinking traditional beer (*xikhapakhapa*) with a woman who dances to music playing on a stereo. In the next scene the man begins to cough. He removes his shirt and shows the audience

that it is wet with sweat. To the beat of drums the man is taken to a traditional healer (*n'anga*) who performs divination (*ku femba*) and then provides the man with medicine. The man continues to cough and he visits the traditional healer for a second and then a third time. At this point the family intervenes and argues with the healer. They point out that there is treatment for the disease available at the clinic. The healer argues back saying that she needs to make her money. The next scene is at the clinic. The nurses (wearing old fashioned nursing caps) assist the TB patient, asking questions and scribbling on papers. The other family members complain about the money they have spent paying the traditional healer. The nurse replies 'TB does not need a *n'anga* [diviner]. You should have taken the patient to the clinic straight away'. The man is referred to hospital where a doctor examines him and gives him a prescription. He says in an authoritative voice in English 'You will get pills from your nearest clinic'. He then turns to the audience and says again in English 'If a person coughs a lot he should not be taken to a *sangoma* [traditional healer]'. He points out that the hospital provides treatment for free while the healer charged the family lots of money.

The drama clearly articulates an opposition between 'traditional' healing and Western biomedicine. It blames traditional healers for wasting peoples' money and duping them into thinking that they can cure TB. In contrast, Western biomedicine is free and effective. Later in conversation with Solomon, one of the organisers, I ask what the main reasons are for non-compliance with TB medication. Solomon replies that drug stock-outs and long queues at the medical centres are the main reasons, and that patients often struggle to get access to their medication. Tradition it seems has very little to do with problems of compliance.

## CONCLUSIONS

The social history of the AIDS epidemic described above has in many ways echoed the sentiments expressed by the old man Madimbi with whom I began this chapter. Epidemic spread is intimately related to social and economic transformations beyond the control of ordinary people, rooted in a history of the erosion of, as Madimbi would have it ‘a traditional way of life’. The appeal to bring back the traditional ways (*xintu*) made by men and women like Madimbi and to regard AIDS as a product of modernity or ‘the way of the whites’ (*xilungu*) is a counter to official, public health discourses that directly challenge tradition and African culture. In public health AIDS rituals, divisions between rich and poor, the modern and the traditional, and young and old are articulated through symbols and performances. LoveLife promotes an American, if not global, popular culture that extols fast foods, basketball and open discourses about sexuality. Awareness campaigns such as those held for the TB home supporters blame traditional healers for the spread of TB and promote the virtues of Western Biomedicine. The feasting at AIDS rituals such as World AIDS Day are celebrations of status at which poor people are reminded of their position in life.

These rituals reflect an emerging middle-class culture that many black South Africans have joined but from which many more are excluded. Hunter (2010, 209) argues that LoveLife’s elitism resonates strongly with ‘deeper social fissures’ in a context where many young people have been ‘left behind’. Those who stand to benefit most from interventions to prevent the spread of HIV are those who experience barriers to participation.

This chapter has also highlighted the importance of a historical perspective in explaining the spread of HIV, challenging the over-reliance on cognitive behavioural models of individual risk. Infections and disease spread are not simply outcomes of individual risky choices. Political and economic forces constrain the opportunities and choices available to people and create conditions of vulnerability (cf: Craddock 2003; Marks 2002). As Farmer puts it, ‘HIV, (...), has run along the fault lines of economic structures long in the making’ (1992, 9).

As I go on to show in the next chapter, behaviourist models that underwrite public health approaches to prevention are unlikely to have an effect on the spread of HIV. This, I argue, is because the transmission of HIV is shaped, not so much by individual behaviours, but by the social structure of sexual relations.

## END NOTES

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<sup>1</sup> See Bill (1994) for a fascinating exposition of the metaphorical relationship between eating and sex in Tsonga folk tales.

<sup>2</sup> This text is an edited version of a longer transcript. My tape recorder was still running and I was able to record Madimbi’s speech.

<sup>3</sup> The Malawian mine workers were repatriated ostensibly for public health concerns, although economics may have had more to do with this decision (Chirwa 1998).

<sup>4</sup> A dry period began in 1979 with droughts occurring in 1981/84 and 1991/92: 70% of the region’s cattle perished in the 1991/92 drought. This drier period had not abated by 1995 (Shackleton et al. 1995) and a few years later (1998 and 2000) very heavy rains led to widespread flooding (Freeman 2002).

<sup>5</sup> The ministry of health produces an annual survey of HIV and syphilis prevalence, based on data from a national sample of antenatal clinics. The survey provides indicators on the progress of the epidemic and prevention. Yet, the survey contains several biases: the subjects are women, of childbearing age, who attend public health clinics. This excludes sexually active women who use contraception, older women, and women who

can afford private care. Moreover, because HIV reduces fertility, HIV positive women are less likely to conceive (Shisana & Simbayi 2002; Whiteside et al. 2002, 3-4).

<sup>6</sup> These statistics are from an unpublished report of the Department of Water Affairs and Forestry (Department of Water Affairs and Forestry ND).

<sup>7</sup> Due to periodic drought, birds, and boring worms, farmers preferred robust drought hardy maize called 'traditional maize' (*swifake xa xintu*). The cobs were stored in grain huts (*xidludlu*) and dried. A particularly labour intensive task performed mainly by unmarried girls (*tintombi*) or recently wedded women (*vakothi*) was the production of maize flour. The kernels were pounded into flour in a mortar and pestle. This flour was then ground it into a fine powder using a grinding stone. The coarse brown grain was separated from the finer white flour. This was left for 24 hours to ferment in water. The sour porridge (*vuswa*) produced from the white flour was prepared especially for the senior men of the household.

<sup>8</sup> Bonner's (1995, 118) analysis of pass records in the 1930s and 1940s is revealing. Of African men employed in Johannesburg only one-third remained in employment after eight years. Between 1936 and 1944, 50 per cent had returned to their homes in the African reserves.

<sup>9</sup> This is similar to 'sweet-hearting' (*ukusoma*) documented in ethnographic accounts on the Eastern Cape (See: Hunter 1936).

<sup>10</sup> In the Eastern Cape this was called *hlobongo* translated as 'sex between the thighs' (Wood 2002).

<sup>11</sup> Village names sometimes retain the original farm names. These names reflect the romantic imaginations of the former white farm owners: Edinburgh, Croquet Lawn, Agincourt, Orinoco, Ludlow, Green Valley, Dinglydale, Xanthia and Arthur's Seat are good examples.

<sup>12</sup> With the application of the policy of apartheid after 1948, and especially the rigorous enforcement of legislation in the 1960s, removals took on a more systematic nature. Legislation like the Group Areas Acts of 1950 and 1957, the Natives Resettlement Act of 1954, the Native Trust and Land Amendment Act of 1954, and the Native (later Bantu) Laws Amendment Acts of 1952, 1963, 1965 and 1970 provided the authority and the machinery for the mass removals. At the same time the institutional framework for Separate Development was established by the Bantu Authorities Act of 1951, the Promotion of Bantu Self-government Act of 1959, the Bantu Homelands Constitution Act of 1971, and the Bantu Affairs Administration Act of 1973 (Baldwin 1975)

<sup>13</sup> Bonner (1995) notes in the later 1930s and early 1940s, young men escaped from their rural homes without their parent's consent mainly to earn money – 'to buy respectable clothes' . 'A number of points emerge from these individual histories - the driving pressure of poverty, social instability and a curious mixture of caution, determination and unquenchable hope' .

<sup>14</sup> The origin of the term is 'girl', usually used to refer to Black women in domestic employment in white households.

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- <sup>15</sup> Abduction and rape may also account for these disappearances (cf. Niehaus 2003).
- <sup>16</sup> The first missionary station in Bushbuckridge was established in 1916 by the Catholic Swiss Mission. They introduced the first clinical services in Bushbuckridge in Cottondale in 1931 and the Ethel Lucas Memorial (ELM) hospital was built in Acornhoek in 1936. Initially mission health services were rejected. Nkuna (1986, 150) cites a missionary report that attributes this to culture: 'The Blacks of the area, who were still under the sway of witchcraft and superstition, did not trust the whites and their medical institutions'. However, the demand for hospital treatment grew and by World War II up to 20 000 outpatients were recorded. By 1970, the ELM Hospital and its nine satellite clinics treated almost 21% of the local population (302 000). Three doctors were responsible for 62 000 in-and out-patients and managed 230 beds (Nkuna 1986, 154).
- <sup>17</sup> It is likely that their descriptions refer to the first epidemic of venereal disease in South Africa, a result of increasing mobility (Jochelson 2001) and prostitution (Bonner 1990). Statistical evidence points to a growing but varied syphilis epidemic across the country. Between 2% and 47% of various populations tested positive for syphilis between 1930 and 1946 (Kark 1949, 182).
- <sup>18</sup> Chicken heads and feet, commonly known as 'walkies and talkies', are the cheapest cut of the fowl.
- <sup>19</sup> Niehaus found that male unemployment had increased between the years 1990/1 to 2004 from 16 to 43 per cent (Niehaus 2006b, 526).
- <sup>20</sup> In terms of the Native Urban Areas Act 1923 and The Pass Laws Act of 1952 it was compulsory for all Black South Africans over the age of 15 to carry a pass book at all times. The law stipulated where, when, and for how long a person could remain.
- <sup>21</sup> This was revoked in 1984 by The Matrimonial Property Act (Act 88).
- <sup>22</sup> Four infants of unspecified gender and age have been excluded from the analysis.
- <sup>23</sup> Almost half of the township of Mohlakeng lived in shacks (in 1994, 46 per cent of the local population or 56,000) and 48,000 in backyard dwellings (Sihlongonyane 2001, 36).
- <sup>24</sup> Randfontein is a mining town located at the nexus of several mines. It presented opportunities for women to generate an income due to the high concentration of men who work there. Anglo Gold and Gold Fields (GFL Mining Services) and Rand Gold operate eleven shafts. Collectively, they employ between 60 000 and 80 000 predominantly male miners. Between 40% and 50% of the miners are from outside the borders of South Africa (Gilgen et al. 2000, 13-15). HIV prevalence in mining towns in the Randfontein area is extremely high. In the town of Carletonville, 30% of men aged 35 as compared to 50% of women aged 25 were HIV-positive. Almost 35% of women between 14 and 24 years of age were infected with HIV compared to 9% of males in the same age band (Williams et al. 2000).



- <sup>25</sup> The song refers to two local personalities responsible for the road's construction: Jojo Malamule – minister of public works in the former Gazankulu administration, and the local *ndhuna* (headman) infamously named Hitler.
- <sup>26</sup> The lyrics are inanely repeated over and over: 'A pizza hut, a pizza hut, Kentucky fried chicken and a pizza hut, A pizza hut, a pizza hut, Kentucky fried chicken and a pizza hut, McDonalds, McDonalds'.
- <sup>27</sup> The response to the AIDS epidemic has been aptly described as an 'industry' (Pisani 2008). This is in recognition of the significant investment of resources dedicated to prevention on a global scale (Altman 1998). The financial resources dedicated to AIDS are the largest ever committed to a single health prevention plan. Ten years previously funding for AIDS was 485 million US Dollars. By 2008, this had increased to ten billion US Dollars (Cohen 2008). To talk of 'The AIDS Industry' is to talk not only of institutions and resources but also discursive practices (Altman 1998).
- <sup>28</sup> Two wooden spoons linked with a chain form part of the coat of arms of the former Gazankulu cultural and political party - *Ximoko Xa Ri Xaka* (Whip of the Nation).



**Picture 1: Youth pose under a *loveLife* Billboard in Acornhoek (Photo: Asa Walhstrom)**



**Picture 2: Young boys chill in the *loveLife* Y-Centre (Photo: Asa Wahlstrom)**



**Picture 3: The marching band pose with wooden AK-47s at World AIDS Day (Photo: Jonathan Stadler)**

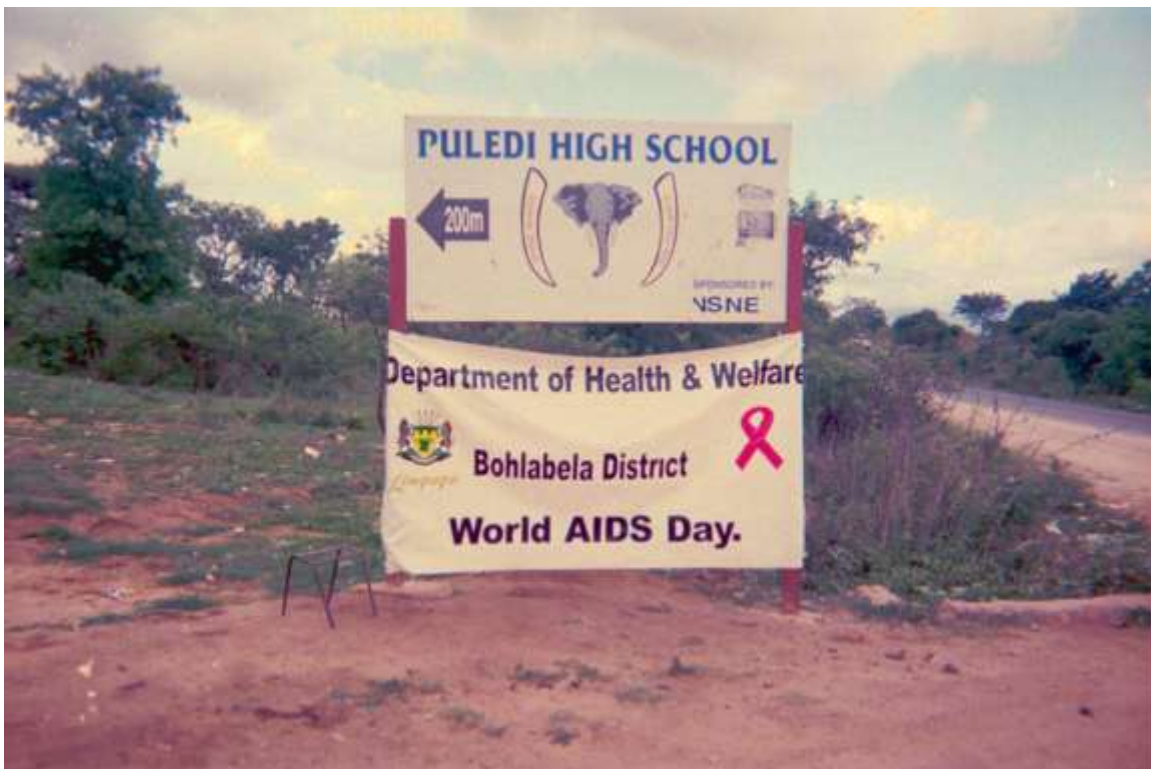


**Picture 4: Boxes of condoms on display at World AIDS Day (Photo: Jonathan Stadler)**





Picture 5: The *loveLife / Earthship* visits Acornhoek (Photo: Asa Wahlstrom)



Picture 6: World AIDS Day, 2002 (Photo: Jonathan Stadler)

## CHAPTER THREE

### **INFECTIONS: THE SOCIAL STRUCTURE OF SEXUAL RELATIONS**

Whereas the previous chapter outlined historical transformations that shaped the social, economic and political context of the AIDS epidemic, the proceeding discussion seeks to explore the reasons for the rapid spread of HIV in Bushbuckridge through sexual relations. In the chapter I argue that transformations in the sexual economy have given rise to the prominence of multiple, concurrent sexual partnerships. These are relationships that overlap in time. The significance of this patterning of sexual relationships is the emergence of fairly robust, socially undifferentiated, and spatially dispersed sexual networks that act as highly efficient conduits for the transmission of HIV.

The role of multiple and concurrent sexual relationships in driving the spread of AIDS has been well developed in the recent literature (Epstein 2007; Halperin & Epstein 2004) although it has also been disputed (Tanser et al. 2011). Nonetheless, it is argued that concurrency has important implications for the speed, size and persistence of HIV in a population (Mah & Halperin 2009; Morris & Kretzschmar 1997). Because viral load or the amount of HIV present is at its peak in the initial or acute and final stages of infection, HIV is easily transmitted from one person to another during the initial asymptomatic phase. Concurrent sexual relationships contribute significantly to the formation of sexual networks that can involve a large number of people, spread over a broad geographical area. This means that in particularly dense sexual networks, everyone has the potential to be linked to an individual who was recently infected and is thus highly infectious.

Importantly, sexual network analysis allows us to go beyond epidemiological constructs of ‘risk groups’ and ‘risky behaviours’ toward understanding the social dimensions of the spread of HIV. Conventional epidemiological methodologies focus almost exclusively on risky individual behaviours rather than ‘risky situations’ (Obbo 1993). Epidemiological surveys measure sexual risk behaviours in relation to HIV prevalence or incidence. Early in the AIDS epidemic, studies focussed on the identification and targeting of ‘risk groups’ for example, gay men, sex workers, migrant men, and truck drivers. These populations were defined as ‘core transmitters’, that created pools of infection and ‘bridges of HIV infection’ into the general population (Jochelson et al. 1991). Yet, the ‘core transmitter’ model and ‘risk group’<sup>1</sup> has limited application in South Africa where the epidemic is of a generalised nature (Iliffe 2006). HIV infection also occurs amongst men and women who are not defined as sex workers or who are not especially promiscuous. The idea of specific and identifiable ‘risk groups’ as a Western cultural construct fits poorly with the African situation (Epstein 2007).

A good illustration of the concept of sexual networks is Kohler & Helleringer (2006) documentation a vast sexual network comprising of more than 60% of the total population of Likoma district, in the northern region of Malawi. They found that the sexual network was not attributable to a group of highly active individuals (a ‘core group’), but the tendency to share sexual partners, resulting in direct and indirect linkages between individuals in a common network. Exposure to HIV in this situation depends not only on sexual conduct, but on an individual’s position within a sexual network. Moreover, the network is invisible to individual actors, only becoming partially visible in the event of illness and death.

While research into sexual networks provides fairly persuasive data to illustrate the concept, these are not always able to address the question why multiple, concurrent sexual relations are so widespread. In order to address this question, a better understanding of the social structure of sexual relations is required. This has been partly addressed in Chapter 2 that described the shifting sexual economies relating to transformations in the political economy.

The focus of this chapter is the current features of different forms of sexual relations. I begin by exploring forms of relationship beginning with childhood, late adolescence and early adulthood, and in adulthood. In their sexual biographies, my informants described an array of sexual relationships: the sexual games of children; the casual sexual encounters and long-term romantic partnerships of youth; marital and extra marital affairs; and sexual relationships involving the exchange of cash, favours and gifts. Their narratives reflected on sexual desire, procreation, meeting material needs, sexual experimentation, masculine domination, romantic love, and companionship and affection. Unlike the prevailing views of a chaotic, unrestrained sexuality, men and women, young and old, entered into different forms of short and long term associations that were clearly defined. Different types of sexual relations were conceptualised as distinct; or conversely, individual actors interpreted their sexual relations in terms of a broad range of pre-existing forms that addressed a range of material and emotional needs (cf. Setel 1999, 141).

Beginning in childhood and early adolescence, sex is considered to be ‘not real’, it is a game played by immature boys and girls. Yet as biographical accounts revealed, youngsters often had penetrative sex at a young age. Youth talked of romantic long-term



relationships, defined as abstinent and monogamous, yet had casual sexual relationships. Sex within marriage is regarded as procreative, while extra marital affairs are erotic. However, the definition of marriage itself is often elusive and highly ambiguous. Extra marital relationships are often constructed as marriage and carry the expectation of procreation and long-term material support. However, these expectations may not be shared equally by men and women. Most significantly, different forms of sexual relationship were not necessarily exclusive. Extra-marital relationships did not contradict marriage; sex in exchange for material support did not negate the need for emotional and romantic relationships; casual sexual encounters did not nullify long-term romantic relationships. This meant that multiple partnerships were not mutually exclusive.

### **PLAY, ROMANCE AND SUGAR DADDIES: FROM CHILDHOOD TO YOUNG ADULTHOOD**

Play sex or what youth referred to as *matanyula* is not considered ‘real sex’. Until a boy starts to experience nocturnal emissions or wet dreams, he does not have the capacity for ‘real’ sex as he does not produce seminal fluid. Seminal fluid is referred to as blood (*ngati*) that has turned white through the heat of sex (cf. Niehaus 2002a). Wet dreams are sometimes referred to as ‘boys’ menstruation’ and signal the onset of sexual maturity. However, at a young age, semen is not regarded to be potent enough for conception.

In their biographical accounts, young men spoke about spending their days in the company of their peers, herding cattle or goats, or foraging for food (termites, mice, small buck) in the bush<sup>2</sup>. Their earliest sexual experiences took place in these settings. My male informants talked about stimulating themselves while swimming in the river, spying on

girls bathing naked and couples having sex in the bushes. There were also rumours of boys who had sex with domestic animals. For example, a young boy allegedly ‘raped’ his neighbour’s dog. However, my informants dismissed this as a sign of insanity brought on by abnormally high levels of sexual desire.

Narratives of sex placed a strong emphasis on penile – vaginal sexual intercourse. Many regarded masturbation as abhorrent. They sniggered at a loveLife publication that advocated masturbation as an alternative to penetrative sex. One young man said he feared being arrested if caught masturbating. Sibusiso, an 18-year old school goer talked about wet dreams and masturbation:

We talk about this [wet dreams], but we don’t know where it comes from. I know that if you do not have sex for a long time the older sperms have to leave to make room for the new ones. Some guys are embarrassed and too shy to talk about it – they relate this to masturbation, so they are embarrassed. They call masturbation *ku ba deyisa* [to play dice]. This is because of *chavisa* [taboo, fear, respect]. No one would admit that they have masturbated. I have a friend who admitted it; he was a very open guy, but other guys will say that it is a very bad thing to do. Wet dreams show that you are ready to start to have a child.

In their sexual biographies, young men pointed to the role of older peers in discovering sex. Aubrey told me that when he was a child ‘still wearing short pants’, his older brothers teased him because he lacked sexual awareness. Aubrey recalled how his brothers would tease him about his inexperience:

They said ‘yesterday I got sex’. I asked them ‘What’s that?’ They said ‘You don’t know? You are a *xiphukuphuku* [fool]!’ They said ‘Look at us. We played and we had sex last night with a girl next door’. If you didn’t get anything everybody was laughing at you that you are a fool and you are afraid of girls.

Mandla, a young man in his mid-20s, said he would boast about his sexual potency when he was younger:

I used to speak to girls about sex. I always bragged about how strong I am, and how far I can go – I would say that I *ku ba ma bi delo* [I beat the furrows in the ground – to have vigorous sex]. I lied to them because I am just playing. They didn't believe me. They knew I am just joking around. They said that I am too young to have sex.

Although first sexual contacts with girls were usually non-penetrative (cf. Niehaus 2006a)<sup>3</sup>, my informants expressed some confusion over what sex really entailed. Mandla, talked about his first time; 'I started having sex at the age of 11. We did not have proper sex. I thought I was having proper sex, but later I realised I was not'. Sexual contact occurred while playing games such as 'hide and seek' (*kuku*) or 'little house' (*swiyindwana*). Boys grabbed girls and rubbed themselves against them, simulating sex. Yet, early sexual encounters also involved penile penetration. Collins remembers playing 'hide and seek' (*kuku*) as a shy twelve-year old with a girl five years his senior:

When we went to go and hide, she said 'let's not go out let's stay here'. She was 17 and she taught me [sex]. Her problem was that she did not have the courage to tell a boy that she needs it so she was able to do it with those younger kids.

Early sexual experiences mimicked marital relations in the popular game of 'little house' (*swiyindwana*). Children constructed play houses in the bush and played at mothers and fathers. The 'mothers' cooked meals of mice and fish acquired by their 'husbands' in tin cans over small fires. Later they pretended to have sex by lying on top of each other, fully clothed. Simon Hlatswayo remembers being 13; his 'wife' was 14: 'She took my clothes off and she pulled me on top of her. She put my penis in her vagina.

After many, many experiences I ended up enjoying it'. Sipho, a young man in his early twenties claimed he had his first sexual experience at the age of seven. He and a friend were sitting in a shelter they had constructed from cardboard next to the railway line, taking a break from herding cattle, when they were approached by an older girl. 'For us she was a lady. We were still seven or eight. She asked me *maswi kota ku endla leswi xana* [do you know how to do this?]' Sipho initially refused, but was soon convinced and 'did sex' with her.

Boys also initiated sex, sometimes coercing young girls by offering gifts of money and food. An eleven year old girl was said to offer sex in exchange for biscuits and cakes. Negros remembers paying her to have sex when he was 13 after having heard about sex from his older brothers:

When they [his older brothers] had sex they would tell me it is nice so I felt like doing it. It is not really nice – it is just something you enjoy. I just made it come out [ejaculate], just from taking it [penis] out. She was 12. It was just money. I gave her money and she gave me what I needed. It was two rand. That was too much in those times. I remember that I broke her. She was a virgin. I just showed her money she took it and we went to the bushes and then we went to her home and then I had sex with her for ten minutes and then I left her.

### **Jolling and casual encounters**

The emphasis on play sex associated with childhood continues into adolescence. Amongst older youth, sexual relations are collapsed under the term *ku jola*<sup>4</sup> literally meaning 'to party'. The emphasis is on transgressive sex that lies outside of formal, traditional proposals, bridewealth (*ndzovolo*) and marriage, away from the scrutiny of elders, in youthful social spaces such as taverns and clubs. In these settings sexual relations are coincidental, uninhibited and without regard for rules of respect (*hlonipha*).

School fieldtrips are opportunities for sexual relations. Teachers usually turn a blind eye to sex between the students; fairly often they were involved in relationships of their own. When Comfort went to the Echo Caves on a school trip he had sex for the first time in the back seat of the bus. ‘She was so beautiful. I went to her and I told her that I love her. She said ‘no problem’ so I was very happy. That was my first time to get sex’.

Alcohol plays an important role in jolling and getting drunk is frequently an important condition for sexual relations during youth. For example, Joshua, a student in his late teens, had sex for the first time with a woman he met in a tavern:

As I mentioned I am a drunkard! So I decided to go to Thomisane Tavern. I got a prostitute and I fell in love with her. It was not love but I just wanted to have sex with her because I was over-drinking.

Collins lost his virginity on Christmas day at the age of 18. ‘Everyone was drunk and so was I. I found her sitting there. I talked to her and proposed to her. I took her home and made sex with her’. Another young man stated: ‘If I am sober, of course, I mean I don’t even think of women. But I mean, of course you have to drink beer and if you are drunk you will need a woman’.

Casual relationships were also spontaneous encounters unencumbered by proposals of love and romance. Bonginkosi was 15 years old and had a steady girlfriend. However, when they were apart he had sex with other girls. Once he arrived at a friend’s house to find him having sex. Bonginkosi and his friend took turns to have sex with the same girl. ‘She told us that she was tired, but we said “let me finish, I will only take five minutes”’. Similarly, although Jerry (18) had a romantic long term partner, he had casual sexual relations whenever the opportunity arose. One evening a girl he knew called him

to come over to her house. She was watching soft pornography on television. Jerry said ‘It started affecting me, so I started kissing her and she never said no’.

Casual sex with many different girls is regarded as vital for young men’s experience, to learn about women, or as someone said ‘to taste the fat ones, the short ones and the tall ones’. My informants sometimes made unbelievable claims about the number of sexual partners. Mandla (17) said he had 25 girlfriends until the age of fifteen although he admitted not all were sexual relationships. At one point he had eight girlfriends each from a different village:

It is expected that I have a girlfriend in each village so that when I visit [relatives] I can spend time with each. I am in love with all these girls and I have sex with all of them.

Similar to Hunter’s (2005) analysis of the contemporary *isoka* (playboy), young men in KwaBomba sought to express their frustrations at being unable to become men by marriage, through the conquest of women. This also manifested as competition between male youth over girls sometimes resulting in violent clashes between young men over girls.

### **Romantic relations**

In contrast to jolling young people also had relationships that emphasized long-term commitment and mutual understanding between partners. Setel describes a similar distinction in northern Kenya between ‘recreation’ and ‘partying’ (*starehe*) relations and more serious girlfriends (Setel 1999, 110). Accounts of these relationships stressed the importance of moral character and the establishment of trust. These attributes are critical components in the development of the relationship. For example, Humphrey, aged 22,

had a girlfriend from Cottondale village. They met at a Nazarene Mission Church conference and then became good friends. Initially, Humphrey did not ‘propose love’ to her:

I wanted to find out about her behaviour. When I knew that she was a good person, I started to propose. I told her I think we must fall in love because I have learnt about her. She said I must wait.

Humphrey said that he felt that she ‘is the right one for me; she is assertive, she is talkative. You know she doesn’t go with many boys’. Because these were expected to be long term relationships which may result in marriage, HIV was an immediate concern. Elvis, an unemployed man of 25 talked about his steady girlfriend, and expressed his concerns about HIV:

She is 20 and lives here so I met her on the street. I spent some time looking at her. I was looking at what kind of person she is. I realized that there was HIV so I wanted to see how many boyfriends she had. I found that she was in love with another boy but not anymore. I asked her friends and they told me that she is good and that she doesn’t love boys too much. I kept an eye on her. I was worried about HIV - that is why I wanted find out. If she had got two boyfriends I would not have gone for her because that would have meant that she had that disease. I even wanted to see what her behavior was - does she like to go out, does she like men, at month end does she go to [tavern] lounges or something, is she that kind of person. I found that she was not that kind. She is a good girl. She lives at home – she shows she loves me. We have talked about AIDS with each other – I asked her if she knew about HIV, but she said that there is no HIV in Bushbuckridge. It is only Gauteng people who have HIV only in Gauteng Province.

Longer term relationships were constructed as romantic. Youngsters used endearing terms such as: ‘my one and only’, ‘sweetie’ (in English) and ‘my love’ (*murhandziwa*); ‘together until death’ (*mafasilahlana*); ‘my flower’ (*xiluva xanga*); ‘my peppermint sweet cough syrup’ (my peppermint *sweeta ra mkhuhlwana*), and expressed

in narratives such as ‘I chose the one of my heart and then I gave her my heart’. Romantic love was regarded as the basis of marital relationships, marking a shift from the importance of fertility in the agricultural era. Importantly, this does not mean that notions of romantic love have only recently begun to emerge (Hunter 2010). Rather, it indicates that romantic love has recently started to dominate narratives about marriage (Smith 2001).

Akin to the formulaic proposal (*ku gangisa*), romantic relationships begin with a proposal of love (youth used the word ‘prop’), communicated in a letter or verbally, often through a friend acting as an interlocutor. Some suitors persisted for months or even years, despite constant rejections. Promise was 17 when Nyiko proposed to her. It took him five months of courtship before she accepted his proposal. During this time he bought her small gifts, school lunches and cold drinks. Promise’s current boyfriend is 21. They met at school while she was still dating Nyiko, but it took two years before she accepted his proposals. Ntshembo (22) waited long for a response from his girlfriend after he proposed to her but was extremely persistent:

I told her my feelings for her. She didn’t tell me the truth from the beginning. It took weeks before she told me. It was hard waiting, but I thought, if she really belongs to me, I can wait. I believe if something belongs to you, it belongs to you

Girls also proposed to boys. Matimba (21) had proposals from five different girls, delivered in letters hidden in books. ‘They say “I am waiting for a reply” or “please hurry” and “give me your answer immediately”’. Matimba refused to accept these proposals, because as he put it ‘It is better for me to listen to the church and my parents, because maybe I will succeed in my life’.



Unlike *jolling*, sex in romantic relationships was delayed. At 17, Collins proposed to a girl named Noreen, the daughter of the school principal. Noreen bought him lunch at school breaks and gave him gifts of jewellery. Collins and Noreen never had sex and there was limited physical contact. ‘She talked to me and as she was talking she was brushing my leg with her hand and so I found my hand on top of her thigh’. The two remained sweethearts for many years, writing each other letters. Delaying sex was important to 17 year-old Doctor in his relationship with Ntombi, a girl in his school. Doctor wanted to have sex but only did this with casual girlfriends. As he put it, he did not want to ‘pressurize her. She’s a serious girlfriend. If you love them, it’s not all about sex. Now I’m waiting to see what is happening’.

Born-again Christians (*bazalwane*) are expected to remain abstinent until marriage. Church sermons focus on delaying sexual intercourse and stress the sanctity of marriage. The Nazarene Revival Crusade Church (NRCC) (an offshoot of the Nazarene Christian Mission) assists young men and women by providing financial sponsorship for their weddings if they remain virgins until marriage. The International Pentecostal Holiness Church (IPHC) performs match-makings at special services for the youth. These relationships are supervised by the church elders. Pre-marital and extra-marital sex is strictly forbidden<sup>5</sup>.

Patrick was 23 and in a two-year old relationship with Petunia, a born-again Christian. Patrick respected Petunia’s decision to delay sex until marriage, as he put it ‘to play the waiting game’. Patrick said that he did not want to rush into sex, but preferred to ‘sit down and talk, to balance everything’. He was prepared to wait until Petunia returned from university and would then discuss having sex.

Marks, a young technical college student, fell in love with Memory, a young girl who attended the Nazarene Revival Crusade Church. He struggled to get Memory to agree to his proposals of love. Marks resorted to joining the church to convince her:

It was difficult to propose to her. She was very afraid. But we went to church together – she believed me that I didn't have AIDS because we were going to church together and I was pretending to pray. It was not very easy. But she couldn't refuse me when I told her that I loved her. But it was not that easy because she believed in God and I took her away from her way of being a born again. She cannot belong to the church anymore. 'Born Agains' are not allowed to have sex before marriage.

Church membership, particularly Pentecostal churches were believed to provide a form of protection against AIDS. This view is substantiated by research elsewhere that suggests that Pentecostal church communities will have lower rates of HIV infection. This is because the church creates a discourse that makes premarital and extramarital sex morally opprobrious (cf. Garner 2000).

The International Pentecostal Holiness Church (IPHC) claimed to protect and heal its members of AIDS by exerting influence on decisions about behaviour. In the words of a devout IPHC member:

If you stay here then God will protect you – even if you have AIDS then God can forgive you and maybe you can live. God cannot protect you from AIDS, but if I am going to church and I propose a girl there is something that is going to happen in my heart that is going to make me not to go to her to talk to her because God is with me – I can't prop [propose to] her – I can go to the wedding but I can't propose very easily because God is with me. But if God is not with you I can propose anyone you see on the street. So it is there you are going to find AIDS.

Yet, young people experienced tension between maintaining a 'true love' relationship and sexual passion and desire. Male youth invoked a hydraulic theory of

sexual energy, arguing that repressing sexual desire caused unfavourable health consequences such as facial acne, mental confusion and irritability (cf. Collins & Stadler 2000). Boys and men are regarded as having far stronger sexual desires that they are unable to control unlike women. The youthful, Happy struggled to control his sexual desire and so played soccer to make him too tired to want to have sex:

It is difficult to live without a girlfriend because we all have feelings but we shouldn't allow our feelings to control us. You can get into trouble – you can rape if your feelings control you. I restrict my feelings. If I feel like having sex I stay away from girls.

Others were not able to control their desire. Seventeen-year-old Clements repeatedly slapped his girlfriend across the face when she refused to have sex with him. She promptly broke up with him. He reflected: 'I don't think I was right. I thought that she wanted to have sex. That is what made me angry. I really wanted to take her home. In future I will ask her for her reasons for refusing sex'. Clements' statement also draws attention to a contradiction between sex and love. Aubrey was seventeen when he tried to convince his girlfriend to sleep with him. He narrated the debate between him and his girlfriend:

I said to her 'I am here to take you with me'. She asked me 'what for'. So I said 'it's obvious you know why. You said that you love me'. She said 'because I was loving you, your words that you said made me say that I love you and it is true that I was loving you and I did not have a chance to come to you and tell you I love you. Do you think that I am a prostitute?' Then she asked me what we were going to do. So I said 'let's just go now, don't ask me a lot of questions'. She said 'OK I am coming'. On the way, she asked me again 'what are we going to do?' I said 'wait you are disturbing me. I am thinking' When we reached my home she said 'OK we are here what do you want?' I said 'I want you. I want to [have] intercourse [with] you'. She said 'Ha! You are mad. I am not into that. Love is not for intercourse.

However, not only girls reacted in this way. Tlangelani was 12 when he met Munene in 1996. Munene proposed to Tlangelani at a sports event. ‘She asked me if I was in love with someone. I said no, I wasn’t. She said can you fall in love with me. I said no problem, I can do it’. Munene gave Tlangelani generous gifts of air time, a wrist watch and a ‘sweetheart card’ and the couple dated for four years. But Munene broke up with Tlangelani after he refused to have sex with her. ‘She said I was stupid not wanting to have sex with her’.

Anxieties about contracting HIV and falling sick with AIDS have become important in decisions about sexual relations. Victor, a 19-year-old boy, had a steady girlfriend and wanted to wait until he turned 21 before he tried sex; ‘other boys don’t know anything – that is why they have sex at a young age. But I am afraid of AIDS and I need to take care of my body’. Victor’s statement reflects an emerging discourse of the educated and responsible ‘AIDS aware youth’ (cf. Hunter 2005) in contrast to ‘uneducated’ and ‘ignorant’ youth who had casual sex. Youth who participated in the activities of HIV prevention programs such as loveLife (Chapter 1) were also strong proponents of this perspective.

Young peoples’ material circumstances also influenced sexual decision making. For example, by the time he was 25 years, Riot had not yet had sex. His neighbours agreed that he was a boy ‘who knew how to behave’ (*mufana wa ku ti koma*). Riot came from a very poor family and was aware that an unwanted pregnancy would cause huge problems for his mother. Riot’s friends often teased him because he did not have a girlfriend:

They say I am old enough and I must have a *cheri* [girlfriend] so that I can be the same as them. I don't agree with them because I know where I come from. I do not want to create more problems for my mother. I don't want a baby because I am still young. I want to prepare myself for a better future. That's all I can say.

Two years after he made this speech, Riot impregnated Juliet whom he intended to marry. He reckoned that since he had found employment as a roofer he could now afford to begin a family.

Importantly, casual sexual relations defined as jolling and romantic relationships with potential wives were not exclusive. In his account of his sexual relationships, Vusi (a young student) reveals the different meanings associated with different forms of relationship. Vusi has a steady relationship with Portia, a young Christian woman with whom he has a child and he provides limited support:

It took me six months – one year to propose to her. I made as if I was playing with her. I said 'I love you – I love you' but she just ignored me. But I was very serious until she told me this is not good; let us go for studies and when you find a job then you can come – we are not working we cannot maintain our family. So I tried to rob her until she agreed to do what I wanted. She said she loved me but it took a long time. She was a virgin. I even lied to her and said I was a virgin and that I wanted to start with her. I didn't use a condom because she was a virgin, but I made her pregnant last year. I visit her every two or three weeks. I just see her and give her money and then leave and something for the kid, for the nappies.

At the same time as his relationship with Portia, Vusi has several other girlfriends:

Aish! Now I have too many girlfriends especially this year; well just six or seven. Some they promise me that they love me. I have only had sex with four of them. One is in Ngodweni, the other is in Tzaneen; the other is in Dwaarsloop. Some of them I met at school. My friend the taxi driver takes me places and I meet them when they are shopping, we swop [phone] numbers and then we arrange to meet but sometimes they don't give me what I need. I just buy food to make them happy.

Vusi only has sex with some of them if and when he can. He plays a small role in their lives and he acknowledges that they too have other boyfriends. Vusi recognizes that these relationships could expose himself and Portia to AIDS:

It is simple for them to get boyfriends. I know that they can have AIDS but I use condoms. I think now if I am the victim of AIDS, my child will be alright. She is fine so I want to protect her. My girlfriend [Portia] doesn't know about the others. If she found out she would fight with me and she would leave me because she loves me too much.

After this fairly rational account of his sexual relations Vusi confessed that he also has sex with girls he meets in taverns. He is aware that these one night stands could have disastrous results:

I am worried about what I did yesterday – I was drunk and I did it with that girl. I could even die today because these girls do abortions. Then they go to taverns to get boys to wash themselves clean.

Interestingly, Vusi does not mention AIDS as a potential threat. Instead, he expresses the fear that girls have sex with men to cleanse their wombs. Ideally, a woman should wait for three menstrual cycles following an abortion to properly expel the polluted blood (Niehaus 2002a). Yet, young women, impatient to start having sex again, seek out men to have sex to cleanse their wombs. During sex, the man absorbs her polluted fluids and falls extremely ill with a fatal affliction known as *ku wela* (fall down).

Another example is Moses who provided details of 18 relationships from the time he was eleven until he was 22 years old. Moses regarded the first seven relationships as childhood 'play' because he did not have 'proper sex' or ejaculate. The girls he had sex with were about the same age and were all sexually inexperienced. Once he turned 16

Moses started to experience ‘proper sex’ and met girls who were sexually experienced. He had sexual relationships with two partners. At the age of seventeen Moses moved back to his mother’s home and abstained from sex for an entire year out of respect for her. When he turned 18 Moses moved back to KwaBomba and resumed sexual relationships. That year he had another two sexual partners. Moses’ relationships tended to be of shorter duration. When he was 19 and 20 he had two relationships that only lasted one month each. Between the age of 20 and 21 Moses accumulated five coterminous partners. One of these he defined as his ‘wife’. Although he had not paid bridewealth she is pregnant with his second child. His first pregnancy was with a woman with whom he had a casual affair. He still sees her but does not envisage a long future to the relationship. In addition he has another relationship with a woman who he considers to be marriageable material. The other two women are girlfriends who Moses sees on an irregular basis who also have steady partners.



**Table 5: Moses' sexual biography**

<i>First meeting</i>	<i>Partner types</i>	<i>His age</i>	<i>Her age</i>	<i>Duration of relationship</i>
Playing hide and seek with girls in the street	Playing	11	11	Still sees her
At the local shop	Playing	12	11	6 months
Sports Stadium, Thulamahanshe	Playing	12	11	2 months
Sports Stadium, Thulamahanshe	Playing	12	12	1 month
At school	Girlfriend	13	12	1 year
At a school soccer match	Girlfriend	14	NK	4 months
At school	Girlfriend	15	14	5 months
During school break	Girlfriend	16	15	10 months
Mother's younger sister organised the relationship	Girlfriend	16	15	1.5 years
No relationships	--	17	--	--
At school	Jolling	18	16	7 months
During a school trip to Kruger National Park	Jolling	18	17	5 months
Thulamahanshe school soccer game	Jolling	19	17	1 month
Thulamahanshe –mother's next door neighbour	Jolling	20	18	1 week
Hluvukani Village at a church conference	Jolling	21	20	Current
Hluvukani Village Development Summit party	Jolling	22	19	Current
Hluvukani village during a night vigil	Wife	22	19	Current
Locally in KwaBomba	Jolling	22	NK	Current
Locally in KwaBomba	Jolling	22	NK	Current

The significance of the relationship categories such as sex as 'play', 'real', 'recreational' and 'romantic' have implications for what young people consider as risky in terms of the transmission of HIV. The anonymity of recreational sexual relations and the lack of trust highlighted the importance of using condoms in these relationships. In contrast, sex in true love relationships stressed partner compatibility and trust between partners, and the desire for fertility (cf. Sobo 1995).

## Sugar daddies and young girls

Older men who had affairs with younger girls were called ‘Big Daddies’ (*ngamula*). These were usually relatively wealthy men, or men who had access to an income. They were also men such as teachers who could wield power over younger girls. ‘Big Daddies’ involved in sexual relationships with younger women were often criticised for exploiting younger women, taking advantage of their relative power and influence. Neighbourhood gossip described girls who ‘moved with the Big Daddies’. Yet, at the same time the material contributions men made toward women and their households was viewed in a favourable light and enhanced their respectability.

Young women also responded in different ways to older men’s attempts to have relationships. When Masingita was sixteen, her mathematics teacher made several sexual advances towards her that she successfully fended off: ‘He would tell me to visit his office after school saying that I needed extra lessons’. However, other girls she knew had sex with this same teacher, hoping that this would improve their chances of passing their exams. Patience Hlatswayo had a relationship with her teacher when she 16-years-old. The relationship was mediated through small gifts of luxury food he gave to her. When Msizi was 16 her teacher constantly harassed her until she gave in and agreed to have sex with him:

The teacher I had an affair with was staying at Thulamahanshe. His name was Siphamandla. He just came to work at KwaBomba High. He was a math teacher. It started in the class; if it was his period he would start asking me questions. When he was teaching he would always be rude to me. One day he called me to the staff room. He said ‘you know what I love you – that is why I am horrible to you in the class’ I told him to stop. He didn’t stop! He carried on doing the same thing. So I thought if I want to stop him I must fall in love with him. Just to shut his mouth.

A preference for older men who had access to incomes was expressed by some girls, especially in comparison to the cashless and unsophisticated village youth. Tinyiko, an 18-year-old, compared her current boyfriend, an older man from Johannesburg with younger boys who ‘just want to have sex’. She regarded young, ‘local’ boys with some disdain. ‘I had a boyfriend a year ago, and all he was interested in was sex. When I told him I wasn’t ready he told me that he would leave me. The boys here are always drunk (...) every girl is the same to them’. Access to cash to pay for gifts was fundamental to these relationships with older men. Xolani (22) and Dyondzeka (24) commented:

Xolani:

The reason is because the sugar daddies will buy me to sleep with them. They will give me money. The young boys don’t have money – they are still at school. It will end when me and the young guy break up, and I will continue with my sugar daddy.

Dyondzeka:

Other thing is that sugar daddies think that young girls are still young and their bodies look better than their wives. You will find that their wives at home are tired to have sex – sometimes they don’t want it. Young girls have more energy than their wives. I think sugar daddies are great because if you want something they will do it quicker than young guys. They will buy you *Chicken Licken* [fried chicken fast food] and clothes – whatever you want. Boyfriends don’t have money to do that kind of stuff.

Although older men who had sex with younger girls attracted considerable neighbourhood gossip, the circumstances of many families meant that the support that these men provided was welcomed and the relationships were tolerated.

## TRANSACTIONAL RELATIONSHIPS

Transactional sex or what Hunter (2002) fittingly describes broadly as the ‘materiality of everyday sex’ is prominent in the literature on AIDS (Dunkle et al. 2004; Kaufman & Stavrou 2002; Leclerc-Madlala 2003; Meekers & Calvès 1997; Wojcicki 2002a, 2002b). The literature offers a diversity of forms of transactional sex: as gift-giving between adolescent sweethearts (Kaufman & Stavrou 2002); ‘survival sex’ or ‘commodity sex’ (Hunter 2002; Wojcicki 2002a, 2002b); ‘formal’ commercial sex work (Wojcicki & Malala 2001). This indicates the inappropriateness of the Western concept of ‘sex worker’ and its adjunct assumptions that fail to capture the subtleties of these various forms of transactional sex (Standing 1992; White 1980). For example, Wojcicki (2002b) describes exchanges of sex for beer in shebeens. Hunter (2002) draws a distinction between ‘sex for survival’ and ‘sex for commodities’, noting how these distinctions are rooted in divergent historical transformations. Sexual affairs are often the only means by which women gain access to men’s earnings (Kotzé 1992).

Yet, sex is used to transact more than financial reward, and is not always related to poverty. Nor is the only reason for sex work, economic. Instead women seek ‘symbols of modern life’ (Leclerc-Madlala 2003, 214). Transactional sexual relationships can also be a way for young women to gain some form of power and to build their identities as women (See for example, Cole 2004). For instance, Huli women begin sex work not for economic reasons alone, but because of a kinship system that has failed them, and a combination of sexual violence, the indifference of male kinsmen, and bridewealth problems (Wardlow 2006).

In the discussion that follows I explore these themes and show how transactional sex was constructed in sometimes opposing ways by men and women, young and old.

### ***Ku piretsa and ku phanda***

A woman could have sex in exchange for beer or cash with a man she had just met at a tavern. This was called *ku piretsa* or *ku hluwa*. The term *piretsa* is derived from the English cognate ‘pirate’, implying that the woman ‘stole’ or ‘crooked’ the man by tricking him into thinking that she loved him. In some cases the woman would accept drinks from a man in a tavern without the intention of having sex with him.

Some forms of transactional relationships are spread over a longer period of time. For example, a young woman visited an old man once a month on pension days leaving him once she had taken his money. She would return after a month had passed to again stay with him so as to gain his pension money. Another young woman was labelled ‘moneylender’ (*machonyisa*); like a loan shark she took possession of her lover’s bankcard and withdrew his salary each pay day. These types of relationship were also referred to as ‘plucking a chicken’ (*ku hluwa*). Informants described how a single woman could have several different sexual partners, each of which provided for a different need. For example, men were referred to as having a variety of portfolios: the ‘minister of housing’ paid rental or bought building supplies; the ‘minister of communication’ paid for cell phone air time and so on.

In these narratives, men were regarded as sources of cash to be used and exploited, thereby stressing women’s agency and the vulnerability of men. Yet, women were subjected to moral critique for having an obscene ‘love for money’. This sometimes resulted in violent retributions.

Contra to these moralising discourses, women often framed their relationships in terms of economic survival. They defined the exchange of sex for material reward as doing *phanda*, a term borrowed from the IsiZulu *ukuphanda* meaning ‘to dig up or dig by scratching’ (Fassin et al. 2008; Wojcicki 2002a). The term became popular in the early 1990s and eclipsed the equivalent XiTsonga phrase ‘*ku hanza*’ ‘to scratch the ground, to be in search of food’ (Cuenod 1967). Women who did *ku phanda* were likened to chickens that indiscriminately peck in the yard and beyond, looking for morsels of food. *Ku phanda* was regarded as a form of labour (cf. Rebhun 1999a) through which one could survive and even accumulate wealth. It was a legitimate pursuit, the only option that impoverished women had for self-improvement and personal development.

Gladness, 28, offered her definition of *ku phanda*, based on her personal experiences:

*Ku phanda* is if someone goes out and tries to get money – even me I used to do the same thing, because of shortage of food at home, soap and clothes. At home sometimes my parents won’t give me everything I want, so I think it is better to go out and do the *ku phanda* thing. I am doing it because I can’t afford to buy clothes for myself and I just go around where there are many men and I knew one of them will start talking to me and then I will fall in love with him. In 1995 I realized that most girls are not demanding things from their parents - so why I do I want my parents to do everything for me. I start doing this *ku phanda* – I thought I was just trying it – it really works. It doesn’t make too much money...just to survive and if I want something for myself I can buy it.

### **Love, sex, money: Xolani and her many lovers**

The background to Xolani’s story is of growing up in a small and impoverished family. Xolani’s homestead is located in a neighbourhood where I conducted much of my fieldwork. The household head, MakwaXolani worked as seasonal labourer for a local farmer and former member of the Gazankulu Homeland administration who owned a

mango plantation. She received a weekly wage of R100 with which to support her five children. MakwaXolani's was a contract labourer for provincial road construction projects. After the birth of their fifth child he simply disappeared. News from one of his co-workers was that he met a woman while working in Witbank and now lived with her in Thembisa, a township on the East Rand.

Without a reliable source of income the household was often without food. MakwaXolani occasionally relied on neighbours for their support and an irregular food parcel from the Department of Health and Welfare. In 1999 the mud brick house in which the family lived was destroyed by torrential flooding. MakwaXolani and her children moved into a neighbour's one-roomed thatch hut. One adult, two adolescent children and three smaller children slept and lived together in the most unpleasant circumstances. The youngest children stayed home during the day because they could not afford the fees for crèche and school uniforms.

In 2005, MakwaXolani was a recipient of a two bedroom brick house, from the department of housing. Yet, the family continued to suffer. MakwaXolani and her husband originally moved to KwaBomba to create a better life for themselves, away from their relatives. Yet, several years on her face was pinched and thin from worry, constantly reminded of her situation by her hungry children who sometimes foraged in a neighbour's garbage dump for stale bread and food scraps. These events had a significant effect on Xolani, the eldest daughter.

In 2000, when Xolani was 22-years-old she started to have affairs with men in exchange for cash, food and commodities:



I just woke up one morning thinking ‘who is going to help me?’ I wanted money to buy food and clothes. Then I thought I would go out and ask them [men] for money. I thought no. I cannot go and ask for money without having an affair with that person. If he has got something he can give it to me like a gift. If I hear my mother complaining about something like there is no meat or tea bags, I will go out and ask from my boyfriends to buy what I need

Xolani’s boyfriends were numerous and varied. Each offered a different form of support. A man she met in Randfontein bought her groceries and made cash deposits varying between R100 and R200 into her bank account. Another man from KwaBomba, a teacher, purchased clothes for Xolani and her siblings at Christmas. Xolani was fairly cynical about these relationships. Of one of her lovers she said:

I didn’t love him – I just wanted his money. Because if you go out for *ku phanda* it is not that you love the person – you just want to crook the person. I just told myself I must just go out there and start crooking people.

Xolani had a fair degree of control over the nature of her relationships with men. She often broke off a relationship if a man became too oppressive and controlling. Her strategy was to create the conditions for support but to avoid the relationship becoming too much like a marriage. For example, Xolani moved in with Desmond, a young man who inherited his father’s business. He supported Xolani and gave her cash to start her own business selling clothing at pension days. However, Xolani deserted Desmond when it became apparent that he expected her to perform the role of the daughter-in-law (*makothi*), cooking, cleaning and doing the washing and ironing. On another occasion Xolani moved in with a man who worked as a petrol pump attendant. His long working hours meant that the two hardly ever saw each other although he expected Xolani to remain at home waiting for him. He also forbade her from meeting other men. Bored and frustrated, Xolani went into Acornhoek and Hoedspruit to meet men in the tavern

lounges. This angered Desmond and when he threatened to kill Xolani she left him for good.

Despite the nature of these relationships, Xolani also sought out lovers who would provide romance, sexual satisfaction as well as financial support. She gave a candid description of a former boyfriend.

First we will be touching each other and kissing, and then I will be on top of my boyfriend and touching his – you know what I mean – after that it will be the same thing as what I have done to him – licking me going down there. That is why I love him. Because the way he romances me makes me feel good. Sometimes I become crazy if I think about him. I have had many boyfriends – but this one is the best. Even just to look at him I just become tingly – even if I just think about the way he does those *dinges* [Afrikaans: things] to me<sup>6</sup>

Material support did not necessarily mean that there was a lack of affection. Support was a way of displaying love. Of a lover who lived in Randfontein she said: ‘My other boyfriend loves me very much. He is prepared to look after me and I am prepared to look after him’. Another boyfriend, a member of the South African Defence Force Xolani called ‘Mr BM’ (he drove an early model BMW) supported her well and was also romantic ‘he buys me things such as roses and groceries’. Mr BM took Xolani to hotels and guest lodges for dinners and overnight stays. Xolani admitted that she did not often have sex with Mr BM as he was only interested in her company.

Xolani’s description of her relationships with men shows a wide range of concerns: sexual satisfaction, romance, support, and access to luxury goods. Clearly it would be a mistake to collapse the rich variety of sentiments she expresses into ‘survival sex’ or ‘commodity sex’. The use of sex and promises of love to gain money and commodities are not merely rational exchanges. Rather, money within these relationships

was frequently invested with ‘emotional meanings’, and was used to express a wide range of sentiments: care, respect, love, authority, and trust (cf. Kaler 2006, 337)

## THE MARRIAGE PROCESS

Marriage in South Africa has steadily declined since the 1960s (Hunter 2007), and generally takes place later in life (Garenne et al. 2001). However, assessing what actually constitutes customary marriage is extremely problematic (cf. Budlender et al. 2004). Marriage may better be described as a process rather than an event (Krige & Comaroff 1981). The process of paying bridewealth can take several years, effectively deferring marriage indeterminately (Hunter 2005; Stadler 1993). This can be ascribed to the financial barriers that men face in paying bridewealth. Bridewealth costs are high and sometimes undetermined, resulting in men’s indebtedness to their in-laws.

In KwaBomba, a marriage is regarded as complete following the ‘traditional’ (*mthimba*) or ‘white’ (*umshado*) church wedding ceremony, performed after bridewealth has been fully paid up. In the past, the *mthimba* was celebrated with traditional dancing (*muchongolo*). By the 1950s, few weddings were being performed. The *muchongolo* was effectively banned due to the often violent clashes during dances (Niehaus & Stadler 2004).

In the current setting the public performance of marriage has virtually disappeared. Only two weddings took place in KwaBomba during my fieldwork. A woman of 35 and her husband of the same age held a ‘white wedding’ (*umshado*) in a church and followed this with a feast at the bride and the groom’s homestead. The other, a traditional wedding (*mthimba*) was for a 46-year-old woman and her 58-year-old

husband who have lived together for over 20 years and have several children. The ceremony took place over a period of one year.

Nonetheless, many young adult villagers described themselves as ‘married’. Their relationships were based on co-residence and colloquially known as ‘take and sit’ (Afrikaans *vat en sit*). A co-residential relationship entails the payment of a fine known as *lavelani haleni* (‘search over here’ [for your daughter]) by the ‘husband’ to the ‘wife’s’ parents. This entitles the woman to stay for a short while with the prospective husband. She is awarded the status of a visitor, although she is expected to take responsibility for washing her own clothes (especially undergarments) and contributing towards cooking, fetching water and other household chores. This is an impermanent set up and the woman may leave at any time. Kotzé, writing about Dixie Village, to the south of KwaBomba, captures the vagaries of these relationships:

a marriage is taken to exist when a woman agrees to live with a man and takes up all the domestic duties of a wife at the man's home, with the intention of doing so on an enduring basis (irrespective of the fact that the bond may not last for long), and the man assumes the responsibility of providing the woman with cash, food, clothing, household utensils and basic furniture (irrespective of the extent to which he succeeds/fails to do so), even though *ndzovolo* (bridewealth) has not been delivered to the woman's parents (Kotzé 1992, 146)

Nokthula’s (25 years old and employed as a butcher’s assistant) story illustrates the whimsical nature of marital relationships:

I had three boyfriends and after that I told two of them I do not love them anymore. So I continued with the other one who was left...until he made me pregnant with a baby boy. We really felt blessed. We stayed for a long time visiting each other until he had finished university. After that I started working at the butchery [in Bloemfontein]. I must say it was not nice for us to be staying far away from each other. He started having affairs and I also started to have boyfriends in Bloemfontein. So he heard about my new boyfriends he became

angry with me. He started coming home to KwaBomba with his new girlfriend. So it is where I decided he doesn't love me anymore so that is when I started going out with my new boyfriend really seriously.

Co-residential arrangements may be based on the promise to pay bridewealth to the wife's parents using a payment called 'to show' (*ku ti komba*). At the *ku ti komba* ceremony the prospective wife is asked if she accepts the money. Her assent legitimises the residential arrangement and she can move to her 'husband's' homestead. Yet, the in-laws usually refuse to accept the full value of the *ku ti komba* as a payment toward bridewealth and impose cash fines for transgressions. For example, if pregnancy preceded payment, a cleansing ceremony (*ku xuva*)<sup>7</sup> first needs to be performed before *ku ti komba*. The *ku xuva* entails the slaughter of a goat (supplied by the man) and the sprinkling of the contents of its gall bladder (the chyme) around the homestead. Failure to perform this ritual will result in the prospective husband being fined.

Bridewealth negotiations may begin after paying *ku ti komba*. After the first child is born, the woman will earn the prefix 'mother of' (*makwa*) and the man will be called 'father of' (*bava*) followed by the first born child's name. At the second bridewealth payment ceremony a small ceremony (*ku mhamba*) is performed to request ancestral sanction of the union. A ritual libation of sorghum beer is made and the ancestors (*swikwembu*) are asked to protect the new wife from harm.

Each part of the marriage process requires financial investments and participation on kin. Moreover, final bridewealth payments can be in excess of twenty to thirty thousand Rand. Many couples live for years without having finalised bridewealth payments. Even after bridewealth has been paid, the wife's parents can claim additional funds from the husband. This means that marriage is always in a somewhat ambiguous

and fluid state. This can serve women's interests. For example, young women may leave their husbands claiming that bridewealth had not been paid in full (Stadler 1993).

Although bridewealth is inflated, payments are made in a series of instalments. This means that a woman or her parents can consider refunding bridewealth if necessary.

Given Mayinga was a drunken and abusive man, often forcing his wife Ntombi to have sex with him even though she refused. Things had steadily worsened since he had paid *ku ti komba* of R5000. He claimed that since bridewealth had been paid he had rights over her body. Eventually Ntombi threatened to leave him. When they argued said that she could easily return the money he paid in bridewealth. Ntombi also resisted Given's requests to have a civil marriage because this would bind her to a relationship that may be difficult to get out of. She pointed out that traditional marriages were more flexible and did not require courts and lawyers.

The flexibility and ambiguity of 'traditional' marriage also favoured men's aspirations. Prince was 23 and still at school, yet he described himself as married to two women, Nini and Oreal. He first met Nini at a bottle store where he proposed his love for her. After several weeks of pursuing Nini she eventually agreed. After Nini gave birth to Prince's child the three started to live together although Prince only paid *ku ti komba*. Prince then met Oreal. 'She is the most beautiful woman, white and fat, with curves. All the teachers and school students were looking at her'. One day during school Prince found himself alone with Oreal in class. 'When I talked to her, I felt as if she's mine. And I was pitching a tent [getting an erection], but she didn't see it'. Later, Prince and Oreal walked home from school and they agreed that they were in love with each other. They had sex at Oreal's home when her brother was at work and soon Oreal fell pregnant giving

birth to a son. Prince paid Orel's brother R50 to accept the damages (*ku hlawula*) and promised to start paying bridewealth. Although Oreal and Nini are aware of each other, Prince has not let on that he is still seeing Nini. Prince did not think that having two women at the same time was in anyway problematic, and regarded this as a strategy to assess which of the two would make a better wife. 'I am waiting for the one who is making the mistake. Like if one of them goes with another man'.

A consequence of the ambiguous state of many marriages is a high turnover of partners. Although many people regard themselves as married, these are extremely fluid situations. The following two cases illustrate these dynamics.

### **Ntokoto and Nyeleti**

Ntokoto was 18 when he impregnated his girlfriend, Nyeleti. After accepting the pregnancy, and performing *ku xuva*, Ntokoto paid *ku ti komba* and Nyeleti joined Ntokoto at his parent's homestead with their baby. He was unemployed and depended on his father's earnings as a school night watchman. Nyeleti wanted to complete her schooling but Ntokoto's mother expected her to care for her baby and assist her with household chores. Ntokoto then discovered that Nyeleti had had an affair with a school teacher and refuted paternity. The couple divorced. Ntokoto then met Thandiwe, a young woman who worked for a local NGO. Yet, Thandiwe constantly cheated on Ntokoto and refused to settle down with him. Ntokoto decided to propose to Mercy, a young trainee nurse. They lived together and Ntokoto paid *ku ti komba*. Yet, Ntokoto was still very in love with Thandiwe. Although he liked Mercy he did not love her. For two years Mercy and Ntokoto lived together as husband and wife, while Ntokoto carried on a secret affair with Thandiwe, sharing her with her other partners.



## Michael and Eunice

Michael paid *ku ti komba* and settled down with Eunice and their first born son. As a trainee policeman Michael resided in police barracks away from home. Eunice complained that Michael came home late at night and sometimes spent three or four days away from home. Michael refused to account for his movements. After one year Michael visited Eunice's mother and explained that he intended to break off the relationship with Eunice. Michael had been having an affair with Brenda, a work colleague. A few months later Michael married Brenda in a civil wedding ceremony and purchased a house in a Johannesburg township. This relationship lasted six months. At the time she was marrying Michael, Brenda was having an affair with a senior colleague. When Michael discovered this he requested a divorce, losing the house to Brenda in the process. After a few months Michael paid *ku ti komba* and established a new household with a much younger woman. Within the space of two years, Michael had three 'wives'.

As these cases suggest, the flexibility of marriage led to a rapid turnover in marital partnerships. The brittleness of conjugal unions is underscored by data from research conducted elsewhere in Bushbuckridge. In an earlier study, I estimated that 42% of marriages ended in separation or divorce (Stadler 1995). Niehaus' research in Impalahoek recorded that 27% of 227 marriages were dissolved (2001, 100). Kotzé (1992) found that in Dixie Village (southern Bushbuckridge), only one man was single and unmarried, while 41 men had married 70 times (some up to five times each) and 69 women had married 71 times. The ambivalence and instability of marriage leads to a rapid turnover of partners which potentially exposes both men and women to HIV infection (cf: Nabaitu et al. 1994). Most significantly, sexual relationships within

marriage are defined as procreative, signifying that condoms are not used during sexual intercourse.

## **GOING OUTSIDE THE HOMESTEAD: EXTRA-MARITAL RELATIONS**

Extra-marital relationships were talked about as ‘going outside’, or ‘eating outside’ the homestead, referring to having sexual relations that were not recognised by the payment of bridewealth. Men legitimised extra-marital relationships by referring to the practice of polygamy (cf. Spiegel 1991) and reasoned that they kept their mistresses secret because their wives would not support the idea of a second wife. In the current setting polygamous relationships were very unusual. During the early 1970s most households were resettled into residential stands. This curtailed men’s ability to maintain large households and to create separate living quarters for different wives. I knew of one man, a healer, who had three wives in one homestead. Older male migrants continued to maintain urban and rural wives, although the costs associated with running multiple households made this unattractive.

Married women usually rejected the idea of sharing their husband with another wife. For example, Jerry was a married man who also had a long term relationship with a woman from another village. Jerry wanted his mistress to live together with his wife under one roof. However his wife objected. Secretly, he consulted a healer (*n’anga*) who gave him magical medicine (*muthi*) to cause his wife to become fond of his mistress. Another married man attempted to trick his wife into accepting his mistress as the second wife. While she was out shopping he invited his mistress to move into the house. Upon

her return his wife was told that if she did not agree to the new wife she would have to leave.

Wives were not powerless against mistresses. In a case heard by the KwaBomba Civic Association<sup>8</sup>, Jacobs Sibuyi, a 38-year-old married man was charged by his 35-year-old wife and mother of his four children, with neglecting his conjugal duties. She alleged that Jacobs, who worked as a night watchman (*amaxingalane*), came home from work every morning at eight o'clock. Shortly thereafter he would leave the house to visit his mistress to have sex with her. Jacobs would eat lunch and return home before six o'clock each night to collect his supper and go to work. At the hearing, Jacobs denied having an affair claiming that he suffered from 'painful kidneys' that made it difficult for him to ejaculate<sup>9</sup>. Yet, Jacob's mistress was present at the meeting and confirmed that Jacobs made love to her 'several times a day'. At the insistence of the committee members, Jacobs apologised to his wife and agreed that he would try to have sex with her on a more regular basis. Two weeks later Jacobs' wife returned to inform the civic members that little had changed. The civic recalled Jacobs to a second hearing and pronounced him guilty of failing to meet his responsibilities to his wife and sentenced to a public whipping. He was lashed several times on his back with a whip (*sjambok*. Afrikaans: a whip made of animal hide or hardened rubber), by a member of the executive committee of the Civic Association. A witness recalled that Jacobs screamed from the pain while onlookers laughed. Later Jacobs' wife reported that her husband had started to have sex with her on a regular basis. Jacobs was praised by the civic for amending his ways. He was permitted to continue to have a relationship with his paramour, but was warned not to neglect his wife.

Mistresses are regarded like wives, but not all men want their mistresses to become second wives. Some men maintained several secret mistresses. Mistresses were referred to as a 'secret wife' (*xigangu*) or 'under the armpit' (*makwapheni*) or 'roll-on' (like the deodoriser). They maintained secret wives financially, sometimes to the detriment of their wives and families. For example, men purchased building materials, paid for school uniforms and helped out with funeral expenses. Some men maintained a large network of mistresses. A well-known money lender (*machonyisa*) had mistresses in each of the six villages where he transacted business. He provided building supplies, furniture, and paid for their children's school fees. A retired school headmaster purchased an extremely expensive bed, tiled the floor, purchased a used Toyota, and regularly purchased groceries for his mistress. These expenditures created competition between wives and mistresses, particularly once the man died. After the money lender died his son's took back the furniture and even the corrugated tin that roofed his mistresses' houses.

Men also pointed out that a mistress is different to a wife. Unlike a wife, a mistress is sexually adventurous and provides sexual satisfaction. Rothmans, a 40-year old store manager recalled that his mistress once surprised him by exposing her breasts to him in the dining room. He found this highly erotic. In contrast he described his wife as dull and unadventurous in bed. Men felt free with their mistresses to experiment with different 'styles' such as 'dog style (from behind)', 'woman on top' and 'sheep style' (standing up). Sex with extra-marital lovers also expressed secretive sexual desires. He remarked

Even though we Blacks live together with our wives at home, the men have something they are hiding that is secret. They are afraid to do something especially in bed. So the mistress is free to do everything she likes to do. She will do different styles. Your wife will do it [sex] normally.

As my informants appeared to say, sex outside of the domestic sphere with mistresses and sex workers is exciting and hugely erotic in comparison to the ‘utilitarian sexuality of the domestic sphere’ (Fordham 1995, 172). ‘(W)hen compared with the world of normal life it seems to function, in a sense as an alternative model of the sexual universe, where anything is possible’ (Parker 1992, 231). In contrast, sex within marital relationships was regarded as solely procreative. A wife who suggested alternative sexual positions or styles ran the risk of being accused of having affairs. Likewise a man who expected anything other than normal sex showed disrespect towards his wife.

This account of Dorcas, a 42 year old woman, was recounted to me by her friend and neighbour. Dorcas had an affair with a soldier from Phalaborwa. This man bought everything for her including a car. She had everything in the house. They stayed together for many years but were not married. After her husband met another woman he began to change. If she cooked at home he would say that her food was shit, whereas before he loved her food. He would not eat at home. Sometimes when he was off he would go to his new *cherri* [girlfriend]. They would fight often. He stopped supporting her and buying food for her. She went to the management at the army base and asked them to help. They offered her a job working in the kitchen. She was then sent for training and then she was given a job cleaning guns. One day her ex came into the place where she was working, broke the window and started beating her, whipped her on her back with a pistol. She fainted. When she came to she went to the police and reported him. He was arrested. She then told the army that she was returning home to look after her mother and she wanted to

return to school. Things were really bad; she had no money and no one to support her. She left school and she met another man from Giyani. This man really loved her but the *mamazala* [mother-in-law] really hated her because people from Giyani really do not like people from Bushbuckridge. They call them *dya ghana* (eat while you are looking up at the sky). Bushbuckridge people call the Giyani people *nwa didana* (whether it is hot or cold they always wear the traditional Shangaan dress). At night she would sleep and feel a very cold wind going through the house, even during summer. She suspected that the *mamazala* was sending this cold wind into the house. If the husband was away and working at night it was even worse. Other people could not see or feel the wind that she was complaining of. She decided to go home because she was afraid that the *mamazala* would end up killing her. Her husband said that she must not go home, but she returned to live with her mother again. Currently she has no permanent lover but has boyfriends. She does not have children.

For women, the status of the mistress was in many respects regarded as superior to that of a wife. The following case draws attention to the apparent benefits that unmarried mistresses enjoyed in contrast to married women.

### **Shirley's Dr Love**

Shirley (a 25-year old unemployed woman) gave an account of her relationship with a man she called Dr Love, a 34-year old, married, taxi driver. One day after giving Shirley a lift and spending the day with her, Dr Love parked his taxi under a tree in an open field and chatted with her. Shirley reconstructed the discussion between herself and Dr Love:

He asked ‘do you realize what is going on here?’ I said ‘No’. [He said] ‘I am doing this because I love you’. I said ‘Eh-eh [no]. I don’t love you’. He asked me why. I said ‘I don’t know what kind of love you have’. He said ‘the love I have I want to marry you but I want to learn about you first’. I agreed that I would like to learn about him as well and we both agreed to wait two years before making a decision to marry.

Shirley refused to have sex with Dr Love for over eight months. ‘I didn’t trust him. There are others who say I love you but they just want to taste you and then they go. They are liars’. Because Shirley lived with her parents, Dr Love would take her to guest houses and motels when they wanted to have sex. Although Shirley’s position as the secret ‘second wife’ was precarious, she enjoyed a life-style that compared well with that of the wife. She remarked

It is better to be a mistress than a wife. Although some husbands take their wives out it is not very usual. If you are a wife you are the wife of the house so you must stay at home. Even if you want to go out with him he will stop you and say ‘stay at home!’

### **CASUAL SEXUAL RELATIONSHIPS**

In contrast to the long-term relationships between men and their mistresses, married men also had short-term relationships. These were more like the youthful sexual recreational relationships described earlier in the chapter. They were fleeting sexual engagements based on chance meetings with young women who hitched rides in cars on the main road, or while drinking in the taverns and shebeens.

In their narratives, men stressed their need for sex but not for companionship or love. A casual affair with a tavern woman was distinct from an affair with a mistress. Israel, a young man who sold electricity at the local post office lived with his wife and child. Each night Israel drank at a local tavern. He would buy a girl a drink and then have



sex in the bushes with her on the road side. He remarked: ‘after fucking<sup>10</sup> her I always go home and wake up my wife and do it [have sex] with her.’ He did not feel that he was cheating on his wife because he did not pursue a relationship with these casual partners.

Abel Magagule, a young teacher, described the conduct of a former colleague, Lifebuoy Gumede. He was a ‘drunkard’ who would ‘fuck anyone who was available. He didn’t want an affair – he just wanted to fuck’. Lifebuoy drank in shebeens until ten o’clock every night and would usually find a young girl to have sex with. A former pupil described Lifebuoy’s behaviour:

He was going up and down. Even now if you wanted to visit him you would not find him. Even if you went at five o’ clock you wouldn’t get him. Even if you went at eight o clock you wouldn’t get him. He was still going up and down and searching for the ladies or the girls

The social spaces in which men drank shaped the dynamics of the relationships formed in these circumstances<sup>11</sup>. Places where people drink are distinctively masculine (van Jaarsveld 2005). Drinking and womanising form part of the repertoire of ‘male privileges’ (Rebhun 1999a). Alcohol consumption and casual sex are intertwined activities that are seen to ‘go together’ (Fordham 1995). Public drinking is ‘the male ritual par excellence, in as much as it is one in which in men constitute and reconstitute their potency and masculine identity in a theatre of self-construction’ (Fordham 1995, 163). Public drinking was one of the ways in which young males asserted their claim to masculinity.

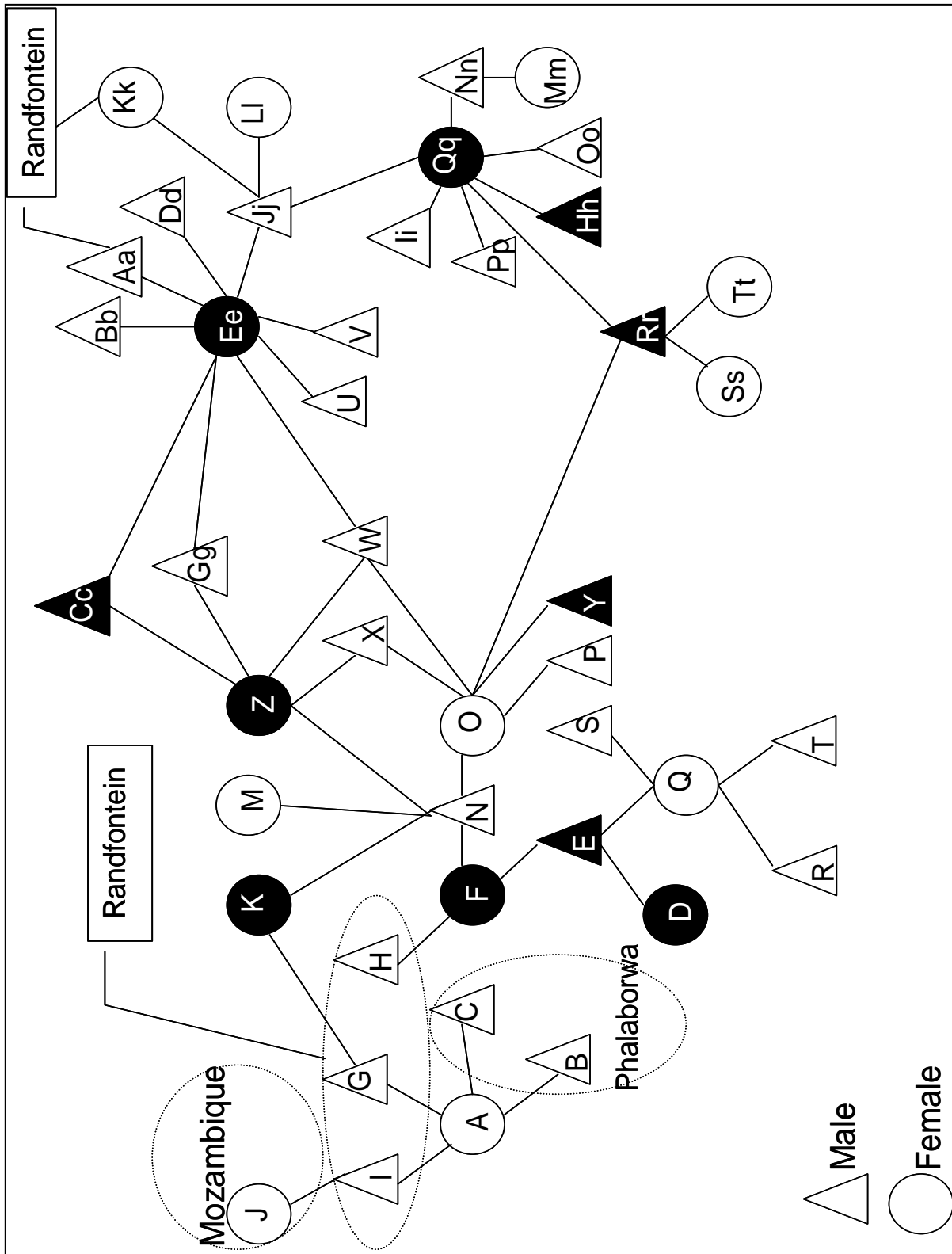
Young women who drank at shebeens and taverns were regarded as ‘loose’ (*ngwavava*) and as prostitutes (*ngwadla*) and were considered to be overly sexually aggressive. As one of my informants put it, ‘they are too cheeky’: they spoke in loud

voices, smoked cigarettes, drank beer and made sexual overtures to the male drinkers. Men would hardly ever consider taking their girlfriends to shebeens and tavern lounges. Shebeens were places not deemed fit for respectable women. When a few young women came to Sollys' Tavern with their babies on their backs and started dancing and drinking, the male drinkers chased them away, threatening to beat them with sticks and bottles. My male informants agreed that these settings were not places to meet 'decent' women.

### **SEXUAL NETWORKS OF INFECTION**

So far I have argued that a result of a diversity of relationship forms is the emergence of multiple and coterminous sexual relationships. Different forms of relationship are defined as responding to different needs both material and emotional, creating the possibilities for a multitude of relationships that occur at the same time. The relationships are most conducive to the spread of HIV are those that are transacted over time and in space such as those between men and their wives and their mistresses. This is evident in the structure of sexual networks, such as the one portrayed in Figure 2. This network is based on a post-hoc analysis of data collected through sexual biographies and neighbourhood accounts of other peoples' sexual relationships. A review of this material revealed that certain named individuals were linked through sexual relationships, sometimes at the same time, and often in multiple ways.

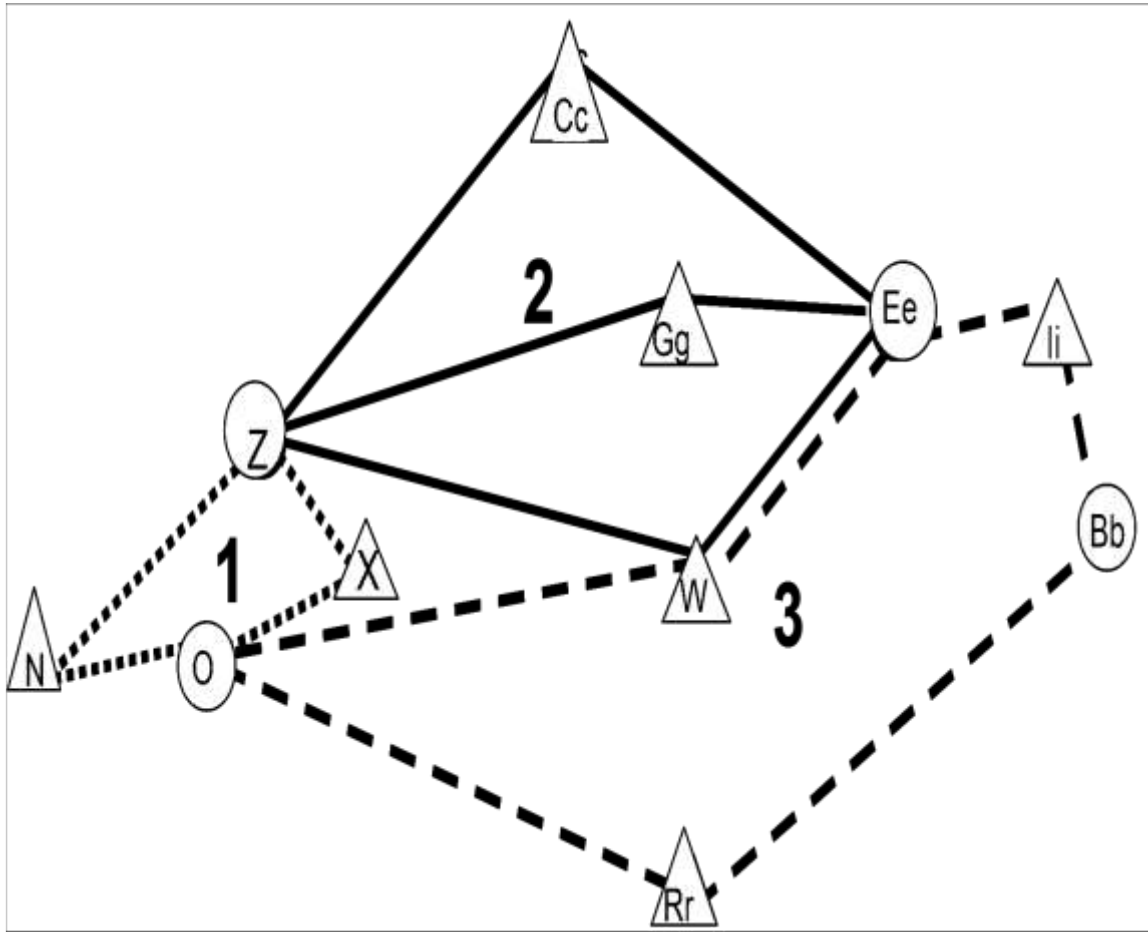
Figure 2: Diagrammatic representation of a sexual network



Demographic features: The sexual network depicted in Figure 1 comprises 41 individuals. More males (27) than females (14) make up the network. Ages ranged between 19 and 64, with an average age of 28 for females and 39 for males. The network also represented a wide range of social classes. Included in the network were teachers (5), policepersons (3), businessmen (8), truck drivers (3), taxi operators (2), unemployed (12), scholars (2), self-employed (4), and two are unknown.

The network spread beyond Bushbuckridge and included individuals from Randfontein, Tzaneen, Phalaborwa and even Mozambique. For example *J* is *I*'s wife; *I* is a mine worker employed in Randfontein who maintains three households: in Beline (Gaza Province in Mozambique) where his wife resides, in Randfontein where he has a small shack, and in KwaBomba where he has helped his mistress (*a*) build a house. This not only gives the network national and international interconnectedness with other sexual networks, but creates the opportunity for multiple sources of HIV to enter into the network.

Sexual partnerships: Notably, more men (11) than women (7) had multiple sexual partners. Seven of the 27 men had two sexual partners, while four had three or more sexual partners. However, on average, women tended to have a higher number of sexual partners. Seven of the women in the network had three or more sexual partners. *Ee* had nine sexual partners, and *Qq* had six partners.



**Figure 3: Diagram of a sexual network showing the three main network hubs**

Multiple linkages: The sexual network has a fairly robust structure due to the existence of multiple linkages between individuals and parts of the network. Figure 3, portrays the network as consisting of three sub-networks which are composed of the following individuals: (1) *N, Z, O, X*; (2) *O, W, Ee, Jj, Qq, Rr*; (3) *Z, C, Ee, W, Gg*. Each of these sub-networks is connected to the other through more than one relationship: **1** is connected to **2** through *O*'s relationship with *W*, but also *Z*'s connection to *Cc*; **1** is connected to **3** through *O*'s relationship with *W* but also with *Rr*; **2** is connected to **3** via *Ee*'s relationship with *W* but also between *Ee, Gg* and *Cc*.

AIDS deaths: Six males and six females were identified as having died from AIDS related infections. Notably, nine of these individuals were those who also had multiple partnerships. However, and equally important, two men and one woman were in single partnerships.

This analysis of a sexual network reaffirms the significance of migrant movement, forms of transactional sexual relationships and long term unions between men and their wives and mistresses. The network is broad in terms of spatial spread, but also with regard to social demographics, involving a wide range of men and women. This means that even those who occupy fairly peripheral positions in the network have the potential to be exposed to HIV. The overlapping relationships that create multiple connections between individuals mean that the network can survive even if individuals leave.

## CONCLUSIONS

This chapter underscores the observation that multiple, concurrent sexual partnerships facilitate the spread of HIV through sexual networks. This translates into a need for HIV prevention messages to call for a reduction in the number of sexual partners, to diminish the connections between one and others in sexual networks. Yet, it is critical that the emergence and prevalence of multiple concurrent partnerships is understood in terms of social and economic transformations and that the focus of prevention interventions address the underlying structural reasons for multiple partnerships. To understand why multiple concurrent sexual partnerships occur requires an understanding of the social structure and meanings of these relationships; in other words their social and cultural construction (Parker 2001).

In their sexual biographies, my informants described the many different ways in which sexual relations could be defined and interpreted. The multiple meanings attached to these relationships legitimised having multiple relationships without necessarily engendering conflict. Sex with one partner constructed as a long term romantic relationship did not contradict having another partner for support, companionship or sexual experience. Men and women's narratives highlighted that sex was regarded as a means of social reproduction as well as satisfying emotional needs. Having many partners ensured that all their needs could be satisfied.

A focus on the social structure of sexual relationships avoids the pitfalls of ascribing HIV risk solely to individual behaviours and deficits in knowledge. The study of sexual networks reveals that individual sexual behaviours do not necessarily determine risk of HIV infection. Instead it points toward individuals' positions within the network and their interconnectedness with others. Sexual networks help to explain the dispersal of HIV. Yet the question that remains is why such networks continue to persist despite the obvious risks of infection (cf. Thornton 2009).

One of the reasons for the durability of sexual networks is the multiple linkages between clusters within the networks. As was clearly illustrated in the case study presented in this chapter, the death or departure of an individual from the network does not undermine its internal structure because of the presence of multiple linkages.

Another important feature of the sexual network is its invisibility. The sexual network is an invisible structure to those who constitute it. This is because certain forms of relationship are secret. For example, extramarital affairs may be kept hidden from spouses. Moreover, members of the network may not be aware of the existence of others



in the network due to geographical separation. In the case study presented in the chapter, the sexual network transcended national and international borders.

The connections within a sexual network may only become partly visible if individual members become ill or die from HIV/AIDS. Yet suspicions of AIDS are suppressed and hidden. There is seldom public acknowledgement that a particular individual died from AIDS. Without this acknowledgement, the network is able to continue to develop. This may also explain why silences surround death from AIDS. Revealing the cause of death as AIDS threatens to make apparent the relationships and flows of infection between individuals. In the next chapter we start to explore in more depth the ways in which AIDS was concealed and revealed in everyday life.

## END NOTES

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<sup>1</sup> The epidemiological concept of ‘core groups’ refers to small numbers of people infected with HIV or sexually transmitted infections that transmit the disease and therefore sustain epidemics. ‘Bridge populations’ are comprised of persons who have sex with core group members and with the general population (Aral 2000). The idea of risk groups is additionally problematic as it promotes blame and a false sense of immunity amongst those who are not defined as at risk.

<sup>2</sup> For the majority of girls and boys in KwaBomba, coming of age falls outside of parental regulation and authority. Many children grow up with limited adult supervision. A survey of school going children undertaken in Bushbuckridge reported that 18% of respondents lived without either of their biological parents and 43% with only one biological parent, usually their mothers (Stadler et al. 1996). A detailed analysis of the insecurities of childhood in the lowveld can be found in van der Waal (1996) and Kotzé (1992).

<sup>3</sup> Approximately half of South African adolescents are sexually active by the age of 16 (Eaton et al. 2003). In a national survey, the median age of sexual debut was 16 for males and 17 for females (Pettifor et al. 2005). A survey conducted by the Health Systems Development Unit (HSDU) of adolescent sexual health amongst 900 school going youth aged 16 to 21 years reported a slightly earlier average age of sexual debut of 15 (Stadler et al. 1996). These surveys define sexual debut in terms of penile-vaginal

penetrative sex. Yet, my informants made a clear distinction between the play sex of childhood and the real sex of later adolescence.

- <sup>4</sup> The words *jolling* and *joller* were probably first associated with the sub-cultural style of the white male ‘Ducktails’ in the 1950s (Mooney 1998). They also appear in Malan’s biographical account of coming of age in Johannesburg in the 1960s: ‘The word is essentially untranslatable, but any tattooed gangster from the coloured slums could define its essential ingredients: *drank, dagga, dobbel en vok* – drink, dope, dice, and fucking’. (Malan 1990, 52) Epprecht (2001) notes that *jolling* means selling boys for prostitution and for anal sex.
- <sup>5</sup> Being a church member does not imply protection against HIV, but as Garner (2000) argues, religious affiliation may reduce extra-martial and pre-marital sexual activity.
- <sup>6</sup> The interview from whence this quote comes was conducted by a female research assistant. It is unlikely that she would have been quite so open in my presence.
- <sup>7</sup> The chyme from the gall bladder of the goat has cleansing properties and is used in Kgaga mortuary rituals (Hammond-Tooke 1981, 92). The use of the chyme in the *ku xuva* is intended to cleanse the family of pollution resulting from the pre-marital pregnancy.
- <sup>8</sup> The Civic Association is a village based group that usually deals with cases of common law (assault, accusations of witchcraft, domestic conflict), as the first step before referring these to the *bhandla* (court of elders) who could in turn report to the *kgoro wa hosi* (chiefs court) and finally to the magistrate or social worker. Criminal cases were often first heard by the civic association community policing forum and then referred to the magistrate. In the case under discussion, Jacobs Sibuyi was asked to sign consent to be lashed. This was to stop him from laying a charge of assault against the members of the civic association who meted out the punishment.
- <sup>9</sup> This was consistent with a widely held idea that the kidneys cleansed the blood and were essential for sexual functioning.
- <sup>10</sup> The act of having sex was described by the verb *ku kanza* which also describes stamping maize meal in a mortar and a pestle. The penile – vaginal imagery is obvious.
- <sup>11</sup> Flowers’ *et al.* (2000) observations of interactions between gay men in pubs, public toilets and parks (the ‘bars, bogs and bushes’) illustrate this point extremely well. For example, meetings in pubs were more likely to engender conversation between men. Patrons were also under constant surveillance from others in the bar which encouraged restraint. In contrast, meetings in the parks and toilets were spontaneous, clandestine and impersonal, with no need for conversation or discussion, let alone negotiations around safer sex. See also Henrriksson & Månsson’s (1995) ethnography of a gay men’s sauna in Stockholm. Certain spaces within the sauna where sexual advances are acceptable are classified as ‘hot’, while the ‘protected’ areas were spaces where sexual advances are not permitted.

## CHAPTER FOUR

### SECRETS: REVEALING AND CONCEALING AIDS

Personally, I don't know anybody who has died of Aids (...) I really, honestly don't (President Thabo Mbeki in an interview with the Washington Post; Robinson & Tabane 2007).

According to my view I do not see anyone who has AIDS in this village

He is right because a person who is HIV positive is just like you or me – they do not have AIDS.

Our problem is that we have seen people dying, but they are hiding. They are not saying that he or she was killed by AIDS, but that they are killed by this or that.

AIDS is a big problem but people are not open. You can read what is happening...you can see what is happening, a number of people die in the same way and show the symptoms of AIDS but people can't say it is AIDS. I have seen a number of people dying the same way. There are about four – some are ill and I suspect it is AIDS. But you can't tell that that person is dying from AIDS.

(Members of the KwaBomba HIV/AIDS Youth Committee in a group discussion, April 2002)

Former president Thabo Mbeki and my youthful informants quoted above articulated similar uncertainties about AIDS. However, while Mbeki's position on AIDS can be interpreted as a challenge to the racist casting of AIDS as an affliction of unbridled African sexuality, the youths I quote allude to another set of concerns. They note the paradox of the invisibility of the disease in the presence of the obvious and rising rates of morbidity and mortality<sup>1</sup>. As they observe, HIV is not only invisible, but the

epidemic itself is surrounded by excessive secrecy and avoidance. For them, AIDS has an ephemeral character; it is omnipresent but hidden under layers of secrecy, coded talk and metaphor. Many of the ways of talking about AIDS in public and private settings are coded (Lambert & Wood 2005), or communicated in other ways, such as song (Lwanda 2003).

In this chapter I explore the reasons for the secrecy and concealment that surrounds the AIDS epidemic. Public health messaging and AIDS activists make repeated calls for people to test for HIV, to reveal their status, and to be open about the disease. Secrecy and concealment are regarded as barriers to effectively combatting the spread of HIV. Yet in spite of the massive investments to ‘break the silence’ this continues to characterise the public response.

In the AIDS literature, concealment is a ‘barrier to behaviour change’ and ‘silence is equal to death’. Challenging concealment or ‘breaking the silence’ (the catch phrase of the 2000 International AIDS Conference) has become a ‘global *leitmotiv*’ in AIDS awareness campaigns and marketing (Schneider & Fassin 2002, S46). The predominantly urban based activist group, the Treatment Action Campaign (TAC), subvert silence, adorning brightly coloured t-shirts declaring the words ‘HIV Positive’. At AIDS rituals, HIV positive participants bravely disclose their status and are loudly applauded<sup>2</sup>. The metaphors, rumours and concealed talk about AIDS are vehemently condemned as misinformation, myth, denial and avoidance, and a reason for the continued stigma of AIDS.

Despite the loudness of the voices calling for people to break the silence and overcome stigma, AIDS is extremely difficult to talk about in a direct way and therefore

is hard to act against<sup>3</sup>. Part of the reason for this response is that many South Africans are simply unaware of their HIV status. Government voluntary counselling and testing services launched in public health services expand access to testing, yet many infected people only test for HIV antibodies once they become sick or even terminally ill.

In the literature, disclosure of HIV status is regarded as a positive affirmation of having the disease and also part of the process of healing, a liberation from the burden of secrecy and shame, reducing stress and assisting in coping with a positive sero-status (See for example: Almeleh 2004; Paxton 2002). There has also been some mention in the literature of the subjective experiences of HIV testing; in Australia as a symbolic reinforcement of self (Lupton et al. 1995), as a ritual of regenerative confessional in the US (Sheon 1999), and as type of moral regeneration in the setting of a clinical trial in Soweto, South Africa (Stadler et al. 2008). In these cases, the HIV test reinforced perceptions of the healthy self and transformed the way in which HIV and AIDS was conceptualised. Adopting a broader socio-political focus, Robins' (2006) accounts of AIDS sufferers who are placed onto effective treatment regimens of ARV highlights their transformative experiences and their newly forged identities as AIDS activists and 'responsibilised citizens'.

The early diagnosis of HIV infection has material benefits for patients in facilitating access to care, and preventing the further spread of HIV. Despite this common sense, many of those I interviewed were disinclined to be tested for HIV and preferred to wait and see if they were infected by monitoring their own health status. Others used proxy measures of their own status, for example the health of a sexual partner or new born child. As a result patients often arrived seeking care when they were critically ill,

resulting in extremely poor prognoses for recovery. Those who did test seldom collected their results<sup>4</sup>.

Ironically, South African public health policy reinforces the concealment of HIV. Following a bioethical tradition that is founded on an individual rights-based approach, AIDS is not a notifiable disease (unlike tuberculosis); efforts to make it so were strongly, and successfully resisted by NGOs and community groups in the late 1990s (Sidley 1999). Unlike the situation in countries such as Cuba where AIDS is handled as a public health emergency (Scheper-Hughes 1994), the protection of individual autonomy and the right to privacy is of paramount importance to the ethics of HIV/AIDS (Robins 2006).

I suggest that the silence and concealment of AIDS may be usefully understood as ‘cultural censorship’ (Sheriff 2000). Cultural censorship implies that silence about a particular issue are ‘socially shared’ and the ‘rules of its observance are culturally codified’. ‘Unlike the activity of speech, which does not require more than a single actor, silence demands collaboration and the tacit communal understandings that such collaboration presupposes’ (Sheriff 2000, 114). Cultural censorship is distinct from ‘political’ and ‘self-censorship’ by its social and customary nature. Yet, as Sheriff points out, silence is informative, perhaps more so than that which is verbalised. Leap (1995) observes the uses of silence in conversations about AIDS as a way of conveying information:

Sometimes, when AIDS is the topic under discussion, people explore their thoughts and feelings in great verbal detail; other times, they make their thoughts and feelings known by saying nothing at all. All discussions of AIDS are rule-governed speech events (Leap 1995, 227-228)<sup>5</sup>.

Along these lines I suggest that secrecy and concealment can be revealing acts, or performances, that offer visual and verbal clues as to that which they seek to hide. The act of withholding information reveals at the same time as it attempts to conceal; secrecy itself is a form of communication that imparts information. Therefore the censorship of the cause of illness and death can never be complete.

It is also often assumed that the secrecy of AIDS owes itself to the shame associated with the sexual cause of its spread. While, talking about sex is governed by rules of etiquette and respect, it is not the association between AIDS and sex, but with death that results in fear and avoidance. The construction of AIDS as a deadly disease, early in the epidemic created a lasting impression and generated much fear and avoidance. The association of AIDS with death imparts symbolic power to the act of naming the disease. Words are regarded as powerful in their capacity to concretise concepts, to call them into being<sup>6</sup>. This explains the avoidance of the terms ‘HIV and AIDS’, and the fears associated with biomedical testing procedures for HIV.

The identification of illness and death as due to AIDS also threatens social relations and identities by exposing causal pathways of blame. As Setel (1999, 103) writes: ‘the emerging AIDS epidemic was like turning on the lights in a room long kept intentionally dark’. AIDS as a disease not only threatens to expose secret sexual relationships, it also creates the atmosphere of blame and the prospect for revenge. And within the context of the funeral it threatens to declare this in public. The disease and its pronouncement have the potential to foreground the deadly networks that connect people and transmit the virus. A public announcement of death from AIDS raises questions of culpability and promotes blame. Therefore, to borrow McNeill’s phrasing (2009, 368),



silence can be regarded as a ‘safety precaution’ or a ‘protest of innocence’ ‘against the constant threat of guilt by association’.

The concealment of the AIDS body raises somewhat different concerns from the censorship of AIDS talk. Concealment is integral to the performance of suffering from AIDS. This is due to in part the physical effect of the disease on the body and the ways in which this is interpreted. The AIDS body evokes horror and repugnance. Narratives about the effect of the disease on the corporeal body highlight the inner decay that threatens to burst through the epidermal covering. Sores, pimples, skin lesions and the inability to consume and contain are evidence of this degeneration. In this way the body reveals that which is concealed.

The discussion below starts to explore the public health construction of AIDS as a deadly disease and then proceeds to examine how this was articulated through cultural censorship and avoidance in different contexts.

### **‘AIDS IS DEATH’: CONSTRUCTS OF A NEW DISEASE**

AIDS was initially encountered as an idea (cf. Pigg 2001, 481), constructed through the media and health propaganda. Stories about AIDS in the popular press were important in shaping the ways in which people responded to the disease. Many of the early reports highlighted that AIDS is incurable and deadly. These stories were also highly stigmatising (cf. Connelly & Macleod 2003). Gabriel was a young university student when he first heard about AIDS. An article in *Pace Magazine* discussed the dangers of AIDS; a picture of doctors, wearing face masks and surgical gowns surrounded a coffin that had been tied up with ropes. Gabriel interpreted the picture:

The ropes were to prevent the doctors from touching the coffin and the masks were to prevent them from inhaling anything from the corpse. I was really frightened by this. It meant that if you have AIDS people will be afraid to bury you and will not touch you

These initial impressions of the disease as extremely deadly and highly contagious continued well into the epidemic (cf. Niehaus 2007). AIDS is avoided because it is something to be feared and is codified as ‘the killer of the nation’ and ‘the three/four letter thing’ (Lambert & Wood 2005). Riot, was a schoolboy when he first heard of AIDS: ‘I took it seriously because I knew it can kill. I take it into consideration that AIDS kills’. Marks, commented: ‘AIDS is living and it kills’. A young girl recalled:

I heard on TV that AIDS is killing people. They start vomiting, having diarrhoea, they become thin and end up dying. I see people sick from AIDS sometimes the person is always sleepy and around the mouth will have sores

These impressions were reinforced in public education activities. A poem read out at the graduation ceremony for home based care volunteers offered a vision of the epidemic in which being HIV positive was associated with rape.

AIDS you are a monster  
Where do you come from?  
You have no respect  
You kill everyone young and old  
Rich and poor  
Everyone is being raped everyday  
Young children as young as nine months are being raped  
Young children are being raped  
AIDS is spread through rape  
AIDS is spread through rape to the African Continent

Church programs for young people focussed on the deadly effects of AIDS and promoted blame. A young man attended the International Pentecostal Holiness Church:

They talk about AIDS in the church. This was where I heard about AIDS a lot. They say that AIDS is living and it kills. If you go out and have sex with ladies in taverns or ladies who linger around who have many boys then you can find AIDS

Conspiracy theories about the origins of the epidemic were also widespread. An early rumour speculated that AIDS originated from humans having sex with monkeys, baboons and dogs. Mandela, now a young man, recalled the talk at his high school about AIDS in the mid-1990s, where he heard that the disease was caused by men sleeping with monkeys. Yet, Mandela did not take the story seriously. He said:

No, no, no. I don't believe that if a monkey can live with this disease it will kill a human being. What is the difference between a monkey and a human being? The blood is the same and the disease lives in the blood.

Others speculated that the apartheid government manufactured the disease to kill black South Africans (cf. Niehaus & Jonsson 2005). The idea that AIDS was a government conspiracy was not restricted to the apartheid government. Some theories attributed the absence of a cure for AIDS to pharmaceutical profiteering. Medical researchers suppressed the discovery of cures by traditional healers as this would undermine their power. A young man had heard debates on the radio and concluded:

They [medical researchers] are worried that the AIDS cure will be made locally and in the traditional way. They will lose their profits. This is why they cannot make it known to the people that there are cures for AIDS available.

While AIDS was an imagined disease for most of the early 1990s, by the early 2000s, the disease became horribly real, inscribed in the bodies of the ill and evident in the increasing numbers of funerals. The personal experience of seeing the ill and dying was critical in changing the way people thought of AIDS. As a young man stated, the

‘dream’ became ‘real’. ‘Others tell us that it is just a joke, a dream. *They* are dreaming’. He pointed out that many people had died in the village; ‘So now they can see that AIDS is real’. Mandla recalled that he started to believe that AIDS was real when he was visiting his mother in hospital and he saw a woman with AIDS. ‘After I heard that she had passed away I felt scared, yeah’. Cornelius, a young man of 24 had a similar experience:

Jonathan: Can you remember the first time you heard about AIDS?

Cornelius: Ya, um, it’s toward the end of 1999. Many people talked about AIDS, but I took it as a joke. I thought that maybe it can’t kill a person, it’s not really cruel. Yeah, so around 2000, the end of 2000, I saw a person. It was 16<sup>th</sup> November. So that when I started to realize it is a disease and it kills. That person was my cousin. So on the Friday we saw him in the mortuary, so the doctors, told us that, she died because of AIDS.

Despite these experiences and public knowledge of the disease, suffering and death remained private issues.

## SECRECY AND SUSPICION

In KwaBomba, as in many other similar settings, public reference to AIDS is usually avoided; euphemisms, acronyms, signs, slogans and metaphors are used in everyday talk to denote AIDS<sup>7</sup>. Quite appropriately then, AIDS is sometimes called the ‘disease with many names’. The aliases used to stand for AIDS often play on the fact that the acronyms HIV and AIDS are made up of three and four letters respectively. For example ‘**H**ouse **I**n **V**ereeniging’, a ‘taxi trip to Johannesburg’ - three fingers are held up to signal for a taxi to Johannesburg, and a popular brand of washing powder ‘OMO’, like

HIV is an acronym of three letters<sup>8</sup>. The nicknames awarded to AIDS reveal linkages between AIDS and conspicuous consumption; for example ‘Z3’ (BMW sports car); ‘three numbers plus bonus’ from the national lottery in which three numbers equal three letters that spell out A I D, the bonus was the ‘S’ suggests the desire for instant wealth and AIDS, but also the risky gamble that sex had become in this era (Stadler 2003b).

At funerals, AIDS is never referred to directly as the cause of death, although mourners sometimes signal their suspicions by exchanging glances and showing three fingers spelling out H-I-V (Stadler 2003b). ‘They talk at the corner of the funerals – not in the speeches’ remarked a young woman.

Church ministers I spoke to agreed that the silence about AIDS is problematic. Yet, few did anything to challenge the silences. At the funeral of a man who died of AIDS the minister stated obliquely that the man ‘was responsible through his actions’. David Madonsella, a minister of the church and a member of the umbrella inter-faith body ‘Faith Organisations in HIV/AIDS Partnership’ (FOHAP) worried that the silences around AIDS are seldom confronted by ministers in the church. Although many church sessions with the youth discuss HIV/AIDS, this was usually only in terms of promoting abstinence before marriage. David once spoke about AIDS at a funeral, but admitted that out of respect for the family of the deceased only spoke in very general terms. ‘You can’t expose the sickness without their consent’, he remarked, and ‘Human rights can cause problems’ – alluding to the confidentiality of HIV status.

Regular events are organised at which openness and full disclosure is encouraged. In 2001, World AIDS Day was held in the town of Bushbuckridge. Gospel singers Solly Makulu, Mumsy Ndlovu, and *kwaito* star Spokes H performed for the entire Limpopo

Provincial cabinet and thousands of residents. After the entertainment the huge crowds were divided into regions each of which had their own tent for catering. ‘They spent millions’ I was told. During the day’s proceedings a number of people appeared on stage and announced that they were HIV positive. This was in the spirit of openness, to fight against the stigma of AIDS. ‘But’, as one observer said, ‘they were probably paid to say this’.

AIDS was not mentioned in the political campaigning leading up to the national elections in 2004. In the ANC’s door-to-door campaign people were asked to list problems that they were experiencing, AIDS was never mentioned. Niehaus cites a ward chairman in Impalahoek saying ‘No! We were never asked a single question about AIDS. People don’t like talking about it’ (Niehaus 2006b, 540). These sentiments are reinforced in the words of a teenager who attended the loveLife Y-Centre in Acornhoek:

No one comes out and says ‘I have HIV, come and see me, I want to be an example for you’, no one! But there are many people who have HIV, but they will not come out and say ‘come and see me’ as an example, because they have it and it’s a dangerous disease. So that’s why I think that many people they have it. Even me; I think that maybe, it may be possible that I have it.

As he notes, the act of concealing the disease is not sufficient to quell others suspicions. Secrecy is incomplete and concealment is not absolute. Moreover, concealment as a practice of everyday life subtly and sometimes not so subtly reveals and conceals (cf: Piot 1993). Goffman (1963) in his frequently cited book on stigma notes that people strive to maintain a balance between concealment and disclosure of information, in different contexts and situations, with different categories of individual. ‘To display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to

lie; and in each case, to whom, how, when, and where' (Goffman 1963, 42). In Bushbuckridge, AIDS was indeed a secret, but one that everyone knew about but never alluded to directly. Jean Comaroff points to the subtleties of concealment and exposure in talk about AIDS:

The inaudibility of talk about AIDS is often less a matter of brute repression or secrecy than of complicated communicative practices in the context of radical uncertainty. Nuanced registers and indirect forms of speech flourish in a field haunted by the ubiquitous presence of the disease. For death is the unspoken referent around which much everyday signification has been reoriented (Comaroff 2007, 202).

Concealment was not simply silence, but entailed a studied avoidance, partial censorship, and insinuation. Metaphor was a key device in the process of telling and of partially revealing. Importantly, as Piot (1993, 358) notes, the use of metaphor as a way of revealing creates ambiguity, and an 'on-going interpretation and reinterpretation'. This is aptly illustrated in a schoolboy's account of a school teacher's funeral. The oratory at the funeral had identified diabetes as the cause of his teacher's death. I asked the schoolboy if he thought this was true.

Ah no! (JS: *Did anyone believe that?*) Ah no! (JS: *So, why did they say it was diabetes?*) I think it is in our culture that at a funeral we are not allowed to say this one died from an embarrassing thing. For example if he was shot when he was robbing some place like a *xigavenga* [thug] you won't mention that he died in that way.

As the boy quoted above noted, silences are interpreted culturally as a way of communicating suspicious circumstances. Suspicions of AIDS are precisely *suspicious* based on incomplete evidence channelled through local gossip. Disclosure in the public space of a funeral has significant implications for social relations. Funerals are focal



points in which attention is drawn to the conduct of an individual. For example, the number of people who attend the funeral is a statement about the deceased's status while he or she was alive. My informants told me that if they failed to show support for others by attending their funerals, their own funeral may be poorly attended. Moreover, not attending a funeral creates suspicions of complicity in death. In the context of an AIDS death, announcing the cause of death would amount to a 'public curse', a statement that those connected to the deceased would themselves also die (Durham & Klaitz 2002).

Disclosure of AIDS was contained within the domestic, private domain. Matthews, a college student, talked to me candidly about his sister who had died two weeks previously.

She was my father's brother's daughter...she was born in 1978 ... many people didn't understand about this it is not the sort of thing that you can speak about openly – even my friends don't know that my sister died of AIDS, we can only speak of it in the family. I didn't explain to them I just told them that my sister is dead. Her friends may know that she died of AIDS because they went about with her everywhere. The younger sisters don't believe because they didn't see her symptoms. She was fat but just before she died she became very, very thin. She was single but she had a boyfriend he was a taxi driver that is why I believe that because they have AIDS.

Matthews' comments on the death of his sister raise the distinction between the public denial of AIDS and its private acknowledgement. AIDS is something that can only be spoken of within the family, as Mathews put it. However, even so, Mathews' sisters were not made aware of the facts of their sister's death.

McNeil (2007) suggests that public secrecy in the context of funerals needs to be contextualised within wider-ranging attitudes towards death and suspicions of witchcraft. In his analysis of AIDS deaths that occurred in the Venda region, McNeill suggests that

avoidance of identifying the cause of death and naming it is a strategy to avoid direct association with the deaths in order to ‘seek diminished responsibility for the recent increase in what are believed to be unnatural deaths.’ (McNeill 2007, 260) The avoidance of identifying, naming and indeed talking about death cannot solely be attributed to AIDS denial.

Paradoxically, secrets often have a way of surfacing; and silence and avoidance became inadvertently an acknowledgement of AIDS; its negation tends to confirm its existence. For example, my informants claimed that Mbeki refuted AIDS because he was infected with HIV himself.

Although AIDS was subjected to censorship, AIDS was a revealing disease, one that rendered visible that which was said to lie beneath. This is due to the natural history of HIV infection. During the early or acute stage the infected body may display signs of infection, such as a severe rash. However, as the viral load of HIV in the body reduces over time, the body may appear healthy. It is only once opportunistic infections such as tuberculosis and diarrhoeal diseases attack the body that disease really manifests itself physically. Sontag notes the irony of a disease that attracts the most secrecy is also the most revealing: ‘The illness flushes out an identity that may have remained hidden from neighbours, job-mates, family, friends’ (2001, 113).

Avoidance around AIDS presents a conundrum for research, HIV prevention, treatment and care. Despite the intimate nature of ethnographic research, anthropology does not hold an especially privileged position with regard to the research of secrets and concealed or ‘deep knowledge’ (Apter 2005). Certain areas of everyday and ritual life are secret and hidden from public view. An example is the highly secretive initiation rituals.

Initiation ceremonies for example included public rituals, but for the large part were restricted to the neophytes and the initiated (Stadler 1995). Knowledge about witchcraft was also highly secretive, restricted to older men and women who possessed the knowledge and the capacity to commit acts of witchcraft. Importantly, knowledge of the craft implied the capacity to commit acts of witchcraft (Stadler 1996). Research about AIDS confronts similar barriers. Secrecy also meant that the sick and dying were often hidden, denied care and proper treatment by family members and were shunned by their neighbours and work colleagues (Cameron 2000; Campbell 2003; Delius & Glaser 2005; Niehaus 2007)

Silence and concealment may also be regarded as an effective manner of revealing and indeed performing suffering and affliction. Vena Das' (1997) reflections on her conversations with Indian women provides some insights into the reasons for the elusiveness in their narratives of their traumatic experiences during the Partition:

When asking women to narrate their experiences of the Partition I found a zone of silence around the event. This silence was achieved either by the use of language that was general and metaphoric but that evaded specific description of any events so as to capture the particularity of their experience, or by describing the surrounding events but leaving the actual experience of abduction and rape unstated (Das 1997, 84)

Women conceptualised their bodies as repositories of 'poisonous knowledge'. However, contra to the idea of the need to release and expunge through verbalising their experiences, their silences protected them and allowed them to continue with their lives. They were able to carry on – not by bearing witness through speech, but through silence (Das 1997, 85).

The silences around AIDS are somewhat analogous. Although my informants did not allude to the metaphor of poison to describe the concealment of AIDS, their narratives alluded to the dangers of breaking the silence, of revealing their suffering and the extremely negative impact thereof for themselves and their surviving family members. HIV was an extremely powerful secret, and as I explore below, a dangerous form of knowledge.

### **DANGEROUS KNOWLEDGE**

The avoidance of HIV testing is partly attributable to the widespread rumour in Bushbuckridge that nursing staff were purposefully, or accidentally, infecting patients with HIV. The nursing sister in charge of testing at a community clinic complained that she had heard people in the village saying that she infected her patients with HIV. She linked this to a dramatic reduction in requests for testing.

Yet, the fear of testing seems to run deeper than this. It concerns not only on the possibility of being infected by careless or malicious nursing staff, but a belief that the HIV test communicates deadly knowledge that results in illness. A middle aged woman expressed her concerns of what a HIV positive diagnosis would mean to her.

They say you don't know if you have got it [HIV]. I will go and have a test. Then I will know that I am HIV positive so I will start to become thin because of *ku vilela* [worry].

In contrast to public health narratives that highlight the benefits – both medical and psychological – of HIV testing, a sero-positive test result was potentially detrimental to one's health. As a 24 year old woman remarked, this could even result in death: 'I

cannot test because one week after hearing that I am HIV positive I will just die. I will become thin from the worry’.

Anxiety and worry result in an affliction called *mbilu va vabye*, literally ‘heart sickness’. This is similar to the popular concept of ‘stress’. A person who has heart sickness has ‘given up hope of ever being cured’, their ‘heart is lost’ (*mbilu yi vava*) or ‘they have lost hope’ (*ku ka u ’nga tsembe*). This was widely recognized and classified by traditional healers in KwaBomba as a deadly, but treatable affliction. NwaKhomani, a female traditional healer, often treated patients with herbs who as she put it, have ‘lost heart’. ‘Sometimes we give them *muthi* to make their heart feel free, to be free of pain. This is to make them feel happier’. NwaKhomani reinforced the idea that a painful heart was from ‘thinking too much’<sup>9</sup>. Jamaica, so named from the days he wore dreadlocks and played football for a club in KwaZulu-Natal also dealt with patients who had heart sickness. He explained in some detail:

*Ku fa hi mbilu* [death from heart] is when a person who thinks too much and becomes very angry; his heart will pump far too much. He will be caught by the *mbilu yi vava* [heart sickness]. A person will think too much if there is always fighting at home. Usually it is the wife who is affected but the fights are between the husband and the wife. The body starts to change – the veins will start to show underneath the skin. The person is always unhappy, always looks sad. You can die from this – usually you will have a heart attack. People don’t want to know that they have AIDS because they fear that their lives will be miserable.

However, it was not only the diagnosis that people feared. The test itself was a powerful intervention that could transform the body. The logic of this can be elucidated by examining another procedure which is commonly performed by traditional healers (*tin’anga*) called *ku tlhavela* (literally, ‘to cut’). A healer (*n’anga*) makes small incisions on the back of the knees, elbows, breast bone, wrists and nape of the neck using a razor

blade<sup>10</sup>. *Muthi* (medicinal substances, usually a grey or black powder) is rubbed into the incisions. The joints are the points at which the body is most vulnerable to attack because it is here that blood is closest to the surface of the skin. This procedure fortifies the body against witchcraft, a sort of ‘ritual immunisation’ (Jolles & Jolles 2000). People who felt vulnerable to occult attack regularly (often at Christmas time when family members gather together) performed the ritual as a prophylaxis against witchcraft. A similar ritual was performed on the corpse of a person thought to have died from witchcraft to return the witchcraft back to its owner (For a similar account see: Niehaus 2001, 26)<sup>11</sup>. The symbolic potency of this ritual is realised by the action of cutting into the skin and mixing the *muthi* into the veins, and at the same time uttering the words ‘let this illness return to the one who sent it’ (see Chapter 6).

It may be that the perceived potency of the HIV test lies in its symbolic association with the *ku tlhavela* ritual. The hypodermic needle injection used in biomedical treatment is often regarded as having symbolic potency, perhaps seen in a similar way as the incisions made during the cutting ritual; as van der Geest and Whyte (1989, 360) observe the ‘metonymic associations are especially strong’<sup>12</sup>. When faced with new biomedical technologies – such as diagnostic testing procedures that may not be well understood, new meanings are constructed that refer to practices which are more familiar, in a process of the domestication of the new and unfamiliar. Drawing blood in the HIV test was therefore viewed as an intervention in itself. This action combined with the disclosure of the results had the power to transform the body from a state of health to illness. In the cutting ritual, words are spoken, to ‘activate’ the power of the medicine which the *n’anga* has used. Likewise the words ‘HIV positive’ achieved potency because

of the association with the insertion of the needle into the skin, but also because these were secret words. It is in this sense that testing for HIV was regarded as dangerous knowledge, given added potency through the clinical procedure of piercing the skin and withdrawing blood. In terms of this local model, testing was much more than disclosing information about a patients' HIV status<sup>13</sup>.

Lastly, the avoidance of testing reveals a fear not only of the results of the test itself, but a fear of the words 'HIV' and 'AIDS'. The play with the lexicon of AIDS highlighted at the beginning of this chapter suggests a fearfulness of naming the disease, as if this has an innate power. Certainly, in the context of extremely high rates of mortality, the acronym AIDS has assumed symbolic status; it has become an immensely powerful and dangerous word<sup>14</sup>.

Up till now I have talked more generally about responses to testing and peoples' ideas about this. A distinction needs to be drawn between the experiences of men and women in this regard.

### **SHY MEN AND SUFFERING WOMEN**

Discourses about the censorship and concealment of AIDS reflected on the divergent experiences of men and women, their respective vulnerabilities and strengths. Men were described as being naturally 'shy', unwilling to talk about sensitive issues, preferring to keep intimate experiences of suffering away from the public gaze. Men were more hesitant to talk about AIDS, more likely to deny its existence and less likely to test for HIV. Men, it also appeared, had more to lose than women, by having their HIV status known. In contrast to this weakness and vulnerability, women bore suffering and had



greater strength in absorbing the pain of illness. Women also had more experience and were far more familiar with the world of biomedicine. This was due to their participation in clinical services in accessing gynaecological examinations, health talk, contraception and other services, through which women's bodies were medicalized (cf. Martin 1992).

The gendered nature of concealing and revealing of AIDS was corroborated by the clinician in charge of an AIDS program at Tintswalo Hospital. She observed that women tended to be in the majority at support group meetings. Men, she remarked, were wary of attending these sessions and much preferred to be dealt with in private consultations. In December 2008 the clinic recorded a total of 6638 users; 2381 of those are men and 4257 are women (Mfecane 2010). Their suffering was not something to be revealed in public.

The gendering of AIDS discourses can be partly explained by the general tendency of women to trust in and utilise biomedical services, experience higher rates of use of clinical services and therefore possess more knowledge about biomedicine. Most women are first exposed to biomedical knowledge and allopathic therapies when they start to use hormonal contraception that is dispensed at public health clinics. Many clinics hold health talks and well-baby clinics at which they also lecture on AIDS. HIV testing is mandatory at antenatal clinics. Outside of the biomedical setting, in various churches, the regular prayer of the mothers (*xikongela wa manana*) hold discussions about AIDS.

In contrast, men had limited experiences within the biomedical setting of the clinic. They were 'matter out of place' in the public health clinic waiting rooms as these were feminised spaces, dealing with 'women's business'<sup>15</sup>. Men often preferred to self-diagnose and self-treat or consult a 'private doctor' or traditional healer. This gendered

dynamic reflects on a public health service that feminises HIV and AIDS. Women are more susceptible to HIV infection and therefore women are targeted in HIV prevention efforts.

These ideas were conceptualised as embodied. The female body was regarded as weaker and more susceptible to illness due to the strain of childbirth, the loss of menstrual blood and the build-up of polluted substances in the body from sexual intercourse. In the popular imagination, women were likely transmitters of hidden disease, more so than men.

For example sexually transmitted diseases (STD) are hidden within the womb and were often asymptomatic. Men in contrast displayed the symptoms of STDs. Male accounts of disease and infection was also quite different to women's. In an exercise of 'body mapping' conducted at Tintswalo Hospital a group of young men and women were asked to draw separate diagrams to portray a body infected with a STI. The female group drew the basic outline of a faceless woman, with a detailed diagram of the fallopian tubes and the womb, showing the site of infection. The male group presented a drawing of a man, fully clothed, with stained trousers and an unhappy look on his face. They explained that the man was embarrassed because the discharge from his penis leaked through to his trousers, nor could he walk properly because of his discomfort. The contrast between the masculine concerns about the social aspects of disease, versus the female preoccupation with the inner body was striking.

Women and men's subjective experiences and interpretations of disease were quite distinct. Men were seen to be more vulnerable than women to the pain of knowing they are infected, while women had greater strength and could sustain the pain. In this

way a woman's body was a more appropriate site of suffering than the male body. A woman's heart was the location of her strength and her emotions. The heart, it was said, can be the 'biggest witch' (*mbilo wa noyi*). If a woman has been wronged (usually by a man) she absorbs this pain and suffering into her heart. Yet, the heart could also do great damage to those who had wronged them. At night the painful heart causes the sufferer to cry tears and call out the names of those who had wronged them.

The gendered nature of thinking about illness and resilience was articulate in men's tendency to conceal HIV and women's tendency to reveal. For example, I had much more success in talking to women about HIV than men.

Men were extremely open about secret love affairs, but conversations about AIDS were quite the opposite. I often chatted to Goodwill, a young unemployed man, and considered him as a relatively willing informant. When I asked Goodwill about AIDS his entire demeanour changed. The following extract is from a recording of an interview with Goodwill. It starts at the point when I began to ask him about the deaths from AIDS in KwaBomba.

*When did you start noticing the deaths?* In 1999

*What happened?* Ahem – you know why I cannot talk about this ... I do not know where you are going to play this tape. Someone from KwaBomba is going to hear this and will know it was me who spoke to you.

*So you are worried about mentioning something about AIDS and someone who has AIDS? What would happen if someone heard this interview?* Ahem ... it is illegal to talk about such things, maybe they will sue me.

*They would sue you?* Yes and I do not have enough money to pay for the case

*Where did you get the idea that it is illegal?* It just seems that it is (...) I do not know how I can say this ... I am not feeling relaxed.

Mandla [my research assistant intervenes]: He is actually saying he is afraid to talk about it.

Goodwill hesitated and then eventually refused to talk about AIDS because he did not want to be labelled a gossip but also as he suggested because AIDS-talk was illegal. This confirmed what I had heard from others; that to identify someone as HIV positive could result in criminal prosecution or a fine of one cow in the headman's (*ndhuna*) court. Moreover, Goodwill was particularly concerned regarding my recording the conversation.

Another extract, this time from an interview with a male school-goer reflects similar sort of fears in revealing personal information about AIDS.

I have just heard that there are a lot of people here [who have died of AIDS] but I don't know them...I don't know them...if someone dies from AIDS then they are afraid to say that someone died of AIDS so I can't say that I know someone that died, ... I can't say that.

Sometimes the memory of those who had died from AIDS was completely expunged. I recall an interview with a young man who denied the existence of his sister who had died two years prior, apparently of AIDS illnesses. David, my research assistant, was shocked at his denial and remarked that it was as if the young man's sister had never even existed, that he had erased her from memory. When we had finished the interview, David said 'He knew that I knew that his sister had died of AIDS. But how can he just forget her!'

While conversations with men about AIDS often encountered these sorts of barriers, women were far more willing to open up and talk about their subjective experiences of the epidemic. I recall standing in Gladys Shai's yard while her elderly mother identified one by one those who she suspected had died of AIDS, pointing to the individual homesteads in the street, only holding back on actually identifying the individuals concerned. NwaMbembe, a middle aged domestic worker, suggested that mandatory testing should be conducted at schools to expose HIV positive youth. At our first meeting I asked her when she had heard about AIDS.

I started hearing this last year because most people were dying then.

*Where did you hear about it?* From the radio, watching TV and seeing relatives dying. Another relative - they are burying him tomorrow because of AIDS (...)

*Is this is the first time you have seen someone dying from AIDS?* No it is not the first time. My sister-in-law, and my brother's daughter, also died from AIDS. They were sick and they were even admitted to Tintswalo [hospital]. I visited them...they put her in her own room. She was very thin and *ku tsuka* [light in complexion]. They also took her to the *n'anga* [traditional healer] and ended up taking her home. They wrapped her with a nappy. Where she slept she looked like a tiny parcel...it is a horrible disease if you know you have got it you will end up killing yourself [laughs].

Women were also more likely to express their personal concern that they perhaps could be infected with HIV. NwaMbembe commented on the possibility that she could be infected.

It will be you left Jonathan. You will be alive because you know a little bit about this disease. But at the back of the small hill near the railway line, I used to have sex with men, so you won't know if I haven't got it.

Older women were also open in discussing sex and the transmission of HIV. The following transcript of an interview with NwaEphraim illustrates the ways in which sensitive information was communicated:

Jonathan: *So, you have heard about AIDS?*

NwaEphraim: AIDS? Yes I know it. I heard that if you lie on your tummy with a man you get AIDS. The time you are doing this you are pressing each other and so you get AIDS, but I can't exactly say what's going on. I mean it is not like a cow that goes moo. That moo is saying everything.

Women were also more likely to ask me for advice and practical assistance with a sick child, brother or husband or if they themselves were sick with AIDS.

### CONTAINING THE AIDS BODY

They can build our underground tunnel so we can meet each other and talk about *vu vabya* [illness/sickness]. So if they find we have got this disease we will be going under the ground praying down there and singing and we will be just consoling ourselves.

These words were spoken by a middle-aged woman who had admitted to me that she was somewhat unsure about her own HIV status. She evoked a macabre vision of people buried before death, living and even singing and praying. Her statement was even more ghoulish considering the widespread belief in the zombies (*xindhachani*) who occupy the land of the living at night carrying out chores for witches owners (Niehaus 2001). Most of all, her commentary drew attention to a concern with secluding the AIDS body. Concealment and containment is a familiar strategy in dealing with the ill and the dying. Being kept within the confines of the homestead was a sign of illness or a state of

vulnerability. People in a state of pollution (menstruating women for example) are often confined to the homestead. Certain afflictions that are revealed on the surface of the skin (leprosy, small pox, measles) also result in seclusion.

Seclusion, I suggest has to do with peoples' thoughts about the AIDS body. Narratives about AIDS focussed on the physical appearance of AIDS sufferers and highlighted wasting and erosion, and the need to contain this. People with AIDS were 'tiny parcels', 'skeletons' and 'clothes hangers', and also 'rotten' (*borile*). AIDS slowly ate away at a person from the inside of the body. The sores that appear on the surface of the skin were regarded as manifestations of the erosion of the body inside. HIV was commonly conceptualised as a microscopic worm that grew and reproduced itself until consuming the body. A woman was described as having rotten breasts; another's perineum had eroded away. A healer (*n'anga*) induced diarrhoea in her patients. She claimed that this expelled male and female maggots and their offspring – hundreds of tiny maggots. A story I first heard in Soweto in 2005 and soon thereafter in the lowveld told of an AIDS patient whose vagina was inhabited by a large maggot. According to the account, staff at Tintswalo Hospital charged a R10 entrance fee for spectators to see the maggot emerge from the woman's vagina, having first been enticed by a piece of pink meat or ox liver<sup>16</sup>. These accounts draw attention to fears about the permeability of the body and how AIDS resulted in the exposure of the corrupted interior of the body. They create images of the erosion and decay. The images of the AIDS body were extremely disturbing and disquieting. Talking about his neighbour, a young man recollected that he had been so frightened when he saw her shrunken state that he had run away.



The ideas about the AIDS body were inspired in some part from AIDS awareness campaigns that highlighted the strong association between the disease and death.

Although AIDS awareness campaigns consciously moved away from scare tactics and promoted more positive imagery about AIDS, the association between AIDS and death remained strong in the popular imagination.

Niehaus (2007), commenting on the stigmatisation of AIDS sufferers in the lowveld offers a convincing interpretation for this response: ‘persons with AIDS are symbolically located in an anomalous domain between life and death, and are literally seen as ‘corpses that live’ or as persons who are “dead before dying”.’ (Niehaus 2007, 848)<sup>17</sup> Therefore, seclusion and concealment was an appropriate response to dealing with the liminal body of the AIDS sufferer, best hidden away ‘in tunnels’. And as I discuss later in the thesis, this was also an important part of the repertoire of how people ‘do suffering’ (Struhkamp 2005). Concealment and secrecy are also strategies to avoid harm coming to other household members.

### **‘A house hides a lot of things’: concealment in everyday life and death**

Peaceful Ndlovu was in her early twenties and still attending school when she became ill with AIDS. She resided with her parents in a large household of 22 people, including her brothers’ wives and their offspring. The household relied on the migrant incomes of two working men, resulting in a serious strain on household resources. My narrator put it in this way: ‘the *vakothi* [daughters-in-law] would make a huge pot of porridge and then each person must find their own relish [to accompany the plain starch]’

Peacefull’s illness had worsened after she had given birth to a baby girl. Like many other women, childbirth was a massive strain on her health and she had been

admitted to Tintswalo hospital for several weeks after experiencing uncontrollable diarrhoea and vomiting which had left her weak and dehydrated. Neglected and unwell, her baby died at 16 months. Peaceful was visibly ill and her family must have suspected that she had AIDS. Peaceful herself was first made aware of her status during routine testing at the antenatal clinic. Lucas, her older brother (recently retrenched from Telkom) was the only family member who she told. One day in desperation she told him that she felt like killing herself. When he asked why Peaceful told him she intended to ‘go out there’ and spread HIV. Lucas talked to her and looked after her. When she was desperately ill, Lucas took her to hospital and visited her there. No one else in her family came to see her. Peaceful had spoken to Lucas about her fears of disclosure. She felt that if her family were told that she was HIV positive, this information may be used against her when she was fighting with her other siblings or her parents. Her fears were not unfounded. Peaceful had seen how her cousin Mamela was taunted by her siblings. Mamela received food parcels from the local civic association and was the recipient of a government disability grant. Her sisters often squabbled over Mamela’s money, claiming that she did not deserve this. Moreover, Mamela’s grandmother frequently drank too much home brewed beer (*xikhapakhapa*) and in her inebriated state sang about her granddaughter’s illness while walking home from the *shebeen* at night. Risking public humiliation was too large a price to pay.

When Peaceful died Lucas met with his parents and informed them that Peaceful had disclosed her HIV status to him. Lucas claimed that he had kept her HIV status secret because he wanted to spare them the stress and shame they would experience if they

knew. Perhaps, he speculated, they would have killed themselves because of the humiliation.

Peaceful Ndlovu's case illustrates how concealment from family members created barriers to seeking care. Yet, at the same time it reveals how concealment is a strategy to avoid the destructive effects of disclosure on intra-household relationships. In this case withholding information was used to protect Peaceful, but at the same time to protect her parents from stress and shame. Peaceful had chosen to confide in Lucas to relieve herself of the burden of suffering alone, and because of their especially close relationship. These sentiments were well articulated by a young unmarried woman who talked about the social repercussions she imagined would result if she had to die of AIDS and this became known to people in her community. The emotional and social harm resulting was so awful that she would consider suicide.

If I know I had AIDS I would drink Two-Steps [rat poison]. My parents and children will be worried that the children at school will laugh at my children. They will say 'she died of AIDS'. And this disease takes a long time. The parents will sit at home and worry. Even after I die the children will continue to laugh and say – your mother died of AIDS. Your family will end up getting bad luck. Even the other villagers won't like your family – they will think that the whole family has AIDS

The idea of the contagious nature of 'bad luck' (*xinyama*) and the emotional impact on others is clearly expressed. It is important to read the quote carefully – the speaker did not say that she will commit suicide for her own benefit – like euthanasia but to avoid the social harm that could befall her parents and her children who would be tainted by her illness and death. Hers was a form of self-sacrifice.

## CONCLUSIONS

This chapter has lent some support to observations made elsewhere regarding the social and cultural basis to the secrecy and concealment of AIDS. In KwaBomba, reluctance to test for HIV and talk about AIDS, and the concealment of the AIDS body was not attributed to individual denial, but the prevention of exposure to dangerous knowledge. The material presented in the chapter also showed how disclosure and revealing has divergent meanings in different contexts and with different categories of person. Importantly, men were regarded as more private than women, and less resilient to suffering.

A theme, critical for understanding the social response to AIDS has emerged from this chapter. Concealment and secrecy has implications not only for the care and support of the AIDS ill, but also with regard to peoples' capacity to deal with the AIDS epidemic at a social level. Citing Bellman's work on the Kpella, Piot (1993) draws attention to the idea of

(T)wo realities: one that everyone knows about but which agree to conceal, and the other 'the realm of discourse that indirectly refers, through what Bellman calls "deep talk" (allusive metaphorical speech) to the real'. The existence of this second reality creates a field of varying, ambiguous, and often conflicting interpretations of the real. One never knows for sure whether one "got" the message or not

I have suggested that in KwaBomba, talk about AIDS, particularly in the public domain occupies the second realm of 'deep talk'. This has not only created ambiguity but has also contributed towards the mystification of the AIDS. This has very significant consequences which are observable in the widespread failure of 'communities' affected

by the AIDS epidemic to act against it; to make demands for services; to seek out treatment and care; to mobilise resources to support the sick and the dying.

The most pertinent example of the reluctance to act against the epidemic are the secret funerals organised in KwaBomba<sup>18</sup>. A contrast may be drawn with the funerals of the mid 1980s and early 1990s that were sites of political activism, and were ideal opportunities for dramatizing peoples' suffering and mobilising against apartheid (cf. Van Kessel 1993). Funerals were extremely evocative moments, instrumental in mobilising people into action. Yet, the concealment of death and the obfuscation of its causes in the era of AIDS rendered deaths from that disease, meaningless.

## END NOTES

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<sup>1</sup> HIV is linked, but separated in time, from AIDS. At the initial stage of acute infection, standard tests are unable to detect the presence of HIV in the infected body. After the 'window period' of three months, the immune system responds to the presence of HIV and this response is detectable. The infected person may remain asymptomatic for some time until Stage Three HIV infection begins and the person is now considered to have full blown AIDS (Evian et al. 1993).

<sup>2</sup> Bravely because of the dreadful consequences this public disclosure has had for AIDS activists such as Gugu Dlamini who was murdered after declaring her HIV status (Stadler 2003a). Almeleh (2004) notes that public disclosure is often selective (Cited in: Ashforth & Nattrass 2005), and is sometimes thought to be disingenuous (Levine 2005 cited in Ashforth & Nattrass 2005).

<sup>3</sup> For example the judge and AIDS activist Edwin Cameron's address to the 2000 International AIDS Conference held in Durban, South Africa made an impassioned call for an end to discriminatory practices against people with AIDS (Cameron 2000).

<sup>4</sup> In a survey of HIV testing in 2000, conducted in Agincourt in Bushbuckridge only 10% of patients at one facility and 15% at another returned to receive their HIV test results (Pronyk et al. 2002).

<sup>5</sup> I am aware of the large anthropological literature on ritualized and ritual secrecy. However, the main focus of this discussion is on the use of silence and the obfuscation of AIDS in everyday interactions and in everyday language which is somewhat distinct

from ritual secrecy where secrecy is an ‘esoteric phenomenon tied to formal ritual contexts’ (Piot 1993, 353)

- <sup>6</sup> Following Malinowski’s lead in his description of spells, Tambiah (1968) explores the notion of the power of the spoken word as represented in Christian, Buddhist and Trobriand belief systems: ‘deities or first ancestors or their equivalents instituted speech and the classifying activity; man himself is the creator and user of this propensity; finally, language as such has an independent existence and has the power to influence reality’ (Tambiah, 1968:184). Tambiah’s concern here was with the power of words. Words had a different degree of power depending on how and where they are spoken. They can be audible but not understood by all; as words audible and understood; and ‘secretly uttered’ and thus private.
- <sup>7</sup> These are sometimes extremely creative and meaningful. For example in Zimbabwe HIV was **Henry the IV** (Andersson 2002), in Tanzania AIDS was the Acquired Income Deficiency Syndrome (Setel 1999), and in Malawi *zomwezi* (the usual) or *matenda a boma* (the government disease) (Lwanda 2003, 113).
- <sup>8</sup> This combination of seemingly unrelated and often opposing phrases or objects to stand for the acronyms HIV or AIDS is reminiscent of Lévi-Strauss’s concept of *bricolage* (Lévi-Strauss 1966 [1962]).
- <sup>9</sup> The aetiology of *ku fa hi mbilu* shared similarities with a folk illness often described in the literature as nerves (Low 1985), and associated with headaches, dizziness, fatigue, weakness and stomach-ache, and as being generally associated with sadness, anger, fear, and worry and was more frequently a feature of females than males (Rebhun 1999b).
- <sup>10</sup> Most healers I observed requested patients to bring their own razors in the interest of preventing accidental infections.
- <sup>11</sup> A Mozambican refugee described another version of this. After the incisions were made a live chicken was placed inside a plastic bag and buried in the soil. The idea was to cause the suspected witch to choke to death.
- <sup>12</sup> Vaccination campaigns in various African contexts reveal the believed potency of injections (See for example: Feldman-Savelsberg et al. 2000; Samuelsen 2001).
- <sup>13</sup> In many contexts the diagnosis of life threatening disease is withheld from patients in order to protect the patient (Lupton 2003, 71).
- <sup>14</sup> In certain contexts words and naming have the power to harm and even spread misfortune (*xinyama*, lit. shadow or cloud) (See for example: Chapman 2006). Witchcraft could also occur through cursing and through talking. For example, I was often warned to avoid talking to strangers who may greet me and thereby steal my money using magic (*saramusi*). By opening the mouth the unsuspecting victim allowed the thief to transport the money into their pockets, replacing it with useless newspaper.

- <sup>15</sup> This refers to the practice of women making certain forms of knowledge of female physiology and reproduction secret in order to maintain control over this aspect of their lives, and exert some power over men (See for example: Browner & Perdue 1988).
- <sup>16</sup> This evokes the infamous scene from the film *Aliens* (Ridley Scott, 1979) in which an alien bursts out of the chest of one of the crew members.
- <sup>17</sup> A similar interpretation is offered by Jackson (2005, 332) who notes that in relation to chronic pain sufferers: ‘transitional states and ambiguous beings and objects, being neither one thing nor another, are disturbing and threatening; I argue that chronic pain sufferers’ liminal status invests them with similar threatening powers’.
- <sup>18</sup> Funeral ‘culture’ has been transformed in many settings from the high death toll due to AIDS (See for example, Kiš 2007).





**Picture 7: Mourners hasten to the graveyard – heads covered to show respect  
(Photo: Jonathan Stadler)**



**Picture 8: The hearse leaves the mortuary (Photo: Jonathan Stadler)**



**Picture 9: Witnessing a burial (Photo: Jonathan Stadler)**

## CHAPTER FIVE

### EVIDENCE: ACCOUNTING FOR THE EXISTENCE OF AIDS

If, as we have seen, AIDS is a concealed and secretive epidemic, how is evidence of the epidemic acquired; how is this communicated and what implications does this have for responses to the epidemic at the local level? As I observed in the previous chapter, AIDS talk is not completely silenced; coded references to the disease are made in everyday conversations, and most particularly in gossip and rumour. I suggest that the discursive forms of gossip and rumour construct a folk or local epidemiology of AIDS, and in so doing informs how people respond to the epidemic by creating categories of person that are believed to be likely carriers of HIV.

In the chapter I consider the ways AIDS is made known through semi-public, subaltern forms of communication. Although there is considerable social pressure not to talk about AIDS within public settings, ‘deep talk’ about the epidemic is contained within gossip and rumour. What I describe in the chapter as gossip or rumour can also be likened to ‘pavement radio’ as coined by Ellis (1989). He suggests that pavement radio thrives in communities where official forms of broadcast are censored or absent. These texts form an oral archive of the evidence of AIDS. They construct a type of ‘reality’ of the epidemic which is an alternative to public health propaganda. However, because gossip and rumour are vague and prone to exaggeration, the evidence they create are often disputed and challenged. In the chapter I suggest that the ‘private’ discursive domains of gossip and rumour, in contrast to the tacit censorship of AIDS, construct a local

epidemiology that identifies who dies of AIDS and why. I argue that these discursive forms are critical in informing individual and social responses to the AIDS epidemic.

In the chapter I draw on the idea of a local or popular epidemiology. In contrast to the ‘official’ epidemiology, local or popular forms are generated by people directly affected by a threat to their health. ‘Popular epidemiology’ in the literature is an alternative to conventional forms of epidemiology, is directed by non-professional community members and is usually linked to community activism. It emphasizes social structural factors in understanding disease spread and also counters the conventional understandings of risk. Examples include Lyme disease in affected communities in the US (Brown & Mikkelsen 1997; Clapp 2002).

The chapter starts by exploring anthropological approaches to gossip and rumour about AIDS and compares this to local constructs. It then goes on to show how these forms of everyday speech are critical in spreading information about the AIDS epidemic and in mobilising popular opinion as well as resisting official discourses of AIDS.

### **GOSSIP, RUMOUR AND AIDS**

Gossip and rumour are popular responses to social crises and calamities (Geissler 2005; Rosnow 1988; Turner 1993; White 2000). The AIDS epidemic is no exception; the shockingly high number of deaths from AIDS has created a crisis in meaning and signification (Treichler 1999). South Africa’s AIDS epidemic has been fertile ground for rumours about AIDS. An example is the ‘virgin cleansing myth’ that for some time was assumed to encourage child rape but for which there is little evidence either at the community level (Niehaus 2003) or from an official perspective (Jewkes et al. 2002).



Although AIDS poses a real public health threat, it is also a cosmological problem articulated in terms of familiar narrative frameworks such as rumour and gossip (Feldman-Savelsberg et al. 2000; Niehaus & Jonsson 2005; Pigg 2001; Smith et al. 1999; Stadler 2003a; Treichler 1999). For example, conspiracy theories about AIDS as a form of state-sponsored genocide, provide a ‘means for people to make sense of political or economic conditions’ (Butt 2005, 413), and articulate a counter discourse of blame (Farmer 1992). In Indonesia, rumours about purposeful HIV infections through contaminated needles reflect fears about the vulnerability of the individual and social body, the need to be vigilant about protecting it, and the potential for misuses and abuses by hostile forces (Kroeger 2003, 244). In South Africa, accounts of child and / or virgin rape as a cure for AIDS shares distinct metaphorical resonances with folk concepts of health and cleansing (Leclerc-Madlala 2002), but also creates moral panics about uncontrollable male sexuality. Research conducted in Bushbuckridge highlights the gendered concerns expressed in rumour: women accuse envious nurses and men for the spread of AIDS, while men tend to spread rumours that contain theories of AIDS as a conspiracy. Women’s ideological association with the domestic domain and men’s experiences with job losses and deindustrialisation in a global labour market account for these gendered differences (Niehaus & Jonsson 2005).

Public health writings tend to problematize gossip and rumour as an ‘information gap’ (Geissler & Pool 2006), and therefore a barrier to prevention<sup>1</sup>. Yet, ‘rumours are more than just wrong or incomplete information; they are socially constructed, performed, and interpreted narratives, a reflection of beliefs and views about how the world works in a particular place and time’ (Kroeger 2003, 243). Moreover, they are not

simply conventional storytelling, but powerful discursive practices (White 2000). For example the rumours surrounding medical research can be regarded as local level discourses about bioethics and the treatment of trial subjects (Geissler & Pool 2006).

Because it is almost impossible to trace the source of gossip and rumour, and control its flow (Andreassen 1998, 41), it can also be a potent form of hidden retaliation. As Besnier (1994, 4) puts it, the gossip narrative can be a 'prime site of political resistance' due to its 'mundane setting and apparently innocuous nature'. Butt (2005) notes that gossip and rumour operate as 'collective imaginaries reacting to experiences of inequality', and technological transformations and modernization. They are therefore an important part of local cultural social practice that become powerful 'weapons' at times of severe suffering or perceived threats (Butt 2005, 414-415).

Gossip and rumour may claim to be true, but are not always believed unequivocally (cf. Turner 1993); they can be challenged and disputed as quasi-factual accounts to be regarded with scepticism (Geissler & Pool 2006; White 2000). However, the absence of truth is not what is important about gossip and rumour (Besnier 1994). What *is* important is that the story is deserving of retelling, as it resonates with local sensibilities, experiences and ideas.

Gossip and rumour may be distinguished according to who participates in telling the story. Rumour usually encourages broader participation in the narration and construction of narratives, while gossip is more exclusive. Who one gossips about and who participates in the gossiping reflects and reinforces social networks and relations. Gossip is an exclusive discursive practice that delineates boundaries of belonging and group membership and refigures social relationships, through a process of exclusion and

inclusion (Smith et al. 1999). It reflects and recreates social tensions, alliances and divisions within particular social contexts. Gossip talk is used to maintain boundaries, reinforce cultural identities, and create a sense of social cohesion (Gluckman 1963).

### GOSSIP AND RUMOUR: LOCAL PERSPECTIVES

Contra to the literature, my informants expressed a distinction between gossip and rumour. Gossip is described by the verb *ku hleva*. Literally translated this means to ‘to tell a secret’ that is told in confidence. Rumour is a type of story that goes around from person to person, described by the term *maveriveri*, a phanopeia that evokes the image of randomness. In practice however, gossip and rumour are difficult to distinguish.

Gossiping and rumour-mongering are potent discursive practices in Bushbuckridge. In particular, gossip and rumour plays a significant role in negotiating the identity of witches. Verbal statements are used as evidence in suspicions of witchcraft (cf. Niehaus 2001, 116). For example when a man’s daughter died, he accused his neighbour of witchcraft. Giving evidence at the court of elders (*bhandla*), he reported that the week before his daughter became ill and died his neighbour had responded to his greeting with the words: ‘We cannot complain because we will all die anyway’. These words were evidence of his malevolent intent. In a separate case, a woman lost two sons and her daughter-in-law when their car was hit by a truck on the main road leading to Nelspruit. At the funeral she was heard muttering the words ‘soon we will all be equal’. These words were recalled when the father of her daughter-in-law was killed one night while returning home after drinking, and in quick succession his daughter died the next week after a brief illness. My informants pointed out that these deaths equalised the deaths of



her two sons, just as the bereaved woman had foretold and were evidence that she used a magical form of retribution.

Gossip and rumour are also powerful weapons used against people who shirk good neighbourliness and common decency. For example, residents of one of the neighbourhoods where I hung out often gossiped about Lindiwe, a young woman who displayed excessive pride. Lindiwe was scornful of her poorer neighbours; she scolded little boys who scavenged in her rubbish dump for stale bread and rotten meat and reprimanded a neighbour who wanted to use her fence (itself a symbol of her aloofness) as a washing line. When her wealthy, older lover died in a car accident it was widely rumoured that Lindiwe had used magic to kill him for his money. Villagers lined up to visit her home, mostly to view the expensive bed Lindiwe's lover had purchased for her. They stood outside in the yard, talking about her. The following exchange took place between two neighbours:

Neighbour 1: Ooh! Lindiwe has roofed her house! Did you see the bed – it has mirrors?

Neighbour 2: She really knows how to use her *masenge* [genital area]. If it was not for her, her mother would not manage to support [herself].

Neighbour 1: The day they kill her, her mother will shit in her pants and faint, because no one will help her going around looking for men.

In this exchange the gossipers blatantly (and crudely) state that Lindiwe was a prostitute who used her body to buy commodities and luxuries (a decorative roof and a bed with mirrors). There is also the suggestion that Lindiwe had angered people; her lover was the father to several adult children who expressed their dislike for Lindiwe on

several occasions. Many residents shared similar sentiments about Lindiwe, and her sexual conduct was the subject of many conversations. As time passed she gradually lost the support of former friends and neighbours and became more secluded. As she no longer had access to an income from her deceased lover, Lindiwe fell on hard times. It was rumoured that she had fallen pregnant with a new partner in order to access the child support grant.

Owing to the public nature of peoples' private lives, secrets are extremely difficult to keep; my informants were often able to provide extremely detailed information about the most intimate aspects of other peoples' lives. Therefore, although gossip was highly secretive and restricted, it was always possible to eavesdrop on secret conversations. For example parents and elders often try to prevent young people from listening in to their conversations. However, children are often invisible, as a young girl noted: 'You know on the road when people come back from work they talk to each other so we can listen'. A man and his lover had sex in the dense bush surrounding the village. A young boy saw them having sex and stole their clothes. The naked couple tried to run back to their respective homes without being seen. My informant who recalled this story remarked: 'there is nothing you can hide in the village'.

While gossip is a potent discursive practice, participating in gossip is also a risky business. Spreading gossip about powerful individuals can result in reprimand and punishment, if the source of the gossip can be identified. For example, a local shop owner punished his employee for spreading rumours of his involvement in a ritual murder by dragging him down the road tied to a cow. An elderly man became inebriated after

drinking traditional beer and gossiped with his fellow drinkers about the identity of a witch. A few weeks later he was found dead, apparently poisoned.

Known gossipers (sometimes called ‘Mrs Gossip’ Zulu: *Nwamgobozi*) enjoyed the power of gossip over others; yet this was often short lived. Gossipers were scorned and derided when they themselves experienced misfortune and became the object of gossip.

One case comes to mind. Dyondzeka and Eunice attended university together, both studying for the same degree. Whereas Eunice studied hard and achieved her degree after four years, Dyondzeka was not as successful and dropped out. She presented her parents with a fake degree certificate. Both women had boyfriends. Eunice had a child with Mondli who was employed with the South African Police Services. She visited him frequently in Hammanskraal near Pretoria and always returned with new clothes. Dyondzeka was jealous of Eunice. Her boyfriend was unemployed at the time and she seldom purchased new clothes. She would gossip about Eunice saying things like ‘She thinks she is a madam’. A year after Eunice’s child was born, Mondli broke up with Eunice; he had started to have affairs. Dyondzeka befriended Mondli’s girlfriends and always made sure she had an opportunity to gossip about Mondli’s ex – Eunice. When Mondli’s sister died, Dyondzeka attended the ‘after tears’ party; Eunice was not invited. Dyondzeka’s fortune changed and she was married in an ostentatious ‘White Wedding’, symbolising her husband’s commitment to her. Now employed, her husband built her a house and purchased furniture and a used car. Years later, her husband was discovered cheating on Dyondzeka. Eunice commented ‘I thought he was committed to him – they had a White Wedding. She laughed at me when I broke up – you really shouldn’t laugh at

others' misfortune'. Dyondzeka went into virtual seclusion, conscious of the stories circulating about her situation. Many recalled the fact that Dyondzeka had spoken cruelly about Eunice.

## **CONSTRUCTING A POPULAR EPIDEMIOLOGY OF AIDS IN KWABOMBA**

I suggest that it is useful to regard narratives about sexual relationships and AIDS contained within gossip and rumour as constituting a 'folk' or 'popular' epidemiology. Popular epidemiology is distinct from its 'professional' counterpart, derived from different sets of signs and indicators. The orientation is local, based on a 'local knowledge' (Geertz 1983) of illnesses and personhood. For example, in their analysis of infant mortality in the Brazilian northeast, Nations and Amaral (1991) distinguish between the 'official infant mortality rate' and the 'popular or culturally construed meaning of death'. Yet, both professional and popular or 'folk' epidemiology are cultural constructs (Setel 1999) located in specific historical, cultural and political contexts and possess social and cultural dimensions (Lupton 2003).

The concept of a 'popular epidemiology' appears prominently in Setel's (1999) ethnography of AIDS in northern Tanzania. In particular, Setel takes note of the disjuncture between anticipated facts about the epidemic contained within professional narratives of AIDS, and the lived experience of people infected and affected by AIDS; the popular epidemiology. This difference, he suggests, exposes contradictions in the idea of individual risk; for instance, individual conduct that exposes people to HIV but who remain untouched by the disease. A 'popular epidemiology', this implies, is an attempt to comprehend and deal with the ambiguities and paradoxes of risk.

My research endorses other researchers' findings that AIDS is often interpreted in terms of folk afflictions and aetiology but seldom as witchcraft. (Heald 2002; Ingstadt 1990; Niehaus & Jonsson 2005) (See Chapter Seven). My informants defined AIDS clearly and unambiguously as a disease of the blood (*vu vabya wa ngati*) spread through unprotected sex, or contact with infected blood for example in a motor car accident<sup>2</sup>.

While the path of HIV infection is unambiguous, the symptoms of AIDS are not. My informants expressed considerable confusion regarding the symptoms of AIDS, as this young man said:

They can say in KwaBomba that there are a lot of people with AIDS but you don't know who they are – you just see people getting thinner. You don't know that it is AIDS – some die, some don't die.

And, quite accurately, an elderly woman observed that there were many symptoms of AIDS:

There are different symptoms that go *hambana, hambana* [around and around]. Some people say 'sores', others say 'it is a rash'. Other people get so confused they don't know what to say anymore.

She suggested that the Department of Health provide photographs of people with AIDS to resolve this confusion. The symptoms of AIDS are also muddled with other diseases. Most frequently, AIDS is confused with *tindzaka*, an affliction caused by sex with a person who is in a state of pollution, for example during mourning prior to undergoing ritual cleansing (*machiyiwani*). The main symptom of *tindzaka* is a perpetual cough, abdominal swellings, fever, and wasting; if untreated this can be fatal. The similarities between AIDS and *tindzaka* are so pronounced that it is difficult to

distinguish between them. A teacher at a primary school said he was unable to make up his mind whether his neighbour had died of *tindzaka* or AIDS<sup>3</sup>.

At the hospital they said it was AIDS. People here [in the village] said it was *tindzaka*. I am confused – I cannot tell if you have AIDS or *tindzaka*. The symptoms are the same.

As these comments demonstrate, there is limited consensus regarding ‘who dies from what’, based on reported and observed symptoms.

A social diagnosis of AIDS is made by the ‘manipulation and interpretation of a different, though no less real, set of signs’ including health education messages, rumours and gossip, and ideas about moral character (Setel 1999, 185-186). As Taussig (1980) notes, the symptoms of disease are not solely biological and physical, but are also ‘signs of social relations disguised as natural things’ (Taussig 1980, 3). The ‘language of illness’, usually suppressed and denied in professional biomedical accounts, are foregrounded in the way patients talk about their illnesses (See Kleinman 1988)<sup>4</sup>.

The popular epidemiology I encountered in KwaBomba constructs categories of person who best fit the idea of AIDS, and draws on ideas about ‘good behaviour’<sup>5</sup>. When a young woman died her neighbours debated about whether this was caused by AIDS. The words of her former school teacher are revealing; he argued that ‘poverty and low standards of hygiene’ had caused her death, that she was ‘still too young’, ‘behaved herself’ and ‘never went to taverns’. However, he admitted that there may have been aspects of her life about which he was unaware, and remarked ‘Maybe there was something I did not know about her’. In another example, a mother of two who died from a disease that ‘looked like AIDS’ was not identified as having died from the disease.

According to her neighbours she ‘behaved herself, never had affairs’. Gossip was therefore central to making a social diagnosis of AIDS as a cause of death.

Gossip about AIDS often had its source in the conversations between nurses who worked at the hospitals and clinics. A young woman noted how gossip about AIDS flowed from these sources:

Some nurses at the hospital are not only friends with the nurses from the hospital, they are friends with the other friends, they gossip with those friends, that gossip will be taken all around until it is spread all over.

Funerals were another source of gossip about AIDS. Private conversations ‘in the corners’ of the funerals speculated about AIDS. For example, after the funeral for a young woman, conversations focussed on her frequent trips to Randfontein. Ntwanano Shabangu was born in 1975 and died in 2003, on 22 June. Dike, a young man and Ntwanano’s neighbour grew up with her and knew her very well. He recalled that she was a really good looking, ‘grand young lady’. Ntwanano’s father was a retired security worker for Five Roses Tea in Isando on the East Rand of Johannesburg. Her mother was unemployed and she had two older brothers who were employed. The other two sisters and two brothers were still at school. Ntwanano’s mother and father separated when Ntwanano was fairly young and her mother travelled to Randfontein in the early 1980s to find part time work selling fruit and vegetables and second-hand clothes (See Chapter 2). The family was not extremely poor, although the father had a reputation for drinking his income away. In 1995 when Ntwanano was in her early twenties she started to have numerous lovers. She also started to make regular trips to Witbank. A female school friend talked about her:



She would go to many different places. She was selling her body to anyone who wanted to have sex. Because she was really good looking she would get picked up by truck drivers. She was not satisfied at home. She wanted to get something by herself. She would go for two weeks at a time or even for the entire school holidays. At first she would only go during the holidays but when she started to prostitute herself she would miss school to go to Johannesburg.

Based on the gossip about her from her neighbours and friends Table 6 describes Ntwanano's sexual partners. These descriptions draw attention to specific categories of employed men who are often suspected of being infected with HIV: labourers, drivers, teachers, and men with money.

**Table 6: Ntwanano's sexual biography**

<b>Sexual partner</b>	<b>Description</b>
School boy	Ntwanano's first boyfriend. They met at school.
Labourer	A young married man from Edinburgh. Employed with the Department of Water Affairs. Fathered Ntwanano's first child.
Criminal	A young man who died in a shoot-out with the police in Soweto.
Unknown man	A stranger who drove a Toyota Tazz and only visited late at night.
Truck driver	A middle aged man employed by Mayinga Stores often stopped overnight at Ntwanano's homestead.
Truck driver	A youngish man who worked for a cold drink distributor and whose truck was seen parked over night at Ntwanano's homestead
Teacher	A teacher, who died at 31. He was married for a year but fought constantly with his wife. Described as a drunkard. He dated Ntwanano
Teacher	A stranger from another village
Wealthy man	A young man from Merry Pebble Stream village. His family was wealthy and he owned a luxury car. The relationship lasted until Ntwanano fell pregnant for the second time and he refused to accept the pregnancy.

Gossip about AIDS was in some respects more fearful than the disease itself. Although uttered in private spaces, gossip has potentially devastating social and public consequences. Gossip about AIDS can transform status, spoil identity and destroy

relations, and contains the potential to inspire ‘moral panics’. However, it is not just what is said but the fact that a person is the topic of gossip that is damaging.

Yet, gossiping about topics such as AIDS carries with it the insinuation of complicity. Those who gossip risk being accused of ‘knowing too much’. McNeill (2007) uses the term ‘degrees of separation’ to describe the strategy of avoiding insinuations of personal culpability and involvement. It is critical then that gossip is indirect and relies on insinuation. This is very apparent in gossip about AIDS that is characterised by ambiguity and hidden in carefully coded references. This is nicely illustrated in the following reconstructed conversation between two women:

1. Abigail: Where is Morgan’s wife?
2. Dorothy: She is sick
3. Abigail: Why, what’s the matter?
4. Dorothy: Don’t you know that Morgan used to go around with another mistress [female teacher] at Songeni [primary school]
5. Abigail: No!
6. Dorothy: Did you know that she died?
7. Abigail: No!
8. Dorothy: Yes, it seems like now the wife is starting to be sick as well

This brief exchange begins with an innocent enquiry about the whereabouts of Morgan’s wife (line 1). However, the question is loaded with meaning, partly because it insinuates that she is not where she should be, and because it creates a sense of mystery about her<sup>6</sup>. In the exchange Dorothy reports that Morgan’s wife is ill (line 2), and without specifically mentioning it, suggests that this could be AIDS by referring obliquely by using the phrase ‘go around with’ to refer to her husband’s affair with a female school teacher colleague of his (line 4) who recently died (line 6). Although their dialogue does

not make direct reference to AIDS, Dorothy's statement at the end 'it seems like now the wife is starting to be sick as well' (line 8) strongly suggests AIDS could be the cause.

Paradoxically, by *not* mentioning the cause of the illness, the exchange between the two women draw attention to the secrecy of Morgan's wife's behaviour, therefore insinuating that she had something to hide, which in this context could only mean AIDS.

In the next example, two young women talk about Poppie, a woman of the same age who was rumoured to have died from AIDS. The disease is mentioned by name, yet this is only once the first speaker has provided a list of symptoms to assert that this was the case.

**Woman 1:** Poppie was running around with many men. There was a time she became really sick. They took her to the doctor when they came home with her she started vomiting and had non-stop diarrhoea until the mother and father took her to the hospital. That time she was pregnant. When it came time for her to deliver and she had her baby. After that she became worse and worse ... for about two years. She ended up dying at home with her parents. She left her baby and he does not seem healthy; in fact he may have died.

**Woman 2:** The father of the baby also died. They buried him last week. They did not say anything at the funeral about the cause of death. But people will know that it was AIDS because some went into the house and they saw the body and when they come out they were saying that the body was very thin and very small

An important aspect of gossip about AIDS is the construction of evidence through narration. As the excerpt above demonstrates, certain pieces of information are conveyed that establish the evidence for AIDS. Interestingly, the account begins with the statement 'running around with many men' that allocates personal culpability toward Poppie having multiple relationships. It proceeds to list physical symptoms and then the possible source of infection (the father of the baby) and its consequences (the death of Poppie's child).

Similar aspects are noted in the next account, an extract from a conversation between Mathews, a school boy and his older friend, Mandla, about Smekie Mathonsi.

**Mathews:** I was visiting my girlfriend. I met one boy. He told me Smekie is dead. So he explained she was killed by AIDS. So I said ‘Why do you say that?’ He said ‘She was sick for a long time and her hair looked very thin and her body was thin’. So this is the thing. So when I go again I met another person. She told me that Smekie was dead. So I said why. So she said she was killed by AIDS. So I asked why do you think that [she died of AIDS]? That girl said that Smekie was a prostitute girl...the girl said she was warned to stop prostitution but she never listened. (...) I believe it because I knew her. I told Mandla. I said to him there is a girl who is dead and many people say she died from AIDS. So maybe it is true, I don’t know.

**Mandla:** I said I can believe this because it is a girl I know and she is a very big prostitute and she is the kind of girl who goes to shebeens and she hangs out with the guys who have cell phones or maybe a car and so she was that kind of a girl. So I believed it.

Interestingly, these accounts refer to physical symptoms, body shape, but also to types of men (who have cell phones and cars) and places (shebeens) that are associated with the spread of HIV. This statement acknowledges that AIDS is a mobile disease, and one that spreads within a context of inequities and desires for luxury commodities.

The examples of gossip in the preceding paragraphs are about named individuals. Yet there were other forms of gossip that referred more generally to people whose identity was not clearly stated. These formed moral narratives about young women and older men in general.

## WOMEN WHO BUY THEIR OWN COFFINS

Young women who die of AIDS were often called ‘prostitutes’ (*magosha* or *isifebe*) and ‘loose women’ (*n’gwadla*). In the gossip that surrounded their deaths, they

are symbols of unrestrained female sexuality (cf. Fordham 2001). They attract a moral critique that focuses on their desires for luxuries, commodities and cash. These narratives also reflect a concern with the transience of money. Unlike money that is generated through hard work and labour, ‘easy money’ transacted through sex is corrupt<sup>7</sup>. Money has a dual moral significance: money that is earned through hard work and labour can sustain the future of the household. In contrast cash that is transacted through sex deprives another woman and her children of her husband’s earnings. Such money is ephemeral and cannot last. It is called the ‘money of tears’; the sadness that is caused by deprivation undoes the worth of the money.

This sentiment is summed up in the rhetorical statement ‘buy your own coffin’, the idea being that women who think they are acquiring wealth, are deluded and instead acquire AIDS. For example I was told about a cleaner, employed by a game lodge, who had sex with an American tourist for R2 500. The next day the tourist handed the woman a suitcase full of money, and told her ‘You now have AIDS ... take this money and use it to buy your coffin’<sup>8</sup>.

This story is a moral text about the pursuit of wealth and the erosion of sentiments of kinship and neighbourliness. Funerals and the rituals surrounding death are key events in village social life; in certain respects the funeral is the quintessential ritual in lowveld culture: failure to regularly attend funerals risks being ‘buried alone’. Coffins are extremely expensive and usually financed by the broader family or community. Families who are too poor to afford coffins evoke pity and sympathy and sometimes neighbours and kin make voluntary donations to purchase a coffin. Even those with small irregular incomes join burial societies and schemes. Participation in burial societies is not only a

question of financial contributions, but is a fundamentally social act necessitating attendance at members' funerals and sharing in the preparation of the feast. In contradistinction, to 'buy your own coffin' is a potent statement of the rejection of kinship, good neighbourliness and sentiments of reciprocity.

The second version of this story is woven into local witchcraft beliefs. In the story, a young woman in her 20s meets a wealthy, older man. He is extremely charming and takes her to good restaurants, buys her clothes and always drives her everywhere she needs to go. He does not demand anything from her except to visit his parent's home. The man asks the girl to enter a huge hut. It is pitch black inside as there are no windows. He tells her to sit quietly, to remain still and whatever happens not to scream. He closes the door. The hut is dark and quiet. She then hears something moving and feels something touching her. Suddenly something is sucking her breasts. But she remains silent as the man instructed. Her breasts are continuously sucked for hours and hours until she feels weak and collapses. Eventually the man opens the door to the hut. He says 'you are now dead, you will die'. He gives her a briefcase full of money and says 'this is for your funeral, take it and use it to buy a coffin'. He then drives her home and takes her to her parents. He gives them the money saying 'bury your child'.

This story was related to me by a young woman who works in a hairdressing salon in the upmarket suburb of Rosebank in Johannesburg. The account resonates with rumours of witchcraft familiars that drain the blood of humans and thereby create wealth for their owners (See Chapter 7).

## INFECTED CONDOMS AND DYING WITH OTHERS

This section discusses two rumours about AIDS. The first concerns a widespread narrative about the presence of HIV in Government Issue condoms. The second, the spread of HIV through purposeful infection by HIV carriers who do not wish to die alone.

In 2003, the following report appeared in the *Mopani News*:

### Aids rumours dismissed

Rumours that some doctors working in private surgeries are spiking medication with HIV/AIDS infected blood in order to panic unsuspecting patients are spreading like wild-fire in the Greater Bushbuckridge area. Traces of 'live' or 'dead' worm-like creatures are said to have been spotted in some medications (Matlala 2003 )

This was not the first time I had heard about worms found in condoms. Indeed, the notion of HIV infected condoms was fairly widespread, not only in Bushbuckridge (cf. Epstein 2007). Rumours about condoms are often dismissed as 'myth' (Versteeg & Murray 2008), reflecting fear and doubt (Campbell et al. 2007). McNeill (2009) argues that the close association of condoms with AIDS underlies this rumour. I suggest that the rumour has different meanings depending on who is doing the telling. Moreover, as a rumour, it is not always unequivocally accepted as 'true', but has broader social and political meanings.

The first time I encountered the rumour a group of young schoolboys told me about the appearance of worms which they thought were evidence of HIV inside an unused condom. They told me how a boy they knew but would not name filled a condom with tap water and exposed it to sunlight. After a short while 'tiny worms' could be seen suspended in the water. One of the young men performed this procedure for medical staff



at Tintswalo Hospital. The doctors inspected the condom using a microscope and confirmed the presence of HIV. My friends were curious about the experiment and agreed they would withhold judgment until they had tried it for themselves. I asked them why, if it was indeed true that condoms were infected with HIV, would anyone want to spread HIV in this way. They replied that this was done purposefully in order to infect black people with HIV:

...they said that the doctors ...who made the condoms and gave them away for free...wanted people to get disease from those condoms. So even myself should I prove it and come to find that they were telling the truth I am sure I am not going to use a condom.

The story achieved popularity, not because it was utterly believable, but because like most conspiracy theories it successfully challenged authority, in this case scientific authority and appropriated scientific apparatus (the experiment and the microscope) to do so. The rumour also resonates with young men's ambivalent experiences and perceptions of condoms. The condom is the only way to prevent HIV; yet it also effectively prevents reproduction, and the exchange of fluids during sex (cf. Taylor 1990), rendering men virtually impotent. This is perhaps why men compared using a condom to 'throwing away your future children'.

The rumour of the virus in the condom reflects a creative form of resistance against government health messaging that urges condom use, frequently providing little in the way of alternatives. Importantly, the rumour was most popular amongst younger men, those targeted by condom promotions and whose 'irresponsible behaviour' was seen to be behind the spread of AIDS. In contrast, younger women that I spoke to about the

rumour disputed it. They argued that young men promoted the story because they simply did not want to use condoms. This was an excuse not to have to put on a condom.

## **RUMOUR AND MORAL PANICS**

In August of 2002 a notice stamped with the official Department of Health logo, was displayed on the walls of the health centre. In bold capital letters it declared:

**TO: ALL THE COMMUNITIES OF THULAMAHANSHE**

**BEWARE OF BEAUTIFUL LADIES WHO ARE HIV POSITIVE. DO NOT GIVE THEM LIFTS IN YOUR CARS!!!!**

Photocopies of the notice were distributed to taxi drivers and motorists. A similar warning was broadcast on the community radio station Radio Bushbuckridge.

Residents of KwaBomba speculated that the warnings referred to young women who pretended to hitch rides to Thulamahanshe, but were really looking for customers to pay them for sex. NwaMbembe, a domestic worker in Hoedspruit, claimed that she recognised two young women referred to in the public notice. She elaborated:

Now it is hot so you won't find them next to the road, but when the sun goes down and if you drive a car on the road you will find them next to the road, and if someone stops the car they will just get in the car because they don't know where they are going to sleep...they walk the tarred roads waiting for these guys.

Her words had a sinister ring and suggested that this was no ordinary prostitution. The true intentions of the young women who stood by the road were suggested by other accounts; these speculated that the women intentionally spread HIV. Charlie aged 29 corroborated this view:

A girl from Ludlo village has been seen hanging around Maganga Bottle Store in Thulamahanshe. People are aware that she has HIV. They also know that the purpose of her hanging around is to pick up men and to spread HIV to them.

Mandla – a young unemployed man – told me about Comfort Ndlovu who worked for the Bushbuckridge Water Board. Comfort was seen ‘proposing love’ to one of the young women at Ximambane’s, a tavern in KwaBomba. Later Mandla heard rumours that Comfort was infected with HIV. ‘I cannot sleep with any girl that Comfort has slept with because he slept with the one who is spreading AIDS so maybe now he has AIDS’ he remarked.

In another version the young woman was rumoured to have spread HIV amongst the school boys at a local high school. According to MaSeerane, a school teacher, the woman proposed to the young boys but refused to use a condom. ‘Several boys slept with her and they are now HIV’ MaSeerane asserted.

In the following version of the rumour, a young woman returned from Johannesburg, infected with HIV. A male informant picked up the story from his drinking companions:

There is a young woman who is from Oak Town [a township] and she went to Johannesburg to do *ku pirates* [to trick men to have sex with her for money]. She went for a test in Johannesburg and they told her she was HIV positive. She decided to come back to Bushbuckridge. She hung about at night at the KwaBomba Bottle Store and then sleeps at KaZitah Village, and then during the day to PW Mnisi High School. She hangs out there [at the school] for two or three weeks during lunch times. The boys would propose to her. The first night one boy would take her to his place. The second night another boy would take her to his place and so on. She slept with five boys at PW Mnisi High School. After that she moved to KaManzini to Shongwe High School. She did the same thing there for about two weeks. She slept with eight boys there.

One of the boys realized that something wrong is going on. She then went back to Buck Town where she met a guy called Frans. He took her to his place. When

they wanted to have sex Frans said ‘I am using condoms’. The girl said ‘no you are not using a condom with me’. Frans said ‘if you don’t use a condom I do not want to have sex with you’. She said ‘okay, you can sleep over there without having sex with me’. This guy suspected something and started to question her. ‘Why don’t you want to use a condom?’ She wouldn’t tell the truth but he realized that there was something wrong with her. The following day she woke up and left. Meanwhile the Radio Bushbuckridge was announcing that the police are looking for a young woman who is dressed in a particular way. If anyone sees her they must come and report this to them. They also said that she is HIV positive and is going around to the schools and sleeping with the young men from the schools. The police went to the KwaBomba Bottle Store and hung out there in plain clothes. Someone pointed out the woman to them. One police man went to her and proposed to her. She agreed and they went to the car. When he got into the car he took her straight to the police station. They questioned her and she told them the entire story and they say she is still in jail at this moment. They even announced in the radio that she has been found and arrested.

The rumour depicted the young women moving around from place to place infecting men, a metaphor for viral spread. This had the makings of a ‘moral panic’. La Fontein usefully defines moral panics as ‘the construction of a social problem as something more serious than the routine issue of social control’ (La Fontein 1998, 19). Fordham notes that moral panics centred around prostitutes ‘whose unrestrained sexuality clearly marked them as contravening the behavioural rules for good women’ (Fordham 2001, 260).

This idea of intentional infections was not unfamiliar to my informants who recited the slogan ‘infect one, infect all’ and a belief that HIV positive people infected others to avoid dying alone (cf. Leclerc-Madlala 1997). Yet, these rumours also had a powerful effect on individual perceptions of their capacity to avoid infection. A young man told me he had tested negative, but had little hope of maintaining his status because it was only a matter of time before someone purposefully infected his girlfriend. However, other responses were more decisive. An older married man proposed that villagers form a ‘committee’ (posse) to track the girl down, kill her and present her

corpse to the police. Another said he would personally tear her body apart and throw the pieces in different directions in the same way as she spread the virus.

At the time when this rumour was doing the rounds the KwaBomba muchongolo dance troupe composed a song that warned men to stay at home and to avoid women who spread AIDS:

**Tshikani ku yendla vavanuna (Stop moving with women, married men)**

<i>Vata ku dlaya nwa 'ananga</i>	They will kill you my son
<i>Tshikani ku yendla vavanuna vavansati va dlaya</i>	Stop staying with women, men, women can kill
<i>Ami swi voni leswaku se ma hela hi</i>	Can't we see that we are getting finished with
<i>Vuvabyi bya HIV AIDS la ha andel naa</i>	the disease called HIV AIDS out there?
<i>Vuyelani amakaya mi nga si hlangana na xifu xa</i>	Come back to your family before meeting the
<i>masiku lawa lexi vango i AIDS.</i>	death of nowadays that they call AIDS

In these texts blame is articulated in terms of young women's bodies that circulate intentionally spreading HIV. It is not improbable that infections are spread intentionally, or knowingly, as a few cases reported in the media have suggested. Yet, these narratives can also be regarded as moral critiques of the ways in which women use their bodies.

Flominah Khosa was 19 years old and had left school without completing her final year. She resided with her parents in KwaBomba but changed residence fairly frequently, moving into different men's houses. The young men I spoke to remembered her as 'a beautiful young woman who would sleep with drunken men for only two Smirnoff Ice [vodka and lemonade mixer]':

She did not want to die alone. Before you can sleep with Flominah you have to buy her delicious Sunday food. That is all she needs to stay fit and healthy. She is not looking for money – she only wants food. She is doing this just to spread the disease. She doesn't want to die alone – she wants to die with many other people.

Towards the end of 2004 Flominah was identified publicly as a threat to the communities of Riverdale and KaManzini; community members threatened to chase her away as they feared she was infecting male residents with HIV. My informants provided conflicting accounts of how Flominah became infected. According to one, Flominah was first infected after having sex with a number of policemen, one of who was married to a woman who was suspected to be HIV positive. Another theory is that she had contracted HIV after having spent some time in Randfontein where she sold sex to mine workers. Locally, she was rumoured to have had an affair with a teacher who was suspected to be ill with AIDS in 2001. He slept with Flominah when she was still a school student. Another teacher met Flominah at a tavern in KwaBomba. When he discovered that she was HIV positive he was extremely frightened but according to his friends showed no signs of having been infected by HIV. Another lover was in his late 50s and also a teacher at the KwaBomba High School. He was also the chair of the Community Policing Forum. His affair with Flominah Timba was common knowledge to young and old in KwaBomba as he had boasted once that he had had sex with Flominah but had used a condom. Yet, according to rumour he had recently started to appear ill. 'He is he is not looking that great, his body is not looking good. Flominah infected him. He is going soon' remarked a fellow member of the committee.

A young man, who had been studying law in Johannesburg, also had an affair with Flominah. He was known to have had sex with two teachers from KwaBomba who were suspected to have AIDS. He was also known to have a regular sexual relationship

with a woman in Tzaneen and another woman who regularly travelled to Johannesburg and had sex with men there. My informant continued to relate the story:

She also had several teachers who were her boyfriends. We used to see several men who would come looking for her. She went to taverns a lot on weekends. People used to say ‘she will get something from outside and give it to the local boys’. She would hang out with men who were not known. They will end up stealing or killing somebody and the problem is that we do not know where they are from’. Sizwe told her to stop hanging around with men: ‘get your own boyfriend – you are bringing too many outside men in here – they are harassing other people and they are causing problems’. People were cross with her. They said that she had increased the number of people who are HIV positive in KwaBomba. And because she told people that she had AIDS she contributed towards the awareness that people had that many people in KwaBomba were HIV positive.

Through gossip, it was possible for neighbours and fellow villages to construct a sexual biography of those people who they suspected of dying from AIDS. In some cases this informal knowledge was used to avoid infection by avoiding particular individuals. In others potential threats to the community were acted upon.

## CONCLUSIONS

This chapter has described how the AIDS epidemic was constructed in KwaBomba through gossip and rumour. These texts invest AIDS with meaning, and thus to a certain extent, attempt to ‘control’ it (Treichler 1999, 5), simultaneously rejecting a notion of risk that is based solely on ‘individual irresponsibility’. The local, popular epidemiology that gossip and rumour creates can be regarded as a struggle between local and official accounts of the epidemic over who has the authority to define risk and create categories. Balshem (1991) argues that a working class community in the US with high levels of cancer, rejected being ‘blamed as victims and targeted for education’, and



responded ‘with a critique of their own’ . And, Farmer’s ethnographic treatment of AIDS in Haiti shows how Haitians rejected dominant discourses and classifications of AIDS as a ‘Haitian disease’.

The material presented here suggests that rumour and gossip are powerful channels through which people talk about HIV/AIDS. They create debate and dialogue in an otherwise silent epidemic. Gossip provides an arena in which the symptoms and causes of AIDS are talked about using ‘local frames of reference’ (Pigg 2001, 509), unlike more formal educational settings, such as workshops, that may mute expression. Rumour and gossip are also powerful media through which information about HIV/AIDS can travel.

But it may also be that the epidemic is just so incomprehensible that we are unable to talk about it, to render it meaningful in any way. This is not simply denial of the facts of AIDS, but reflects the incapacity to comprehend the extent of the illness and death that AIDS has brought. I have suggested that the popular epidemiological handling of AIDS morbidity and mortality have attempted to move beyond the bare statistical representations of the epidemic, to uncover the underlying social, political and economic dynamics of HIV infection.

A last point needs to be made about the contrast between professional and popular epidemiological evidence. As noted earlier, both are culturally constituted, that is to say are derived from particular social and historical contexts and can be seen to be socially constructed (Setel 1999). In the world of AIDS research, the one – based on ‘hard data’ is given primacy over the other, often labelled ‘anecdotal’, myths, or rumour. The problem, as Allen (2006) writes is that these less easily quantified and enumerated textual accounts

of AIDS are ‘set aside as perhaps interesting, but largely irrelevant when it comes to policy’. This seems odd when the very nature of the evidence is based on peoples’ self-reports of their most intimate experiences (Allen 2006, 8).

The rumour and gossip accounts described in this chapter are in many ways similar to those that concern witchcraft. Indeed, information about witchcraft is often spread through gossip and rumour. Furthermore, the accounts of AIDS spread resonate with witchcraft beliefs. To what extent discourses of AIDS and witchcraft are similar is discussed in detail in the following chapter.

## END NOTES

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<sup>1</sup> The public health discourse of rumours as barriers to adherence and healthy behaviours (For example regarding adherence to contraception see DeClerque et al. 1986) continue to prevail in AIDS research for example the need to rectify and challenge ‘myths and misconceptions’ of AIDS beliefs (Bastien et al. 2008).

<sup>2</sup> A group of school children grilled me about the various paths of HIV infection. Having sex with a dead person who had HIV and if two lesbians shared a dildo and one was HIV positive are examples of some of the surprising theories they proposed. These do not detract from the idea that HIV is sexually transmitted.

<sup>3</sup> Although there are obvious parallels between the symptoms of *tindzaka* and those of pulmonary tuberculosis, my informants presented these as distinct afflictions. One healer argued that she was able to tell the difference by listening to the cough, which in the case of *tindzaka* seemed to originate from below the diaphragm. Researchers have also noted the emic distinction between a ‘traditional’ TB and a ‘Western TB’ (Edginton et al. 2002 ).

<sup>4</sup> I am conscious that the disease – illness distinction is often over imposed, and that disease is itself recognised as a cultural construction (Inhorn 1995).

<sup>5</sup> I refer here to Heald’s (1986) observation that the identity of thieves and witches in Gisu society in Uganda is contingent upon ideas about moral personhood. The propensity to commit criminal acts or acts of witchcraft is based on the Gisu idea of excessive *lirima* which compels young men to steal and older men to commit witchcraft. In Setel’s (1999) ethnography of AIDS in Tanzania, AIDS is conceptualised as an outcome of excessive *tama* that he defines as similar to the English ‘desire’.

- <sup>6</sup> I was told never to ask a man or especially a woman about the whereabouts of their spouse.
- <sup>7</sup> It is noteworthy that Weiss (1993) reports a similar rhetorical statement about women in Tanzania in the midst of the AIDS epidemic there. Women are said to buy their own graves (but not coffins). He suggests that this refers to the position of women and gender relations more generally, in particular the desire women express for commodities, and men's inability to control their desires.
- <sup>8</sup> This bears a striking similarity to 'AIDS Mary' or 'AIDS Harry' rumours that were reported in Johannesburg many years ago. In these accounts a woman or a man wakes up after a one night stand and finds the message 'welcome to the AIDS club' scrawled in lipstick' on her bathroom mirror.

## CHAPTER SIX

### REVENGE: RECASTING AIDS AS WITCHCRAFT

Anti-AIDS activists in Swaziland are facing a growing problem as thousands of HIV/AIDS sufferers in the rural areas flock to traditional healers believing the killer disease was caused by witchcraft and not unprotected sex (SAPA 2003).

As this statement suggests, witchcraft beliefs are invoked in cases of AIDS illness and death, rejecting biomedical explanations and undermining attempts to prevent the further spread of the disease. The danger of this happening has led to public health promotion urging people to distinguish clearly between AIDS and witchcraft. One slogan reads: *Don't Be Fooled. AIDS Is Not Witchcraft. AIDS is Real. Avoid Sex Before Marriage, Stick To One Partner or Use a Condom* (PATH 1997).

The conflation of witchcraft and AIDS has not gone unnoticed by social analysts. Ashforth's research in the Soweto townships near Johannesburg suggests that residents there confuse the symptoms of AIDS and *isidliso*, a poison sent by witches. He suggests that given the high rates of morbidity and mortality due to AIDS, South Africa faces a parallel epidemic of witchcraft.

As the pandemic of HIV/AIDS sweeps through this part of Africa, suspicions of witchcraft arise amongst many in the pandemic's path. To the extent that this occurs, the pandemic becomes an epidemic of witchcraft (Ashforth 2002, 122)

In Bushbuckridge, I found little to support Ashforth's assertion. Here, villagers contrasted clearly between witchcraft and AIDS. Some, such as this young man, regarded AIDS as a more potent source of illness and death: 'AIDS is much more powerful than

the witches. There is no way they can send AIDS'. Others felt that AIDS had replaced witchcraft as the mode of suffering. An elderly woman commented: 'We used to suffer from the witches, but nowadays AIDS is the new witchcraft'. Although people often invoked witchcraft as a cause of their illness, this was not well supported. During a workshop held with villagers to discuss and prioritise health issues, witchcraft was identified as the most critical issue, closely followed by HIV/AIDS, cancer and violence. Again, witchcraft was clearly distinguished from AIDS.

When, at age 27, Xolani showed signs of HIV infection, her mother urged her to consult the AIDS clinic at Tintswalo Hospital. Xolani's mother's suspicions were well founded: Xolani had lost weight, had open wounds on her body, was losing her hair, and her lips were raw. Her mother had recently discovered that she herself was HIV positive, infected by her husband who had returned home after a long absence and then left her again. Xolani refused to go to the hospital. She claimed that she was a victim of bewitchment sent by other women who were envious of her relationship with a wealthy mine worker in Randfontein. Her mother and neighbours that I spoke to denied Xolani's claims as a poor excuse. 'She is afraid to go to the hospital because they will say she is HIV', said Xolani's mother.

Researchers have also found little to support the assertion that people believe that AIDS can be sent by witches. In one survey the researchers asked: 'do you believe that witchcraft causes AIDS'. Few of their respondents answered in the affirmative.<sup>1</sup> In the anthropological literature, the aetiology of AIDS in southern Africa has more in common with pollution beliefs than with witchcraft (cf. Heald 2002; Ingstadt 1990; Niehaus & Jonsson 2005). It appears that the connection between witchcraft and AIDS is a myth

inspired primarily by sensationalist media reporting, misunderstandings, and perhaps the quest for the exotic.

Nonetheless, throughout my fieldwork, witchcraft insinuations and accusations emerged in cases of suspected AIDS illnesses and deaths. AIDS sufferers and their family members frequently sought the services of traditional healers. In these cases witches were ‘smelt out’ (*ku femba*) by witch diviners (sing. *n’anga*, pl. *tin’anga*). Witches were believed to send a disease that mimicked the symptoms of AIDS.

One possible explanation for impugning witchcraft is that this is a convenient scapegoat in the absence of more suitable explanations for AIDS. For example, Yamba (1997) argues, witchcraft beliefs are rational responses in the absence of a biomedical solution. This coalesces with the (erroneous) view of witchcraft as ‘African science’ (Ashforth 2005a). Yet, this does not explain why witchcraft beliefs and not theories of pollution are evoked in cases of AIDS illness and death.

The comparison between biomedicine and witchcraft is also misguided. Witchcraft beliefs and biomedical knowledge are not necessarily opposing systems, but attempts to answer different types of questions. Witchcraft beliefs are a ‘personified theory of accountability’ rather than an attempt to understand the mechanics of causation, as is the case with biomedical explanations (Andersson 2002). However, what witchcraft beliefs do address are the effects of the AIDS epidemic on peoples’ sense of security. The high incidence of illness and death promotes a greater fear of witchcraft (cf. Colson 2000). Given this, witchcraft accusations reflect ‘spiritual insecurities’, that indeed could erupt into an ‘epidemic of witchcraft’ (Ashforth 2005b). But this does not necessarily imply that people believe witchcraft is responsible for the AIDS epidemic. Rather,

increasing mortality and morbidity intensify feelings of insecurity and fear and people respond by invoking witchcraft.

Along these lines, I agree that witchcraft does not solely offer a theory of causation. Instead I argue that witchcraft accusations can be seen as a form of therapeutic practice that has emerged in the path of the AIDS epidemic. Because AIDS tends to affect the young and often the most productive members of society, suspicions of unnatural death are extremely common. By redefining these deaths as the result of bewitchment, people are able to take steps to protect themselves against further attacks. For example, residents may fortify their homesteads and their bodies, conduct ancestral sacrifices to request their protection, or participate in church confessionals. These actions may help to mitigate anxiety and fear and provide a sense of control over the epidemic. Furthermore, unlike infections with HIV, witchcraft attacks can be avenged. Public censorship prevents individual family members from publically identifying AIDS as the cause of death and from acting against those who infected the deceased. To do so would be to admit to personal culpability and cause shame for other family members. Redefining AIDS related illness or death as witchcraft provides the opportunity to use vengeance magic, returning the affliction to its instigator, causing that person and often their kin to die in a similar fashion. In these ways witchcraft provides a means to successfully breach the censorship surrounding AIDS.

Part of the reason why it is possible to shift between witchcraft and AIDS is due to the ambiguities surrounding the cause of death. Secrecy as I noted earlier generates mystery and uncertainty about the origins of the illness and the cause of death. Even when the symptoms are identical to known signs of AIDS, this can be reinterpreted as a



form of fictive AIDS<sup>2</sup>. At another level of analysis there are appealing analogous similarities between the idiom of witchcraft and that of AIDS. This is most obviously expressed with regard to the themes of secrecy and desire, and the identity of those seen to be most likely to be the victims of AIDS and witchcraft. People who are HIV infected are *like* witches, but only at the level of metaphorical analogy.

This chapter is structured along these lines. I begin below by exploring the analogous similarities between discourses of witchcraft and AIDS. Witchcraft is a dynamic belief, reflecting and incorporating advances in technology and generating new types of affliction. I then look at how AIDS symptoms are incorporated into beliefs about witchcraft. Following on from this the final section of the chapter uses case studies to illustrate how witchcraft is used to satisfy the desire for revenge in cases of AIDS death.

### **WITCHCRAFT AS AN ANALOGY FOR AIDS**

The phenomenon of witchcraft in the Bushbuckridge area has been well documented (Niehaus 2001; Ritchken 1995; Stadler 1996). Residents evoke witchcraft in the event of incomprehensible misfortune of a physical and a psychological nature. Death resulting from illness, accident and other misfortunes can be ascribed to witchcraft, as may divorce, loss of employment and insanity.

There are three forms of witchcraft: poisoning, mystical potions, and witch familiars. Methods of attack are usually surreptitious and invisible. The victims of witchcraft are transformed into zombies (*xindhachani*) and forced to perform labour for the witch. Witches are motivated by their envy ('jealousy') of other peoples' fortune.

Logically, accusations of witchcraft are often levelled at the poorer, older men and women who are most likely to experience feelings of jealousy and resentment toward the younger generation. Elders also possess the secret knowledge required to conduct acts of witchcraft (Stadler 1996). The prevalence of witchcraft accusations have increased over the last 50 years, a result of increasing tensions between neighbours and within families (cf. Niehaus 2001). This is also because of the economy of witchcraft. Almost any person can purchase mystical potions (*muthi*) to commit acts of witchcraft. Witches were believed to use loaves of bread to fly at night. Villagers insisted on purchasing their bread fresh in the morning as they feared the bread left over from the night before may have been used as a form of transport by witches. This story serves as a metaphor for the democratisation of witchcraft: anyone can buy a loaf of bread, the most ordinary and pedestrian grocery item.

It would be a mistake to regard the belief in witchcraft as unchanging and static. In their accounts of witchcraft, my informants described witch-gatherings as modern bureaucratic organisations. Witches were believed to hold regular business meetings on the local sports field at night, where they drafted lists of people targeted for attack, and debated strategies to kill their victims. It was not surprising then to hear how witches adapted their methods to suit the AIDS era.

A significant transformation is in the treatment of witches, which has become increasingly violent. In the 1950s, suspected witches were removed from their homes and sent to the open bush to live. For example, a village located close to a game reserve was a home for expelled witches, symbolically appropriate because of its proximity to wildlife. Yet, in the 1980s and 1990s, more forceful means were used to punish witches. Those

suspected of witchcraft were assaulted, stoned and burnt to death through ‘necklacing’<sup>3</sup> (Niehaus 2001). In the early 1990s, an informant revealed how she had witnessed a witch-hunt during which an elderly woman was burnt to death. She recalled how the fat dripped off the woman’s burning body (Stadler 1996).

But, retribution can also be expressed through mystical means. Victims of witchcraft often employ vengeance magic, sending the affliction back to its originator (or ‘owner’), causing them to suffer the same misfortune. In 1982, 58 year-old Mablom (Flowers) Maimela was found dead in his room. He had hung himself from the wooden beams that supported the tin roof of his two roomed house. Mablom did not leave a note. His mother consulted a *n’anga* who sniffed (*ku femba*) out Mablom’s two sisters and his brother as the culprits who had bewitched Mablom, causing him to commit suicide. A healer, Iscariot, was consulted to take further action. Iscariot was reputedly an extremely powerful man who had learnt his skills from a healer in Mozambique. Iscariot first talked to the Maimela family and told them that if any of them were guilty it was advisable that they needed to confess. If any family member confessed then he would leave the issue alone, deeming it to be a family matter. Nobody in the family admitted guilt, and Iscariot proceeded. He took seeds from a certain plant and buried them on top of Mablom’s grave, above where the head lay. After some time a plant began to grow, bore flowers and then seed pods. The seeds burst and spread over the grave, forming new plants. At the same time as the first seeds burst Mablom’s sister suffered a fatal heart attack. Very soon after, Mablom’s second sister died. Mablom’s mother, realising that the vengeance magic was working, approached Iscariot and asked him to stop the process. But Iscariot replied that he was powerless ‘how can I stop a plant from spreading’ he said.

Sexuality and especially unrestrained sexual desire are core themes in witchcraft beliefs. Witch familiars such as the *nwamlambo* and the *tokolotši* have sex with their owners. The *nwamlambo* transforms itself from a snake into a beautiful white man or woman for the sexual pleasure of its owner (see below for a detailed discussion of the *nwamlambo*). The *tokolotši* has exaggerated sexual features and has sex with its victims. The following accounts explore these beliefs in detail.

### **Married to the *fenha***

A thirty two year-old unmarried woman, Felicia Ngumane, complained that she was unable to have long-lasting intimate relationships with men. Although Felicia had several lovers and gave birth to three healthy children, she never married. In our interview she told me tearfully: ‘The others of my age are all married. The girls call them *manana* [mother]. But me I am still *sesi* [sister]’. Her social status and the ability to demand respect from women junior to her in age was seriously compromised.

Felicia explained that her predicament was because she was already ‘married to a baboon (*fenha*)’. At night when she slept she could feel its hot breath in her ear, and often awoke feeling wet between her thighs, as if she had had sex. Her sexual partners were repulsed by the pungent scent of the baboon’s semen and its furry body (cf: Niehaus 2001, 54). Felicia’s great grandmother was a ‘big’ witch and passed the *fenha* on to her first born daughter, Magreth. On Magreth’s wedding day to Ximiresi the marriage party (*tishangwana*) helped to build Magreth’s hut. According to Magreth’s mother’s instructions they placed a small twig in a bottle and hid the bottle between the poles and the mud bricks of the hut wall. At night the twig transformed into the *fenha* and had sex with Magreth. This had a disastrous effect on Magreth’s marriage. Ximiresi drove trucks

in Benoni on the East Rand. His visits home and remittances became less frequent when he acquired a second wife and built a new home for her in Daveyton. Concerned by his behaviour, Magreth's mother-in-law consulted a *n'anga* who revealed the existence of the *fenha*. Magreth rid herself of the *fenha* by giving it to Felicia and her marital circumstances improved.

Felicia consulted several healers who diagnosed her problem. She consulted a prophet (*maprofeta*) of the apostolic St John's Church who instructed her to use candles and burn pages of the Bible to cleanse her home and expel the *fenha*. However, Magreth learnt of these intentions and chastised Felicia: 'how can you do that – we are church goers. We don't use *muthi* here'. Felicia was not surprised at her mother's reaction and said 'She knows that if the *fenha* leaves me it will go back to her'.

### **Theko Magagule's secret**

The *munjhonjhela phansi*<sup>4</sup> allows men to have sex with women without physically touching them, like a modern remote control<sup>5</sup>.

Theko Magagule was an elderly man who had never married. Local youth used the pejorative label *ngwenza* (bachelor) to describe him. They claimed he was single because he was stingy and on occasion would eat an entire chicken on his own. Theko's appetite for meat, much like his appetite for women, was characterised by a lack of reciprocity<sup>6</sup>. Theko used his *munjhonjhela phansi*, to have sex with unsuspecting women at a local shebeen where old men and women drank maize beer (*xikhapakhapa*). After a few jugs of beer, Theko would fall asleep with his hands deep inside his pockets. Female patrons complained of a wet sensation in their vaginas. When they looked at Theko they

could see his hands moving inside his pockets. They claimed that Theko pretended to sleep while manipulating his *munjhonjhela phansi* to have sex with them.

### Snakes and secret lovers

As a young man, Farius Ndlovu desired a beautiful wife, but was unsuccessful in his proposals to women. After many rejections Farius came across an advert in the classifieds of *Ilanga* (a Zulu language newspaper) that guaranteed him success with attractive women. He sent off R100 as requested and received a parcel containing a small root and instructions for use. When Farius saw a woman he desired he simply had to touch the root and speak to her. Farius was soon married to a beautiful woman who was described as ‘light in complexion’<sup>7</sup>. After being married for some years, one night Farius discovered a huge snake in his bathtub. He ran away and called out to his wife to beware of the snake. To his surprise his wife emerged from the bathroom. Later, he recounted this event to his uncle who told him his wife was a *nwamlambo*.

Despite the overtly erotic and sexual content of these narratives, villagers did not draw a direct link between the sexuality of witchcraft and the spread of HIV<sup>8</sup>. Felicia was not at risk of contracting HIV from the *fenha*. Nor did Theko’s *munjhonjhela phansi* spread HIV. Although witch familiars were dangerous to their owners and those around them, they were not a source of HIV. However, I suggest that these narratives draw attention to themes that are common to popular thought about witchcraft and AIDS. These themes are discussed in detail below.

## SECRECY AND DESIRE: NARRATIVES OF AIDS AND WITCHCRAFT

Secrecy and excessive and untrammelled desire are themes that often emerge in narratives of witchcraft and also about AIDS. The two discourses have parallel concerns about secretiveness and ways in which to control desire.

AIDS and witchcraft share official denial of their existence. For example, at the time of my fieldwork, uncertainty surrounded the existence of AIDS. Although the existence of the disease was acknowledged, reflected in campaigns and fiscal spending, the causal link between HIV and AIDS was often denied by state officials. Likewise, the belief in witchcraft is acknowledged, but its existence is denied because of its inappropriateness with the modern African state (Ashforth 2005b). Current legislation makes it illegal to impute or point a person as a witch, a crime punishable by a fine or imprisonment<sup>9</sup>.

The official denial of witchcraft and AIDS is mirrored by responses at the local level. Informants were hesitant to use the name of a person that they suspected of witchcraft, fearing prosecution. Similarly my informants treated the identity of people suspected to be living with HIV/AIDS in an extremely secretive manner. Villagers were appalled by health workers who gossiped about patients who were HIV positive. They were aware that civil charges could be made against those who breached confidentiality<sup>10</sup>. The state was seen to protect the identity of witches and people suffering from AIDS or infected with HIV.

Interestingly, the official position on witchcraft has resulted in suspicions that the state and its organs collude to protect witches. However, the state's position regarding AIDS (under Mbeki) did not provoke similar speculations.



AIDS and witchcraft also share a common difficulty with establishing evidence. Witches cannot be identified from their physical features. Witches assume the form of familiars at night, but hide during the day. Witchcraft accusations are often based on circumstantial evidence: the sight of a baboon or a snake in a person's yard, incriminating statements, a close relationship with well-known witches and 'excessive secrecy' establishes the identity of witches (Niehaus 1997, 255-256).

Witchcraft is also invisible and undetectable, until this manifest as illness. Mystical potions are concealed on foot paths and entrances to properties to catch unsuspecting victims. Witches eat their victims invisibly while they sleep and use dreams to send poison, and can pass unhindered through walls and underneath doors (Stadler 1996).

Similar ideas exist with regard to AIDS. HIV infection is undetectable unless subjected to a blood test. The results are kept confidential. Locally HIV is called *xitsongwanwana* which translates as 'microscopic'. Certain signs and symptoms can be used to establish the evidence of illness, yet not without uncertainty. As I pointed out earlier, the evidence of AIDS is often difficult to ascertain is highly ambiguous and subject to debate (See Chapter 4).

Accounts of witchcraft are concerned with the problem of unrestrained desire. Witches are thought to be completely dominated by their desires: 'Witches, like animals (...) do not merely succumb to their desires at times, but are completely dominated by their cravings for food, sex, money and revenge' (Niehaus 2001, 49). This is most cogently expressed in beliefs about witch familiars. As I suggested earlier, familiars such as the *tokolotši* represent an 'animal-like craving for uninhibited sexual expression'

(Niehaus 2001, 46). The *nwamlambo* provides sexual gratification, wealth and power to those who acquire it, but is highly destructive because of its excessive and increasing demand for (human) blood. The *nwamlambo* ‘objectifies the desire for money in a context of social and economic deprivation, and highlights the destructive social effects brought about by the unrestrained quest for wealth’ (Niehaus 2001, 47). Men often acquire the *nwamlambo* due to their lust for women. In contrast, women seek wealth and commodities.

Geschiere (1997, 11) states that witchcraft is the ‘dark side of kinship’. A witch requires intimate knowledge of their intended victims. At times they also require the cooperation of a person on the inside, for example a household member, who can provide an opening for the witch to enter. Villagers diligently fortify their homesteads against attack. Yet these fortifications can be broken.

Along these lines, narratives about the spread of HIV express concern with the dangers of the world outside the homestead. AIDS is acquired by those who go outside and infect those who remain at home. Women complained that their husbands had extra marital affairs and infected them. ‘You don’t know what he does when he goes out there’ commented a young woman. Secret sex took place at night, in the bushes next to the road with strangers. Most significantly, HIV is a silent epidemic, only manifesting itself as AIDS after a period of a few years. Many villagers were aware that people who are infected by HIV cannot be easily detected. People infected by HIV were also rumoured to surreptitiously and purposely infect others, so as ‘not to die alone’ (Chapter 5). As with witchcraft, narratives of AIDS drew a link between AIDS and sexual desire.

The symbolic resonances between AIDS and witchcraft are based on their highly secretive nature and that suspicions and accusations rely on circumstantial evidence and subjective interpretations. Both AIDS and witchcraft also attempt to deal with the perennial problem of untrammelled desire and restraint.

My observations are borne out in the ways witchcraft and AIDS are positioned in church sermons of Pentecostal churches. A poster at the local shopping centre once announced a revival tent church: *'Yes!!! HIV-AIDS Victims healed and 3 of them are here to testify!!!'* *'Sick, Demon Possessed, Cripple and trauma deliverance'* The International Holiness Pentecostal Church (IPHC) held public confessionals to heal the sick and those possessed by demons and witch familiars. Men and women confessed to alcoholism, unfaithfulness, witchcraft and AIDS. According to the IPHC, AIDS, like witchcraft, possessed the body and could be expelled from the body. By confessing their sins (such as AIDS and witchcraft and other afflictions) the sufferer released their afflictions. A senior member of the IUPHC explained how this worked:

The word of God enters the ear and goes to the place where the person feels pain. For you – you just sit there and listen. But even if the pains do not disappear you will feel good, you will feel happy. They don't even touch you. You just sit there on your chair. The *mufundise* [preacher] reads from the Bible and explains the words that he has read. The words heal.

The IPHC hosts its annual pilgrimage in Zeurbekom near Randfontein in the North West. During one of these ceremonies a man witnessed another who literally soiled himself after hearing the words of the preacher, so powerful were the words. The diarrhoea was a sign of the expulsion of disease from his body.

The metaphorical similarities between witchcraft and AIDS have been noted elsewhere. Fordham (2001), remarks that in Thailand prostitutes are demonised and portrayed as the antithesis of ‘good women’ because of their ‘uncontrolled and rapacious sexuality’ (2001, 295). Like witches, prostitutes invert normal social behaviours and expectations: they were only seen at night, they appropriate male behaviours (such as drinking), yet they are able to conceal their true identities during the daytime. Finally they are accused of destroying the moral and the physical foundations of society and of spreading HIV.

Kelly (1976) provides a fascinating discussion of witchcraft and sexual relations in New Guinea that has relevance to the current analysis. He argues that ‘(W)itchcraft and sexual relations occupy analogous structural positions within a larger conceptual system’ in which ‘life and death are complementary and reciprocal aspects of the transmission of life-force’. A person’s life force is contained within a man’s semen, but is in limited supply. In terms of this conceptualisation, women ‘who engage in excessive sexual relations’ are accused of witchcraft. They wastefully and greedily take the life force of men. Likewise, male youth who engage in unsanctioned homosexual intercourse are like witches, because they deplete other men’s life forces (semen) at their expense (1976, 50-51).

At an analogical level witchcraft beliefs provide a manner of conceptualising AIDS. However, I suggest that it would be simplistic to interpret this to infer that people living with HIV/AIDS are literally conceptualised as witches. Rather, I follow Kelly’s lead who argues that ‘the analogic correspondence between acts of witchcraft and acts of sexual relations connotes a *like* relation between the characteristics of the (respective)

actors' (Kelly 1976, 5, emphasis added). The analogy is appropriate because of the distinct symbolic resonance between the two discourses, in terms of the denial and secrecy and the attributes of avarice.

### **AIDS AS A KIND OF WITCHCRAFT**

Writing almost 100 years ago in Portuguese East Africa (Mozambique) the Catholic Swiss missionary and ethnographer Henri Junod noted how witches often used subterfuge to mask their actions. Witches enticed young men to leave home to work on the mines in South Africa. Because mining accidents were so common, witches used this as an opportunity to kill young men without alerting suspicion that they were victims of witchcraft. Junod wrote:

When a boy dies in the mines, as hundreds of them do, his parents think: - 'He has been killed by such and such a disease.' But the author of his death is not in Johannesburg, he is here at home; it is the *noyi* [witch] who hated him and made him go by '*ntchutchu*' [inspiring him] (Junod 1962 [1912], 512).

In a similar fashion, my informants pointed out that witches hid behind AIDS while they killed their victims. Moreover, AIDS sufferers weakened by the disease were easy prey for witches who could cause their deaths without being suspected. In a similar vein, witches also produce innovative forms of illness that mimic the symptoms of AIDS and thereby avoid detection. Here are two examples and a case study that illustrate these innovations in witchcraft in response to the AIDS epidemic.

### **The new witchcraft: *mabandi***

An appropriate example of the new witchcraft was an affliction called *mabandi* ('the belt'). This appears as a rash that formed irritating and painful welts around the torso (like a belt)<sup>11</sup>. A few older informants speculated that *mabandi* was actually the manifestation of what the elderly NwaAbraham called 'fire of the night' (*ndzilo vu siku*). She said: 'It is like a fire that has burnt you while you sleep...you just woke up with burns on your body like blisters'. However, unlike *mabandi*, *ndzilo vu siku* caused small blisters that were scattered randomly all over the body. The blisters usually disappeared soon after they appeared. NwaEphraim, a healer who had treated several patients with *mabandi* explained that unlike *ndzilo vu siku*, *mabandi* could be fatal. It required immediate treatment to prevent the 'sores from forming inside the body'. When Gloria, a 30 year old HIV positive woman was pregnant with her second born she developed a rash like *mabandi* and consulted NwaEphraim who smeared petroleum jelly mixed with ash on the rash. NwaEphraim also made incisions between the sores 'to cut the belt' to prevent the sores from spreading. Her new born baby died before it was six months old and Gloria died of AIDS related illnesses in 2004.

NwaEphraim was shocked by the huge number of cases of *mabandi* that she had seen that year (2003-2004). Many of the cases she saw were people from a village in the southern part of Bushbuckridge where migrants from Mozambique often settled. NwaEphraim attributed the outbreak of *mabandi* to a new form of witchcraft from Mozambique.

This is the first time I have ever seen it like this...it is from Mozambique...it is like something walks on you and bites you as it is walking along your body. Then

you get pustules. It is like AIDS, but it is not AIDS because there are many young children who are infected with *mabandi*. It burns your skin and it burns inside you. While it is eating you outside, it also eats you inside and you lose weight. One of my patients – a young girl – had this. She had eaten a poisoned sweet.

Her reference to Mozambique as the source of *mabandi* resonated strongly with the idea that foreign Africans often held the knowledge of new and powerful forms of witchcraft. NwaEphraim conjured up a vision of total mayhem in which people were using witchcraft to kill for the pleasure of killing:

People from Mozambique used to use *muthi* to capture animals. Now they are using this magic to kill people. They are killing people for nothing – they won't even take your money. They just kill you.

The affliction was 'like AIDS' but its source was witchcraft. Another affliction that is similar to AIDS is 'slow poison'.

### **Slow Poison**

Nhlakanipho Mnisi was a 25 year old woman and an only child. Her family was relatively comfortable; her father had worked for the railways and had left his wife and child with a pension. Nhlakanipho worked for the local municipality, clearing the main roads in and around Bushbuckridge. She had a reputation as a loose woman (*ngwadla*). The neighbourhood boys joked about her: 'she supports the nation' (*u pfuna ri xaka*) they said. They knew that if they were desperate for sex they could sleep with her for a little money. In 2001 Nhlakanipho visited her friend Abigail and the two of them went to Gauteng. When Nhlakanipho returned from Gauteng in 2002 she was pregnant with her son Nyiko. The baby was born with severe disabilities. He was mute, couldn't move his legs and struggled to feed himself. Nhlakanipho received a disability grant for the boy



and hired a local woman to care for him. In 2003, Nhlakanipho became ill and was admitted to Tintswalo Hospital in Acornhoek. One day Nhlakanipho's mother discovered Nyiko lying on a mat in the sun abandoned by his care provider. The neighbours heard the apparently drunken Nhlakanipho's mother shouting 'It is better that I finish this boy – look at how he is suffering'. Three days later Nyiko died. Nhlakanipho's mother visited Nhlakanipho in hospital. Nhlakanipho was extremely ill: she had lost a huge amount of weight and had sores all over her face. Drips were attached to her arms. The old woman ripped out the IV lines. When she returned home she told her neighbours that Nhlakanipho was dead. Later it was revealed that Nhlakanipho died three days after her mother's announcement. By now it was known that Nhlakanipho's mother had killed both her grandson and her own daughter using 'slow poison'. This was explained as an outcome of a dispute between Nhlakanipho and her mother over household resources.

### **The many theories about MaKwaMary-Jane's death**

When I first met MaKwaMary-Jane (mother of her first born child, Mary-Jane) she complained of being unable to swallow properly, persistent diarrhoea, and painful mouth sores. A common affliction the AIDS ill experience is severe oral thrush caused by the bacterium *candida albicans*. This appears as a white coating on the tongue and lining of the throat. These conditions create difficulty in swallowing food and liquid (Evian et al. 1993).

When MaKwaMary-Jane died, neighbours, relatives and friends suggested that she had been infected with HIV, although suspicions of witchcraft soon emerged following her burial. MaKwaMary-Jane married Robert Mathebula. They were described as 'first loves' and 'childhood sweethearts'. They met when they were school children at

a Christian revival gathering. MaKwaMary-Jane gave birth to two girls. She was extremely happy with her new status as mother. Atypically her mother- and father-in-law adored her. MaKwaMary-Jane soon dropped out of school. She boasted to her friends about the panties and beauty products that Robert bought for her. He even hired a domestic to clean and wash for MaKwaMary-Jane. He also encouraged MaKwaMary-Jane to complete her schooling.

After ten years of marriage, Robert met Dineo, a school teacher from a wealthy family in Thulamahanshe. Robert told MaKwaMary-Jane to take her children and go home to ‘wait’ at her parents. He married his new girlfriend and purchased a four roomed house in a suburb in the previously white only town of Hoedspruit.

Penniless and desperate, MaKwaMary-Jane left for Witbank, hoping to sell second hand clothes to support her children. In Witbank she met Sesi, another young woman from KwaBomba. Sesi introduced her to sex work and for a while the two travelled up and down the N4 with truck drivers. Later, MaKwaMary-Jane moved in with a married man in Witbank. However, after one year she became ill and returned to KwaBomba to live with her parents.

On her last night MaKwaMary-Jane slept with her daughters. According to those who attended MaKwaMary-Jane’s funeral, on the day she died she said goodbye to her daughters. She gave her eldest her mobile phone, saying ‘I have nothing to give you...but you can use this to remember me by’. Robert did not attend her funeral and it took him several months before he visited his daughters.

Narratives about MaKwaMary-Jane’s death had very distinct implications for her moral character. Stories about her sexual activities in Witbank were sympathetic; after all

she had little choice and had two young girls to support. Yet at the same time my informants suggested that there were other things that women could do to earn money to support their families. A close friend of MaKwaMary-Jane remarked ‘She didn’t have to sleep with men. Others make money selling or even working for the whites in their homes’. Others speculated that she had been infected by Robert. Policemen were notorious womanisers. Blame for MaKwaMary-Jane’s illness and death was directed towards Robert on only one occasion: a few months prior to her death MaKwaMary-Jane was taken to a medical doctor in Mkhuhlu. The doctor examined MaKwaMary-Jane and informed her sister that she was suffering from severe stress. MaKwaMary-Jane’s sister argued that Robert’s treatment of her sister had resulted in this condition. Stress is often a euphemism for AIDS.

A third clearly discernible theory was that MaKwaMary-Jane was bewitched by the wife of her lover from Witbank. A few days after the funeral I met MaKwaMary-Jane’s sister at the Acornhoek Plaza. Close to tears she divulged that MaKwaMary-Jane had not died of AIDS. Prior to becoming ill, MaKwaMary-Jane had a dream in which she had eaten a piece of fatty meat offered to her by her lover’s wife. The meat was *xidyiso* (lit. to eat), a mystical substance that could transform into any manner of creature which then inhabit the upper intestine and throat. *Xidyiso* is most often sent through dreams.

In MaKwaMary-Jane’s case the *xidyiso* changed into a frog that could be felt moving up and down her throat and into her stomach. This prevented MaKwaMary-Jane from swallowing properly and eventually killed her through suffocation. MaKwaMary-Jane’s lover’s wife was not known to the family, but she had met MaKwaMary-Jane on one or two occasions. When MaKwaMary-Jane was ill and living with her parents in

KwaBomba her Witbank lover had tried to speak to her over the telephone. When he attempted to come to visit her at her home his wife smashed his foot with a brick rendering him immobile.

This account asserted MaKwaMary-Jane's innocence. It also allowed for the allocation of blame to be directed towards another woman. It created an opportunity to direct anger for her death away from MaKwaMary-Jane, especially for her sister who had been extremely close.

The fluctuations in theories about the cause of death and the confusion that resulted fitted into an overall pattern observable in other accounts of suspected AIDS deaths. At first, gossip circulates identifying AIDS as the cause of illness or death. Then, during the funeral, or following it, talk of witchcraft emerges. For me, as an outsider, it was possible to observe the constant tussle between explanations that attributed illness and death to witchcraft and those defined this as AIDS. Constructing AIDS as a form of witchcraft did not simply deny the existence of AIDS. The witchcraft idiom made it possible to identify a human agent, and as I argue below, avenge AIDS deaths.

### **AVENGING AIDS: COMBATING WITCHCRAFT**

Ashforth (Ashforth 2005b) writes of 'spiritual insecurity' amongst residents of Soweto who constantly fear occult attacks, intensifying suspicions of witchcraft, and potentially accusations thereof. In KwaBomba I was not able to gauge whether witchcraft suspicions had increased in relation to the rise in mortality from AIDS. In the period of escalating mortality there were no large scale witch-hunts, nor were there significant outbreaks of accusation of suspected witches. However this is not an indication that fears

of witchcraft were not increasing in relation to AIDS illnesses and death. Indeed, the response to an increased sense of spiritual insecurity may be expressed through counter-attacks using mystical means.

A response to increasing fears of occult attack is hyper-vigilance in protecting the home and the body. Villagers fortified the boundaries of their homes using mystical substances. They also fortified the body through the insertion of medicine into their blood (*ku tlhavela* – to cut). Fortification of body and home not only prevented attack, it also enabled the victims of witchcraft to avenge illness and death.

The potential for violent revenge against alleged witches was highlighted in many of the cases of AIDS death that I recorded. Revenge is an important aspect of local concepts of justice, particularly so in cases of what is often defined as ‘bad death’ (cf. van der Geest 2004). Accidental deaths were construed as wrongful and often resulted in revenge attacks. In one case revenge was acted out on a young man’s face with a broken bottle because he had caused the death of a young girl in a car accident. The men who did this told him the scars on his face would remind him of what he had done. In the early 1960s, a migrant returned home to find his wife had been poisoned. He suspected his neighbours. He and his brothers attacked the neighbours with stabbing spears, slaughtering three people. They fled to live in Phalaborwa only returning 30 years later.

Yet, revenge is also enacted through witchcraft. Simon Hlatswayo was 23 years old when he accidentally ran over and killed his neighbour Goodwill, a 15 year old school boy, and also Simon’s good friend. It was hardly Simon’s fault: Goodwill was drunk and simply ran in front of Simon’s car. Simon apologised to the family and paid for the costs of the funeral. However, he was aware that his life was in danger and he fled

Bushbuckridge and lived in Soweto for the next 12 years. Two days after his return to Bushbuckridge Simon had a car accident and died in the very same spot where Goodwill had met his fate. It was widely rumoured that the family had used vengeance magic to cause the accident.

What about cases of AIDS? Although people may harbour extreme anger and frustration and desire to avenge infections and death, these emotions and designs are suppressed. To accuse another of infecting you is to accept personal liability for acquiring the disease. Redefining AIDS death as witchcraft creates the possibility for revenge. Two case studies are presented below. In the first, witchcraft is used to defend the family against misfortune. In the second, witchcraft is used to avenge death.

### **The Good Friday Deaths**

The long Easter Weekend is an opportunity for family members to gather together and socialise at home, to relax, and do repairs around the house. The maroela (*nkanyini*) berries ripen and beer (*vukanyini*) is brewed and shared amongst neighbours. Tombstones are laid and unveiled, ancestral rituals (*ku mamba*) are conducted, men pay bride wealth (*ndzovhola*) and celebrate. Thousands of ZCC members make the pilgrimage to the holy site of Moria, and members of the International Pentecostal Church go to Zeurbekom to attend special services. It is a time of intense spirituality and sociability, but also of tensions within families. Family members, who have not seen each other for some time meet, discuss and exchange gossip. Old rivalries, jealousies and hatreds come to the surface.

For the Mzimba family, the Easter vacation had become a time of mourning and bitterness. The family consisted of two houses, of the first and the second wives, their

children and grandchildren. Shortly after the creation of the Gazankulu Bantustans in the late 1970s the large polygamous household split up due to continual conflict between the two wives and between their respective children. Conflict revolved around the failure of the first wife to care for the children of the second wife and intense jealousies over who was the preferred wife.

For many years this time of year was announced with a death or some form of misfortune. And, even when deaths did not occur, Good Friday was the occasion for unveiling a tombstone or releasing a widow from mourning, recalling deaths that had passed. Ten deaths over a 7 year period, 1998 – 2005 (See Table 7) had occurred between the months of February and May, coinciding with the Easter holidays.

**Table 7: Deaths in the Mzimba Family**

<i>Age, Gender</i>	<i>Symptoms</i>
32, Female	Incessant menstruation
38, Male	Diarrhoea and vomiting
37, Female	Headache
45, Male	Not known
48, Male	Vomiting blood
65, Female	Vomiting blood
39, Female	Vomiting blood
43, Male	Vomiting blood
35, Female	Typhoid
4, Male	High fever and convulsions

According to the family members I interviewed, all but one of the ten deaths listed above were attributed to witchcraft. Vamia Mzimba, the first wife, a frail woman in her 60s, was accused of causing these deaths. Her identity as a witch was made public on several occasions. For example, during a funeral at another household, an 18-year-old



boy wielding an axe shouted at Vamia ‘you and my mother killed my father so you had better go before I kill you’. The boy was subdued by the other men. Vamia was suspected to be in league with the boy’s mother, also suspected to be involved in witchcraft.

The Mzimba homestead was situated next to a small dam. Vamia owned ducks and geese that bathed in the water. Yet, her neighbours recalled mysterious events surrounding the dam. Once, a fisherman attempted to suck water out of the dam to catch fish. As he was busy setting up his equipment he noticed a small tin of snuff floating in the water. He tried to pick it up and then looking up, saw an old white man with a long grey beard, floating in the water. The fisherman ran away, calling to the people in the neighbourhood to beware. It was rumoured that the old man was Vamia’s *nwamlambo* in human form. Vamia’s nephew told me how Vamia had come to acquire the *nwamlambo*. Several years ago, the old woman earned a small income by selling flower pots to residents of the towns on the East Rand. Her husband worked in Springs, and whenever she visited him she would purchase flower pots from a warehouse in the town. Vamia walked house to house in the white neighbourhoods offering to swop her flower pots for second hand clothing. She then sold the clothes in Bushbuckridge where, prior to the mass importation of Chinese made clothes, there was huge demand for used clothing. Yet her business did not run well. Vamia purchased her *nwamlambo* after consulting a healer who told her it would guarantee her wealth by convincing her white customers to give her their best clothes. At first Vamia fed chicken blood to the *nwamlambo*. Later, it required goat and then cow blood. But, by the early 1990s the *nwamlambo*’s appetite had grown to desire human blood and family members began to suffer.

The death that concerns us here is that of her first born son, Robert. The 38 year-old worked for an Italian bakery in Johannesburg. He was married and had four children. About three years before he died, Robert experienced mysterious afflictions. Whenever he tried to have sex with his wife his penis would shrink into his scrotum. If he managed to penetrate his wife he would immediately have diarrhoea. His wife speculated that Robert had a former secret lover (*xigangu*) who wanted to win him back and had bewitched him to stop him having sex with her. In 2003, Robert became seriously ill. The first symptom was an irritating rash all over his body that erupted into watery sores. Later he complained of fatigue and chronic diarrhoea. Early in 2005, plagued by illness, Robert resigned from his job. He returned home. On the way home Robert collapsed and was taken to his home in KwaBomba, close to death. The family hired a car and started off for hospital. Tragically, Robert died before arriving at hospital.

The funeral was held on the following Saturday. The night after the funeral, when only family members remained, Robert's mother danced and sang songs in the funeral tent. 'Why do you laugh and sing and dance' asked her co-wife, to which she replied, 'I am so happy...I have been given what I had asked for'. Two years previously Robert had started to build a house in Thulamahanshe, a township near KwaBomba. His mother opposed the move and they had argued bitterly. It was clear to everyone who saw her dancing and singing that Vamia was celebrating her victory over her son.

The night of the funeral, Robert's first born daughter, Memory calmly and openly accused her grandmother of killing Robert. She said 'I don't understand why it is that every Easter we have to bury someone or we are removing mourning clothes. I still want

to ask that question to my grandmother'. The old woman's oldest step-son also commented quite openly:

I am tired of burying my brothers and sisters every year it is always at Easter time. I am going to buy a gun and kill the whole bloody family – all of them. If this doesn't stop

Not more than six months later and Vamia's last born daughter's four-year old son died. According to witnesses, she was at home while her grandson was in hospital. Referring to her grandson she asked 'is he already dead?' When her daughter heard about this she took a short, thick club and beat her mother severely. Twelve months later, Robert's widow died.

A detection ritual (*ku femba*) ritual was held to detect who was responsible for the deaths, although suspicions were directed at Vamia. During the ritual the *n'anga* 'sniffed' Vamia out and acting as her medium, confessed to causing the deaths of several family members.

While there was general agreement within the extended family that the cause of Robert's death was witchcraft, private conversations revealed contradictory interpretations. Ezrom, a close relative, was in agreement that many of the deaths were due to witchcraft. Yet, after Robert's widow died, Ezrom speculated that this was proof that Robert had indeed died from AIDS. There were also strong suspicions that another two of the deceased had succumbed to AIDS and their deaths were not caused by witchcraft.

In spite of this new evidence, members of the second wife's household felt concerned that they may become the next victims. A healer was consulted and the

homestead was fortified. At Christmas, each household member was protected against witchcraft by making small incisions at the nape of the neck and rubbing medicine (*muthi*) into the cuts. The incisions also provided a guarantee that the sender of witchcraft would be avenged. Ever since these ritual actions were undertaken, Vamia was rendered powerless and according to one of her children, ‘acts as if she is mad’.

### **Avenging a wrongful death**

When Sibongile, a 40 year old married woman was close to death, her niece informed me that her illness was caused by AIDS. Another relative who spoke to the funeral home director confirmed seeing the words ‘AIDS’ written on Sibongile’s death certificate. Sibongile, had suffered for two years with tuberculosis, a disease that is often recognised as a co-infection amongst people with compromised immune systems due to late stage AIDS.

Two months before she died, Sibongile’s husband, a migrant worker from Mozambique, took Sibongile to consult a powerful *n’anga* in that country. The healer fortified Sibongile’s body by making small incisions (*ntseme*) on her wrists, at the nape of her neck and below her collar bone. Medicine (*muthi*) was then rubbed into the incisions. As he performed the ritual, the healer stated that should Sibongile die, the person responsible for her death will also die.

On the evening before Sibongile’s funeral family members drove to Elite funeral home to inspect and bring Sibongile’s body home. Among the mourners was NwaMaGodi (Sibongile’s father’s sister). Upon entering the mortuary NwaMaGodi started to shake and shiver so strongly she was unable to proceed. The funeral procession travelled with the body to begin the night vigil. NwaMaGodi, still shaking and feverish

went to her house to collect a blanket. She never returned. Later that evening, NwaMaGodi's grandchildren discovered her sprawled on the ground a few metres from the toilet. She was pronounced dead on arrival at the hospital.

After Sibongile's funeral, family members discussed the implications of these events. They recalled Sibongile's visit to the healer in Mozambique and the words that he had spoken. Several family members changed their initial suspicions that Sibongile's death was caused by AIDS. The sudden and surprising death of NwaMaGodi provided evidence of witchcraft. MamaLindiwe - Sibongile's younger sister - claimed that NwaMaGodi had sent a disease similar to that of AIDS to kill Sibongile. Other relatives and neighbours speculated further that Sibongile indeed had AIDS yet was also bewitched. Perhaps NwaMaGodi had recognised that Sibongile was AIDS ill and had taken advantage of this, hoping that her witchcraft would go undetected.

## CONCLUSIONS

This chapter has suggested three possible areas of intersection between AIDS and witchcraft. In the first instance, witchcraft is an explanation for illness and misfortune and provides a means to conceptualize the massive suffering that the AIDS epidemic has caused. This is made possible because narratives of witchcraft and AIDS share similar, recurring social concerns of sexual avarice and secrecy. Witchcraft is a metaphorical analogy for AIDS. Yet, the relationship between AIDS and witchcraft does not only exist as metaphor and symbol. Witches are thought to have created innovative forms of bewitchment that mimic AIDS, and use the high levels of mortality to cover up their deeds.

The second important point about the existence of witchcraft is that it breaks down the finality of AIDS illness and death. It creates new possibilities beyond that of infection from a socially shameful and secretive disease. Conceptualizing AIDS as witchcraft provides the possibility of dispute and ambiguity. And as I have shown, it makes it possible to act against the epidemic in ways outside of the constraints and limitations of biomedicine. AIDS deaths are not avenged; despite the enormous numbers of deaths and the emotional anguish these cause, and the desire to avenge them. Those suspected of spreading HIV are not punished. In contrast however, witchcraft may be avenged, through accusation and the hunting of witches, or through the employ of vengeance magic. It is in this allocation of blame for death, not necessarily only AIDS deaths that the danger of the destructiveness of witchcraft beliefs lies. As AIDS mortality increases, it is likely that the tensions and conflict within households that are currently occurring may threaten those relationships that are most required for care and support of the infected and affected.

## END NOTES

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<sup>1</sup> The HSRC national HIV/AIDS survey reports that six per cent of those respondents over 50 years of age and 4.2 per cent of those aged 15 to 49 'believed that witchcraft could cause AIDS' (Shisana and Simbai, 2002:82). In another of 150 schools in South Africa, Peltzer and Promptussananon (2005) report that 10.4 per cent of their respondents believed that AIDS could be transmitted through witchcraft, although 35 per cent of their respondents reported that they 'did not know' the answer. Finally, Kalichman & Simbayi's (2004) 'street intercept survey' of 487 men and women in Cape Town reports that 11% of respondents 'believed that AIDS is caused by spirits and supernatural forces', while 21% 'were unsure'.

<sup>2</sup> Mogensen (1997) notes that witches in Zambia could not send real AIDS, but sent something that was 'like AIDS'.

- <sup>3</sup> A car tire is placed around the body of the intended victim and set alight.
- <sup>4</sup> The *munjhonjhela* is a bird that resides in the tall thatch grass ducking its head up and down as it runs.
- <sup>5</sup> Reports of this form of witchcraft appeared in the local news: 'Bushbuckridge - Limpopo women are claiming they're being raped "long distance". The women in Edinburgh village near Bushbuckridge say their attackers are using *muti* called *Mtshotshaphansi* that allows men to rape the women without being physically present. "I don't sleep at night because I keep on feeling as if a man is having sex with me, causing me to reach a climax and I become very tired," Hleziphi Ngwenya told a public meeting at the kraal of local induna Mngoni Malamule' (Hlatshwayo & Mnisi 2004).
- <sup>6</sup> An obvious metaphorical relationship exists between eating and sex. The same term *ku dya* (to eat) is used to refer to eating and sexual intercourse
- <sup>7</sup> Physical beauty is often associated with a light complexion. Dark skin was regarded as ugly and a sign of illness or emotional disturbance. A light complexion also implied affluence. Labourers and farm workers became dark from toiling under the hot sun.
- <sup>8</sup> The popular daily newspaper, The Daily Sun, often carries front page stories about witch familiars that cause AIDS. My informants did not support these claims.
- <sup>9</sup> This refers to the Suppression of Witchcraft Act No. 57.
- <sup>10</sup> Action can be taken against someone who identifies you as HIV positive in terms of defamation of character.
- <sup>11</sup> I lack the training and first hand evidence and thus cannot do more than speculate that *mabandi* may be herpes zoster or shingles, a condition often associated with HIV infection (Evian et al. 1993).



## CHAPTER SEVEN

### SUFFERING: BIOGRAPHICAL ACCOUNTS OF ILLNESS AND DEATH

Until now the thesis has focussed largely on public responses to the AIDS epidemic, rather than individual experiences. This chapter seeks to fill this gap. In the chapter I draw on the biographical accounts and illness narratives of two men and to a lesser extent one woman. Their accounts highlight the failure of health services to provide palliative care and lifesaving drugs. They also highlight the failure of kinship and good neighbourliness in caring and supporting the ill and dying.

The neglect of AIDS sufferers are often explained in relation to stigma based on an moralising discourses that associate AIDS with sexual promiscuity (Deacon et al. 2005; Stein 2003). The sexual conduct of men often attracts moral opprobrium; in gossip men who have many sexual partners are labelled ‘womanisers’ while women are called ‘loose’ prostitutes. They are identified as carriers and transmitters of HIV and may be blamed for its spread. While these discourses can create moral panic, they do not necessarily result in stigma. Men’s capacity to have multiple sexual partners is often construed as a sign of their success (because women cost money) and an affirmation of their identity as potent, skilful men (*wanuna ntiyela*). My male informants talked openly about their sexual conquests without fear of censure from either myself or my research assistants. Men also appeal to fictive traditions of polygamy and ideas of a natural male sexual drive and the need for release to legitimise their sexual conduct. Women who had multiple sexual partners were accused of sexual impropriety, greed and avarice. Yet, their sexual conduct was also interpreted more sympathetically as a legitimate survival

strategy; they sought men to support their children in the absence of reliable husbands. By so doing they framed their relationships with men as productive activities (See Chapter 3).

An alternative explanation for AIDS stigma can be found in the strong association between the disease and death. As I argued earlier (Chapter 4), considerable fear and anxiety surround HIV testing and even the word ‘AIDS’. This, I suggested, is due to the biomedical construction of AIDS as a fatal illness that inevitably results in death. Because death is regarded as a process of transitioning from life to death rather than a once off event, ‘... persons with AIDS are symbolically located in an anomalous domain between life and death, and are literally seen as ‘corpses that live’ (*setopo sa gopela*) or as persons who are ‘dead before dying’ (Niehaus 2007, 848). The idea of the living corpse resonates with local constructs of AIDS as an affliction that gradually consumes the body, rotting it from within. The belief that the virus is like a tiny worm that grows into larger maggots that feeds off the flesh of its victims further contributes to the vision of decaying corpses. So do descriptions of the AIDS ill as skeletons.

I suggest that this construction of AIDS underline care givers and close kin’s fears of the AIDS body and is dramatized in their attempts to conceal and contain its contaminating influence. The management of the ill and dying is a dramatic performance of the liminal status of the HIV positive person.

This response to illness is not unique to HIV/AIDS. Historically, people who suffered from leprosy were often secluded and kept apart from other family members. A traditional healer showed me a small hut (*ndumba*) she had built some distance from her homestead where she would house long-term leprosy patients, as recently as 1994. She

fed the patients through the doorway, never entering the hut. Another kept his patients chained to blocks of cement in his yard to prevent them from moving around the homestead (or escaping). Pregnant women are also kept secluded for a period of time after giving birth to protect them against the harmful pollution of sexually active bodies. Medical protocols for dealing with infectious patients reinforce notions of contamination. Tuberculosis patients were isolated in a ‘TB village’; a cluster of prefabricated huts built on the outskirts of Tintswalo Hospital, surrounded by a wire fence.

In their personal accounts of their illnesses, my informants described spatial seclusion and alienation, and their diminished sociality. They recognised and to a certain extent acquiesced to the cultural constructs of AIDS as a polluting condition that required them to be isolated and contained. In this sense their illness experiences were interpreted according to prevailing discourses of how to suffer. Yet, their experiences of illness and death cannot be solely understood in terms of these cultural meanings.

I suggest that in order to fully comprehend their experiences it is necessary to explore the details of their wider lives and that this can only be revealed through a more detailed biographical approach. Biography serves as an antidote to the relative absence of personalised accounts in the literature. Despite interest in the experience of illness and dying in the context of AIDS, there are few examples that deal with how AIDS sufferers themselves interpret their experiences<sup>1</sup>. The promise that this approach holds is not in terms of the representivity of individual biographies for the general population but in terms of the insights they offer regarding the experience of living with illness. This approach, as Farmer (2005) writes, reveals the ‘texture’ of appalling affliction and how larger scale social forces shape individual experiences of AIDS that lies beyond the

‘biomedical voice’ (Riessman 2003). Biographical accounts reveal how broader social processes and events are ‘translated into personal distress and disease’, and how macro processes such as racism and poverty ‘become embodied as individual experience’ (Farmer 2005, 30). Social forces structure individuals’ vulnerability to infection, and shape their illness experiences. This is conceptualised by the notion of social suffering.

Social suffering is not an objective fact that can be measured, or enumerated, but is a social construct with multiple meanings that vary in different contexts (Kleinman et al. 1997). For example Bourdieu (1999, 4) highlights the problem of relying on gauges of material poverty in present day France as the ‘sole measure of all suffering’. This he argues ‘keeps us from seeing and understanding a whole side’ of suffering. The process of defining and categorising suffering as an objective fact may result in the denial of care and exclusion of individuals from membership of the moral community. As Morris (1997, 40) suggests, suffering is often defined according to notions of nationhood, race, ethnicity, religion, gender or class (Herzfeld 1992). Moral texts exclude certain categories of person from the dignity afforded to others.

Farmer’s (2005, 59-66) disturbing account of the treatment of HIV positive Cuban political refugees by the US forces in Guantánamo is particularly revealing. Inmates were identified as HIV positive by wearing bracelets, lived in a camp surrounded by barbed wire, and ate maggoty food. The American forces forcefully injected female inmates with hormonal contraception. Inmates who offered resistance were beaten and arrested. The unhealthy conditions and overcrowding led to rapid co-infection with tuberculosis amongst the inmates.

The concept of ‘social suffering’ is also an attempt to go beyond biomedical and public health constructs. Kleinman and Kleinman (1997, 2) offer a two-part definition; first, social suffering is a ‘collective mode of experience that shapes individual perceptions and expressions. Those collective modes are visible patterns of how to undergo troubles, and they are taught and learned, sometimes openly, often indirectly’. Therefore, the expression of suffering and how this is interpreted is socially constructed. The second part of their definition refers to the social interactions that participate in ‘illness experiences’ and how these form a core role in the experience of suffering. Most importantly, they point to how both aspects of suffering are shaped and reshaped ‘by the distinctive cultural meanings of time and place’.

An important tool that is used in understanding the experiences of suffering is the ‘illness narrative’. This is a story of the illness experience told from the perspective of the sufferer. It is also an attempt to construct meaning from suffering and thereby to alleviate pain (Kleinman 1988). However, it is important that we do not assume that the creating meaning necessarily has benefits for individuals. Indeed, the performance of suffering may exacerbate distress and present a barrier to accessing care and treatment (Leavit 2008).

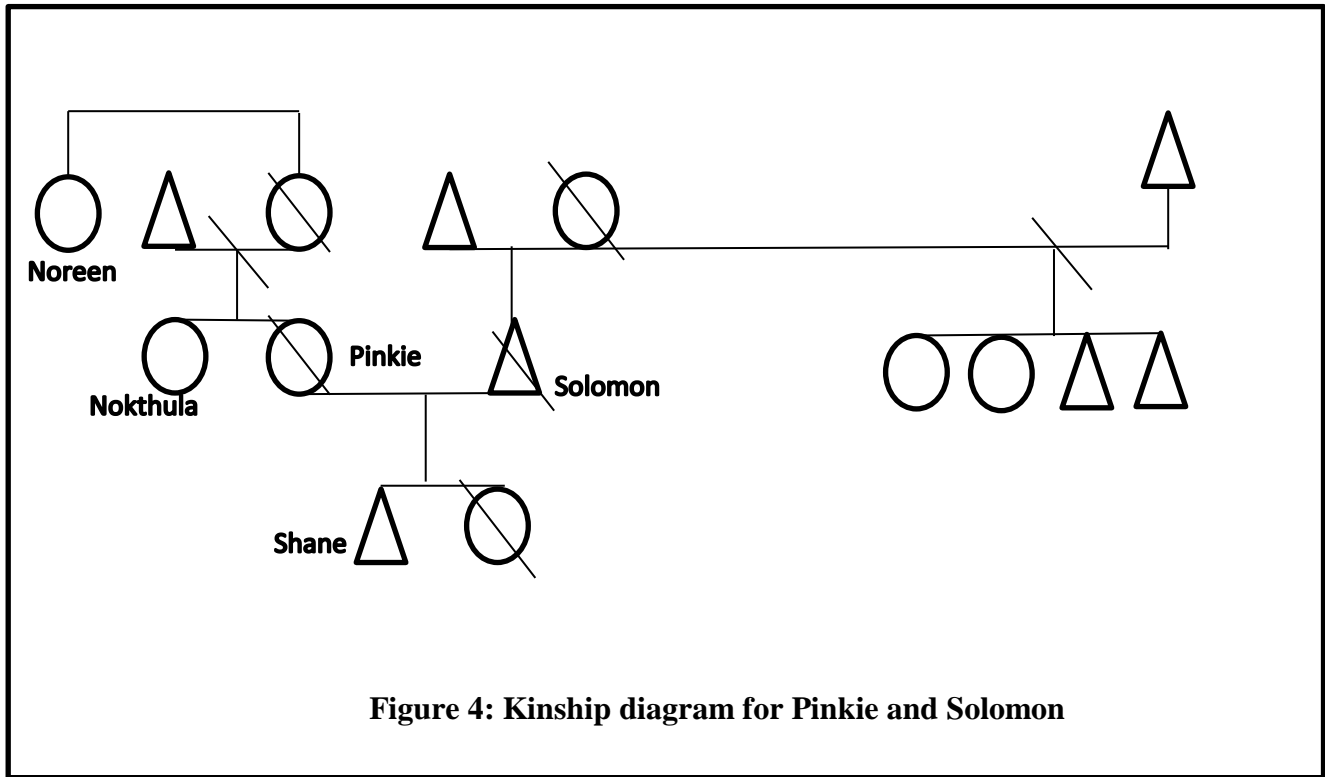
The accounts presented in this chapter draw attention to particular meanings of suffering, specific to social context and history and in particular that of social censorship and concealment. They provide insights into understanding how social responses to AIDS contribute toward the experiences and expressions of affliction.

Both accounts draw attention to the devastating loss of agency and personhood, specifically in relation to masculine identity. The secrecy that surrounds AIDS suffering

denies men who are afflicted with AIDS from performing masculinity in the public arena and therefore restricts their sociality. Being ill means being relegated to the domestic domain, cut off from social and sexual networks, unable to participate in reciprocal activities such as labour, drinking, and sexual relationships. Being physically incapable to work means financial insecurity as well as denial of social worthiness. The physical effects of AIDS illness which is characterised by an inability to consume, to grow, and to contain bodily processes is a metaphor for the erosion of sociality. Henderson (2004, 45) aptly describes the AIDS body as ‘vertiginous’: ‘The failure of bodies to hold, to maintain a modicum of coherence is externalised and mirrors an experience of collapsing sociality’. In another respect, the image of illness and death surrounding once healthy and vital bodies casts shadows over the notion of ‘traditional’ masculinities associated with sexual prowess and multiple sexual partners. Hunter’s (2004) historical analysis of the Zulu playboy (*isoka*), suggests that this social identity has become corrupted, linked to the spread of a deadly disease.

### **SOLOMON AND PINKIE**

I first met up with Solomon and his wife Pinkie in May 2004 in Johannesburg and followed their progress from December of that year in Bushbuckridge until April 2005. I conducted five formal interviews with Solomon and spent several evenings and early mornings accompanying him and Pinkie on trips to the AIDS clinic and casualty ward at Tintswalo Hospital in Acornhoek. The following account is structured around my participation in trying to seek care for the couple and the conversations and interviews that took place.



### Leaving KwaBomba to build a new life: 1970-2000

Solomon was born in 1970 on a commercial farm called Kiepersol near Hazyview. His mother was married to the Mnisi of Kasteel, an impoverished family with little means of support. Tiring of the endless struggle to survive, she left her husband and took her children to live with her brother in KwaBomba. As she was still married to Mnisi, she acquired a stand under that name and built a house in KwaBomba. As a single mother, Solomon's mother sought the work of desperate women as an unskilled labourer

picking oranges on the citrus estates. It was here that she met Solomon's father and together they raised Solomon.

Solomon spent his early years on Kiepersol Farm. He learnt how to speak Afrikaans and drive a tractor, skills that were vital for his later employment. In the mid-1970s, Solomon's mother and father left Kiepersol and returned to KwaBomba. They were amongst hundreds of households who left the white – owned farming estates at that time. Mechanisation and farmers' preference for seasonal and casual labour forced farm labour households to live on the newly created Bantustans. Solomon's mother was enthusiastic to relocate closer to schools that were being built to accommodate mother tongue Tsonga speakers.

The move to KwaBomba united Solomon with his stepsiblings. However, when Solomon's mother died of cancer in 1985 the step-children confronted Solomon's father and demanded he leave the homestead. They claimed that the homestead belonged to the Mnisis, and that he had no right to live there with them.

Solomon felt aggrieved at how his siblings treated his father. Escalating tensions between Solomon and his stepsiblings led him away from KwaBomba to seek work in the East Rand town of Brakpan. Solomon started work as an apprentice boilermaker and was soon earning a good wage as an independent contractor.

Solomon first met Pinkie in KwaBomba when she was visiting a neighbour. He fell in love with Pinkie and boasted to his friends that he would marry her.

I asked her to marry me and she agreed because she said she didn't want to play around anymore. It was very important to complete the *lobola* [bride wealth] payments because if you don't then you get shit from your in laws if your wife dies.



The couple moved to Tsakane and celebrated their marriage with a party. Only Pinkie's kinsfolk attended the wedding. This symbolised Solomon's complete detachment from his family in KwaBomba.

Over the years, Solomon built up his home. His son, Shane, attended a decent school. Solomon financed a second-hand Audi and Pinkie learned to drive. They purchased furniture, a television, and a music system, a fridge and a stove. Like many migrants Solomon also built a second homestead in KwaBomba. Yet his investments in the Tsakane homestead stood in stark contrast to the pathetic two-roomed structure he erected in KwaBomba. This symbolised his lack of attachment to and interest in his rural family. Pinkie and Solomon were able to exist independently of their respective families. Pinkie's sister (Nokthula) and her mother's sister (Noreen) were their only link to KwaBomba. Pinkie's father was unknown to her and her mother had died when she was still young.

### **Illness and the loss of autonomy**

Solomon first started to fall ill in 2001. He was weak, had a severe cough, and chest pains. A private physician diagnosed Solomon with pulmonary TB and promptly referred him to the Far East Rand Hospital. Solomon's lungs were drained of fluid and he remained an outpatient for eight months. Solomon continued to take TB treatment administered by a local clinic near Tsakane. His recovery took far too long and it was almost 18 months before Solomon was well enough to return to work in 2003. However, even then he often became ill and would take off one week out of every four. His doctor advised him to request early retirement. Unfortunately, this spelt financial ruin for Solomon. He was behind on his car repayments and had to cancel his plans to build a new

house. In November 2003, Solomon suffered a minor stroke and his employer placed him on extended sick leave.

Solomon claimed that throughout his illness he was unaware that he was HIV positive. He speculated ‘the doctors were too scared to tell me I had HIV’. He imagined that his ‘chest problem’, as he put it, was caused by inhaling dust from the grindstone he used at work. Many of his co-workers said that this dust caused tuberculosis. Nonetheless he had a nagging worry that he may have HIV.

When I think too much about this disease I can get heart sick. This is what caused the stroke. I feel pain, I cannot breath, I feel hot, and I sweat. I was so worried and I never told anyone. I think maybe I have got AIDS and I worry. If you don’t know then nobody can help you. If you don’t explain then they can’t help you. It is good if the Doctor says you have this and you must take that [treatment]. I would worry but I never thought of killing myself. I prayed to God and thanked Him for making me better. I also worried when my wife was sick and I prayed that she would be better. I was suspecting that she had HIV.

Pinkie was diagnosed with HIV in 2003 after she fell pregnant for the second time. Their baby only lived for 18 months. Solomon claimed that he was unaware that his child had died of AIDS and was unaware that Pinkie was HIV positive. Solomon recalled his reaction when he discovered he was HIV positive.

I had heard of HIV – in fact, I thought maybe this is HIV. But, when the Doctors told me I was shocked and I cried for a little while. Then I told Nokthula [his sister in law] and she said that many people at home [in KwaBomba] have this disease...I told her to tell Pinkie. I was really scared to tell her. But, she [Pinkie] was not angry when she found out. She just asked me ‘why didn’t you tell me before? Don’t worry you must go to work again. You are still a man. Other people also have this disease. You must forget about it. You will get heart sick again if you worry too much. We have always heard about this on the radio and now it is happening to us as well. You must behave like a person who has not got the disease – otherwise it will simply get worse’. She never blamed me. I never blamed her.

In these accounts Solomon draws attention to the need to avoid thinking about the disease and Pinkie's insistence that Solomon could continue to function normally as a man.

My relationship with the couple happened by chance. In May 2004, I received a telephone call from Pinkie's sister telling me that her sister and brother-in-law were ill. She knew that I was interested in AIDS and thought I may be able to offer advice. At the time Pinkie and Solomon were living in Tsakane. When I visited the couple in Tsakane Pinkie was severely ill and appeared shrunken under the heavy blankets on her bed. According to her sister, Pinkie refused to eat solid food, preferring porridge with the consistency of baby food. Solomon was slightly better off, but extremely gaunt and walked with obvious pain. I decided to take the couple to the Johannesburg General Hospital. Despite being armed with a referral letter from a physician colleague of mine our visit did not last long. The matron in charge of the clinic dismissed me without even having seen Pinkie or Solomon, or my letter. Our next stop was the Lillian Ngoyi Health Centre, located within the sprawling grounds of the Chris Hani Baragwaneth Hospital in Soweto. Here we met with similar resistance. The senior clinician instructed us to consult first at a primary health care clinic and to be referred to Lillian Ngoyi. We had clearly cut out a step the health system had designed to avoid over burdening tertiary care institutions with walk in patients. The clinician did not try to conceal her irritation and hostility toward the three of us. She chastised Solomon of using 'a white man' to get favourable treatment. She told me 'many whites bring their garden boys here and I tell them the same'. My presence was obviously more of a hindrance. After some haggling and pleading a kindly nurse gave Pinkie and Solomon files and were soon seen to by the

physician. HIV tests were conducted and the results were discussed. During their consultation the doctor speculated that Pinkie was the source of the infection as she appeared to be at far more advanced stage of disease progression than Solomon. She also claimed that Solomon's condition was partly due to his use of traditional medicine that had a positive effect. Solomon and Pinkie were told to return to collect their CD 4 counts and were prescribed vitamin pills.

I suspect that Pinkie and Solomon lost hope of finding a medical solution in Johannesburg because later in 2004 the couple moved back to Bushbuckridge. Here they lived with Pinkie's aunt, Noreen in her three roomed house in Thulamahanshe. When it became apparent that the couples' health was not improving, family members, notably Noreen and Solomon's mother's brother (*malume*) encouraged Solomon to consult with traditional healers. In 2004, Solomon consulted with more than ten healers. He was extremely cynical. 'Healers don't help – they just take your money' he complained. Traditional healers were expensive and Solomon still owed thousands of Rand to various healers in Bushbuckridge and in Tsakane. One healer bathed him in chicken's blood. Solomon, doubting the efficacy of this treatment, took the chicken home and ate it. Another healer claimed that Pinkie bewitched Solomon. Yet, Solomon regarded this as a ludicrous supposition and simply the healer's attempt to 'make me afraid and get more money'.

**Table 8: Solomon's consultations with healers**

<i>Reason for consultation</i>	<i>Treatment</i>	<i>Charged<sup>2</sup></i>	<i>Paid</i>
1. Paralysis resulting from stroke	1. Divination and liquid medicine	R800	R450
2. Burning sensation in foot	2. Soil rubbed on foot	R350	R350
3. Pustules on head	3. Snuff and Vaseline mixture rubbed on sores.	R50	R50
4. Body weak	4. Divination	R150	-
5. <i>Ndzaka</i> (coughing, night sweats, weakness, weight loss)	5. Caused by having sex with Pretty after child died. Prescribed muthi to drink and to inhale.	R50	R50
6. <i>Ndzaka</i> (as above)	6. Perform <i>ku mhamba</i> (ancestor ritual)	R50	R50
7. <i>Ndzaka</i> (as above)	7. Bath in chicken blood	R50	R50
8. Weakness in body	8. Herbalist provided Philemon with 5 litres of herbal mixture. Had good results. Lasted for 40 days.	R1200	R600
9. <i>Ndzaka</i>	9. Divination and sacrificed chicken	R50	R50
10. Weakness	10. Prayed for Philemon and laid hands on his body.	Free	--
11. Gonorrhoea	11. Private physician in Springs treated Philemon.	R230	R230
12. Passed out at work	12. Taken to private physician and revived.	R140	R140
13. AIDS ill	13. Lilian Ngoyi Clinic, Soweto. Anti-biotic, vitamins, HIV test and CD 4 count	Free <sup>3</sup>	Free
14. General weakness, psoriasis on feet and legs, sores on head.	14. Purchased medication from local pharmacy	R240	R240
15. General weakness, coughing, diarrhoea, loss of appetite, headache (general AIDS symptoms)	15. ZCC healer potion consisting of: FG tea (strong tea), Trekker coffee (chicory blend), olive oil, raw garlic, brake fluid) sold in a ten litre bucket to be taken by the spoonful every hour.	R350	R350

In December 2004 when I visited Pinkie and Solomon I found that their conditions had improved slightly. They were eating well and were well looked. Noreen

met a ZCC priest (*mufundise*) who claimed to have developed a treatment for AIDS, a concoction of FG Tea (herbal emetic), Trekker Coffee (strong instant chicory), olive oil, garlic, ginger and motor car brake fluid. The mixture sold for R300 per bucket. Solomon and Pinkie finished an entire bucket in one week. The mixture was predictably foul tasting. However, they claimed it gave them appetite and energy. Solomon felt that it relieved his chest: 'It goes to the wounds in my chest and patches these' he remarked. After taking the mixture Solomon told me proudly that he could now walk the 500 metres to the river from the house. Pinkie was able to sit up in bed for the first time in weeks and come outside to greet me. Although I was doubtful of the efficacy of the medicine, I felt hopeful. However, the benefits were short-lived. Solomon and Pinkie were plagued by diarrhoea and vomiting and lost their appetites.

The couple also enrolled at the AIDS Clinic called 'Rixile' ('The Sun Rises'). Doctor Martins, Pinkie's physician told me that she suspected that Pinkie had contracted a rare type of pulmonary TB but the diagnosis and treatment were not easily available and prohibitively expensive. Doctor Martins said:

You know, Jonathan...if this were a first world clinic situation like in Germany she would be put on ARVs and TB medication and steroids and we would save her. As it is there is very little we can do for her. I think she is not going to make it.

Doctor Martins was correct. Pinkie died late in January 2005 (See Chapter One). Solomon continued to seek treatment, but died soon after Pinkie in August 2005.

### **After Pinkie's death**

Up until Pinkie's death, Solomon lived with Pinkie's family in KwaBomba. Although he had little money, Pinkie's family supported and cared for him as best they were able. As soon as Pinkie died, Solomon moved out of her room into an outside hut. One week later, after the ritual cleansing Solomon moved back to his house in Tsakane. I heard rumours that he had started a new relationship with a woman who worked for a home based care organisation.

I understood Solomon's desire to leave Bushbuckridge. Solomon's illness meant that he could no longer maintain his independence and faced a major dilemma: to return home to his unkindly stepsiblings or live with Pinkie's relatives who had showed compassion towards him. Solomon harboured strong suspicions that his stepsiblings were waiting for him to die so that they may inherit his car, the house in Tsakane, and its contents. They were also aware that Solomon stood to receive severance pay from his employers. Solomon had a reoccurring dream in which his stepsister visited him in hospital, and offered him food to eat. In the dream, he cried out asking her why she wanted to poison him.

Resolute that his stepsiblings would not acquire any of his accumulated possessions, Solomon transported his furniture, television, video machine, beds and couches to Noreen's house. Even though his car had long been repossessed by the bank, he pretended that it was being repaired to make his stepsiblings, as he put it 'think they will get my beautiful car when I die'. Solomon was open about his resentment towards his stepsiblings:

When I was sick they ran away, they want my car. They are saying ‘I want this car when he dies’ But not one of them helped me. Not once! My sisters only want to see whether I am dead because they want my car and they want my house

After he moved away from KwaBomba, I lost contact with Solomon. According to Noreen, the day before Solomon died his older brother visited him in hospital and demanded Solomon’s bankcard and secret pin code. The brother withdrew the balance of Solomon’s severance pay. He then shared the money amongst his brothers and sisters who feasted on meat and beer for the entire week.

Solomon’s account draws attention to tensions that many men experience between maintaining their ties with their rural home and kinsfolk and playing a role within these networks, and at the same time, establishing their own households and independence identity. In a context of extreme poverty, wage earners are placed under considerable pressure to support their wider extended family. In many cases men desert their kin and attempt to establish themselves independently in the urban areas. This was illustrated in Solomon’s case by the financial investment placed on building a home in the urban areas while neglecting to do the same in KwaBomba. Men who make large financial investments in building houses in the rural homestead show their intentions to retire at home. Solomon made it clear that he did not consider KwaBomba home, owing to the failure of his relations with his half-brothers and half-sisters. The significance of his illness was that it eroded his independence from his extended family. His distress during his illness and after the death of his wife focussed on a struggle to maintain his independence that he ultimately lost. In a metaphorical sense, Solomon’s body was consumed by a disease that also consumed his social identity.



## **KHAYELLHLE MHLANGA**

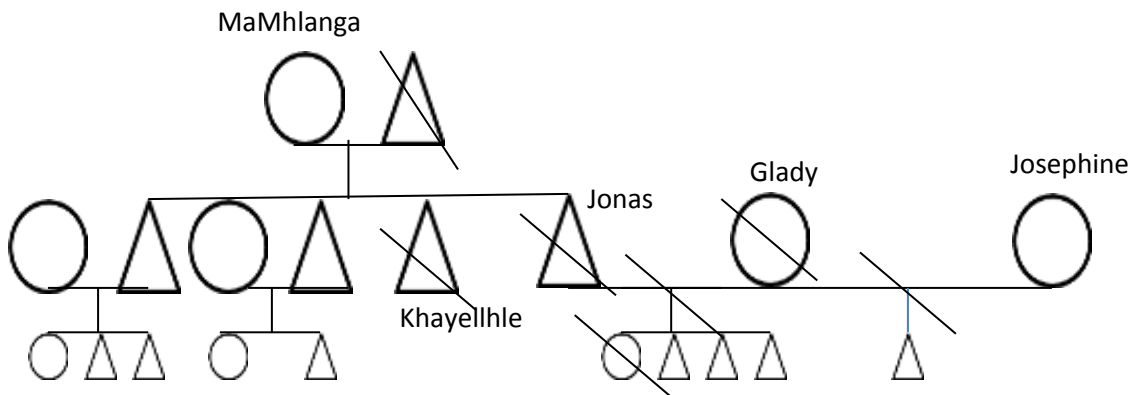
Khayellhle Mhlanga was 46 years old; he was strong and wiry from a life of hard physical labour, but his face betrayed the severity of his illness. Khayellhle's cheekbones were gaunt, his cheeks looked bruised, his lips were pink with fresh scar tissue, and he wore a woollen hat to hide his thinning, downy hair. MaMhlanga initiated my first meeting with her son. She had heard about my interest in AIDS and wanted me to assist with Khayellhle's application for a government disability grant. The application was successful but Khayellhle benefited for only one month before he died.

During our first meeting, MaMhlanga did most of the talking while Khayellhle coughed and nodded in agreement. He seemed physically drained and I felt hesitant to interview him. Over the next 18 months his health fluctuated dramatically from good to bad and I learnt to expect the worse every time I returned to visit him.

The household had limited financial resources to support a person as ill as Khayellhle. MaMhlanga was unemployed. She received a state pension of R750 per month supplemented by selling mats woven from plastic bags. These funds were used to buy E-Pap (maize meal mixed with vitamins), fruit and vegetables, and the taxi fare to the hospital<sup>4</sup>. The household comprised eight adults and seven children. Three children received a Child Support Grant (R170 per month per child). Most of the household lived in a four bedroom house, paid for by Khayellhle's father's life insurance policy. We usually met on the veranda, shaded by a leafy creeper.

In our meetings, Khayellhle spoke softly but candidly about his history of infection, illness, failed relationships with women and his violent past. A prominent theme that emerges from his narrative is his growing inability to exercise agency, the

sense that AIDS had stripped him of his masculinity. In order to understand how and why this occurred, it is necessary to view his illness within the broader context of his life.



**Figure 5: Kinship diagram of the Mhlangas**

### **‘I started to run wild’: work and women (1958 – 2000)**

Khayellhle was born in KaGomane village, one day’s drive from Maputo in the Gaza Province of Mozambique. Khayellhle’s father worked on a South African gold mine and was absent from home until Khayellhle was about eight years old. Until six years of age Khayellhle lived with his father’s mother and looked after her cattle. Khayellhle recalled the constant struggle to find food: ‘The problem was hunger – everyone was hungry. But my grandmother made sure that we always had something to eat before we went to sleep’. They ate boiled dried game meat (*biltong*) served with wild fruit mashed into a pulp. Like the other herd boys, Khayellhle hunted mice and collected termites to

eat during the day. Khayellhle's father returned home when Khayellhle was eight years old and sent him to school. Khayellhle loved school but performed poorly as he had to herd the cattle in the mornings and afternoons.

When Khayellhle was twelve years old, witchcraft suspicions and accusations broke up the family. One day, while playing, Khayellhle's little brother Ozeus disappeared, appearing hours later in a hole in a tree. The children suspected that their grandmother was responsible for his mysterious disappearance. Khayellhle's grandmother became furious when MaMhlanga questioned her about what had happened to Ozeus. Suspicions of witchcraft hardened after Khayellhle's older brother Jonas died after a short illness. After Jonas was buried, MaMhlanga reported mysterious sightings of the boy. She suspected that her mother-in-law had transformed Jonas into a zombie (*xindhachani*) to work for her in her fields (cf: Niehaus 2005).

Fearing for her children's lives Khayellhle's mother fled with them to South Africa. This was in 1969 long before the influx of refugees from Mozambique into South Africa. The family travelled by train to the border and jumped the fence and walked the remainder of the journey. MaMhlanga's brother lived in KwaBomba and he helped her find a stand and paid for Khayellhle's schooling. Back at school, Khayellhle was happy. He did well and was content.

I remember sitting together with Joyce [his best friend] at school. I was promoted from Sub B [Grade One] to Standard One [Grade Three] because I was really bright. I was appointed as a prefect to report on the noisy children in the class. They would get beaten with a *sjambok* [leather hide whip] when I reported them.

Unfortunately, Khayellhle's school career was short lived due to a lack of funds.

Khayellhle's uncle (*malume*) came to his assistance and found him work as a shop

assistant in the East Rand township of Brakpan. Life in the city was hard for a young Shangaan-speaking man and the savvy townsfolk took advantage of his inexperience. They called him ‘*barrow*’ (a naïve country boy) and teased him for his ignorance of the ways of the town. ‘I couldn’t speak their language [IsiZulu] and so they thought I was stupid’. At night when Khayellhle locked up the shop, gangsters (*tsotsis*) beat him up and tried to take the shop keys. Khayellhle soon learnt to protect himself and carried a long stick. The next time the gangsters threatened Khayellhle he beat them up.

As he now earned a small income, Khayellhle intended to marry Joyce, his friend from school. ‘She was my only friend at school. I didn’t have a male friend’. However, his mother forbade the union. Joyce lived immediately next door to Khayellhle’s family and marriage and neighbours did not mix well; suspicions of witchcraft and theft are common sources of conflict between neighbours and would threaten the marriage. Instead, MaMhlanga negotiated with the Mathonsi family from Acornhoek to marry their first born, Gladys. Joyce was furious. Khayellhle laughed when he recalled the battle between the two young women: ‘They fought with each other until they bled. Joyce really wanted to marry me. She knew that I was working in Brakpan and I could have supported her quite well’.

Khayellhle had few memories of his marriage to Gladys and he possibly regretted the loss of his friendship with Joyce. Khayellhle’s first born son lived with them in their backyard shack in Tsakane. However, the family soon outgrew their lodgings. Khayellhle built a small two-roomed house in KwaBomba and Gladys returned to the village with their three sons. In 1981, Khayellhle secured a well-paying job with Grinaker, a large

construction company. He was often on the road, laying railway sleepers and working on building sites Witbank.

This was also a turning point in Khayellhle's sexual history. Khayellhle had only played at sex (*matanyula*) with Joyce before marrying Gladys. Like other boys of that age, first sexual contacts were limited to playing *ku-ku* (hide and seek) with girls of the same age, and simulating sex fully clothed. Yet, after marriage Khayellhle had numerous extra-marital affairs:

I had never thought of this before I was married. [After marriage] I started to run wild – I had many girlfriends. I started off with one and then had the other. This was a surprise to me. When I was young I had never experienced women. I had a friend called Dlamini. He would visit together with his girlfriend and her friend. So I got involved with her. So that is how it started. A friend can make you do things that you don't really want to do. Dlamini told me straight – here is a woman! When I was living in Brakpan I told myself that I must love one woman in Brakpan and one woman at home.

Back home in KwaBomba, Gladys became friends with another woman who frequently travelled to Randfontein on the West Rand. They exchanged sex for gifts and money with the men who worked the goldmines in the West Rand. News of Gladys' activities reached Khayellhle. The Mhlanga and Mathonsi elders discussed the problem and agreed that Gladys would return to her parent's home, while the Mhlanga family would retain custody over the children. Khayellhle had paid the full bridewealth and he had rights over his children.

Thoroughly disenchanted with the way his relationship had turned out, Khayellhle broke up with his paramour (*xigangu*) and remained chaste for an entire year. Two years later Gladys died of unknown causes.

### **Three murders and jail (1989-1991)**

In the late 1980s, Khayellhle's life course changed dramatically. In 1989 Khayellhle spent eight months awaiting trial in Moderbee prison for a double murder. At the time he was living in KwaThema on the East Rand. Walking home after a night of drinking, a gang of sixteen boys attacked Khayellhle and his companion. As the boys circled in, Khayellhle's friend fled. Reminiscent of his early days defending himself against the thugs of Brakpan, Khayellhle sought to defend himself. He recalled: 'My aim was to use my knife on one of them. Once they heard him scream they would run away. I stabbed two of them and killed both...I aimed for the throat'. Khayellhle felt his actions were legitimate: 'I was happy that I was alive. Instead of me dying, two of them died'. As he predicted the thugs fled. The police arrested and charged Khayellhle with murder. Khayellhle served seven months awaiting trial in Moderbee prison.

In prison, Khayellhle had to defend himself again. Two men demanded Khayellhle's new overalls and attacked him in the showers. With soap in his eyes, Khayellhle grabbed the one man's neck and bit as hard as he could, and killed him instantly. Fortunately the prison authorities regarded the incident as self-defence and did not charge Khayellhle. After this event, leaders of the 28 prison gang invited Khayellhle to join them. The 28 were South Africa's oldest prison gang, with a reputation for savage violence. In 1996 the 28 gang in the Barberton jail killed a man, 'dissected his body with knives and actually ate the liver' (Niehaus 2002c, 89).

Khayellhle explained the advantages of belonging to a gang in prison:

There were about 40 or 50 of us in the cells. Eh it is true – there is a lot of rape in jail. I saw this many times. You were only protected if you had someone who

knew you from outside. Then he would say ‘Hey don’t touch this guy. I know him from *lokshen* [location or township]. But me I had no one. When they lock you up there is only one police officer [prison warder] to protect you. They are too scared to intervene. The reception office was far away. If there was a rape then they had to go far to call the other warders. It was only like this for me when I first arrived. But once I joined the 28s they know you can fight. Then you can smoke with them – they are your big friends. They used sharpened spoons to cut out the heart and they ate it.

After he joined the 28s, Khayellhle was marked with a tattoo on his torso: a dagger tattooed on his left arm and on the right a dagger piercing a heart. On his chest, a snake coiled around a lion and a mermaid:

The lion is powerful like me. I am a lion. I can kill someone, like the 28 are the most powerful group. The snake is a woman. So is the mermaid. The 28 don’t trust women. They say it is better to trust a man than a woman

Having found that Khayellhle acted in self-defence, he was released from jail in 1991. Fortunately he was re-employed by Grinaker. However, he was soon retrenched along with thousands of other workers. Despite his long service to the company, management claimed that there were too many retrenchments to pay out workers in full. As Khayellhle put it ‘A Sotho man from Tzaneen stole our money’. Depressed and angry Khayellhle returned home. This anger translated into excessive drinking in the tavern lounges and shebeens in KwaBomba. Khayellhle favoured Solly’s tavern, a run-down shell of a house. He was often the centre of fights at Solly’s and was arrested on two occasions.

### **Infection, accusation and revenge (1992-2003)**

Where migrant life had disrupted his role as a father and a husband, urban crime and violence further hardened Khayellhle. Desperate for work, in 1992, Khayellhle found

work with a swimming pool construction company in Nelspruit. The work was poorly paid and infrequent. Khayellhle felt exploited and claimed that the owners were corrupt. However he then met Josephine Komane, a single mother of three and moved in with her in KaNyamazane near Nelspruit. In contrast to his previous relationships, Khayellhle had fond memories of Josephine. ‘She was a good, good woman, a born again [Christian]’. Khayellhle and Josephine had a son and they lived together until 2002.

Despite his good intentions, Khayellhle was often away from home and had several casual relationships with women that he met while on site in Witbank and Johannesburg. For Khayellhle, like many other men, contract work provided temporary relief from poverty. Many men drifted between construction work and informal selling, while others gradually slipped out of the market, becoming permanently unemployed, and unemployable. Commitment to a long-term relationship as a spouse or as a father was impossible under these circumstances.

Khayellhle started to drink heavily again and had affairs with the women he met while drinking in taverns. In 2002 he met an attractive young woman named Simpiwe and stayed over at her house for several days. Josephine learned about his infidelity and threw him out. Khayellhle moved in with Simpiwe, a move he later regretted.

Simpiwe was younger than Khayellhle and had several lovers in KaNyamazane. She was also extremely abusive. Khayellhle spoke at length the nature of his relationship with Simpiwe:

The person who destroyed my spirit was that woman that I stayed with [Simpiwe]. She would come home drunk and would wake me up and start to insult me and do horrible things to me. She really killed my spirit. She insulted me about my mother’s panties and she would say anything she liked to me. And she could fight! She beat me on the mouth. She would never get tired, from morning



to night. She would drink a lot. When I was at work I was relaxed but when it came time to go home I would become afraid. If she hadn't seen me that day she would question me when I got home: 'Who did you talk to?' She would argue with me. Eventually I would just stay silent when she spoke to me. When my son [from the first wife] visited me she would get really angry with me: 'What are you talking about with him?' It [her anger] was sudden. We would be sitting together and laughing together and then she would just go mad. Her eyes would go white. When I got home from work she would give me food and water. But later in bed she would change and become mad. It is better to learn about a woman first before you go and stay with her. Even if I had done nothing wrong she would take a broken bottle and stab me on the arms and on the stomach and on my hands. She once burnt my head with a [clothes] iron. She would start hitting me. I wouldn't beat her back because I was afraid of being arrested. Once I called the police and they sent me to the hospital to get a letter [to provide proof of the assault]. They never arrested her though. Once when I was fighting with her she called her daughter and told her 'boil some water, I want to burn your 'father' [not his biological daughter]'.

Prior to her relationship with Khayellhle, Simpiwe was involved with a man who had died. His relatives suspected Simpiwe of witchcraft and when they buried him, the family elders threw Simpiwe's clothes into the grave. Khayellhle thought 'they wanted Simpiwe to follow him to the grave'. Indeed, soon after the burial Simpiwe became ill and consulted a faith healer who revealed that her former lover's family had tried to bewitch her. Khayellhle was convinced that the man had died of AIDS and that Simpiwe had passed the infection to him.

She walks with the disease. She knew that her boyfriend died of AIDS. This woman wants to give everyone [AIDS]. When I was not there she would go to the *shebeens* to have sex with as many men as she could find. This woman just wants to give everyone [AIDS]. She had a big body, big legs. But now she looks way too slim. I found her slim. But she started to get worse when I was with her. Straight, she gave me HIV. I know that for sure. Straight! Straight! Straight! [Definitely]

In 2003, Khayellhle started to become ill. At first, his illness manifested as a skin rash. He was constantly tired and developed sores on his head, torso, and legs. At a

hospital in Nelspruit he was told that he had to be tested for HIV. When he heard he was HIV positive he was shocked.

I had heard about HIV before on the radio for a long time. But I really didn't expect that I would end up getting this disease. It is strange because when I was in Johannesburg I was really running around with women. This was long before I had heard about AIDS. But the time I settled down that is when I got it. [When I was told that I had AIDS] I cried. I was very upset. I sat at home and played Gospel music.

In February 2003, Khayellhle confronted Simpiwe and accused her of infecting him. He recalled the confrontation: 'After this, the way I feel, I think it is you [who infected me]. But she said 'No! You found me well and now you are sick but I am still healthy'. Simpiwe completely neglected Khayellhle. Even though they were living in the same house, she drank beer and even had sex with men in the same room. When Khayellhle visited hospital for a few days, Simpiwe invited a white man who paid her for sex, and even paid her daughter R2.00 to keep her quiet. Later that year Khayellhle broke off his relationship with Simpiwe and returned home to KwaBomba.

Khayellhle did not inform his mother that he was HIV positive. MaMhlanga consulted a ZCC priest (*mufundise*), a faith healer (*maprofeta*) and several diviners (*tin'anga*) to find the cause of her son's afflictions. Khayellhle's health deteriorated rapidly and fearing for his life MaMhlanga took Khayellhle to Tintswalo hospital. Khayellhle was re-tested and he disclosed to his mother that he was HIV positive. 'I told her that those healers she had spent money on were not going to be able to help me'.

Khayellhle was then determined to confront Simpiwe and to get revenge 'for what she had done to me'. He returned to KaNyamazane and accused Simpiwe again of infecting him. Simpiwe became enraged and attacked Khayellhle, biting his arms and

hands. He fled and never returned. Yet, Khayellhle's anger towards Simpiwe grew stronger. He plotted to confront Simpiwe again, intending to kill her before killing himself. He was sure that Simpiwe had infected him as she seemed strong and able while he was weak. He explained that the infector was always healthier than those they infect. 'She took my strength when she infected me'. Khayellhle also resented Simpiwe for the way she had changed his character. As he put it: 'She poisoned my spirit. So now I have no patience. I can get angry about the smallest thing'.

### **The machine inside controls me: Final days (2004-2005)**

Dealing with anger and frustration was a constant battle for Khayellhle. He was especially concerned with becoming 'heart sick' (*vu vabya mbilo*) and constantly sought peace and quiet and avoided situations of conflict. He described his struggle to control his emotions:

I don't need to get angry. I feel weak if I see something that makes me angry. I have such a short temper. If someone doesn't reply to me when I speak to them I feel like running away from them. If someone makes me angry I feel like just looking at them without replying to them. It stays for a long time in my heart what that person has done

Khayellhle attended the AIDS support group at the Rixile AIDS Clinic at Tintswalo Hospital. Fellow members advised him to avoid becoming 'too upset'. They said that keeping calm and avoiding stress extended life. Yet, the greatest challenge that he faced was managing the tedium of illness.

Khayellhle's days were monotonous and repetitive. Apart from me, his only other regular visitor was his brother. One day Khayellhle helped his brother make cement

bricks in the yard, but after only a short while he was exhausted. ‘He does nothing here’ commented Ma Mhlanga. Khayellhle agreed:

I am very bored. No one visits me. I can’t chat to the youngsters in the homestead. I just listen to the radio and sleep. I don’t really have many friends. Before when I used to drink I had friends. Now I no longer have any friends. I just sit and listen to the radio. I would like to talk to other people who have this disease but they are just not interested. They are also scared to talk. I don’t know how to talk to people. It is easy for me to talk in the support group. But, I don’t want it to seem that I am pushing other people to do something that they don’t want to.

The response of other household members reflected increasing anxieties regarding Khayellhle’s physical appearance and potential contamination. When Khayellhle first returned home ill with AIDS, he slept in the living room in the main house. Later he moved to a dilapidated hut in the yard, usually reserved for the young men (*lawu*) situated at the entrance to the homestead. The *lawu* was considered private space, normally associated with the young men’s (*vajaha*) sexual autonomy. The separation of young sexually active men from other members removed their polluting bodies from those of the younger children.

These fears were further illustrated by the behaviour of other household members toward Khayellhle. Early one morning Khayellhle sneaked into the kitchen before anyone was awake and cut slices of bread from a fresh loaf. His younger sister discovered him eating and demanded that MaMhlanga throw the bread away. MaMhlanga smiled as Khayellhle recounted this event, and unconvincingly claimed ‘I ate the bread – just to show them it was okay’. She shrugged off the bread incident and claimed that the girl who had caused the incident was ‘not right in her head’.

Khayellhle's preoccupation with Simpiwe faded with time. He felt no anger towards her and no longer sought revenge. Instead, his thoughts turned towards his current predicament, his concerns for his children's welfare and future. Khayellhle prayed every night with his mother. His prayers were always the same: 'When I pray at night I ask God to give me more days to be alive to be alive for my children'.

In November 2004, Khayellhle left KwaBomba to seek work. His former employer wanted him to build swimming pools in Witbank. Khayellhle completed the first three months of his course of TB medication and felt well enough to return to work. He was painfully aware of the unkind gossip at home that accused him of wasting household resources. His grandmother made it clear that supporting Khayellhle was a waste of food. A neighbour overheard her saying 'What is the point in helping him if he was just going to die?' Khayellhle's younger siblings were respectful toward him while they were in the homestead, but he was aware that they gossiped cruelly about him with their friends from school and in the neighbourhood. Khayellhle consoled himself saying 'at least I know my status. Those ones are still in the dark'.

Khayellhle returned home in December 2005 extremely ill. His journey to Witbank was a failure as he had been too weak to work and had lost his job and wages. Khayellhle's mother cared for her son, feeding him soft porridge, cleaning him up when he had diarrhoea and bathed him. Khayellhle felt that he was close to death, a sensation confirmed by a reoccurring dream. In the dream several men and women appeared, walking around his room, accompanied by an old man dressed in white (the colour of the ancestors) who carried a big stick or staff such as those held by apostolic faith healers.

The man entered the room and left out the back through a door that did not exist. The dream frightened Khayellhle, although the presence of the old man made him feel better

I felt happy and better when I saw him. I didn't feel scared at all. I really want to know where these people came from, although they were not real people. I can dream this dream every night for a whole week. In the dream, I also saw another Khayellhle (laughs) there were two Khayellhles. I tried to talk to 'Khayellhle Two' and asked him 'do you feel the same way as I feel?' When Khayellhle Two wants to reply I always wake up

Other people I talked to about the dream said it indicated that Khayellhle was in the process of dying, that he was already 'gone'. A young woman said 'this showed that he was actually dead at that time'.

At the height of his illness, Khayellhle started to feel as if he was no longer able to exercise control over his physical self. To describe this sensation, Khayellhle talked of his body as if a machine had possessed it.

When I want to vomit, I just start and I can't control it. It is like there is a 'machine' [he used the English word] in my chest that controls my appetite. Sometimes if it doesn't want me to eat then I can't. When I am eating if it has decided I have had enough then it stops me. When I want to go to sleep and if it wants me to sleep on one side and not the other then I will start coughing until I move over to that side. It is the machine inside me that controls me. Even eating it controls me. It is like an automatic machine. If it wants me to stop then it stops and makes me feel uncomfortable. It has been like this for two or three months. It has never been like this before. But if I eat *morogho* [spinach] and pap then it is okay. But if I eat meat it says 'stop'. At home they boil my meat without any oil. I enjoy eating meat and pap but it is the machine that controls me. I believe that there is something that is controlling me. It started when I became really ill and it has become a lot worse. It makes me vomit. Yesterday it was the second time I just simply couldn't control it. It pushes. Vomit, vomit, vomit! It makes me want to vomit. This is when I feel like it is a machine. I can't control it.

Khayellhle's belief that a machine controlled his body resonates strongly with ideas of the body invaded by an external agent, often expressed in witchcraft beliefs.

Witches send snakes and frogs disguised as food through dreams to choke their victims. It is also significant that Khayellhle chose the image of being taken over by a ‘machine’ to convey his loss of control over his body. Machines had a special significance for him. As a young migrant, the image of the machine represented the hard, cruel world of post-industrial capitalism in which men’s bodies were dispensable. The idea of loss of control over the body also speaks to a rupture between mind and body, where his body represented by the machine did not obey his mind. This metaphor gives us an insight into a man’s pain at having lost all hope for a recovery, and his sense of disembodiment.

In our final interview, Khayellhle reflected on his life and infection with HIV with some regret. ‘The way I grew up I was well behaved. If I had continued like that I would never be sick like I am now’. In this statement, he clearly accepted personal culpability for his disease. Yet after a lengthy pause and some thinking, Khayellhle added ‘But even Mandela’s son died of AIDS.....’<sup>5</sup>

I was not present in Bushbuckridge when Khayellhle died. His mother called me on the phone to tell me he had passed. I asked why she had not called me earlier; perhaps there was something I could have done. She said that Khayellhle refused to allow her to contact me and said that there was nothing I could do for him.

Reflecting on the account pieced together from interviews, observations and informal conversations, I realise how Khayellhle presented clues in his narration of his life story of what was to come. His story is as much about his life before becoming ill as it is about his illness. The story describes the constant struggle to maintain control of his personal life, over his sexual desires, of women, and other men, and ultimately of

becoming completely impotent and being controlled by the ‘machine’ – a metaphor for AIDS.

## CONCLUSIONS

The case studies presented in this chapter illustrate the experience of social suffering, defined as a loss of autonomy and power. The implication of this loss is particularly poignant for men of Solomon and Khayellhle’s generation. For both men this meant a failure to perform their roles as providers to support the futures of their children. Their loss of autonomy was most poignantly expressed in Solomon’s real or imagined fears that his siblings were waiting for him to die to appropriate his money. In Khayellhle’s case his loss of control was expressed through the metaphor of being controlled by a machine. As the disease progressed Solomon and Khayellhle experienced the general collapse of their bodies. Their emaciated physiques countered the ideal image of the fattened body; their skin drawn tight over their bones and the sores revealed an internal disorder; their inability to eat and retain food. The nature of their afflictions reflects the collapse of their social status and position.

Anthropologists who bear witness to AIDS face the task of rendering suffering meaningful (Henderson 2004). This is particularly critical in a context where deathly silences surround the AIDS epidemic; silences that the social and medical sciences are prone to mimic. The over-reliance on survey type instruments, focus groups, and rapid appraisals detach the observer from the realities of suffering. Ethnography provides a vantage point to witness and record the immediacies of peoples’ suffering. The biographies presented in this chapter have tried to convey this by situating suffering



within the broader context of everyday life and history. Importantly, writing about suffering is not simply about empathetic description. In trying to write about social suffering and AIDS, I have been especially mindful of Farmer's (1999) observation that sympathetic prose on suffering is not in itself a sufficient response. However, it is critical that peoples' experiences of suffering and trauma are written about in such a way that their dignity is preserved. Nordstrom (1997, 9) reflects on her writings on the trauma of war torn Mozambique:

Treating a person's experience of violence with dignity is arguably the most important part of studying and writing about violence, and it is certainly the most complicated.

In South Africa, suffering is defined according to biomedical calibrations of disease progression decided upon by global health agencies such as the World Health Organisation (WHO) and is used to determine access to medication and government grants. The continued failure to provide adequate care and support for people living with AIDS contributes toward their experiences of suffering.

## END NOTES

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<sup>1</sup> An exception is Fassin et al. (2008) who chronicle the life and times of Magda M, a young South African woman. Her story is of rape as a young girl, entering into sexual relationships with men to survive in Johannesburg, and ultimately death from AIDS illnesses.

<sup>2</sup> A standard amount of R50 is usually charged for throwing the bones. This is paid up prior to the consultation session in order to appease the ancestors. It is not included in the charge for treatment which is extra. It is common practice to pay for treatment only if the treatment offered by the healer is effective.

- <sup>3</sup> Free clinic services are provided for patients. However, Philemon incurred debt as he had to pay a neighbor to drive himself and Pretty to the clinic when I was not available.
- <sup>4</sup> A single return taxi trip to Acornhoek from KwaBomba cost R20. The availability of fresh fruit and vegetables was limited despite the lowveld being a major producer of oranges and tropical fruits. The local supermarkets sold a range of vegetables and fresh produce, but this was often expensive and required regular shopping expeditions that incurred transport costs. Not surprisingly people favoured non-perishable food such as packet soups eaten as a relish with the staple maize meal. Salads (beans and greens) were ‘Sunday food’. Many households continued to eat ‘traditional food’ (*swakudya xa xintu*) such as okra (*guxe*), groundnuts (*timwembe*) and wild spinach (*morogho*). These foods are believed to have healing properties and health benefits. Yet, despite the rhetorical claims of their benefits, villagers displayed preferences for status foods such as meat, rice, and potatoes.
- <sup>5</sup> In 2005, Nelson Mandela announced in the public media that his son had died of AIDS.

## CHAPTER EIGHT:

### CONCLUSIONS

In the conclusion to this thesis I present an overview of the main argument and its significance for the anthropological study of AIDS. I also explore what implications the findings have for the roll-out of AIDS treatment and how this can further understandings of responses to AIDS in the ‘treatment era’.

This thesis chronicles experiences of the AIDS epidemic in Bushbuckridge and addresses the underlying question: why the devastating impact of the epidemic has failed to provoke a more robust public response. I argue that despite the overwhelming evidence of the threat that AIDS poses to the health and lives of the local population and widespread awareness of the epidemic, the disease continues to be a shared secret and suffering is concealed. The ethnographic material presented in the thesis suggests that secrecy and concealment can be more fruitfully regarded as attempts by ordinary people to exert agency in the midst of an unmanageable and unimaginable epidemic.

Although anthropology is located at the margins of public health research on AIDS there is increasing recognition of the importance of ethnographic methods in documenting and analysing responses to the epidemic from the micro-perspective (Parker & Ehrhardt 2001). In particular, ethnographic research questions the relevance of concepts commonly employed within public health in different social and cultural contexts. In this regard this thesis has challenged the tendency to construct silence and concealment solely as barriers to health seeking behaviour and the adoption of healthy lifestyles. I argue that silence, concealment and secrecy are creative attempts to handle

dangerous knowledge (Chapter 4), and can be construed as performances of suffering (Chapter 7). Gossip and rumour form a local epidemiology of the epidemic that shapes individual and community responses (Chapter 4 and Chapter 5). By recasting AIDS illness and death as witchcraft, without directly contradicting the biomedical models of HIV infection and its spread, families could avenge AIDS deaths and protect individuals against misfortune (Chapter 6). In these ways the global AIDS epidemic is rendered local, reimagined in terms of local frames of reference and thereby made meaningful with regard to local histories, categories and ideas about illness.

In the following discussion I explore the possible implications of the provision of AIDS treatment in the light of the findings presented in the thesis. Before proceeding I need to declare the limitations of my conclusions and of the thesis overall. My research ended on the eve of the inception of the national treatment program; regrettably I was not able to explore first-hand the impact of this important event on local experiences of AIDS. Therefore the discussion below is an attempt to reflect upon my research findings in the light of changes in treatment guidelines and policy.

### **AIDS IN THE TREATMENT ERA**

In the era prior to the roll out of ART in public health treatment centres, South African AIDS policy was ‘a sorry tale of missed opportunities, inadequate analysis, bureaucratic failures, and political mismanagement’ (Nattrass 2004, 41). AIDS policy was based on the ‘metaphor of triage’, a rational policy in the context of low resources and high causalities such as in wartime, yet morally dubious in the context of the AIDS epidemic. The policy emphasized prevention and primary health care, but argued that

treatment was ‘unaffordable’ (Nattrass 2004). In terms of the discourse of triage, HIV positive patients were ‘heavy burdens’ on an already overextended health care system. They were less deserving of bed space and resources than ‘healthy’ patients who have a better chance for survival. For example, Le Marcis (2004) described the situation for HIV positive people seeking care in hospitals in and around Johannesburg:

Faced with a major shortage of hospital beds, the doctors often choose not to admit HIV-positive patients at an advanced stage of AIDS, because their chances of recovery are limited...

This scenario was mirrored in my experiences in trying to access care for the terminally ill at hospitals in Bushbuckridge and Johannesburg, as depicted in the accounts described in Chapter 1 and Chapter 7. As I experienced, the emphasis on prevention contributed in no small way to the attitudes of health workers toward patients who presented with HIV. Health care workers found it easy to blame the infected and deny them the care required. More broadly, failures to respond positively to prevention messages were blamed on ignorance, tradition and culture. Indeed, AIDS awareness and education directly opposed ‘tradition’ and created barriers to active community engagement (Chapter 2).

The direction of resources toward prevention strategies rather than treatment was in line with prevailing discourses in the international donor environment. For instance, some donors warned that treatment could be a contributing factor to the spread of HIV because it would increase the life span of HIV infected people and result in disinhibiting sexual behaviour because HIV would be seen to no longer pose a threat. As a result of these attitudes, many poor people in contexts where the epidemic was at its height, were

relegated to HIV prevention only (Hardon 2005, 603), despite prevention's dismal failures.

This double standard continued until the early 2000s when global policy regarding treatment for HIV positive people shifted toward increasing access to drugs, particularly for the poor. The costs of AIDS drugs were radically reduced and co-funding was provided by donors such as the US Presidents Emergency Fund for AIDS (PEPFAR). Underlying this switch in international health policy was increased recognition of the threat that the AIDS epidemic posed for global security and the potential spread of the epidemic to other parts of the world.

In September 2003, in response to pressure from cabinet members and AIDS activists, the South African government announced its intentions to introduce a publicly funded national HIV/AIDS treatment plan; twelve billion Rand was committed to roll-out anti-retroviral therapy in public health institutions<sup>1</sup>. In terms of this new policy, HIV positive people with a CD4 cell (lymphocytes) count of less than 200/mm<sup>3</sup> (a 'normal' count is 500 cells/mm<sup>3</sup>) would be placed on a free treatment program<sup>2</sup>. The aim of the HIV/AIDS and STI National Strategic Plan is to roll out treatment to 80% of those in need by 2011. Yet, progress has been slow, retarded by inadequate health systems and foot dragging (Nattrass 2005a). By 2006, 711 000 people were defined as in need of medication, while only 225 000 were actually accessing ARVs (Dorrington et al. 2006).

In Bushbuckridge, two hospitals initiated treatment and by 2005, 1750 people were on ARVs (Moshabela 2006). The majority of patients were female and had low CD4 counts were at a late stage (stage III or IV) of disease progression. This is expected given the feminisation of AIDS and the tendency for patients to delay seeking treatment

until terminally ill. Relatively good levels of retention to treatment have been achieved in Bushbuckridge. At the Rixile AIDS clinic in Tintswalo Hospital more than 80% of patients continued on a treatment program over a 24 month period (MacPherson et al. 2009).

What are the social implications of the roll out of ARVs? I frame this question, not simply with regard to the numbers of patients accessing and continuing treatment, and the resultant rates of morbidity and mortality, but in terms of its consequences for social suffering.

The literature on AIDS treatment draws attention to the phenomenal success of medical treatments even for those patients who are at an advanced stage of illness. This picture is informed by a predominantly biomedical model, promoted at the expense of locally, patient-defined responses and experience. In contrast, anthropological perspectives on treatment suggest a broader conceptualisation of the effect of medications. For example, Etkin argues:

...the paradigm of biomedicine defines treatment in almost exclusively biophysical terms, largely disregarding cultural and social factors. Thus (...) in order to conform to the biomedical paradigm, there must be a 'primary' effect to which all others are subordinated. (Etkin 1992, 100)

The cultural and social context of therapeutics can reveal how biomedically-designed drugs are reinterpreted through local paradigms. Medicine is used with the intent of transforming the body from illness to health. Yet, medicine also has social significance. Medicines assume a 'social life' in that they have social uses and consequences; they have the power to transform individual bodies from illness to health but they also change minds, understandings and modes of understanding (Whyte et al.

2002; Whyte et al. 2004). Following Appadurai in the 'Social Life of Things' (Appadurai 1986), 'things' such as medicine acquire meaning, when they become part of peoples' lives. Although the effect of medicines and their efficacy is presumed to be universal, their social effects are shaped according to cultural and social contexts.

The power of ARVs to transform the AIDS body is a dominant theme in medical discourse. Drugs can potentially change AIDS from a deadly disease into a chronic disability that can be managed using drugs. It is assumed that the drugs also transform the way people regard AIDS and those who are infected (Karim et al. 2003), for example creating a greater willingness to test for HIV (Kapp 2004). Successful treatment 'normalises' the disease and creates hope for those infected and affected. The treatment program offers:

a more optimistic script, one in which HIV-positive people are able to access life enhancing drugs that can return the patient to health and the possibility of reintegration into the social world (Robins 2006, 312).

And that which was previously an untreatable affliction resulting in social 'death before dying' is reconfigured as a rebirth. Robins (2004) suggests that effective treatment of AIDS results in individuals taking on a new 'responsibilised citizenship'.

The transformative effects of ARVs are evident in the personal testimonies of patients. The constitutional court judge and AIDS activist, Edwin Cameron (2005, 38-39), writes on his personal experience of starting ARVs:

There was only one word for it. It was glorious. The drugs were working. I could feel that I was getting healthy again. I knew that I would be well again. That, in turn, spurred my inner confidence. Physiological wellbeing had a pronounced psychic effect. If the drugs were working – and it was utterly clear they were – it meant that for the first time since my infection more than twelve years before, the



virus was no longer multiplying within me. It was no longer progressively taking over my body, taking over my life. It was being beaten back to some deeply secluded (although latently dangerous) viral reservoirs. But outside these recesses, the rest of my body was free of it. And my immune system was, for the first time in all these years, free of its burdens.

Health workers similarly report on incredible recoveries amongst patients who are at the brink of death, brought back to life after taking ARVs. They see the benefits not only for their patients but also for the morale of doctors and health workers. The senior registrar at the JF Jooste Hospital in Cape Town:

This really was the hospital where people used to come to die; it was like a hospice (...) but now 85% will leave alive. We now see patients coming in who are severely unwell and they get better. 40–50% of all admissions into the medical ward have AIDS. Before we couldn't deal with it; now we can start to try (Kapp 2004, 1710)

Similar sentiments are expressed not only by medical practitioners and affluent judges; the following excerpt from an interview with a traditional healer in KwaZulu-Natal draws attention to a spiritual and social reawakening of a patient taking ARVs:

Really ARVs reawaken people (*ngempela amaARVs ayabavusa abantu.*) I remember that I told you I had a person who was very sick in a way that cannot be described. I told you that I did not know what I could do. He now really has the hair of a person (*Manje usenezinwele zangempela zomuntu*). One can now endure looking at his face (literally, 'His face can now be looked at', '*Ebusweni useyabhekeka*'.) He is stout (*ukhuluphele*). When he walks on foot he is unable to walk slowly, he goes at a fast pace (literally, 'he stabs with doves', '*ahlabe ngejubane*'). He says it is as if he is dreaming of himself [as he used to be before the illness] because of the good life he is now living (Henderson 2005, 45)

The possibility of becoming well enough to work and contribute towards the household reaffirms the eroded social identities of those afflicted with AIDS. Castro and

Farmer (2005) present the case study of Samuel Morin, a HIV positive Haitian man whose physical recovery reinvigorated his social and domestic relations:

Of his recovery, Samuel said, 'I was a walking skeleton before I began therapy. I was afraid to go out of my house and no one would buy things from my shop. But now I am fine again. My wife has returned to me and now my children are not ashamed to be seen with me. I can work again.' (Castro & Farmer 2005, 56)

The healer from KwaZulu Natal and the Haitian man both draw attention to the possibility for re-socialisation: a renewed confidence to leave the seclusion of the homestead, and return to normalcy. Their experience is likened to religious conversion, of being 'born again' (Robins 2006).

A return to health and regaining ones identity as a sociable person was a pressing concern for those who experienced AIDS illness. In Chapter 7, we saw how Khayellhle and Solomon were stripped of their status as fathers, husbands, and sons, due in part to their inability to provide for and support their families. AIDS not only threatened their corporeal existence but also presented an existential challenge to their identities. Following biomedical treatment would have offered hope to a return to normalcy.

Yet, these optimistic scripts of treatment tend to obscure the persistence of inequalities that constrain the choices that people have in their everyday lives (cf. Hardon et al. 2006). In contexts such as Bushbuckridge, access to health services is mediated by resources: transport to hospital and the ability to navigate the bewildering maze of paperwork and tests. Treatment is also mediated by acquiescence to moral scripts of safe sex and an ideology of healthy lifestyles.

The eligibility criteria for treatment are based on biological stages of infection and psychological profiling. In terms of South African treatment policy<sup>3</sup>:

Those accepted for therapy must have a CD4 count of less than 200, no alcohol or substance abuse, and a stable domestic environment conducive to compliance with the treatment regimen (Kapp 2004)

Using these biological, social and psychometric criteria to exclude certain individuals from accessing AIDS medication reinforces social divisions and alienates those who do not meet the criteria. Personal experience of illness is irrelevant to biomedical constructs of disease. In this way treatment policy continues to transform suffering, from a 'moral experience into a mere technical inexpediency'<sup>4</sup> (Kleinman & Kleinman 1997, 15). Reflecting on his ethnography of AIDS treatment amongst the poor in Brazil, Biehl writes:

...bureaucratic procedures, informational difficulties, sheer medical neglect and moral contempt, and unresolved disputes over diagnostic criteria all mediate how these people are turned into absent things. (Biehl 2004, 119)

He suggests that the medical and state bureaucracy surrounding AIDS treatment can be seen as 'technologies of invisibility'.

AIDS treatment amongst the poor poses particular challenges. Kalofonos' reports that treatment created hunger amongst HIV patients in Central Mozambique.

As people on treatment regained their health, they also regained their appetites, as in some cases they became healthy for the first time in months or even years, and the irony of recovering from AIDS in order to suffer from hunger was frequently commented upon. Thus, though people's lives were extended, they were not improved, and were often more challenging than before (Kalofonos 2008, 199).

Kalafonos proceeds to argue that the manner in which treatment was introduced in Mozambique promoted social divisions.

By targeting a biological condition, political and economic concerns are sidelined, and local forms of solidarity are undermined as disease-related distinctions determine eligibility for scarce resources (Kalofonos 2010, 364).

As he notes, despite the dramatic and miraculous transformations of the bodies of the AIDS ill, treatment did not alleviate the condition of the poor. What we learn from this is that biomedical interventions cannot address the political, social and economic context in which infections and illnesses arise. Therefore, while it is indeed possible to roll out HAART in ‘resource poor settings’, to assess the success solely in terms of retention of patients in treatment programs does not address the underlying issues of exclusion and inequalities.

Securing access to medical and welfare support is also mediated through adopting new lifestyle changes, participating in support groups, and demonstrating treatment literacy. In his thesis on AIDS treatment at the same hospital used by my informants, Mfecane writes about the role of support groups in reconstructing masculinities. For example, ‘Any man who had multiple partners was chastised rather than being celebrated as “successful”’ (Mfecane 2010, 287). Access to drugs and support therefore came at a certain cost to dominant masculine identities and acceptance of a moralising discourse that blamed men with multiple partners for the spread of HIV.

AIDS treatment policy also creates paradoxical situations for patients wishing to access care due to the linking of disability grants to health status. Natrass (2005b) comments on the irony of the conditionality of disability grants in the context of high levels of unemployment in South Africa. She warns that by linking welfare grants to health status in this way threatens the prospects of long term adherence to ARVs by patients.

In situations of extreme poverty, material need and dependency on state welfare, AIDS medications acquire a new set of meanings. Defaulting from treatment may therefore be a means to continue to be eligible for state grants. Ill health can therefore become a commodity transacted with the welfare state. Patients may therefore have a vested interest in maintaining poor health<sup>5</sup>. The state grant in South Africa is a major source of income; old age pensions were R950 per month, child support grants were R170, and disability grants were R950. According to a survey conducted in a village in Bushbuckridge, increasing numbers of households were becoming dependent on such grants (cf. Niehaus 2006b). Grants such as those linked to AIDS are regarded as household resources and not solely for the purposes of alleviating individual suffering. Desperation to obtain disability grants may even lead to purposeful infection with HIV<sup>6</sup>:

In the Eastern Cape, there is a saying that you have ‘won the lotto’ if you test HIV-positive because it is seen as a ticket to the disability grant. If HAART is regarded (incorrectly) as a ‘cure’ for HIV, then it is possible that some people may desire to become HIV-positive under the mistaken notion that they will be able to get access to the disability grant and obtain HAART (Nattrass 2005b, 15).

These theories rationalise non-compliance or refusal to take medication in terms of material consequences. Others speculate that competing claims between biomedicine and ‘traditional’ healing can explain non-compliance. As the illness narratives presented in Chapter 7 illustrated, individuals draw on a wide variety of healing options (cf. Ashforth 2005b). People move between traditional healing and Western biomedicine freely to find solutions to their health problems (Nattrass 2005a, 9-10). In Bushbuckridge, AIDS was defined simultaneously as a traditional disease and as a modern affliction. Although ‘traditional healers’ and biomedical health practitioners draw attention to the

divide between traditional and biomedical, people draw on services, diagnoses, and pharmacopoeia that are regarded as both traditional and biomedical (cf. Saethre 2007, 103).

The belief in witchcraft is also sometimes seen to contribute toward the rejection of ARVs and the search for traditional healing in cases of AIDS illness. In Bushbuckridge, AIDS was clearly not witchcraft. Yet, the epidemic stimulated ‘spiritual insecurities’ (Ashforth 2005b) and uncertainties about the efficacy of biomedicine. I argue that witchcraft could be seen as a form of therapy to deal with the emotional anguish and desire for revenge. The witchcraft paradigm is invoked to provide answers to questions of individual misfortune. The provision of HAART in Bushbuckridge is unlikely to undo peoples’ beliefs in malevolent forces such as witches.

The introduction of ARVs in public health settings is a significant step in the fight against AIDS. It represents hope for an end to suffering. However, what medicine cannot solve are the material conditions of peoples’ lives as they struggle to access health care and fight their way through the bureaucratic structures that restrict their access to health. Even those who are successful in gaining access to lifesaving medication face new challenges of hunger, and face new paradoxes that link their access to welfare to health and to their acquiescence to biomedical authority. Given this scenario I am not optimistic that the answer lies solely in a biomedical intervention.

## END NOTES

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<sup>1</sup> Highly Active Anti-Retroviral Therapy (HAART) was introduced in the mid-1990s in the US and Europe. HAART leads to ‘significant reductions in HIV-related morbidity

and mortality’ and ‘is a highly cost-effective medical intervention’ (Chen et al. 2007). Despite the overwhelming scientific evidence, until 2004, the South African state continued to prioritise behavioural interventions to prevent infection. AIDS drugs were ‘too expensive’ to treat the large numbers of AIDS ill (Nattrass 2004).

- <sup>2</sup> Psycho-social considerations listed in the Department of Health Web Site are: Demonstrated reliability; No active alcohol or other substance abuse; No untreated active depression; Disclosure or joined a support group; Acceptance of HIV status; Insight into the consequences of HIV infection and the role of ART before commencing therapy; Able to attend the antiretroviral centre on a regular basis or have access to services that are able to maintain the treatment chain (National Department of Health 2004).
- <sup>3</sup> Recent changes to treatment guidelines changed the required CD4 count from 200 to 350.
- <sup>4</sup> The national roll out of the prevention of mother to child treatment program (PMTCT) is a good example of how the cost benefits of providing pregnant HIV positive women with the drug Nevirapin were weighed up against the future costs of healthy but orphaned children (Nattrass 2004).
- <sup>5</sup> A similar situation arose with state welfare grants for epilepsy sufferers who purposefully missed medication in order to qualify (Segar 1994). More recently the child support grant has attracted criticism that young women purposefully fall pregnant in order to have children and then benefit from the grant (MacGregor et al. 2003).
- <sup>6</sup> This is noted elsewhere: homeless drug users in California regard a HIV positive status as a way of accessing welfare (Crane et al. 2002).

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