The Bio-Politics of HIV/AIDS in Post-Apartheid South Africa

by

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Dedication

This dissertation is dedicated to Pheello Limapo, Thulani Skhosana, and Torong Ramela, for their tremendous courage and inspiration.

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List of Abbreviations

AEC	Anti-Eviction Campaign
AIDS	Acquired Immuno-Deficiency Syndrome
ALP	AIDS Law Project
ANC	African National Congress
APF	Anti-Privatisation Forum
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
Bara	Chris Hani Baragwanath Hospital
CBO	Community-Based Organization
CC	Competition Commission
CD4	This is a measurement of the white blood cell count (T-cell).
COSATU	Congress of South African Trade Unions
DOH	Department of Health
DRD	Durban Roodepoort Deep
FGD	Focus Group Discussion
FXI	Freedom of Expression Institute
Gatt	*General Agreement on Tariffs and Trade*
GEAR	*Growth, Employment and Redistribution*
GTFMP	Gauteng Traditional and Faith Medical Practitioners
GTHTT	Gauteng Traditional Healing Task Team
HAART	Highly Active Antiretroviral Treatment
HBC	Home-Based Care
HIV	Human Immuno-Deficiency Virus
HSRC	Human Science Research Council
IFP	Inkatha Freedom Party
IMF	International Monetary Fund

IPRs	Intellectual Property Rights
KZN	Kwa-Zulu Natal, one of the 9 provinces of South Africa
LPM	Landless Peoples' Movement
MCC	Medicines Control Council
MEC	Member of Executive Committee (provincial government)
MK	Umkhonto we Sizwe, the militant wing of the ANC
MRC	Medical Research Council
MTCTP	Mother-to-Child-Transmission-Prevention
NAPWA	National Association of People with AIDS
NEPAD	New Partnership for Africa's Development
NGO	Non-Governmental Organization
NRCATM	National Reference Centre for African Traditional Medicines
OI	Opportunistic Infection
PAC	Pan-African Congress
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for HIV/AIDS Relief (US)
PMA	Pharmaceutical Manufacturers Association
RDP	*Reconstruction and Development Programme*
RSA	Republic of South Africa
SACP	South African Communist Party
SANAC	South African National AIDS Council
SAPs	Structural Adjustment Programs
SECC	Soweto Electricity Crisis Committee
Soweto	South West Townships
STI	Sexually Transmitted Infection
T-cell	This is a measurement of the white blood cell count (CD4)
TAC	Treatment Action Campaign
TB	Tuberculosis
THO	Traditional Healers' Organisation
THP	Traditional Health Practitioner
TRIPS	Trade Related Intellectual Property Rights Agreement

UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	U.S. Agency for International Development
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization
WTO	World Trade Organization
ZCC	Zionist Church of Christ

Glossary

Amakhosi or Amadlozi (Zulu): Ancestors

Gobela (Zulu): Sangoma who is training initiates to become diviners

Igazi (Zulu): Blood

Igedla (Zulu): A 'witchdoctor' who casts spells and curses

Iketsetseng (Sotho): Do-It-Yourself

Ilobolo (Zulu): Bridewealth

Imbiza (Zulu): A traditional remedy used to cleanse the blood

Imbongi (Xhosa): Usually translated as "praise-singer," although it actually refers to a poet who would act as a "go-between," delivering messages from the leader to the people.

Impepo (Zulu): A traditional plant used to "call the ancestors"

Inyanga (Zulu): Indigenous herbalist

Isithunzi (Zulu): Aura

Isoka (Zulu): Form of masculinity, defined in terms of engaging in concurrent sexual relations

Makhome (Sotho): Indigenous disease associated with having sexual relations with a widow or someone how has recently had an abortion

Mpande (Zulu): A group of diviners who have all been trained by the same *gobela*, and who therefore share treatments and other indigenous knowledge

Muti (Zulu): Indigenous herbs

Pahla (Zulu): An offering to one's ancestors as a sign of respect

Sangoma (Zulu): Indigenous diviner

Surgery: Indigenous healers' consultation room

Ubuntu (Zulu): Southern African philosophy stressing communal respect and solidarity. It originates from a Zulu maxim *umuntu ngumuntu ngabantu*, "a person is a person through (other) persons"

Ukubiza (Zulu): The "calling" by the ancestors that initiates the trainership for becoming a *sangoma*

Umoya (Zulu): Body

Ukuthwasa (Zulu): Training or apprenticeship to become a diviner

Umthwasa (Zulu): An initiate going through the training to become a diviner

Umzimba (Zulu): Spirit

Veld (Afrikaans): Rural plain

Vukuzenzele (Zulu): "Wake up and do it your self"

Abstract

This project explores root causes of health inequality by combining an ethnography situated within communities ravaged by the dual pandemics of poverty and HIV/AIDS with a political-economic analysis of the post-apartheid health system. Drawing on 27 months of ethnographic field research in one former township and two informal settlements outside of Johannesburg, it contends that affected populations' healing ideologies and itineraries, as well as their gender and sexual practices are at odds with the dominant discourses and policies imposed by international health agencies and the post-apartheid state. In examining this disjuncture, the project argues that HIV-infected, Black South Africans have incorporated a culturally hybrid identity – one which amalgamates different African cultures as well as cultural ideologies derived from international, national and local influences. This cultural hybridity is made possible by the historical conjuncture of events which marked the transition from apartheid to post-apartheid, and it allows the subjects of post-apartheid to circumnavigate the material strictures erected by both neoliberal economic restructuring and the pandemic itself.

Biomedical and 'traditional' healing promote contradictory ontologies of the body and are situated within competing institutional frameworks. Further, public sphere discourses insist upon their radical incommensurability. The primary question motivating this research is, then, why do South Africans deeply affected by HIV/AIDS utilize traditional and biomedical forms of healing simultaneously, and without experiencing any sense of incongruity? The project deploys Pierre Bourdieu's concepts of field,

capital and habitus to explore the puzzling way in which people combine multiple healing strategies despite the bifurcated nature of the field of health. In so doing, it analyzes the effect of neoliberal economic restructuring on peoples' health-seeking behavior, the symbolic struggle over the signification of HIV/AIDS ravaging South Africa's public sphere, the relationship between local and global conceptualizations of disease, and the way in which subjects' hybrid health itineraries are stimulating shifts in the configuration of gender, sexuality, and race politics. The hybrid nature of Black South Africans' identities has been ignored by both policy initiatives and academic research, which either attempt to impose biomedical hegemony from above, or at least assume a certain static or culturally homogenous disposition.

Chapter 1

Introduction

"Osiah was HIV positive and in denial. He wouldn't speak about it and yet he participated in all the early HIV awareness campaigns … Osiah … made a powerful artwork which was exhibited as a billboard about Breaking the Silence….and yet he chose not to take antiretroviral medication, and instead went to a traditional healer … When we now have a choice and can provide ARV treatment that can save lives … why does someone like Osiah, surrounded by people who can help him have access to counseling and treatment, why do he and [others] reject that choice and seek treatments from traditional healers?" (Berman 2008).

Liz McGregor's book, *Khabzela* (2005) tells the story of popular Yfm radio DJ Khabzela who died in January 2004 of AIDS. Khabzela had openly disclosed his status on the radio, making him a hero in a country ravaged by stigma and silence. Despite this widely heralded decision, Khabzela made another decision which was not only publicly lamented, but which became a common and troubling mystery. "Khabzela's premature death at the age of 35 could have been prevented. He was a modern, urban, cosmopolitan man, yet despite offers of and access to antiretroviral drugs – which may have given him another ten to twenty years of relatively healthy life – he refused them" (*New Review* 2006). "[M]any South Africans go to a traditional healer before they will see a doctor. Khabzela's response was the norm" (*Observer* 2004).[1]

For many HIV/AIDS activists, scholars, and health-care professionals, this is the primary puzzle associated with HIV/AIDS in post-apartheid South Africa: Why do people who have access to antiretrovirals eschew them and choose instead to pursue other remedies and most notably 'traditional healing'? There are several responses posed.

[1] The by-line of this newspaper article reads: "Safe-sex advocate who broke his own rules went to traditional healers, shunning new drugs" (*Observer* 2004).

First and most commonly, the "AIDS denialism"[2] of President Thabo Mbeki and his allies within the Department of Health has caused widespread "confusion" over treatment options. "The dearth of leadership on Aids … has opened up a lucrative market for tricksters" (*Observer* 2004). While formally, the government was forced by civil society organizations to begin "rolling out" antiretrovirals (ARVs)[3] in the public sector (Department of Health 2003), the Ministry of Health has attempted to undermine the implementation of this policy. Instead, the state has promoted a "healthy lifestyle campaign" in which the use of vitamins, immune-boosters and nutrition are promoted *in the place of* antiretrovirals. The state's questioning of the efficacy and safety of ARVs has subsequently legitimized the promotion of various 'miracle cures,' and charlatanry is on the rise in contemporary South Africa. The problem with this analysis is that indigenous forms of healing get all too often lumped into the category of fraudulent 'tricksters.' Such a correlation is actually reinforced by the denialist government's own discourses on 'traditional' healing. Therefore, indigenous health care is constructed as not only the polar opposite of a rational (and ethical) biomedical treatment program, but it is often blamed for the failure of implementation of ARV roll-out in the public sector.

Another explanation for the "confusion on the ground" that is causing people to disavow biomedical treatment is that the widespread stigmatization of the disease has made people fearful of seeking public health care.

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[2] "AIDS denialism" is the label most commonly used to denote the belief that HIV does not cause AIDS, and that antiretroviral treatment is toxic.

[3] Antiretrovirals are the biomedical treatment for HIV. They are usually taken in combinations of three drugs, from three different *classes* of medications, including: nucleoside reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors and protease inhibitors. The therapy is sometimes referred to as HAART (Highly Active Antiretroviral Therapy).

> "People are dying because of confusion. Tens of thousands of South Africans are dying because they are too confused and scared of being stigmatised to find out about their HIV status and get treatment" – Nathan Geffen, Treatment Action Campaign, Former National Manager and Future National Treasurer (*Guardian* 2005).

> South African Supreme Court of Appeal Justice Edwin Cameron, in his widely acclaimed autobiography, *Witness to AIDS* (2005), tells of his gardener, Gladwell, who is clearly suffering from AIDS. Gladwell knew that Cameron was HIV-positive and that antiretrovirals had saved his life; however, despite Cameron's offers to help, Gladwell returned to Zimbabwe and died there. "Although I thought that I was offering him help, and thereby the choice of living, in Gladwell's mind he had no choice. The stigma associated with AIDS left him no choice … I should have made him an appointment with Dr Johnson. I should have told him I was leaving for Dr Johnson's in 10 minutes. I should have told him he was free not to come. But I was going and I wanted him to come — I wanted him in the passenger seat of my car … I should have told him that my doctor would diagnose, and if necessary treat him, if it was AIDS. And that I would help him deal with his fears and loneliness if it was" (Cameron 2005: 73).

No matter the explanation, the solution to the puzzle, as it is posed in public sphere debates, by scholars, activists, policy-makers and health care professionals is: biomedical education and the defeat of government denialism will allow people to make the rational choice that will save their lives, i.e. following a hegemonic biomedical treatment paradigm. Because South Africa is ravaged not only by the dual pandemics of poverty and AIDS, but also by what Paula Treichler has labeled an "epidemic of signification" (Treichler 1999a), where conflicting discourses and ideologies about the disease abound, many believe that biomedical solutions are the country's only salvation. In order to combat the uncertainty which has arisen from the contradictory messages about HIV/AIDS circulating in the public sphere, it is necessary to prevent the spread of signification, to fix the meaning of AIDS securely within a biomedical paradigm.

And this biomedical solution has become one of the primary objectives of activist organizations in contemporary South Africa – in particular the Treatment Action

Campaign (TAC) and its ally the AIDS Law Project (ALP) which seek to "convert" the population to accepting "biomedical truths and rights-based approaches to health citizenship" (Robins 2004: 668).

> "But, look, the other thing is that, um, there is a confusion not amongst the healers but amongst the users of the healthcare system of what's appropriate … the confusion is mainly … with relation to HIV and AIDS … because HIV is potentially life threatening. Um, you know, the consequences are so much more real. So, if someone chooses -- which I'm sure you know many people, as do I … I know people who've chosen not to go and take ARVs … the bottom line question is, why is there that type of confusion? Why isn't there a message to everybody from credible sources that say … clearly that you should not be doing this. The vitamins and these meds are not going to cure you. These are not cures. They are touted as cures. They are not going to have the same effect as ARVs. So, if you actually really are concerned about saving your life, you need to go on ARVs."[4]

Again and again, in the interviews I conducted with AIDS activists, government officials (who were not a part of the denialist state machinery), health-care professionals, NGO managers and volunteers, litigators, policy-makers – all of the civil society and governmental actors who have dedicated their careers and lives to addressing the AIDS pandemic in South Africa expressed this simultaneous frustration with South Africans' hybrid healing strategies. For TAC and ALP activists, it is particularly acute because they fought a long and difficult battle against a denialist state in order to secure antiretroviral treatment in the public sector, and yet some people continue to pursue alternative methods.[5] The choice to utilize indigenous healing is therefore painted as irrational, contradictory and 'confused.'

But this 'confusion' does not just exist 'on the ground.' It also is prevalent in the discourses circulating in the public sphere which equate indigenous forms of healing with

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[4] AIDS Law Project (ALP) lawyer and activist. Interview held on November 22, 2005 in ALP offices at the University of Witwatersrand, Johannesburg.
[5] The battle between the TAC and the state denialists will be the subject of Chapter 3.

state denialism and charlatanry. In addition, there are broad-based misunderstandings of the effects poverty and social abandonment might have on peoples' health choices. And there is 'confusion' about the ways in which healing is linked to peoples' identities and subjectivities. The premise of this dissertation is to delve into the reasons why HIV-infected Black South Africans seek out particular forms of healing and why, in particular, they mix seemingly contradictory approaches. Biomedical and 'traditional' healing promote contradictory ontologies of the body and are situated within competing institutional frameworks. Further, public sphere discourses insist upon the radical incommensurability between these two systems of healing. The primary question motivating this research is, then, why do South Africans deeply affected by HIV/AIDS utilize traditional and biomedical forms of healing simultaneously, and without experiencing any sense of incongruity?

One way to approach this topic would be to designate three health-seeking behaviors (the dependent variables): the use of only biomedical treatment; the use of both biomedical and indigenous forms of healing; and the use of only indigenous healing. Independent variables would then be selected and could include: hopelessness, disease progression, access, migration status, etc. However, this project will show that predicting health-seeking behavior with such a positivist approach would be not only ineffectual, but would miss the complex ways in which peoples' health choices are socially situated. In order to understand health-seeking behavior, one must understand the context in which people either make choices or are left without choices to make. Health is socially constructed and experienced; therefore, the 'choices' people make are radically contingent on their socio-economic situation, their ideologies, their identities, their

experiences, and their relationship to health institutions, political organizations and the state. And these various social conditions and subjective interpretations are constantly in flux. An abstracted positivist approach fails to account for the way in which identity is a constantly unfolding process and negotiation.

In order to unravel the seeming conundrum of Khabzela's choice to utilize a government-sanctioned 'miracle cure' over the readily available ARVs, Liz McGregor investigates the local conditions and daily experiences that informed his decision, in addition to analyzing the reasons why particular national discourses were more relevant to Khabzela than others (2005). In a similar way, this project will seek to explore the ways in which people engage with public sphere discourses. How are the various signifiers of HIV/AIDS, promoted differentially by the state and certain civil society organizations being received, interpreted and incorporated?

But the project also seeks to establish a multi-directional causal framework. In addition to examining the ways in which powerful structural forces and discourses inform peoples' health itineraries, it equally suggests that peoples' ideologies, beliefs and practices inform and influence state and civil society struggles for legitimacy. Health is not only constructed at the local level, but also at the national (and the international) level. And despite its epistemological claims to objective truth and unmediated reality, biomedical science is just as socially constructed as state denialism or indigenous healing.

> "A virus – any virus – is a constructed entity, a representation, whose legitimacy is established and legitimized through a whole series of operations and representations, all highly stylized. Each of these must be critically analyzed on its own terms rather than accepted as though a scientific assertion about a virus stood for a referent rather than a sign … Western medicine must be seen as an ideological system … it is experienced by its practitioners as inescapably natural,

> as what *is*, and whatever data they collect will sustain a vision of biomedical knowledge as true. Taken for granted as reality, the underlying system of biomedicine is precisely what need not be examined" (Treichler 1999b: 159-160).

Therefore, the project seeks to unlock the 'black box' of health symbolism by exploring the various ideological, economic, geopolitical and cultural stakes of the symbolic struggle currently raging in South Africa's public sphere.

In order to provide a context to the experience of suffering, one must situate ethnography within a macro-social context (Farmer 1988 and 1992; Kleinman et al. 1997; Burawoy et al. 2000; Biehl 2005). And it is for this reason that my analysis combines an ethnography situated within communities ravaged by the dual pandemics of poverty and HIV/AIDS, with an analysis of both the *symbolic* and *political* economies of the post-apartheid health system. It situates peoples' understandings of and experiences with the disease within an analysis of developmental state policy, neoliberal economics, and international policy interventions. In this way, the project links "large-scale events and structures of the world AIDS pandemic" and the "lived experience" of the people in the ethnographic community (Farmer 1992: 262). Ethnographic methods become an essential tool in exploring the way in which disease and health care are both experienced and understood by those who are most affected by the disease, but who have the least to say about how it is addressed at the national and international levels. Analyzing the AIDS pandemic with this particular mixture of macro-sociology and ethnography is essential given the way in which patterns of HIV infection lay bare long histories of structural inequality and oppression.

Overall, my dissertation shows that peoples' healing ideologies and itineraries, as well as their gender and sexual practices are at odds with the dominant discourses and

policies imposed by international health agencies and the post-apartheid state. In examining this disjuncture, the project argues that HIV-infected South Africans have incorporated a culturally hybrid identity – one which amalgamates different African cultures as well as cultural ideologies derived from international, national and local influences. This cultural hybridity is made possible by the historical conjuncture of events which marked the transition from apartheid to post-apartheid, and it allows the subjects of post-apartheid to circumnavigate the material strictures erected by both neoliberal economic restructuring and the pandemic itself. The research primary explores the puzzling way in which people utilize incongruous healing strategies despite the bifurcated nature of the field of health and healing. However, it also analyzes the way in which shifting gender ideologies and sexual practices are implicated in these complex negotiations between 'modernity' and 'traditionalism.' The hybrid nature of Black South Africans' identities has been ignored by both policy initiatives and academic research, which either attempt to impose biomedical hegemony from above, or at least assume a certain static or culturally homogenous disposition.

> "Local explanations for the HIV/AIDS pandemic are outlined and given meaning through being placed within the experience of how the divided and divisive history of South Africa continues to haunt present constructions of worlds and notions of identity in response to widespread death and the politicisation of disease" (Henderson 2005: 24).

Theoretical Framework

Pierre Bourdieu

A Bourdieuian framework will be the basis of the theoretical model I will develop throughout my dissertation. However, one might legitimately ask "why Bourdieu?" Applying theories that were largely developed out of empirical studies of contemporary

France to analyze the South African field of health and healing during an epidemic will require theoretical revisions.[6] The end of apartheid was marked by a conjuncture of societal crises (the political transition, the adoption of neoliberalism and the AIDS pandemic), which has caused tremendous disturbances in a newly constituted field. The legacy of apartheid which inscribed vast economic, racial and cultural schisms into the very fabric and structure of South African society are a far cry from the hegemonic power relations that characterize most Western social systems. And the state of South Africa is not only in crisis, but is in denial. So, then, how is Bourdieu relevant to this project?

The structure of a social system is comprised of fields of production (i.e. economic, scientific, educational, cultural, etc), within which different species of power, or forms of capital (economic, cultural, social and symbolic) are the stake over which the producers and consumers within the field struggle. Fields are "doubly structured" (Bourdieu 1989) by both objective hierarchical relations as well as subjective perceptions and actions. In this way, any field can be understood as both a "force field" of struggles and a "playing field," "governed by general rules and driven by both individual tactics and collective strategies" (Gorski 2006: 4). "Fields present themselves synchronically as structured spaces of positions (or posts) whose properties depend on their position within these spaces and which can be analysed independently of the characteristics of their occupants (which are partly determined by them)" (Bourdieu 1993b: 72). Subjects' habituses are 'learned' through socialization; in this way, their practices are informed by unconscious processes of material and symbolic structuration. However, because

[6] However, Bourdieu's theories were initially inspired by his field work in Algeria during its struggle for independence. While Bourdieu had not yet developed his theory of the 'field' at this stage, I will argue later in the dissertation that these early studies help us to understand the kinds of habituses that emerge out of a colonial context.

subjects are always members of multiple fields, their habituses are equally multi-vocal, generating practices that are often subversive to the logic and structure of any one field.

Members of any field are always in constant competition for legitimacy, for the ability to define which forms of capital are dominant in the field (which therefore determines the hierarchization of the field), and for the accumulation of this valued capital. "[A] species of capital is what is efficacious in a given field, both as a weapon and as a stake of struggle, that which allows its possessors to wield a power, and influence, and thus to *exist*, in the field under consideration, instead of being considered a negligible quantity" (Bourdieu and Wacquant 1992: 98). However, the struggle is in no way utilitarian because capital is often misrecognized as capital, and the struggles that are an intrinsic property of every field are symbolic as well as material.

The dominant members of every field also struggle against one another in the "field of power" (Bourdieu 1996a; 1996b). The state possesses a kind of "metacapital" which gives it power over *all* of the fields present in the social system, and allows it to control the rates of conversion between different forms of capital (Bourdieu 1997: 40-41; Bourdieu 1999b: 57-58).

When a homology is established between subjective and objective structures, the result is *doxa*, embodied common sense, but there are various matrices formed by the interconnection between the schemas of perception and the ontological, structures of logic, so that the result is indeterminate. Because of this indeterminacy, there is constant struggle over the power to define and thereby control the legitimation of a particular worldview (the "vision and division" of the social sphere). These battles take place within each field, and within the field of power, and the state plays a key role in symbolic

struggles over the *nomos*. "[I]n differentiated societies, the state has the ability to impose and inculcate in a universal manner, within a given territorial expanse, a *nomos* … a shared principle, a vision and division, identical or similar cognitive and evaluative structures" (Bourdieu 1999b: 68). As such, the state controls the "production and reproduction" of the "construction of social reality … where irrevocable differences are instituted between the chosen and the excluded" (Bourdieu 1999b: 68).

Bourdieu's theoretical apparatus supplies the most comprehensive, consistent and complex account of the bi-directional relationship between structure and agency. His intervention is crucial because the structure and agency debate has remained dichotomous – social theorists consistently err either on the side of an uncritical celebration of agential power (i.e. Swidler 1986; Ortner 1994) or suffer from the rigid imposition of structuralist logic (i.e. Althusser 1969, 1971; Emirbayer and Mische 1998). Combining insights from historical materialism, structuralism, constructivism and phenomenology, Bourdieu avoids this common pitfall. For Bourdieu, the entire social system is comprised of a relationship between objective social relations and schemas of perception (the "vision and division" of society), and their incorporation in subjects' habitus. In this way, his analysis insists on the important relationship *between* material structures, signifying systems and embodied practice. Causality is always historically and socially contingent, as well as bi-directional. Further, hegemony is secured through conflict, and as such, always tends toward rupture.

There are two important critiques made of Bourdieu's conceptual framework which I would like to address briefly because they are particularly relevant to my usage of his theories in analyzing HIV/AIDS in post-apartheid South Africa.

> "At stake is whether we should understand Bourdieu's analytic apparatus – his conceptual tools like habitus, field, and capital – as applying universally, without modification, or as situationally specific … Bourdieu is simply unclear as to how historically and comparatively specific his conceptual frameworks and analytic strategies are meant to be. He has not done much systematic comparative or historical analysis that would indicate how – or indeed, whether – he would make critical distinctions among epochs or types of societies or cultures" (Calhoun 1993: 66).

Calhoun poses an important question about the general applicability of Bourdieu's theoretical framework; however, I think the answer lies in Bourdieu's epistemological and methodological approach to research. "Bourdieu advocates the *fusion* of theoretical construction and practical research operations. He does not seek to connect theoretical and empirical work in a tighter manner but to *cause them to interpenetrate each other* entirely" (Bourdieu and Wacquant 1992: 34-35; emphasis in original). While Bourdieu certainly offers a theoretical framework which he suggests may be generalizable or at least useful as an analytic tool in a number of (historical or cultural) settings, I believe he would simultaneously be the first to insist that it is only through the application of his theoretical model to new and different empirical objects that one would be able to begin to answer Calhoun's question.

Scientific inquiry requires that the researcher apply historically relevant theoretical concepts to new applications – while simultaneously paying heed to the entire history of the concept. In this way, the concept can be "re-activated" … "in a new act of production" (Bourdieu 1985: 15). "The capacity to actively reproduce the best products of past thinkers by putting into use the instruments of production which they have left behind, is the condition which allows access to a thought which is truly productive" (Bourdieu 1985: 15).

In utilizing Bourdieu's theories in order to analyze post-apartheid South Africa, it is equally important to review the multitudinous criticisms aimed at what has been labeled the "structuralist" and even "functionalist" tendencies of Bourdieu's approach, and specifically his attention to the reproduction and durability of structural stasis, which (according to his critics) leave very little room for the possibility of social change (let alone radical transformation).[7] Again, I think this critique is concerned with Bourdieu's empirical object. In much of his work, Bourdieu is analyzing various fields of production in contemporary France, and as such, he is intent on explaining *hegemonic* power. However, in his work which analyzes societies in flux (Bourdieu 1958/1962; 1977; 1979a; 1988; 1996a; Bourdieu and Sayad 1964/2004), Bourdieu illustrates the precise ways in which radical social change becomes possible.

> "It is no doubt on the basis of the particular case of adjustment between habitus and structure that critics have often seen a principle of repetition and conservation in a concept, habitus, which originally forced itself upon me as the only way to understand the *mismatches* which were observed, in an economy like that of Algeria in the 1960s (and still today in many 'developing' countries), between the objective structures and the incorporated structures, between the economic institutions imported and imposed by colonization (or nowadays by the constraints of the market) and economic dispositions brought to them by agents formed in the precapitalist world" (Bourdieu 2000: 159-160).

His attention to the dual causal direction of structure and agency actually allows him to avoid the pitfalls of *both* structuralism and constructivism. And even in those analyses aimed at explaining the reproduction of domination, Bourdieu's theoretical framework still insists on the possibilities of agency. "I do not see how relations of domination, whether material or symbolic, could possibly operate without implying, activating resistance. *The dominated, in any social universe, can always exert a certain*

[7] For example: Garnham and Williams 1980; Giroux 1983; Gartman 1991; Sewell 1992; Calhoun 1993.

force, inasmuch as belonging to a field means by definition that one is capable of producing effects in it …" (Bourdieu and Wacquant 1992: 80; emphasis in original).

Despite all of Bourdieu's theoretical strengths, there are some limitations in the conceptual apparatus Bourdieu proposed, and there are further difficulties which arise when applying his theories to a case as unique and traumatic as the AIDS pandemic in South Africa. Therefore, several other theorists will prove essential to my analysis: Foucault (governmentality and bio-power), Agamben (sovereignty and bare life), Bhabha (post-coloniality), and a host of scholars who have developed theories of practice (Bhabha, Comaroff, Sewell, and de Certeau). In the final chapter, I will also draw on several pshychoanalytic accounts (Kristeva, Lacan, and Žižek) in order to explore the ways in which the contours of the body politic mirror the disintegrating body of the AIDS sufferer.

Michel Foucault

> According to Bourdieu, it is only in Foucault that we find the most "rigorous formulation of the foundations of the structural analysis of cultural works. Conscious that no cultural work exists by itself, that is, outside the relations of interdependence that unite it to other works, he gives the name 'field of strategic possibilities' to the 'regulated system of differences and dispersions' within which each individual works to find itself … he explicitly refuses to search outside the 'field of discourse' for the principle which would elucidate each of the discourses within it" (Bourdieu 1996a: 197).

According to Bourdieu, Foucault's concept of *episteme* is too autonomous from the social conditions that make it possible, and gives no generative power to the agents and institutions that are confined within it. So Foucault's episteme is thus theorized as a closed, de-historicized and reified space. "He rejects any relating of works to the social conditions of their production" (Bourdieu 1996a: 198). Bourdieu's critique of Foucault could ironically be just as relevant a critique to his own field theory, which I will show in

the next chapter, fails to account for the ways in which fields are always situated within both a national social space and a particular geopolitical configuration of forces. And in fact, Bourdieu's critique is especially ironic given the fact that I intend to utilize Foucault's theories of power in order to supplement the lacks in Bourdieu's field theory.

I will draw on Foucault's theories of bio-power to illustrate the ways in which diseased bodies are targets of both disciplinary (anatomo-political) and governing (bio-political) power. There is a primary difference between certain HIV-infected populations. Some are incorporated into the body politic and are the object of disciplinary power and governmental strategies. The state has shifted its practices of governmentality (Foucault 1991b), so that state power is now leveled at the reconfiguration of habitus. However, others have been geographically, symbolically and socially excluded from the body politic. Because of a shift in the economic system of South Africa, the need for a productive social body is minimized, thereby rendering a portion of the population redundant. In fact, because of the dual pandemics of poverty and AIDS, a portion of the population is not only unnecessary for economic growth, but it is a drain on the state's economic resources. Given the need/desire to reduce social spending, this surplus population is an obstacle toward economic development. But further, this surplus population represents the failure of post-apartheid liberation. In this way, impoverished, HIV-infected South Africans are not only dispensable, but burdensome. This set of the population is the target of thanatopolitics. Given the fact that Foucault's own theories of thanatopolitical power are somewhat internally contradictory, I will draw on the theories of Giorgio Agamben, as well as several scholars who have utilized his theories to analyze populations rendered disposable by neoliberal

economics in the global south (including Achille Mbembe, João Biehl, Jean Comaroff, and Ulrike Kistner).

The final Foucaultian insight on which I will draw concerns my methodology and research design. Whereas *most* of Bourdieu's empirical studies focused on explaining the *reproduction* of hegemonic social systems and the way in which the *dominant* maintain their legitimacy, Foucault developed his theories of power by focusing on those against whom power was exerted: criminals, the insane, the diseased. From this perspective, he developed a new method of analyzing the relationship between theory and practice:

> "It consists in taking the forms of resistance against different forms of power as a starting point. To use another metaphor, it consists of using this resistance as a chemical catalyst so as to bring to light power relations, locate their positions, find out their point of application and the methods used. Rather than analyzing power from the point of view of its internal rationality, it consists of analyzing power relations through the antagonism of strategies" (Foucault 2000a: 329).

The Social Analysis of AIDS

This project will also draw extensively on the wide range of scholars who have already delved into the complicated and diverse topic of HIV/AIDS in South Africa. Most of the social scientific research conducted on HIV/AIDS in South Africa is demographic in nature. Much of this research focuses on the causal factors behind the high levels of infection, including research on: gender dynamics, trends in migration, levels of poverty and unemployment, sexual practices, prevention strategies, and family structure and planning. This literature is far too expansive to list, but I utilize many significant quantitative findings throughout this project in order to provide a broad picture of the pandemic's multiple and pervasive effects. It is important to note two very

significant lacks in the demographic data on HIV/AIDS. Informal settlements are still largely under-explored, and so too is the prevalence and scope of indigenous healing.

Given this project's focus on the complexities of communities' lived experiences with the disease, it draws much more extensively on the literature produced by critical medical sociologists and anthropologists, and specifically on ethnographic accounts which focus on the cultural and symbolic meaning of disease and suffering. Anthropological accounts have contributed the most to explaining the epistemologies and ontology of indigenous healing, not to mention the ways it is put to use by patients. However, there is very little research that has been conducted on the impact HIV/AIDS has had on the profession and ideologies of traditional healing in South Africa. Those scholars who have begun to explore this vast and under-studied topic are utilized to support my own findings (Robert Thornton, Elizabeth Mills, Patricia Henderson, Edward Green, Suzanne Leclerc-Madlala, Adam Ashforth, and Isak Niehaus). These scholars have not only explored indigenous healing in the age of AIDS, but they have equally addressed the hybrid nature of Black South Africans' healing itineraries.

However, *some* of these accounts fail to situate the ethnographic analysis within a broader politico-economic framework. Therefore, the project has also benefitted greatly from the use of a unique sociological field of study which has emerged in recent years, which links large-scale structural factors with communities' lived experiences.

> "It is inexcusable to limit our horizons to the ideally circumscribed village, culture, or case history and ignore the social origins of much – if not most – illness and distress. An interpretive anthropology of affliction, attuned to the ways in which history and its *calculus of economic and symbolic power* impinge on the local and the personal, might yield new understandings of culturally evolved responses to illness, fear, pain, hunger, and brutality" (Paul Farmer 1988: 80; my emphasis).

This small but important group of scholars addresses the relationship between neoliberal restructuring, the national economy of representation, local conceptualizations of disease, and hybrid ideologies of health, gender, race and sexuality (Paul Farmer, João Biehl, Mark Hunter, Jean Comaroff, Deborah Posel, and Adam Ashforth).

The Mutual Pandemics of AIDS and Poverty

"AIDS is the new apartheid" (Archbishop Desmond Tutu, *Independent Online* 2001).

The first two deaths in South Africa attributed to AIDS were recorded in 1982 (*Health-E News* 2004). In 1993, the prevalence rate among pregnant women attending antenatal clinics[8] was 4.3%, but by 2005, the prevalence rate in the same population had sky-rocketed to a staggering 30.2% (Avert 2005; Department of Health 2005a). 4.7 million people have died of AIDS since 1982 (*Sunday Independent* 2008b).

Annually, from 1990 through 2005, the Department of Health estimated national HIV prevalence rates based on survey data collected from pregnant women attending antenatal clinics. These were published in reports entitled, "National HIV and Syphilis Ser-Prevalence Surveys." Based on a sample of 16,510 women attending 399 antenatal clinics across all nine provinces, the South African Department of Health Study estimated that 30.2% of pregnant women were living with HIV in 2005 (Department of Health 2005a). However, there has been growing concern about whether or not prevalence rates, based on antenatal clinic surveys are accurate reflections of national HIV trends (Marais 2005; Zuma 2007). According to Khangelani Zuma, Research Specialist for the Human Sciences Research Council (HSRC), pregnant women are not representative of the greater

[8] Antenatal clinics provide pre-natal care for women, including HIV tests.

population because: 1) they are not practicing safer sex; 2) those attending public antenatal clinics are economically disadvantaged; and 3) the clinics where these studies gather their estimates are sentinel sites, which are also not representative of the broader health system (Zuma 2007). These women are the *most* likely to be infected with HIV; therefore, estimates based on antenatal clinics are *over*-estimating prevalence rates.

In 2002 and 2005, the HSRC began conducting national randomized household surveys, which included all ages, races, types of residence, and *both* genders. According to the HSRC 2005 study, the national HIV prevalence in the population of people two years and older is estimated to be 10.8%, and women had a higher prevalence rate (13.3%) than men (8.2%). People living with HIV/AIDS are found in every race group in South Africa. HIV prevalence in Africans is substantially greater than in any other racial group – 13.3% compared to less than 2% of other races.

The main problem with these household surveys, however, is that many people surveyed 'opt-out' of participating in the biological sampling component of the survey, when HIV sero-prevalence is tested. In fact, 40-60% of the participants opt out of this component of the survey, and *who* opts out is not random (Levinsohn 2007). If those who opt-out are at high risk of HIV, then the survey may *under*-estimate the national prevalence rate as much as 5% (Zuma 2007).

The Development Bank of South Africa recently released new statistics on HIV/AIDS that suggest that the prevalence rate is even higher than the Department of Health estimates. These statistics claim that 7.6 million South Africans are currently infected, and that the prevalence rate for men and women, aged 20-64, is 27% (*Sunday Independent* 2008b). These statistics are touted as being more accurate than the

Department of Health survey because "they were collected at grassroots level and not based on estimates" (Ibid). The validity of these statistics has yet to be tested.

I present these various statistics and the debates about their validity to show the extent of the toll the pandemic has had on the country, but also to illustrate the difficulty in obtaining an accurate demographic sense of the scope of the pandemic.

Households are considered indigent if the total gross monthly income of all members of the household does not exceed R1,700 a month (Statistics South Africa 2006b). Twenty-three percent of the South African population is indigent (Ibid).

> "No sector of the population is unaffected by the HIV epidemic, but it is the poorest South Africans who are most vulnerable to HIV/AIDS and for whom the consequences are inevitably most severe … [I]n already poor households HIV/AIDS is the tipping point from poverty into destitution" (Steinberg et al. 2002: i).

In a household survey conducted in Soweto, Naidu and Harris (2006) found that "affected and non-affected households in the sample received similar total incomes, but affected households earned less regular income" (386). In a survey of 771 AIDS-affected households spread throughout South Africa, Steinberg et al. (2002) found that two-thirds of the households reported a fall in the total household income as a direct result of having to cope with HIV/AIDS (16). "The drop in income was exacerbated by the fact that most of the households studied were already very poor" (Ibid). In addition to direct costs of health care, medicines, transportation and food associated with hospitalization and funerals, there are indirect costs of HIV/AIDS morbidity and mortality, which include the loss of income from prolonged illness (by those infected as well as their care-givers) and the loss of social grants (Naidu and Harris 2006: 387). Funerals, on average (with pre-funeral, day-of, and post-funeral costs added together) cost R32,190 or $4,200 (Ibid:

391). Steinberg et al. also found that while all 771 households in the study were eligible to receive a government grant, fewer than 16% of the households were accessing one (Steinberg et al. 2002: ii-iii). Therefore, not only are impoverished South Africans more vulnerable to HIV infection, but the financial burden of HIV/AIDS further exacerbates their poverty. And many are not accessing the meager social welfare grants available to help alleviate their financial burdens.

One of the primary reasons I chose to study the impact of HIV/AIDS on poor, Black populations is simply because HIV/AIDS is highest amongst this demographic.

A Few Notes on Terminology

The term 'traditional healing' is problematic since it buttresses the false but prevalent assumption that indigenous healing is timeless, rigid and static. It also contributes to the false binary this project is attempting to dismantle between the reified constructs of 'traditionalism' and 'modernity.' However, 'traditional healing' has become a commonplace and even institutionalized nomenclature for all indigenous forms of healing, and healers themselves choose to represent their own organizations and profession using the term. Therefore, despite my own discomfort with the term, it is difficult to avoid. Throughout the dissertation, then, I will utilize both 'indigenous healing' and 'traditional healing' interchangeably.

Muti is a Zulu term that refers generally to herbal remedies, usually implying a combination of different herbs. It is sometimes spelled 'muthi' and at other times 'muti.' I have not been able to discern the reason for this discrepancy, but I have found 'muti' to be more common and have therefore chosen to use this spelling.

A much more politically complicated subject is the use of 'Black' versus 'African.' A Black Consciousness movement developed in South Africa during the struggle against apartheid (its most prominent member being Steve Biko). One of the many ideological tenets of this activist movement was expanding the definition of 'Blackness' to include all South Africans of color (including all African populations, as well as the so-called 'Indian' and 'Coloured' populations) in order to resist apartheid's segregation of races and the internalized effects this had on interracial relations. Therefore, to be more precise in describing the populations with whom I worked, I should consistently refer to them as 'African' and not 'Black.' However, again, this is an issue of political preference versus common usage. Most of the people with whom I worked labeled themselves 'Black,' and it sometimes becomes confusing to use the more general term 'African' to refer to a specific *South African* population. So again, I have chosen to use both terms interchangeably despite the problems associated with such a choice.

Methodology[9]

My research design incorporated a comparative analysis of health care practitioners, indigenous healers and HIV-infected populations in formal townships and

[9] This project has been approved by the University of Michigan Institutional Review Board (Behavioral Sciences, File Number: B03-00001366), the University of Witwatersrand Human Research Ethics Committee (Non-Medical, Protocol Number: H0441105), and the Gauteng Provincial Department of Health Research Committee, Department of Health, Johannesburg. I was granted permission to use the proper names of participants in this study, so long as consent was given. Pseudonyms are provided for most of the informants who chose to remain anonymous. If the participant's first language was not English, an interpreter was made available. Most of the interviews included in this project were conducted through my interpreter, Torong Ramela. Certain participants gave consent to have their photographs taken (in the manner they preferred) and to have them published alongside their names and stories. In addition to the photographs I took myself, I was given permission to use the photographs taken by Andy Clarno. Finally, I have used several of the political cartoons by the imminent cartoonist, Jonathan Shapiro, aka Zapiro. Shapiro gave me consent to reprint his cartoons for this project.

informal settlements. Such a comparative approach allowed me to evaluate the impact of the following factors on peoples' choice of health care: 1) access to (biomedical) public health care; 2) socio-economic status (and educational attainment); 3) incidence of neoliberal economic restructuring (measured in this case by the privatization of basic services): and 4) migration status. In addition, however, I felt it important to situate a large part of this study in informal settlements because of the dearth of information available on these extremely pervasive but understudied environments. Most of the research that has been conducted on informal settlements is demographic in nature. Ethnographic analysis is quite rare.[10]

I conducted 27 months of ethnographic and qualitative research in one formal township and two shanty towns on the outskirts of Johannesburg. Not only does my research focus on a sensitive, risky and controversial topic, but my own identity as a researcher made dealing with barriers of race, class, gender and nationality an inevitable feature of the research design itself. For these reasons, it was politically and ethically important for me to *participate* in the communities where my research was focused before engaging in more structured qualitative research. Overall, I utilized the following methodological approach. In 2002-2003, during my initial stage of data collection, I began by volunteering my time and skills as both a researcher and HIV/AIDS advocate with several organizations in the Johannesburg region. It was through this initial participant observation work that I selected my research sites. Before conducting any formal focus group discussions (FGDs) or interviews, I spent a great deal of time in each

[10] Mark Hunter's cultural and politico-economic analysis of HIV/AIDS, drawn from ethnographic research in an informal settlement outside of Durban has provided an example, a source of comparison and great inspiration for this project (2002, 2004, 2005a, 2005b, 2006, and 2007).

of my research sites, volunteering for local community organizations as an HIV/AIDS advocate, a researcher, or simply a scribe or layperson. In this way, I was able to gain knowledge of the communities and contribute to their battles for health care, HIV/AIDS resources, and basic services. I also utilized particular organizations to gain access to the populations with whom I was interested in working. In this way, community members were able to help me design my research approach and in some cases help carry out the research. This is one of the reasons why a large bulk of my data was gained through ethnographic methods and why it was essential for me to spend such a long time conducting field work.

In Soweto, I volunteered for a major national HIV/AIDS service NGO in 2002-2003 and again for 10 months from December 1, 2004 through September 30, 2005. One particular staff member, whom I have named "Tebogho" became my primary informant. With Tebogho, I spent one day every week for 10 months, traveling between different support groups throughout Soweto, until I began to work more closely with those situated in Dobsonville, Orlando, and Zola.

In November 2005, I also began volunteering with two primary social movements, the Anti-Privatisation Forum (APF) and the Landless Peoples' Movement (LPM), both of which are umbrella organizations that bring together small community-based organizations from throughout the Gauteng region. [11] It was through these two organizations that I first met Thulani Skhosana and Pheello Limapo, who would become my primary informants in Sol Plaatje and Lawley 2 respectively. Each of them sought me out when they learned I was conducting research on HIV/AIDS. They each openly

[11] Gauteng is the province in which both Johannesburg and Pretoria are situated.

disclosed their HIV-positive status to me, and volunteered to help me design and carry out my research in their communities.

Figure 1-1: Pheello Limapo in front of his house in Lawley 2 [12]

Figure 1-2: Thulani Skhosana in Sol Plaatje [13]

[12] Photo taken by the author.
[13] Photo taken by the author.

It was also through the APF that I was able to work with community members in Phiri and Orlando, Soweto.

In terms of gaining access to indigenous healers, my interpreter, Torong Ramela, played a key role. Torong had worked as an indigenous rights activist and advocate for many years. He had personal connections with the leaders of all of the major traditional healing organizations *and* the Department of Health officials who were working closest with the traditional health sector. It was largely through his introduction that I gained the trust of healers. I always began by discussing my project with the leaders of the traditional healing organization and asking for their help and advice in designing a research protocol. With several organizations, I first conducted FGDs with a sampling of their members, and then asked certain participants to sit for interviews. I managed to conduct interviews with the leaders and some of the members of each of the most active traditional healing organizations in Gauteng. At the request of the healers with whom I worked, I also sat in on meetings of the Gauteng Traditional Healers' Task Team GTHTT), a group of traditional health leaders and Department of Health officials. Two healers, in particular, Dr. Martha Mongoya (Deputy Chairperson of the Gauteng Traditional and Faith Medical Practitioners, GTFMP) and Dr. Robert Tshabalala (Chairperson of the Soweto Traditional Healer's Forum) became primary informants for this project. They not only patiently sat through multiple-hour interviews on many occasions, but they advocated for my project in Soweto and encouraged their members to participate.

In terms of accessing the Treatment Action Campaign (TAC), I attended several of their open meetings and simply asked the leaders of the organizations as well as key

members of the AIDS Law Project[14] (ALP) for in-depth interviews. They were extremely open and willing to participate in this project. In addition to the national leaders, I also conducted interviews with provincial and local leaders operating in both Soweto and Khayelitsha, a township on the outskirts of Cape Town, where the TAC has its main community base.

With communities where risk was a serious matter to consider (especially people infected with HIV/AIDS, but also traditional healers and home-based care workers), I conducted focus-group discussions before engaging in personal in-depth interviews. I conducted multiple in-depth interviews with different population groups within my research sites, including: people living with HIV/AIDS, home-based care givers, NGO volunteers and service providers, nurses and doctors, traditional healers, spiritual healers, activists, and government officials. Whenever possible, I also conducted interviews with important stakeholders in each community, including: local counselors, nurses and social workers, church leaders, community leaders, etc.

[14] The AIDS Law Project is a legislative rights NGO, which employs lawyers who have fought multiple important cases relevant to health care access and antiretroviral treatment access. The organization is often conceived of as the legislative arm of the TAC, because they have served as advocates for most of the important TAC court cases, and because many of their members also hold key positions in the TAC. For more information, see ALP 2008.

Table 1-1: Participant Observation

Population Group	**Dates**	**Total # of Months**
People living with HIV/AIDS	December 1, 2004 – December 28, 2005 May 1 – June 15, 2006	15 months
Non-Governmental Organizations providing services for HIV/AIDS	January 15, 2003 – May 20, 2003 December 1, 2004 – November 30, 2005	16 months
Traditional Healers	January 24 – December 20, 2005	11 months
Social Movements	January 15 – May 20, 2003 January 15 – December 28, 2005 May 1 – June 15, 2006	17 months
Clinics and Hospitals	January 15 – September 22, 2005	8 months

Table 1-2: Focus Group Discussions

Population Group	**# of Women**	**# of Men**
People living with HIV/AIDS	29	15
Traditional Healers	92	39
Home-Based Care Workers	13	1
TOTAL	**134**	**55**

Table 1-3: Interviews

Population Group	**# of Women**	**# of Men**
People living with HIV/AIDS	9	14
Traditional Healers	23	21
NGO staff	20	14
Home-Based Care workers	3	1
Nurses/Matrons	8	0
Doctors	0	3
Government officials	3	0
Community Stakeholders	4	4
Dr. Rath Foundation	0	5
Funeral Associations	0	1
TOTAL	**70**	**63**

For further information on my data collection, please refer to Appendices 1-3.

In addition to conducting ethnographic and qualitative research, I also supervised a community participatory action research project focusing on the relationship between neoliberal economic restructuring and access to health care. In this form of research, local participants are recruited, trained and supervised as they carry out the data collection, coding and analysis.[15] I helped to design the project, train community researchers, and supervise the data collection and analysis. This project was carried out in two of my research sites – the informal settlement of Sol Plaatje and a neighborhood in Soweto called Phiri. Through this community participatory research project, we were able to gather some comparative demographic information about the obstacles these communities face in accessing health care, the role neoliberal economic restructuring plays in peoples' abilities to sustain healthy lifestyles, and we also held focus group discussions with stakeholders in the community to gather more detailed information about the way in which particular socio-economic conditions influence peoples' health options and choices.

There are several limitations to my methodological approach. First, the project is situated in the townships and informal settlements of Johannesburg, which as I explain below, attract a very hybrid population. So not only is the project only relevant as an *urban* analysis, it is also a very particular urban space. The generalizability of the results of this study may be circumscribed by this specificity. In addition, although I conducted focus group discussions and interviews with over 100 traditional healers from all over the Johannesburg region, their views and practices may also be somewhat distinctive for the following reasons: 1) most have worked in an urban environment for years; 2) the

[15] See for example: Minkler, et al. 2003; Greenwood and Levin 2006.

Gauteng provincial government has been particularly proactive in reaching out to traditional healers in the region and training them on basic HIV/AIDS, TB and STI knowledge, as well as home-based care; 3) most of the healers were recruited through the organizations with which they were registered. It is important to note these specificities of the project as limitations to the generalizability of my findings.

In addition, I used an interpreter to help me conduct most of my interviews and focus group discussions. Participants were always asked in advance if they wanted to use interpretation or preferred to conduct the interview in English.[16] My interpreter, Torong Ramela, is fluent in at least eight languages, and his skills in simultaneous interpretation and translation are profound.[17] Although my Zulu proficiency is considered intermediate, the complexity and the sensitivity of the issues being discussed necessitated interpretation. In addition, Zulu was not the primary language of many of my informants.[18] While language obstacles certainly influenced the data I was able to collect, I would argue that Torong's participation most often facilitated rather than hindered the research process. Torong was only present during formal interviews and FGDs. I conducted ethnographic research in each of my chosen sites on my own, establishing and developing individual and personal relationships with my primary informants.

Finally, although I spent a great deal of time in my chosen research sites, I did not live in any of them. This was, in part, because of the comparative nature of the project,

[16] Most Johannesburg residents speak English.
[17] He also signed a confidentiality agreement, to protect the identities of participants.
[18] As I will discuss in the next section, African residents of Johannesburg have developed a hybrid language, which amalgamates several African languages as well as Afrikaans and English. Even though most of my informants spoke *some* Zulu, they chose to express themselves in this hybrid way. Therefore, my knowledge of Zulu will not only require further enhancement, but I will also need to study several other African languages to fluently communicate with Johannesburg residents in their preferred dialect.

which required me to move around amongst my different ethnographic communities on a daily basis. In addition, however, my gender and race proved to be obstacles to community participation. In my analysis, whenever possible or relevant, I point out the various ways in which my identity influenced my data. However, there are also innumerable unknown, unperceived and yet important ways in which my race, class, gender, and nationality biased my results. While I recognize the extreme importance of owning up to these limitations in an attempt to 'demystify' my own ethnographic 'authority' (Fox 1991), I do not think they undermine the significant findings only ethnographic research can unveil. Like the contemporary work of Arjun Appadurai and Michael Burawoy, this project, in part, seeks to explore "the nature of locality as a lived experience in a globalized, deterritorialized world" (Arjun Appadurai, as quoted in Fox 1991: 196; See also Appadurai 1996; Stacey 1999; Burawoy et al. 2000). In addition, however, ethnography is the only way to understand peoples' health choices and ideologies. And in South Africa, peoples' lived experiences are out of sorts with both public sphere discourses *and* policy initiatives. Those who have suffered the most cataclysmic effects of the mutual pandemics of poverty and AIDS in South Africa are the experts on the topic. It is essential to give their opinions and experiences voice. Despite its many faults, this project has hopefully made some small contribution toward this end.

Research Sites

Johannesburg is the largest and most populous city in South Africa, and it is also the provincial capital of Gauteng province. In contrast to other major urban centers in South Africa (Durban, Cape Town, Pretoria, Bloemfontein), Johannesburg is one of the

most hybrid cities in South Africa. Since the discovery of gold at the turn of the 20th century, Johannesburg has been a consistent site of mass-scale migration, as culturally diverse people from all over South Africa flocked there to work in the gold mines that surround the city. Johannesburg is referred to as *eGoli*, the "city of gold." For this reason, it boasts the largest economy of any metropolitan region in Sub-Saharan Africa. But in addition to having the most wealth in the sub-continent, it also has one of the highest rates of regional poverty in South Africa – thirty-eight percent of its residents live under the poverty line (HSRC 2004). Despite the lack of unskilled employment opportunities in Johannesburg since the collapse of the mining industry, poor South Africans are still migrating to the area in search of work. With a 32.4% infection rate, it also has one of the higher regional rates of HIV prevalence in South Africa (Department of Health 2005).

Soweto

"It has been said that the path through Africa runs through Soweto; that Soweto is a microcosm, or the soul of South Africa; that Soweto is a shining example of neglect and exploitation: that Soweto means many things to many people" (Louis Rive, "The Significance of Soweto," as quoted in Bonner and Segal 1998: 9).

Soweto is the largest Black township in South Africa with a population of over one million people (Naidu et al. 2004). Soweto is an acronym for "South West Townships" – a name it received in 1963, during the era of its greatest population boom (Bonner and Segal 1998: 10). The vast expanse of Soweto is actually an amalgamation of at least 30 different townships, each with various extensions.

Figure 1-3: Soweto

The first township in what would become Soweto, was called Klipspruit, and it was built in 1905 (Ibid). Black townships were initially built by the Johannesburg City Council (JCC) in order to rid the city of slumyards, which were considered not only disease-ridden but dens of inter-racial mixing (Ibid: 13). In 1923, the Native Urban Areas Act was passed, disallowing all non-whites from living in urban areas, which caused an immense housing crisis (Ibid: 15). Non-white populations were still needed to work in the mines (and as domestic servants). If the slums were to be eradicated, alternative housing needed to be secured. In the 1930s, African populations were forcibly removed from slums and relocated to a new township in the heart of modern Soweto, called Orlando (Ibid: 19). During WWII, African populations began moving to urban areas in mass numbers and settling, in part due to an increase in employment opportunities. However, the building and development of Soweto was slow (mostly due to funding shortages); therefore, most Black urban settlers began squatting in the regions surrounding Orlando. In 1950, the government decided to lease land to Africans to build their own housing, and in 1951, the Bantu Building Workers Act was passed, allowing Africans to be trained in the building trades (Ibid: 28-29). Once the houses were built,

they were leased to the occupants on a sliding economic scale. Therefore, it was in the 1950s and 1960s when most of modern Soweto was built. The council for Scientific and Industrial Research and the National Building Research Institute produced designs for "low-cost, four-roomed, 40-square-metre houses which were soon to spring up in identical rows all over the Witwatersrand" (Ibid: 28). These are the houses that still mark Soweto's vast landscape.

Figure 1-4: Sowetan "Matchbox" House [19]

> "The monotonous physical environment of Soweto … stands in sharp contrast to the heterogeneous population it housed, for here, jammed into three- and four-roomed matchbox houses, was a population of almost infinite diversity" (Ibid: 34).

In the early 1950s, with the passage of the Native Laws Amendment Act, the South African government attempted to impose new divisions on the township populations in order to stem the flow of migrants and to better police and control the African populations whose resistance to apartheid had been intensifying at rapid rate. In

[19] Photo taken by Andy Clarno.

fact, townships were the sites of the greatest resistance throughout the 20th century. "South African policy-makers did not understand Soweto's diverse community, and imposed their own divisions on the population with little regard for social reality. The officials divided the black urban population into categories of tribal (migrant), semi-tribal (immigrant) and detribalised (urban)" (Ibid: 37). In the 1960s, the government attempted to impose ethnic zoning in Soweto. Prime Minister Hendrick Verwoerd (Prime Minister from 1958-66) justified this decision by stating: "those who belong together naturally want to live near one another, and the policy of ethnic grouping will lead to the development of an intensified community spirit" (Ibid: 43).

Therefore, the African urban population was segregated not only between 'tribal' and 'detribalised,' but the government attempted to segregate the permanently settled population by ethnicity. However, while the legislative segregation between migrant and more permanent residents did manage to plow divisions that would be relevant during the anti-apartheid struggle (and still persist today), the permanent Sowetan residents fiercely resisted ethnic zoning. This is because it defied the hybrid identity that had come to characterize Soweto. Over the last century, Soweto has developed its own cultural identity, expressed in music, dance and even language. Unlike in other urban areas where one African language dominates, Sowetan residents speak a hybrid language, a complicated amalgamation of various African languages mixed with Afrikaans and English. And this hybrid Sowetan identity was further entrenched by the struggle against apartheid. From the 1976 Soweto uprisings until the eventual fall of apartheid, Soweto was considered "the very symbol of the black struggle for freedom in South Africa" (Ibid: 10).

Traditional anthropology has idealized the in-depth analysis of one homogenous ethnic entity. Recently, ethnographers have begun to question and challenge this concept of a unitary culture (Clifford and Marcus 1986; Rosaldo 1989; Abu-Lughod 1991; Dirks, et al., 1993; Friedman 1994). Despite these changes in ethnography, the apartheid regime and its compartmentalization of the various African 'nations,' facilitated the use of this canonical ethnographic approach. Although the fall of apartheid initiated dramatic population flux, South African ethnography *continues* to seek out these illusory homogenous communities. For all of these reasons, I decided to avoid selecting one township/neighborhood within Soweto as the basis of my ethnographic study. As such, this project will prove important to the field of ethnography in South Africa because its very methodological design takes the heterogeneity of communities into account.

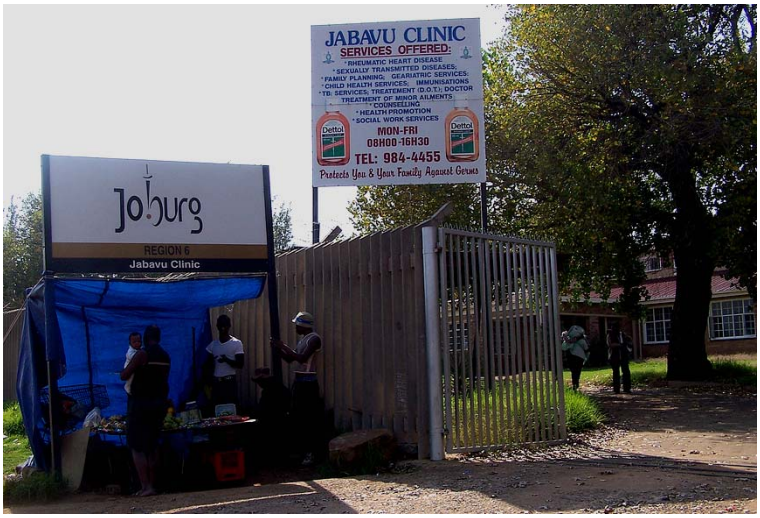
I conducted research (primarily) in several neighborhoods of Soweto, including: Zola, Orlando, Dobsonville, and Phiri.[20] These neighborhoods varied greatly in their socio-economic composition as well as in the health care options made available to the residents. Soweto is well-resourced (with clinics, schools, parks, shopping centers, etc.), the housing is formal, its residents are primarily working-class and most of them have lived in Soweto for several generations. Although most of the formal housing in Soweto was built by the apartheid regime, there are also severely destitute hostel dwellings as well as several shack settlements scattered throughout the broad expanse of Soweto.

[20] There are no stark divisions between the townships that make up Soweto; therefore, while my research was mostly situated in these neighborhoods (because these were the locations of the organizations where I recruited participants), the people with whom I worked resided in the entire expanse of Soweto, and I traveled the entire region in order to conduct personal interviews.

Figure 1-5: Soweto Hostels and Squatter Camps

At the entrance to Soweto sits the Chris Hani Baragwanath Hospital – the largest hospital in the Southern hemisphere. This hospital services the entirety of Soweto, in addition to most of the informal settlements stretching 25 miles south and west of Soweto itself. In addition, there are 13 clinics scattered throughout Soweto, which provide not only public health care, but also host many of the community organizations focused on HIV/AIDS care and treatment.

Figure 1-6: Jabavu Clinic [21]



[21] Photo taken by the author.

In addition to Soweto, I conducted a minimal amount of research in Alexandra, a formal township in the heart of Johannesburg. "Alex," as it is commonly referred to, is the poorest area in Johannesburg and it is situated directly across the highway from the wealthy and luxurious central business district, Sandton. Most of the townships inside cities were destroyed by the apartheid regime, and their residents were forcibly removed to the townships on the outskirts of the city (Sofiatown in Johannesburg and District 6 in Cape Town are the two prominent examples of this process). Alex was saved from this fate mostly due to the intense and ultimately successful resistance its residents mounted. Under apartheid, Alex was still a bit removed from the city. In the 1970s, when resistance was at its peak, Black populations began moving into city centers in defiance of pass and housing laws. With the great influx of Blacks, white, wealthy South Africans fled the cities and in Johanensburg began building up suburbs to the north. In fact, the central business district was picked up from the center city and moved to Sandton after the end of apartheid. Therefore, the location of Alexandra township is unique, and it is so densely populated in part because of its prime location, near well-paid employment opportunities.[22] I conducted FGDs and interviews with indigenous healers in Alex. The NGO with which I conducted participant observation also serviced Alex, and I sometimes attended support group meetings there.

Informal Settlements: Sol Plaatje and Lawley 2

Informal settlements[23] began "mushrooming" around urban centers from the mid-1980s "following the relaxation of influx controls and rising unemployment" (Hunter

[22] For further information on the history of Alexandra, see Sarakinsky 1984 and Bozzoli 2004. For a contemporary analysis of the spatial relationship between Sandton and Alex, see Clarno *Forthcoming*.
[23] Informal settlement is the official government classification of a squatter camp.

2007: 696; See also Harrison 1992 and Crankshaw 1993). And the populations in urban squatter camps continue to rise despite the ever-increasing escalation of the unemployment rate (Hunter 2007: 697). 23.9% of the households in Gauteng are located in informal settlements (Statistics South Africa 2006a: 35).

Informal settlements are the primary site of convergence for the dual pandemics of poverty and AIDS. "People living in urban informal locality types have a much higher HIV prevalence than those in either urban formal or rural formal locality types" (HSRC 2005). The prevalence rate in urban informal settlements is 17.6%, whereas in rural informal settlements it's 11.6% (and it is 9.9% in rural formal townships and 9.1% in urban formal townships) (Ibid). In squatter communities, unemployment exceeds the national average of 35% (HSRC 2004), and in some instances climbs as high as 50-60%. A recent survey conducted in Sol Plaatje found that *of* the residents surveyed 82.5% said that their family lives on less than R1,000 per month ($167), and no respondent's family has an aggregate income of more than R3,000 ($500) (APF 2006b). Given that family size averages between 6-10 people, these are catastrophic poverty indicators.[24] While there are no similar statistics available for Lawley 2, my ethnographic data suggests that the socio-economic conditions of the region are just as desperate. Informal settlements often house not only recent migrants from rural areas throughout South Africa, but also immigrants from all over Sub-Saharan Africa.

[24] Fifty-seven percent of South Africans live below the poverty line ($98/month) (Schwabe 2004). The statistics found in this concentrated study on Sol Plaatje indicate that many South Africans (and especially those living in squatter camps) live far below the poverty line.

Figure 1-7: Sol Plaatje [25]

Sol Plaatje is an informal settlement on the site of an abandoned Durban Roodepoort Deep gold mine, 35 kilometers south-west of Johannesburg. The community is divided into two sections (D and E), each comprised of approximately 1,500 households. Most of the community lives in shacks, and the rest in former miner's hostels.

Figure 1-8: Sol Plaatje Hostels [26]

[25] Photo taken by the author.
[26] Photo taken by the author.

The hostels vary in the number of rooms they possess, but generally, there are between 3-4 occupants in each room. There is bathroom in every other hostel complex, but there is rarely running water and the sewerage often backs up and floods the rooms. In many hostels, the ceilings are caving in and there are holes in the walls and floors.

Figure 1-9: Sol Plaatje Hostels [27]

The only other water sources are standpipes that are scattered throughout the community.

Figure 1-10: Sol Plaatje Standpipe [28]

There is no electricity (for the shacks or the hostels), and there are no sanitation services.

[27] Photos taken by the author.
[28] Photo taken by the author.

Figure 1-11: Sol Plaatje Garbage [29]

The community is also without basic stores and shops to purchase food. There is only one "tuck shop," which is similar to an informal convenience store, for the whole community. Because of Sol Plaatje's geographical isolation and lack of electricity, the tuck shop is limited in what it sells. It is extremely difficult for residents to purchase fresh vegetables and fruits, milk, eggs, etc. The closest fully equipped store is in Roodepoort, which is about 20-30 minutes away via taxi.

There were no schools in the region until the community took action. The Centre for Applied Legal Studies (CALS) at the University of Witwatersrand conducted a research project in 2003 to highlight the plight of Sol Plaatje's children. After the negative publicity and some legal pressure, the local government supplied the community with one elementary school (CALS 2003). However, the community is still without a clinic or any health care provision of any kind.

[29] Photo taken by the author

The residents who live in Section D were relocated to Sol Plaatje in 2002, from their original home of Mandelaville, a squatter camp in Diepkloof, Soweto which the community occupied from 1976-2002. Mandelaville is a 3-block by 3-block stretch of land, which was originally the site of a beer hall and police station, both of which were vandalized in the 1976 Soweto uprisings. The community then applied to the local Council and received residential permits to occupy the vandalized buildings and turn them into permanent dwellings. The settlement grew throughout the 1980s and 1990s (especially after the influx controls were lifted), and in 2002, there were 1,500 households on the plot.

After the 1994 elections, the residents of Mandelaville (even those who still possessed the original residential permits from the 1970s) were told they were illegally occupying private property. Ironically, the government had sold the land to a developer to become the site of a new (private) housing development. The community was told they would be relocated to formal housing, but instead they were forcibly removed to Sol Plaatje. Their relocation was fiercely resisted by the community, and they were finally evicted by court order on January 7, 2002.[30]

In order to justify the forced removal, the Johannesburg Metropolitan Council and the feared eviction company, Wozani Security, told the press that the majority of the residents were 'illegal immigrants' or criminals (Human Rights Committee 2002). "[Our] belongings were loaded in the trucks. In fact, the majority of the people had their belongings either willfully damaged or lost … [and] most people were not even allowed

[30] This background was provided in part by Thulani Skhosana in an interview held on June 5, 2006 in downtown Johannesburg, and other details were found in the South African History Archives, housed at the William Cullen Library at the University of Witwatersrand, Collection AL2878, Freedom of Information Programme, Special Projects A6 on South African Migration.

to take their meagre building materials along" (Nimrod Ntsepe, *Mail and Guardian* 2002a). So, the residents were all piled into trucks and dropped off in Sol Plaatje, a destitute mine dump none had ever lay eyes on before. And once they arrived, they immediately were forced to compete for the hostel dwellings. "It was ugly. Neighbors who had built a community together were fighting each other because if you couldn't get a hostel, you had to build a shack."[31] And many people were forced to sleep outside until they could find materials to build a shack (Human Rights Committee 2002).

One of the main reasons the community fought relocation was because although Mandelaville was an informal settlement lacking electricity, water and proper housing, the residents were close to work opportunities, children could go to school, and there was clinic which bordered the Mandelaville location. In addition, many of the Mandelaville residents had family in Diepkloof and Orlando, and Soweto had been their home their entire lives.

The community has not stopped fighting for proper housing. The court order stated that the City Council had 12 months to provide the residents with *formal* housing. In 2003, the community filed a court case against the City Council, which was consistently postponed. In late 2005 and early 2006, while I was conducting research in the region, there were new plans for the former Mandelaville community. Instead of issuing community members with formal housing in a community with electricity, water, sewerage, education and health care, the City Council had decided to 'upgrade' the Sol Plaatje hostels and build new ones for the shack dwellers in the region. This 'compromise' was also highly contested by the community, whose chances of leaving Sol

[31] Thulani Skhosana. Interview held on June 5, 2006 in downtown Johannesburg.

Plaatje were clearly growing slimmer. In addition, the construction in the region was supposed to afford the community with employment opportunities, but while some community members began working to rebuild one of the hostels, they were never paid. In the six months I witnessed the construction process, only one hostel was targeted for renewal and the construction company had only managed to take off the roof.

As of June 2006, the land on which the Mandelaville community had lived was still empty.

Figure 1-12: Mandelaville [32]

The residents of Section E, in Sol Plaatje were also forcibly removed from Maraisburg, further south-west of Johannesburg. These residents did not resist their relocation because they would be moving closer to the Johannesburg region. Despite sharing the same horrible living conditions and space, the two communities remain isolated from one another. They claim to have major ideological differences. For example, many of the Mandelaville residents were radicalized by their experiences, at least partially because they felt betrayed by the ANC:

[32] Photo taken by the author.

"You know, during the liberation struggle, we used to hide ANC activists in Mandelaville. We did our part in the movement. And then as soon as the ANC wins the elections, they decide to sell the land we had been given, the home where I lived my whole life, to a private company. And they have never delivered on their promises of real housing. So, I don't think they are any better than the previous government – they don't care about the poor either." [33]

Figure 1-13: Lawley 2 [34]

Lawley, Extension 2 is an informal settlement of about 5,500 shacks each housing approximately 5 people (Department of Housing 2005), 100 kilometers south of Johannesburg.[35] Unfortunately, there is very little information available on Lawley 2. There are no demographic data on the population, and there is very little known about Lawley's history. According to documents collected for a court case concerning Lawley

[33] Thulani Skhosana. Interview held on June 5, 2006 in downtown Johannesburg.
[34] Photo taken by the author
[35] The Department of Housing claims there are 5,500 shacks in Lawley 2, with on average 5 people per household (Department of Housing 2005).

squatters in the late 1980s,[36] people have been squatting on the "Lawley Farm" since 1943, after being forcible removed from Alexandra township. In the 1960s and 1970s, more residents took up home on this land. They worked for white farmers in the region, and engaged in contract construction work in the 'Coloured' township of Lenasia, but most worked for Corobrick, a brick factory next to the squatter camp. In fact, today, the Corobrick factory is the *only* source of local employment for Lawley residents and still provides the main rationale for living in this dusty, extremely isolated, flatland. From February 1987 through the beginning of 1988, the local police arrested Lawley squatters on three occasions for contravention of the Illegal Squatting Act. 'Coloured' and 'Indian' workers for the owner of the land, Mr. Perry, and the local police harassed the Lawley squatters repeatedly for 2 years until finally, a court case was filed in 1988 to evict the squatters. On several occasions the police informed the residents that they were not allowed to settle in this region because "it was reserved for 'coloured' populations." The landowner claimed that he planned to build a company on the plot of land on which the squatters had settled. In November 1989, the ten squatters who were officially charged, pled guilty to illegal squatting, but asked the court to consider allowing them to remain on the land because it was close to their places of work. The court said they could not grant permission because the land was privately owned, and informed the residents that they had no alternative site for relocation but that they must leave. The residents applied for and were granted permits to relocate to the informal settlement of Orange Farm 10 miles away, but the residents resisted relocation.

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[36] Affidavits, oral testimonies, letters, and court proceedings for a court case in which 10 individuals were charged with illegal squatting in Lawley in 1987 were available in the Wits Historical Papers, Collection A2346, "Community Research and Information Network." Box D14 on Informal Settlements.

Lawley's fate between the late 1980s and the early 1990s is unclear. But at some point in the 1990s, after the end of apartheid, Lawley was upgraded to an officially registered informal settlement. Pheello claims that when he first moved to Johannesburg in 2001, he filed a C-form, which officially placed him on the Johannesburg City Council's 'housing queue.' In 2002, the government provided Pheello with a plot of land in Lawley and a piece of tin to build his shack. Although Lawley 2 is a far cry from the constitutionally-given right of all South African citizens to "reasonable living space and privacy" (Huchzermeyer 2001: 306), Pheello's preposterous housing allocation is actually a quite common 'solution' the government has implemented for accommodating the eight million homeless South Africans who are constitutionally eligible for proper and sustainable housing (*New York Times* 1996). [37] Although the government boasts that 9.6% of households have received their government subsidies (Statistics South Africa 2006a), if Lawley 2 is the government's solution, then this hardly seems something worth celebrating. Most of the residents of Lawley 2 with whom I worked moved to the area in the late 1990s and early 2000s from regions all over South Africa.

[37] According to the General Household Survey conducted in 2006, 14.5% of households were informal. This means that 2 million households in South Africa are squatter structures, without electricity, running water, sanitation, etc. If one estimates 4 people per household, this means that there are still at least 8 million homeless in South Africa as of 2006 (Statistics South Africa 2006a).

Figure 1-14: Lawley Water [38]

Lawley 2 has no running water. Instead, Johannesburg Water fills these green containers on a weekly basis. However, the containers are never cleaned or replaced; therefore, the water is often moldy or contaminated. This means that the residents must heat the water before it is potable. However, there is also no electricity in Lawley 2. Residents must purchase paraffin or other alternative energy sources, which are both expensive and contribute to poor health. During support groups meetings, the constant rasping and hacking of the members attests to the effects of both shack living on a windy and dusty plain and the polluting nature of paraffin.

The community of Lawley 2 was issued toilets in 2005, but without a water or sewerage system, they are more like port-o-potties. The toilet simply sits on top of a hole dug into the ground.

[38] Photo taken by the author.

Figure 1-15: Lawley Toilets [39]

There are no sanitation services. And the roads are made of dirt and are hardly passable by automobile.

Figure 1-16: Lawley Roads [40]

[39] Photos taken by the author.
[40] Photo taken by the author.

There is one school in Lawley 2, and there is a small mobile clinic, but it mostly dispenses aspirin and referrals to Baragwanath Hospital. There are two nurses who staff the clinic, but on most days, residents have to stand in a queue all day long to see them.

Lawley 2 is situated next to Lawley 1, which is a formal township, for working-class Africans. Lawley 1 has formal housing, electricity, and running water. There is another small clinic there, but it also has minimal capacity.

Figure 1-17: Lawley, Extension 1 [41]

Overview

The political transition in the 1990s was marked by a confluence of crises. First, facing international pressure, the African National Congress (ANC) adopted a neoliberal macro-economic strategy for development, which undermined the social democratic promises it had made to bridge the schisms of apartheid inequality. As a result, the post-apartheid state was immediately thrown into an identity crisis, destabilizing its sovereign power and the boundary and scope of the national imaginary. Finally, because the disease began to emerge during the revolution against apartheid, it was not properly

[41] Photo taken by the author.

addressed in its initial stages. By the time democracy finally arrived, so too did a pandemic that was unequalled anywhere in the world.

This historical conjuncture of events had a variety of effects. First, key leaders in the new government adopted a contradictory state logic, incorporating both economic liberalization and African nationalism. This contradiction has emerged most obviously in Thabo Mbeki's 'AIDS denialism,' which allows the state to simultaneously destabilize the global hegemony of biomedical science *and* avoid financing the public provision of antiretroviral medication. Denialism has been met with fierce resistance, turning the South African public sphere into a laboratory for a vociferous symbolic struggle over the signification of HIV/AIDS. One of the weapons the government wields in this battle is indigenous healing.

Under apartheid, there were two disaggregated systems of health care due to the institutionalization of indirect rule. It was primarily in urban townships where the two systems overlapped, giving rise to the practice of mixing biomedical and indigenous approaches to healing. The post-apartheid state has officially merged the two systems of healing; however, due to the symbolic struggle over AIDS and an unequal distribution of capital between the two healing paradigms, the field is both bifurcated and unstable.

In addition, the symbolic struggle between the state and certain civil society proponents of biomedical hegemony is often played out on the terrain of 'bare life' (Agamben 1998), such that the circumscription of the body politic and the operations of bio-power are primary stakes over which the two forces contend. And certain populations are targeted with thanatopolitical power and abandoned in 'zones of indistinction' at the 'threshold of modernity' (Agamben 1998; Foucault 1978/1990).

Given the bifurcation of the field of healing and the bifurcating effects of bio-power, how have HIV-infected Africans managed to incorporate a hybrid habitus? What are the effects of this incorporation? What does this reveal about the field of health and healing? How can we make sense of the disjuncture between peoples' hybrid habituses and the dichotomized field of which they are a product? These are some of the primary questions I will resolve throughout the dissertation.

Chapter 2 analyzes the field of health and healing in South Africa. Historically, there were two separate fields, wedged apart by indirect rule, and brought together by a post-apartheid state intent on undermining the international power of biomedical hegemony. Employing a Bourdieuian field analysis, adapted to a post-colonial context, the chapter explores the contemporary structure and distribution of capital in the field. Using archival and qualitative research, Chapter 3 analyzes the 'symbolic struggle' currently being waged in South Africa's public sphere over the signification of the disease. In this way, I situate my field analysis within both a national and international context, and I explore the sovereign stakes involved in the ultimate settling of the field of healing. In Chapter 4, I draw on my ethnographic data to provide evidence to support my claim that the HIV-infected subjects of post-apartheid have incorporated a hybrid habitus by illustrating the various ways in which people mix healing strategies and toward what ends. I draw on Bourdieu's initial theories of habitus, developed during his field research in Algeria, in order to analyze this particular emergence of a post-colonial hybridity. Chapter 5 analyzes the phobogenic discourses on Black masculinity which have emerged in a kind of hysterical outbreak alongside the AIDS pandemic, and communities' own engagement with these discourses. In addition, this chapter explores the ways in which

neoliberal restructuring and the pandemic have instigated shifts in gender ideologies and sexual practices. Finally, the dissertation ends at threshold of the social and the individual body. AIDS elicits fears of contaminating and uncontrollable fluids, the transgression of taboos, and the disintegration of the body which parallel certain anxieties about the stability of the national body politic.

Chapter 2

The Field of Health and Healing:

Amalgamation, Instability and Exteriority

"[A] field may be defined as a network, or a configuration, of objective relations between positions. These positions are objectively defined, in their existence and in the determinations they impose upon their occupants, agents or institutions, by their present and potential situation in the structure of the distribution of species of power (or capital) whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to other positions (domination, subordination, homology, etc.)" (Bourdieu and Wacquant 1992: 97).

According to Bourdieu, a 'field' is a patterned structure of social relations, whose participants or 'practitioners' are all engaged in competition (consciously or unconsciously) over the symbolic and material stakes of the same 'game.' Each field is doubly structured (Bourdieu 1989), meaning that its participants are positioned in an objectively structured hierarchy of social relations, but they also vie for symbolic power over the 'vision and division' or *nomos* of the field (Bourdieu 1996a: 132). The positions within the field are interdependent on one another (Bourdieu 1993a). But these symbolic and material structural positionalities are not taken for granted. They are always at risk of transformation because one of the essential components of any field is struggle. The field is always a "*field of struggles* aimed at preserving or transforming the configuration of [its] forces" (Bourdieu and Wacquant 1992: 101), but only according to the regularities and rules over this space of play. Because, although the field is always immersed in

struggle, the fact that the game is worth playing is never questioned. All participants in the field must be equally invested in the *illusio*, a belief in the fundamental principles of the field (Bourdieu 1980). In fact, "… the *foundation of belief* … resides in the *illusio*, the adherence to the game as a game, the acceptance of the fundamental premise that the game … is worth being played, being taken seriously" (Bourdieu 1996a: 333). Players agree to these stakes simply by agreeing to play (Bourdieu 1993b).

"[T]he structure of the field, i.e. of the space of positions, is nothing other than the structure of the distribution of the capital of specific properties which governs success in the field and the winning of the external and specific profits … which are at stake in the field" (Bourdieu 1993a: 30). The different "species" of capital (economic, cultural, social and symbolic) are accorded different hierarchical values in each field and are then wielded by the different players in the field to vie for dominance or legitimacy (Bourdieu 1986). But there is also a particular form of cultural capital which is field-specific, and which is recognized as legitimate by all those who share the same *illusio* (Steinmetz 2007a: 48). The definition of this field-specific capital is not tied to a particular 'taste' or mark of distinction (nor to a particular structural position within the field), so it can also become one of the primary stakes of struggle. Overall, however, the practitioners within each field seek to legitimize the structure of the field that best serves their own (class) interests and capital. Therefore, the definition, value and conversion rate of capital is one of the primary stakes in field-specific struggles.

But the ultimate goal of the struggles taking place in any field is hegemony. Each group within the field seeks to legitimize its own *nomos* (symbolic power) and capital (economic power) as *doxic*. There is an "objective complicity which underlies all

antagonisms": that which is worth fighting for and which "goes without saying" (Bourdieu 1993b: 73). 'Doxa' occurs when the rules of the game and the field's structural hierarchy are silently and consensually accepted and legitimated (Bourdieu 1991: Chapter 5; Bourdieu and Wacquant 1992: 73-74; Bourdieu 1996a: 185-86; Bourdieu and Eagleton 1994). When the field ceases to be recognized for what it is, when the struggle is no longer conscious, when the unspoken 'rules of the game' are tacitly accepted as legitimate, then the field has achieved doxic status (Bourdieu 1993b: 73-74). At this point, those in structurally dominant positions within the field deploy "symbolic violence" in an effort to sustain the status quo. "'Symbolic violence' is thus Bourdieu's way of rethinking and elaborating the Gramscian concept of hegemony" (Eagleton 1991: 158).

In this chapter, I will illustrate the ways in which the post-apartheid health system functions as a field. Field analysis entails the specification of four interdependent relations (Bourdieu 1971). First, the researcher must "map out the objective structure of the relations between the positions occupied by the agents or institutions who compete for … legitimate form[s] of specific authority" (Bourdieu and Wacquant 1992: 105). The layout of the field and the structure of "space of positions" can only be analyzed in a particular synchronic moment (Bourdieu 1993b: 72). Second, it is essential to analyze the habitus of the agents within the field, including their dispositions and social trajectories. Third, the field under study must be situated within the national social space, and its relation to the field of power must be articulated and detailed.[42] "The *boundary* of the field is a stake of struggles, and the social scientist's task is … to describe a *state* of

[42] This entire description of the 'how to' of field analysis is summarized from Bourdieu and Wacquant 1992: 104-105. However, I have re-arranged the order and added a fourth dimension.

these struggles and therefore of the frontier delimiting the territory held by the competing agents" (Bourdieu 1993a: 42-43). Finally, then, the struggles in which the field is embroiled should be detailed in order to determine the current boundaries of the field, but also, its temporal specificity. Both the past and the possible future of the field can be glimpsed through an analysis of its contemporary struggles.

Using field analysis outside of a Western context is rare.[43] Bourdieu had not yet developed his theory of the field while conducting research in Algeria. Because his field analyses were always situated in Western contexts, this may explain why Bourdieu (over)emphasizes the *homologous* relationship between field structures and ideologies and *social* structures and ideologies. Some of the work in this chapter will be exploratory, given the fact that I am taking Bourdieu's field theory into very uncharted territory. However, much of Bourdieu's work (as well as those who have utilized Bourdieuian field theory) provide helpful hints for analyzing a post-colonial field in crisis. For example, this chapter will draw heavily on *The Rules of Art* (1996a) because although it is also an analysis of a field in France, this book provides the historical lineage of the field: from its unstable emergence, through various stages of 'settling,'[44] until it finally achieves full autonomy. As such, it provides the basis for understanding the emergence and instability of fields during historical periods of crisis.

This chapter will begin by showing that under apartheid, there were two completely segregated fields of healing which then merged into a newly constituted, yet highly bifurcated field at the end of apartheid. Next, I will show that despite its

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[43] Steinmetz has utilized field theory to analyze the "colonial state field" in three German colonies (Steinmetz 2002; 2003; 2007). Apter (1999) has applied field theory to post-colonial Nigeria.
[44] The concept of an 'unsettled' field is borrowed from Steinmetz (2005a; 2007b).

segregated and unbalanced structure, the post-apartheid field of health and healing displays the properties Bourdieu insisted were essential to any field. I will also detail the current layout and structure of the field, illustrating the precise way in which it is still institutionally and ontologically bifurcated due to both the legacy of apartheid and the effort to 'modernize.' I will also argue that while Bourdieu recognized that external forces always affected internal field dynamics, he very rarely articulated the precise dynamics of this social and historical contingency. The field of health and healing in post-apartheid South Africa cannot be understood without taking heed of the various external forces that impinge on and shape the health field. This chapter is meant to provide the theoretical framework which will be supported and elaborated throughout the rest of the dissertation.

The Merging of a Field

"Townships were first created by the visionaries of urban racial paternalism … In a coincidence of racial symbolism and caste-like purity, it was sometimes said to be necessary to build such townships because of the dire problems of health and disease caused by inner city slum growth – the 'sanitation syndrome' as it has been called" (Bozzoli 2000: 82).

Under apartheid, there were two separate fields of healing: indigenous healing and biomedical healing, reflecting the segregation of 'nations' necessary for the maintenance of indirect rule. According to Mamdani (1996), the apartheid government strategically deployed segregation on the basis of tribe, as opposed to race, in an effort to "split the majority into compartmentalized minorities" and confine them within segregated Bantustans based on ethnicity (96). "That move was a recognition that the real threat to racial supremacy came from new class forces engendered by the modern economy, forces

that cut across tribal lines and would therefore flourish in the context of a racial mode of representation and control" (Mamdani 1996: 95). As such, the South African colonial state was essentially bifurcated, dividing the population between citizens – white populations with civil rights – and subjects – populations of color, circumscribed by colonially invented cultural identities (Ibid). However, the urban middle and working classes were stuck in-between these two systems of rule. "[They] were exempt from the lash of customary law but not from modern, racially discriminatory civil legislation. Neither subject to custom nor exalted as rights-bearing citizens, they languished in a juridical limbo" (Mamdani 1996: 19).[45] The apartheid government (eventually) directly controlled the urban populations, whereas the rural populations were subject to the "decentralized despotism" of indirect rule (Ibid: 101).

Belinda Bozzoli, one of the very few scholars who studies the social history of urban townships in South Africa, complicates Mamdani's characterization of apartheid urban governance (2000). She notes that prior to apartheid, when townships were first being built to house the industrial workers and domestic servants, they were governed primarily by a system of "welfare paternalism." In Soweto, for example, each sub-township was administered by a white Superintendent, but the Black elite also sat on Advisory Boards and therefore, participated quite extensively in township governance (Bozzoli 2000: 85-86). In addition, the local government financed the townships through subsidies (from central city councils), public beerhall revenue, and levies on employers

[45] It is important to note that Mamdani's *Citizen and Subject* has been criticized by social historians for a wide range of reasons. First, his analysis overdetermines the legal aspects of apartheid (Kistner 2003). Second, his analysis reifies the urban-rural divide, which was never as absolute as the apartheid government would have liked, and this reductionism lends credence to the teleological discourse of liberal modernism (Cooper 1983; 1997a). Finally, the urban working class were not simply wedged between two totalizing determinations; they also mounted the most powerful challenges to colonialism (Cooper 1997a and 1997b; Bozzoli 2000).

(Bozzoli 2000: 87). When the apartheid government first came to power, this paternalism was modified but not eradicated.

It was not until the 1970s that a significant shift in governmentality of the Black urban population was enacted: the financing of townships was privatized; bureaucracy was pervasive and rigid; class distinctions were eradicated and so too was Black populations' participation in local governing structures; townships were segregated along ethnic lines; and most importantly, in order to coercively deploy its strategy of tribalization, urban Black populations were "periodically returned to their homes to renew their tribal connections" (Mamdani 1996: 100).[46] In other words, urban populations were often forcibly removed. But the state's assault on the Black urban population was also conducted through new forms of governmentality. "A proliferation of rules, laws and regulations indicated that government by bureaucratic decree – issued from the central state rather than local government – was to be the order of the day" (Bozzoli 2000: 92). Everyone who was not begrudgingly granted 'permanent' urban status under the Urban Areas Act, and who did not have a work permit (in their own right), was sent back to the homelands (Bozzoli 2000: 96-97). Many women and children were 'returned' to the Bantustans, and men were the target of a new 'hostellization' process. An "'ultramodernist' conception of how everybody else – defined as 'single' urban workers – would be handled was conceptualized and implemented … No families would remain … The plan was to incarcerate 'inmates' in prison-like structures" (Bozzoli 2000: 97-98).

[46] This new apartheid strategy is summarized by Bozzoli (2000) on pages 91-99.

Townships were originally developed to stem what was perceived of as a "squatter pandemic." "The squatter epidemic soon turned into an explosion, with camps emerging in peri-urban areas around the country, outside the scope of any legislation" (Mamdani 1996: 98). Because these squatter settlements were overcrowded, racially mixed, and close in spatial proximity to white cities, they were perceived as a health risk to the white population (Bozzoli 2000: 83). Townships were meant to curb the subsequent "sanitation syndrome" (Bozzoli 2000: 82).

> "They consist of narrow courtyards, containing dilapidated and dirty tin huts without adequate means of lighting and ventilation, huddled on an area and constructed without any regard to sanitary considerations of any kind. In the middle of each slop-sodden and filth bestrewn yard there is a well from which the people get their water supply and they choose this place for washing purposes and urinals. It is as crowded as a rabbit warren. I shudder to think what would occur if plague or cholera broke out in that place. These places are dark dens" (Medical Officer of Health, Johannesburg City Council, 1903. Quoted in Bonner and Segal 1998: 12).

In fact, 'hygiene' considerations were a primary rationale offered for physical segregation. Outbreaks of tuberculosis and syphilis were considered to be proof that the African populations were morally and physically weakened by urban civilization (Fassin 2007). The African's body "… was actively harmed by inclusion in the polis" (Mantel 2007).

"Townships were at the heart of one of the major contradictions in the South African social order of the time – the contradiction between the need to keep wages low, and the need to make sure the reproduction costs of the working class were covered" (Bozzoli 2000: 87-88). It was partially because of this contradiction that clinics were first established in urban townships. The hospital in Soweto was originally built in 1941, financed by the British government, and it was officially opened by Prime Minister

Smuts in 1942, as the Royal Imperial Hospital, Baragwanath.[47] In 1948, the South African government bought the hospital for 1 million rand, and renamed it "Baragwanath." "On 1 April 1948, the black section of Johannesburg Hospital (known as NEH) was transferred to Bara, and the hospital opened with 480 beds" (van den Heever 2008). It was not until 1997 that "Chris Hani" was added to the name to commemorate the Umkhonto we Sizwe (MK) activist who had died in 1993.[48]

There are also 13 clinics in Soweto. The Orlando Clinic (situated in Soweto's oldest neighborhood) was built as early as 1932 (Bonner and Segal 1998: 16-18).[49] According to a matron[50] I interviewed who worked in Baragwanath and the Sowetan clinics throughout the 1970s and 1980s, the clinics were administratively controlled by Baragwanath Hospital under the apartheid regime. She told me that the clinics and hospital were directly controlled by the central state. The majority of the nurses were Black, and there were a few Black matrons, but they were always under the leadership of white matrons and doctors. She also noted with an ironic chuckle that nursing was a well-respected and well-paid profession under apartheid, whereas today, nurses are over-worked and under-paid.[51]

Up until the end of apartheid, indigenous healing remained a peripheral, informal, and ostracized form of health care, utilized clandestinely by the African populations. The practice of divination was declared illegal in apartheid South Africa, under the

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[47] John Albert Baragwanath was a Cornish settler who made a fortune in the South African gold fields.
[48] This history of the hospital is provided by the former Chief Superintendent, Dr. Christo van den Heever. See van den Heever 2008.
[49] There is *very* little information available about the history of the health care system in Soweto, or any other urban township. This is an understudied historical subject that deserves attention. There has been research conducted on the health care provided by mining companies to their workers (Packard 1989; Jochelson 2001).
[50] A matron is an administrative position. She manages all of the nurses in her ward, or at her clinic.
[51] Female Matron, Dobsonville Clinic. Interview held on June 7, 2006 in Dobsonville, Soweto.

"Witchcraft Suppression Act" of 1957 (RSA 1957).[52] The Act was aimed at those who "pretend to exercise or use any kind of supernatural power, witchcraft, sorcery, enchantment or conjuration, or undertakes to tell fortunes, or pretends from his skill in or knowledge of any occult science" (RSA 1957). The punishment ranged from 20 years in prison to "a whipping not exceeding ten strokes" (RSA 1957).[53]

Despite this legislation, traditional healing was largely tolerated by the white populations, and was recognized for the important role it played in Black South Africans' sense of culture. "Witchcraft is an integral part of African culture and is still deeply entrenched in the African way of life" reads a *Star* newspaper article from 1965 (*Star* 1965b).[54] It was often perceived as more amusing than menacing. This perspective is abundantly clear when one examines the names of many of the newspaper articles from the 1940s-1960s that reference traditional healing. Several newspaper articles poke fun by discussing the obsession 'Africans' have with the 'Tokoloshe,' the South African version of the 'boogey-man' (*Rand Daily Mail* 1955, 1956, and 1969; *The Friend* 1964). A *Star* article states: "far too many Europeans regard it [witchcraft] as generally useful, slightly comic, and an essentially harmless part of the Romance of Africa" (*Star* 1965a).

In the Bantustans, which were administered and directly controlled by chiefs, traditional healing could be practiced largely without interference. The traditional healers

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[52] "Witchcraft" was used to denote healers who practice bewitchment, *igedla*, but also those who practice divination, *sangoma* (for example, *Star* 1964). This misnomer is still common, but has receded a bit with greater public education.

[53] This Act was last amended in 1970 (Ashforth 2005: 286), and in 1974, the Health Professions Act (no. 56) was passed, which required that all health practitioners be registered with a governing body. Because traditional healers had no appropriate national regulatory body, they were further legally penalized under this act (RSA 1974).

[54] All of these newspapers from the 1950s-1970s were part of the Institute for Race Relations archive, housed at the William Cullen Library at the University of Witwatersrand, Johannesburg. Wits Historical Papers, 1940-1970. Press Clippings on African Healing. Collection: AD1912, "South African Institute of Race Relations Press clippings." Boxes 112-113: Health.

with whom I spoke, who were active in Black urban townships under apartheid, mentioned the need to conceal their identities and practices during this period. Indigenous healers generally only dress in 'traditional' attire in order to perform ceremonies and otherwise dress in conventional clothing. However, one of the ways to identify a *sangoma* is the beads they wear around their necks and wrists. Urban traditional healers often had to hide their beads under apartheid in order to escape scrutiny and suspicion.[55] However, the profession's public denigration and ridicule was more of a concern than juridical punishment. One traditional healer explained to me: "Under apartheid, because traditional healing was suppressed, people became ashamed of what they are … The profession … was despised by people and traditional healers were labeled 'witch doctors.'"[56]

Despite the availability of biomedical health care and the public denigration of indigenous healing, township residents still utilized the services of traditional healers to a great extent:

> "Witchcraft still has its usefulness in modern medicine among Africans and is strongest where least expected – in the sophisticated townships" (*The Star* 1967).
>
> "In spite of the development of 'White' medical services for Africans, the African belief in the 'isangoma' (witchdoctors) is increasing" (*The Star* 1964).

Therefore, urban townships were primary sites of intersection between indigenous and biomedical healing under the apartheid system.[57] However, the prevalent usage of *both* health care systems does not indicate a merging of the segregated fields.

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[55] Dr. Robert Tshabalala. Interview held on July 22, 2005 in Orlando East, Soweto.
[56] Dr. Koka held in Noord Wyk, Johannesburg on Wednesday, September 7, 2005.
[57] Missionaries also set up biomedical health clinics in rural areas throughout South Africa, which continued to operate under apartheid. See: Comaroff and Comaroff 1997.

Biomedical health care was the only legitimate and recognized form of healing under apartheid. Indigenous healing was tolerated, but ridiculed as illegitimate. Even the nurses who worked for the apartheid health system became accomplices in its denigration. One nurse I interviewed noted that they were taught traditional healing was "dirty, backwards and uncivilized" – even that it was dangerous for the population. [58] Nurses' only contact with indigenous forms of healing, within the clinics and hospitals, was when they were asked to "fix" the complications that arose from 'witchcraft' gone awry (*Natal Mercury* 1965).[59]

> "During apartheid, the white doctors did not want to hear anything that related to traditional healing. If a patient, their patient, consulted with them, and actually told them that 'I have been to a traditional healer,' they would immediately dismiss the patient. Because traditional healing was not taken seriously. The doctors thought that people were eating poison. They did not want to hear anything about traditional healing. Because really, not only traditional healers, but Blacks were like monkeys to them, you know. They were like nothing to them."[60]

Due to the structure of the apartheid system, indigenous healing was institutionally, spatially and ideologically circumscribed as 'traditional,' i.e. tribal. Because it belonged, according to apartheid logic, to the 'Bantu,' it was materially and symbolically isolated into its own sphere of practice, segregated wholly and completely from the biomedical, 'modern' health system, which was only made available to Africans in order to preserve their labor power. Each form of healing constituted its own field until the breakdown of the apartheid system.

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[58] Mrs. Koka held in Noord Wyk, Johannesburg on Wednesday, September 7, 2005.
[59] As I will show, many African biomedical practitioners still take these apartheid lessons to heart.
[60] Dr. Robert Tshabalala. Interview held on July 22, 2005 in Orlando East, Soweto.

One the one hand, not much has changed for the professional of traditional healing. It is no longer *illegal*, but it is still publicly denigrated and patronizingly ridiculed as a cultural norm that undermines the 'progress' of modernization and development. However, largely because of Mbeki's denialism and his *discursive* support for indigenous forms of healing, biomedical practitioners are now forced to recognize traditional healing as at least partially legitimate. It is no longer possible for the advocates, producers and consumers of biomedical healing to blatantly *disregard* traditional healing. And they are forced to defend and articulate their own position (disposition) in *opposition to* this other form of healing.[61] Under apartheid, this was unnecessary. Biomedical practitioners were not forced to compete for consumers. In this chapter, I will show that today, biomedical practitioners and traditional healers are struggling for dominance over the principles of hierarchization and the value of capital relevant to the *same* field of health.

With the transition to post-apartheid, it was necessary that the fields merge for several reasons. First, the citizen and subject divisions imposed by the legacy of apartheid required synthesis. The ANC went through tremendous effort to resolve the historical divisions sustained by a bifurcated system of governance, and particularly those between rural Bantustan populations and urban township populations.[62] Integrating the field of healing and recognizing the legitimacy of *both* indigenous and biomedical health care was part of a larger post-apartheid effort to *reconcile* the 'tribal' and the 'modern.' Although this integration is still far from a lived reality, officially synthesizing the fields

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[61] Data to support this claim will be provided in the next chapter.
[62] For further information on the way in which the ANC attempted to integrate chiefs into the post-apartheid state, see: Myers *Forthcoming*.

of healing is an important step in this direction. Second, because traditional healing is a form of healing used exclusively by the African populations (for whom it is an essential aspect of their identity and culture), it could not be officially de-legitimized without alienating the majority population in whose name liberation was supposedly achieved. Third, Mbeki believed that he could *use* traditional healing to both undermine the legitimacy and hegemony of Western powers *and* to justify his economic interests (this will be further explored in the next chapter). Finally, with AIDS ravaging the exact populations who are most likely to utilize indigenous healing, it became *practically* impossible to eradicate its usage.

Therefore, merging indigenous and biomedical health care into one field was a strategy deployed by the post-apartheid state to synthesize a bifurcated economy and race/class system (made absolutely essential by the emergence of AIDS). But segregation still structures the field: geographically, racially, and socio-economically. Interestingly, the township is the ideal *model* for integration. Township residents have been utilizing *both* forms of healing, syncretizing their incommensurabilities, for a century. The habitus of hybrid usage developed in the urban locations of apartheid. As such, this urban habitus is in hysteresis. At this point, the field is still in its initial stages of emergence, and it is profoundly 'unsettled,' partially because of its immaturity and partially because it is being forced to contend with an epidemic. But before I get into its complex characteristics, I would like to utilize Bourdieu's field criteria to prove that the post-apartheid health system is indeed an integrated field.

The Field of Health and Healing

"There are *general laws of fields*: fields as different as the field of politics, the field of philosophy or the field of religion have invariant laws of functioning …" (Bourdieu 1993b: 72; emphasis in original).

The "invariant laws of functioning," that define every field are: 1) every field is embroiled in struggle (Bourdieu 1993a; 1993b; 1984; 1996a; 1996b); 2) all of the occupants of the field share the same *illusio* – a recognition of and belief in the primary interests and stakes of the 'game' (Bourdieu 1993b; 1984; 1996a); 3) there are particular criteria of eligibility for playing the game, and these are policed by adherence to a codified set of credentials for membership (1996a; 1996b); 4) "capital and field mutually define and specify each other" (Wacquant 1996: xi), and the value, volume, composition and exchange rates of particular field-specific forms of capital are primary stakes in the struggles taking place in the field (Bourdieu 1984: 114); 5) "In order for a field to function, there have to be stakes and people prepared to play the game, endowed with the *habitus* that implies knowledge and recognition of the immanent laws of the field, the stakes, and so on" (1993b: 72); 6) a fully functioning field is an *autonomous* field (Bourdieu 1996a).

Struggle and Illusio

"When we speak of a *field* of position-takings, we are insisting that what can be constituted as a *system* for the sake of analysis is not the product of a coherence-seeking intention or an objective consensus (even if it presupposes unconscious agreement on common principles) but the product and prize of a permanent conflict; or, … that the generative, unifying principle of this 'system' is the struggle, with all the contradictions it engenders" (Bourdieu 1993a: 34; emphasis in original).

The field of health and healing in South Africa is ravaged by a symbolic struggle between the adherents to biomedical science, the proponents of denialism, and

indigenous healers. Because this struggle is the subject of the next chapter, I will simply introduce its relevance and importance briefly here. Because of the devastation wrought by HIV/AIDS, the field of health and healing has an unusual (and heteronomous) relationship to the field of power. I will explore this point in greater detail below, but I mention it here to argue that the winner of the symbolic battle over healing (and subsequently the fight to 'solve' the pandemic), will reap sovereign rewards. The players in the symbolic struggle over HIV/AIDS are vying for legitimacy to inculcate their own vision of the world as doxic. They are fighting for hegemony because the *nomos*, or vision and division of the social space is at stake. "In reality, the struggles which occur within the intellectual field have as a stake symbolic power, that is to say, the power over a particular use of a particular category of signs and, through that, on the vision and the meaning of the natural and social world" (Bourdieu 1985: FN15, 23). Symbolic struggles are also struggles over and for signification – of the schemas of perception (and appreciation), and the classification strategies (of tastes, life-styles, products) – essentially of social class itself. "The reality of the social world is in fact partly determined by the struggles between agents over the representation of their position in the social world and, consequently, of that world" (Bourdieu 1984: 253).

Therefore symbolic struggle and *illusio* are interrelated. Members of the field of health and healing would not be so intent on battling one another over a hegemonic ontology of the body, the signification of disease, and the boundaries of the field of healing, if they were not all deeply invested in its immanent stakes.

> "The struggles for the monopoly of the definition of the mode of legitimate cultural production contribute to a continual reproduction of belief in the game, interest in the game and its stakes, the *illusio* - of which the struggles are also the product. Each field produces its specific form of the *illusio*, in the sense of an

> investment in the game which pulls agents out of their indifference and inclines and predisposes them to put into operation the distinctions which are pertinent from the viewpoint of the logic of the field … in short, the *illusio* is the condition for the functioning of the game of which it is also, at least partially, the product" (Bourdieu 1996a: 227-28)

No one group or position within the field possesses or controls the *illusio*. It is a reification – separated from those who are invested in it – ruling, as it were, over the entirety of the field. "The struggle for the monopoly of legitimacy comes to reinforce the legitimacy in the name of which it is waged" (Bourdieu 1996a: 167). Therefore, the *illusio* acts as a sovereign fetish, but as such, it is also always the primary stake.

In the case of South Africa, the *illusio* has really become the ability and capacity to successfully address and halt the epidemic of AIDS. However, because the political economy of the country is so inextricably tied to its capacity to manage the epidemic, there are also primary economic factors riding on the struggle. And finally, the national imaginary of the post-apartheid state is at risk. Those populations hardest hit by the epidemic are Black and poor – they are the marginalized masses – in whose name the sovereign power has legitimacy, but whose physical well-being is also an economic burden. Liberation can be undermined symbolically because the population who fought and won against the apartheid system is now being decimated by a pandemic and neoliberal restructuring. But it can also be undermined by economic crisis. The tension between these two stakes is a constant feature of the symbolic battle over AIDS taking place in South Africa.

Criteria of Eligibility

> "The only legitimate accumulation … consists in making a name for oneself, a name that is known and recognized, the capital of consecration – implying a power to consecrate

objects … or people … and hence giving them value, and of making profits from this operation" (Bourdieu 1996a: 148).

The criteria of eligibility helps to define the limits of the field, and also acts as a common denominator. Sometimes these criteria are codified into a set of institutional thresholds through which members must pass in order to become legitimate *producers* within the field. These can take the form of institutionalized acts of consecration, as is the case with educational degrees, which serve as necessary requirements for field membership (Bourdieu 1996a and 1996b). Such consecrated credentials are compulsory for practicing biomedical health care. Nurses and doctors are required to complete advanced degrees, pass qualifying exams, undergo residencies, etc. In fact, biomedical scientists, researchers and practitioners all have nationally standardized educational requirements, evaluative procedures, and codes of conduct which police the boundaries of membership.

Traditional healing has always had its own criteria of eligibility. There are two primary kinds of indigenous healers: *inyangas* (herbalists) and *sangomas* (diviners). The diviners are possessed by spirits, who help the practitioner diagnose illnesses and stage healing rituals; the herbalists provide natural pharmacopeia. The two are distinguished by their relationship to the *amakhosi* or *amadlozi* (ancestors). The *sangoma* communicates directly with the ancestors, and is in a fairly constant state of spiritual possession. "Each sangoma belongs to a 'school' or 'family' of fellow healers that have been trained by a senior sangoma-trainer, the *gobela*. This is called the *mpande* or 'root', and signifies the

closely bound group of healers that come from a common 'core' of understanding, treatment, and training" (Thornton 2002b).[63]

The *inyanga* does not have a relationship with the ancestors and simply acts as a traditional pharmacist. S/he does not diagnose patients. They are either referred to the herbalist by a sangoma, or with less serious conditions, the patient self-diagnoses.[64] The *inyanga* is often a hereditary profession. Meaning, the knowledge of herbs was often passed down from one generation to the next. *Inyangas* generally learn their trade through apprenticeship with a master.[65] However, anyone can become an *inyanga*, which makes it very different than the process for becoming a *sangoma* (Abdool-Karim et al. 2004: 7).

In order to become a *sangoma* (diviner), one must first be "called" (*ukubiza*) by the ancestors. "This generally manifests itself as an illness, anxiety or pain in the body, and is due to the desire of the ancestors to communicate with this person, or due to the failure of the person to recognise and respect their ancestors" (Thornton 2002b). I conducted an interview with one white *sangoma* – a Canadian who married an Afrikaner and moved to South Africa in the early 1990s. This is her story of being called:

> "Back in 1994, I got really sick while traveling in Tanzania. So I decided I've got to get back to South Africa and set some help. So I flew back and then began a five-year struggle with my health. I went to doctor after doctor after doctor. Irritable bowel syndrome, chronic fatigue, endometriosis … There was a million and one things. So I was either undiagnosed, misdiagnosed, or eventually it was like, "You're a hypochondriac." So nothing worked. I went back to Canada. When I was in Canada, it was worse. I then decided this isn't working, let me try

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[63] Another primary difference between *inyangas* and *sangomas* is a gender division. Historically, *sangomas* were women, and *inyangas* were men (Xaba 2005). This has changed over time. I will discuss this further in Chapter 4.
[64] All of this information was provided through a series of FGDs held with traditional healers in May and June of 2005 in various regions of Soweto. See also Thornton 2002b.
[65] Male *inyanga*. Interview held on April 22, 2005 in Alexandra, Johannesburg.

> complementary medicine. I tried everything. Ayurvedic, raw food, macrobiotic, juicing, Chinese, homeopath—everything. Nothing helped. I got sicker. So I couldn't work, I couldn't study. I'm like 20, 21. Basically bedridden, and this has been going on for years. And every day it's something new – one day it's diarrhea, the next day I'm vomiting, the next day it was a headache, and now I'm losing weight. So, I decided to try a spiritual approach. I went to a Native American healer. I worked with him for a few months and felt better, but not completely cured. So I came to South Africa, now kind of open to different forms of spirituality. I saw a traditional healer. She threw the bones, and she said, "You have a calling to be a healer. And if you don't answer this call, you're going to die." So I said, "Oh, shit," basically, "What am I going to do?" And she said, "Well, you're here for a reason. I think you need to do it here." Everyone thought I was crazy. My friends, my husband, everyone. I decided to train in Soweto. And this is, you know, there's still that kind of apartheid separation. My in-laws said, "you're going to move to Soweto, like are you crazy?" So I moved there and within two weeks I was well."[66]

When an individual is 'called,' s/he must at the very least conduct a ritual to honor the ancestors. However, if this does not cure the illness, then it is necessary for the person to undergo training (*ukuthwasa*) to become a *sangoma*. Some people ignore their calling. Dr. Martha Mongoya ignored hers for over a year because she had been told by her church that traditional healing was a sham, but her illness worsened, until one day she woke up and could not see. She decided to go for training, and within the first week, her eyesight was restored.[67]

The *sangoma* initiate must select a *gobela* (trainer) under whom s/he apprentices. The *gobela* "both heals and trains their *umthwasa* [trainee] in the arts of spirit possession … and therefore initiates the trainee into the secret knowledge of the traditional healer" (Thornton 2002b). This training can take anywhere from several months to several years. During the apprenticeship, the *thwasa* lives in the home of the *gobela*, and is "expected to serve and respect his/her teacher in all ways" (Ibid). Once the *gobela* decides the *thwasa*

[66] Dr. Rebecca Rogerson. Interview held on August 19, 2005 in Melville, Johannesburg.
[67] Dr. Martha Mongoya. Interview held on April 18, 2005 in Orlando East, Soweto.

has completed his/her training, it is necessary for the trainee to go through a 'graduation' ritual, which serves to both publicly test the *thwasa*'s skill and to show off the new *sangoma* to his/her community.

The graduation ceremony begins when the *thwasa* goes into a trance and channels his/her particular spirit guide, who then greets the guests. The guests are invited to hide objects for the *thwasa* to find through communication with the ancestors, and also to ask the *thwasa* questions about their own ancestors. Finally, a goat is slaughtered, and the trainee drinks the blood of the goat as it is dying. The gall bladder of the goat is then hidden by the *gobela*. If the *thwasa* can find the gall bladder, with the help of the spirits that possess him/her, then the final test has been passed, and the trainee becomes a *sangoma*.[68] This process can fail, and the trainee will either continue his/her apprenticeship or leave the profession. The graduation is held publicly and actively involves the community, so that the community can judge for itself the strength or weakness of the *sangoma*'s powers. And community members take it seriously. If the *thwasa* cannot find the items hidden by the audience or the *gobela*, and then tries to practice in the community, s/he will be shunned and considered a charlatan.[69]

There is, therefore, a very precise series of eligibility criteria to enter the indigenous healing professions, including a long period of training and a qualifying exam. However, the regulation of this process is not nationally standardized.

> "While medical doctors share a common training based on standardised and public knowledge, the traditional healer does not. Similarly, while medical doctors are all qualified at a roughly comparable level of expertise, the traditional healers are not. Moreover, while the knowledge of bio-medicine is public, and

[68] This process was explained to me by Dr. Robert Tshabalala. Interview held on April 18, 2005 in Orlando East, Soweto. For further information, see Thornton 2002b.
[69] Pheello Limapo. Interview held on October 5, 2005 in Lawley, Extension 2.

> verified by rigid scientific methods, the knowledge of the traditional healer is secret and unverified by any procedures except his or her own individual experience and the experience of the small group of healers with whom he or she interacts on a regular basis" (Thornton 2002b).

In recent years, however, the post-apartheid government has decided to institutionalize the practice, codify the training process, standardize the production and sale of herbal remedies, and in general, subject the profession to state regulation. Bourdieu notes that part of the "magical" power of the state resides in the role it plays as "the Central Bank of symbolic credit," which allows it to *authorize* particular criteria of eligibility in particular fields (Bourdieu 1996b: 376), and in so doing control and "endorse … all acts of *nomination* whereby social divisions and dignities are assigned and proclaimed" (Wacquant 1996: xvii-xviii). In South Africa, the state is attempting to redefine the boundaries and membership criteria of the field of healing by integrating indigenous and biomedical health care.

Directly after taking office in 1994, the ANC government developed *A National Health Plan for South Africa*,[70] which included plans to officially recognize indigenous healing and attempt to 'integrate' it into the public health system: "we seek to establish appropriate mechanisms that will lead to the *integration* of traditional and other complementary healers into the National Health Service" (ANC 1994; See also Ashforth 2005: Chapter 12 and Mills 2005).

On February 11, 2005, the South African government passed the *Traditional Health Practitioner's Act, 2004* into legislation. The purpose of the act is: "to establish the Interim Health Practitioners Council of South Africa; to make provision for control of

[70] In order to construct the plan, the ANC drew on the technical advice and support of the WHO and UNICEF (Ashforth 2005: 287).

the registration, training and practices of traditional health practitioners in the Republic of South Africa; to serve and protect the interests of members of the public who use the services of traditional health practitioners" (RSA 2005). The Act sets up guidelines for national standards on education and training, fees, finance, registration, professional conduct, ethics, and disciplinary procedures. The Act is meant to legally circumscribe the scope of traditional health practice, and monitor and regulate the "interprofessional matters and matters and maintenance of profession competence" (RSA 2005). The Act also states that a primary goal is to "promote and regulate the liaison between traditional health practitioners and other health professionals registered in terms of the law" (RSA 2005).[71]

There will be a registrar, appointed by the Minister of Health, who will monitor the registration of legitimate traditional health practitioners. Practitioners will receive a certificate, without which they cannot practice, and the certificate must be renewed on an annual basis, upon payment of a fee. The Council, which the Act establishes, will oversee disciplinary hearings and decide upon punishment or suspension of those found guilty of "unprofessional conduct." Although the Council and the registrar are given certain powers of regulation, most of the power to set guidelines and policies is placed firmly in the hands of the Minister of Health. Although the Act sets out certain *proposals*, the exact policies and concrete measures remain to be established and implemented. However, there are two traditional healers, Nomsa Dlamini and Nkosazana

[71] Interestingly, the South African state disallows the persecution of 'witchdoctors,' who are believed to practice occult spellcraft. "Current legislation makes it illegal to impute or point a person as a witch" (Stadler 2003: 127). See also: Leclerc-Madlala 1997 and Ashforth 2005. I will discuss witchcraft in more detail later in this chapter.

Dlamini, who sit as Coordinators of Traditional Healing on the National Department of Health.

The government has also made significant efforts to test and then register traditional *muti*. The National Drug Policy sets out guidelines for the investigation of the "efficacy, safety and quality" of traditional medicines "with a view to incorporating their use in the health care system" (Department of Health 1996: 26). "Marketed traditional medicines will be established, and a national reference centre for traditional medicines will be registered and controlled" (Ibid). In 1997, the Medical Research Council (MRC) set up a Traditional Medicines Research Unit. "Its goal is to make research possible and train researchers in the field of traditional medicines" (*Equal Treatment* 2005b). In 2004, the Department of Health provided this unit with R4.5 million to test traditional herbal remedies (Mills 2005; Pefile 2005). The MRC also set up the Indigenous Knowledge Systems of Health Unit, "a computer database of all South African plants and their possible medical benefits" (*Equal Treatment* 2005b). In 1998, the government officially passed the *South African Medicines and Medical Devices Regulatory Authority Act* (no. 132), which requires *all* medicines, including traditional herbs, to be registered with the Medical Control Council, MCC (RSA 1998).[72] Finally, the MRC, Department of Health, and the Council for Scientific and Industrial Research developed a proposal for a South African model of a National Reference Centre for African Traditional Medicines (NRCATM), based on a World Health Organization (WHO) policy initiative. "The mission of NRCATM is to promote the scientific validation and production of high quality, safe, and effective medicines based on African Traditional Medicines, thereby

[72] This Council is similar to the US Food and Drug Administration.

contributing to health care, job creation, education and training, conservation of medicinal plants and equitable benefit sharing with owners of Indigenous Knowledge" (MRC 2003: 26-27). The TAC has actually been quite vociferous in advocating for the national testing of traditional medicines. Their primary objective is of course to regulate the usage of potentially harmful natural herbs, and to ensure they do not negatively interact with antiretrovirals (ARVs). But they also insist this testing is important because it will allow traditional healers to claim financial remuneration, based on intellectual property rights (*Equal Treatment* 2005b).

In fact, some testing has already begun. In 2003, the MRC selected 7 traditional herbs for clinical trials. MRC executive director of research Anthony Mbewu said: "We want people to know that we are doing research which looks promising, although we can't guarantee anything. Anecdotal evidence from traditional healers and orthodox doctors is impressive enough for us to do these clinical trials" (Smetherham 2003). In September 2007, after a final regulatory check by the South African MCC, clinical trials began on the natural herb, *Sutherlandia frutescens*, to test its effectiveness in delaying the onset of AIDS in HIV-positive patients (Campbell 2007). Approximately 125 HIV-positive patients at Edendale Hospital in Pietermaritzburg in KwaZulu-Natal province were a part of the trial, the results of which will be announced in August 2009 (Ibid).

In 1999, the Minister of Health arranged a National Department of Health meeting where leaders of traditional healing organizations were invited to come and speak with provincial Members of the Executive Committee (MECs). In Gauteng, two healers from each of the 5 regions were selected to be members of a temporary task team to construct a provincial traditional healing organization. The Gauteng Traditional and

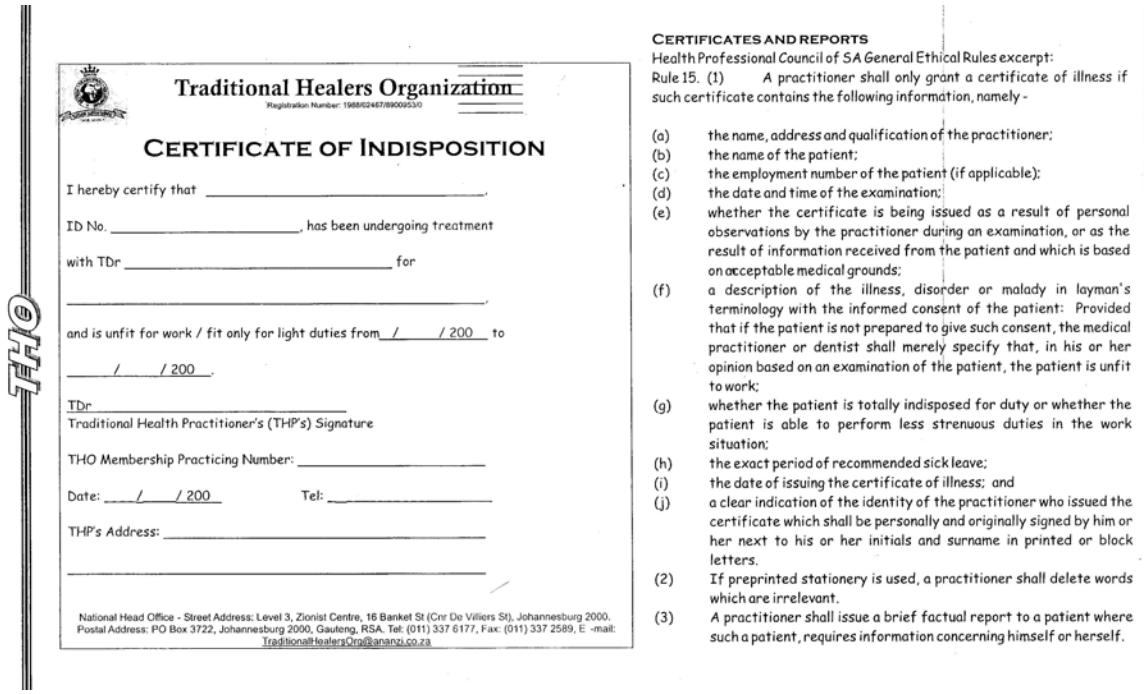
Faith Medical Practitioners (GTFMP) was the resulting structure. The Gauteng Department of Health provided the organization with funding, office space, and tasked it with mobilizing and training provincial traditional healers in the following: education on HIV/AIDS, STIs and TB; training and skills promotion around treating patients with HIV; prevention campaigning. The GTFMP has more than 10,000 registered members equally distributed throughout Gauteng's 5 regions. Members must pay an annual fee of R60. Through registration, GTFMP members get certificates which allow them to legally practice in the province (this is the current process until the national registry is established). Each registered member is put into a database, which is on file at the Gauteng Department of Health.[73]

Although the *Traditional Health Practitioners Act* was passed in early 2005, none of its proposed policies have been enacted. "A significant critique of this Act is that it does not propose concrete measures through which to implement its objectives" (Mills 2005: 146). However, several traditional healing organizations have established their own registries, professional conduct guidelines, and trainings. The GTFMP is rare in that it has an official relationship to the Department of Health. But it is not alone in establishing guidelines of practice for its members. The Traditional Healer's Organisation (THO), formed in 1970, is a national organization boasting membership of more than 25,000. The aims of the organization are: "to create one central body, responsible for registering all traditional healers in South Africa. Setting the standards of health care and establishing Traditional Health Care Centres, thereby improving the quality of life for all individual Traditional Health Practitioners and Traditional Health

[73] This information was provided by Dr. Mndaweni, the Chairperson of the GTFMP. Interviews held on April 6 and April 25, 2005 in the GTFMP Offices in downtown Johannesburg.

Care consumers in South Africa" (*THO Siyavuma News* 2004: 3). More than any other traditional healing organization, the THO has taken the task of institutionalizing and professionalizing traditional healing quite seriously. They have put in place a number of 'official' policies and guidelines, which are based on a biomedical model and attempt to equalize the institutional playing field in the South African health system.

Figure 2-1: THO Certificate of Indisposition [74]



Traditional Healers Organization

Registration Number: 1988/02467/8900953/0

CERTIFICATE OF INDISPOSITION

I hereby certify that _____.

ID No. _____, has been undergoing treatment

with TDr _____ for

_____.

and is unfit for work / fit only for light duties from __/____/ 200__ to

____/____/ 200__.

TDr _____

Traditional Health Practitioner's (THP's) Signature

THO Membership Practicing Number: _____

Date: ___/___/ 200__ Tel: _____

THP's Address: _____

_____

National Head Office - Street Address: Level 3, Zionist Centre, 16 Banket St (Cnr De Villiers St), Johannesburg 2000. Postal Address: PO Box 3722, Johannesburg 2000, Gauteng, RSA. Tel: (011) 337 6177, Fax: (011) 337 2589, E -mail: TraditionalHealersOrg@ananzi.co.za

CERTIFICATES AND REPORTS

Health Professional Council of SA General Ethical Rules excerpt:

Rule 15. (1) A practitioner shall only grant a certificate of illness if such certificate contains the following information, namely -

(a) the name, address and qualification of the practitioner;
(b) the name of the patient;
(c) the employment number of the patient (if applicable);
(d) the date and time of the examination;
(e) whether the certificate is being issued as a result of personal observations by the practitioner during an examination, or as the result of information received from the patient and which is based on acceptable medical grounds;
(f) a description of the illness, disorder or malady in layman's terminology with the informed consent of the patient: Provided that if the patient is not prepared to give such consent, the medical practitioner or dentist shall merely specify that, in his or her opinion based on an examination of the patient, the patient is unfit to work;
(g) whether the patient is totally indisposed for duty or whether the patient is able to perform less strenuous duties in the work situation;
(h) the exact period of recommended sick leave;
(i) the date of issuing the certificate of illness; and
(j) a clear indication of the identity of the practitioner who issued the certificate which shall be personally and originally signed by him or her next to his or her initials and surname in printed or block letters.

(2) If preprinted stationery is used, a practitioner shall delete words which are irrelevant.

(3) A practitioner shall issue a brief factual report to a patient where such a patient, requires information concerning himself or herself.

According to the THO "Code of Ethics":

> "This Code of Ethics has been applied for generations in a format that was passed on verbally through Traditional Healer training. The importance of this Code of Ethics is just as relevant now, if not more relevant, in light of the poor public perception of the Traditional Healing Profession: owing to the damaging affects of the misperception about the profession by colonialism, Christianity and the apartheid system. Due to the current reality of the HIV/AIDS pandemic and of the rapid increase of those needing the services of Professional Traditional Healers it is imperative that we ensure these standards are adhered to [to] protect the Profession and all citizens of South Africa. Currently there are many charlatans, pretending to be 'Traditional Healers,' attempting to take advantage of

[74] *THO Siyavuma News* 2004: 11

> those in need of professional Traditional Healer services. There are also a number of trained Traditional Healers that are abusing their skills, knowledge and power in order to make money. It is the responsibility of every Traditional Healer to ensure that professionalism is maintained by all Traditional Health Practitioners at all times" (*THO Siyavuma News* 2004: 8-10).

According to Phephsile Maseko, the National Coordinator of the THO, it is important for traditional healing organizations to develop their own policies, trainings, and manuals because the Department of Health operates within a "Western paradigm," and traditional healers need to have "programs they can identify with, that acknowledge their wisdom and take their frame of reference into account."[75]

The guidelines of practice, code of ethics, policies, and other formalities so painstakingly constructed by the THO are not recognized by the state or biomedical practitioners, nor are they necessarily utilized by their own members. However, their somewhat trail-blazing efforts do provide an illustration of what the full integration of the field of health and healing might look like.

> "A high degree of codification of entry into the game goes along with the existence of explicit rules of the game and a minimum consensus on these rules; by contrast, a weak degree of codification conveys states of the field in which *the rules of the game are being played for in the playing at the game*" (Bourdieu 1996a: 226; my emphasis).

Although biomedical science is marked by a high degree of codification, indigenous healing has very little. The question of whether the field will be fully integrated is one of the primary stakes in the struggle being waged in post-apartheid South Africa over the signification of disease and healthiness. However, it is significant that while biomedical practitioners tend to view indigenous healing as an informal and

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[75] Phephsile Maseko, National Coordinator of the THO. Interviews held on April 11 and May 15, 2005 in the THO offices in downtown Johannesburg.

inferior healing practice, they also *recognize* its pervasive support amongst the population. They are all too aware that 80% of the population utilizes indigenous healing. And it is this mutual recognition that suggests that the field is integrat*ing*, even if the process is incomplete and unstable. Steinmetz makes a similar argument in his analysis of the German field of Sociology from 1930-1970 (2008). He suggests that recognition (of dominated groups by those who control the "processes of definition" within the field) be understood as a new mechanism for determining the boundaries of 'unsettled' fields (Ibid).

In conclusion, then, the state is making efforts to incorporate traditional healing into the formal health sector, and many traditional healers are profoundly invested in the process. However, the integration of the field of health and healing is still very much in *process*, and it is wholly unclear whether the state will succeed in its efforts to redefine the boundaries of the field (a subject to which I will return in the next chapter). As Bourdieu consistently states: the boundaries of the field are one of the primary stakes of struggle. Internal struggles "take the form of conflicts over *definition* … Each is trying to impose the boundaries of the field most favorable to its interests or – which amounts to the same thing – the best definition of conditions of true membership of the field … [or] for justifying its existence as it stands" (Bourdieu 1996a: 223).

Cultural Capital and Habitus

"[C]apital is a social relation, i.e., an energy which only exists and only produces its effect in the field in which it is produced and reproduced … In practice, that is, in a particular field, the properties, internalized in dispositions or objectified in economic or cultural goods, which are attached to agents are not all simultaneously operative; the specific logic of the field determines those who are valid in this market, which are pertinent and active in the game in question, and which, in the relationship with this field, function as specific capital – and, consequently, as a factor explaining practices. This means, concretely, that the social rank and specific power which agents are assigned in a particular field depend firstly on the specific capital they can mobilize …" (Bourdieu 1984: 113).

Cultural capital can take three forms. First, it exists in an institutionalized state (Bourdieu 1986: 247). For example, educational qualification legally certifies cultural competence, autonomous from its bearer. I just described the way in which both indigenous and biomedical capital is institutionalized through state recognized codes of practice. Second, cultural capital can be objectified in the form of cultural goods (Bourdieu 1986: 246). In the case of the field of health and healing, these take the form of medicines, herbs, medical instruments used for both biomedical and indigenous healing, etc. Finally, cultural capital exists in an embodied state, incorporated into subjects' habitus (Bourdieu 1986: 243-245). Habitus *is* embodied cultural capital (Bourdieu 1984: 72), acquired over time or inculcated through socialization such that it appears innate.

> "[A]nalysis initially conceals … the unity hidden under the diversity and multiplicity of the set of practices performed in fields governed by different logics and therefore inducing different forms of realization, in accordance with the formula: [(habitus) (capital)] + field = practice. (Bourdieu 1984: 101).

Habitus is both the product and the cause of hierarchized systems because it is through the habitus that classification is reified. As such, it is both a *structuring* structure

(which organizes practices and the perception of practices) and a *structured* structure (a product of the internalization of the social divisions) (Bourdieu 1984: 170; See also Bourdieu 1979b). People, therefore, develop a 'taste' for their position in the field.

> "Taste is the practical operator of the transmutation of things into distinct and distinctive signs, of continuous distributions into discontinuous oppositions; it raises the differences inscribed in the physical order of bodies to the symbolic order of significant distinctions. It transforms objectively classified practices, in which class condition signifies itself (through taste), into classifying practices, that is, into a *symbolic expression of class position*" (Bourdieu 1984: 175).

Taste "unites and separates" (Bourdieu 1984: 56); it forms classes and groups in opposition to one another. "The manner in which culture has been acquired lives on in the manner of using it …" (Bourdieu 1984: 2). Culture, itself, functions as cultural *capital* because it is unequally distributed (as objectified, institutionalized or embodied capital), and therefore facilitates the process of securing 'distinction' or domination. It is in this way that Bourdieu suggests that dominated classes can acquire a 'taste' for their own oppression, a "taste for necessity."

A field functions "both as a source of inculcation and as a market" (Bourdieu 1984: 65). And it is when the field is recognized as a symbolic and economic market of production and consumption that the socially hierarchized system of tastes becomes less stable and absolute.

> "Because they are acquired in social fields which are also markets in which they receive their price, cultural competences are dependent on these markets, and all struggles over culture are aimed a creating the market most favorable to the products which are marked, in their manners, by a particular class of conditions of acquisition, i.e. a particular market" (Bourdieu 1984: 95-96).

It is *consumption* that really drives processes of hierarchization (and the struggle for legitimacy). Even though audiences are positioned in a social hierarchy

(economically and culturally) which to some extent structures their taste for particular products or practices (Bourdieu 1996a: 115), each cultural producer is also at the mercy of the market – the producers must, to some extent, 'sell' their symbolic products in order to garner legitimacy.

An example will provide clarification. In *The Rules of Art* (1996a), Bourdieu attributes a 'chiasmatic' structure to the contemporary field of art production. The heteronomous pole of the field, occupied by "bourgeois art," is aimed at securing economic profit. It accrues profits in the short-term by selling a kind of low-brow 'art' to the mass public. Therefore, it caters to 'dominated tastes.' At the autonomous pole of the field is art that is pursued for "art's sake" alone. Wealth and class standing allows the producers of this type of art to survive, since their art only brings profit in the long-term. In the pursuit of cultural capital, they remain "detached" from the "taste for necessity" which characterizes dominated tastes, all the time misrecognizing the fact that in pursuing *symbolic* capital, they accrue economic capital, if only in the long-term. This particular class, which dominates the field, cultivates a habitus of disinterestedness, which becomes their mark of distinction. Each guise of cultural capital (institutionalized, objectified, and incorporated) sustains this system. For example, the masses do not have access to the kinds of education they would require to develop distinguished artistic taste; therefore, they prefer the *objets d'art* that are most popular or in the case of the petit-bourgeoisie, the most expensive. The producers of "art for art's sake" are reliant on other producers for economic profit, and they are also at the mercy of various consecrators of distinction – art critics, art schools, awards, honors, etc. Cultural capital, then, gains

value and legitimacy through its link to the market – either directly or through misrecognition.

In the case of South Africa, the field of health and healing is dominated by biomedical science. Biomedical capital is convertible into social, economic and political capital. In other words, by adopting biomedical ideologies and practices, South Africans can 'purchase' social mobility and recognition (Bourdieu 1984). This can take the form of employment – with the pandemic, a new AIDS service industry has developed which provides jobs to poor South Africans willing to 'sell' biomedical ideologies. But it also allows South Africans to procure citizenship rights. If HIV-infected South Africans are willing to abide by the bio-political requirements of biomedical healing (i.e. adhering to drug regimens, following their doctor's advice, constantly visiting clinics for check-ups and testing, etc), then they can not only access antiretroviral treatment, but along with it, food parcels. In addition, the TAC provides a variety of services to help AIDS sufferers access social security grants, subsidies, recognition of local community organizations (with state remuneration), etc. But the price of admission is adherence to TAC's biomedical cosmology. Therefore, in order to receive certain rewards of citizenship, biomedical 'tastes' and practices are required. Overall, biomedical science has a more wealthy, but smaller consumer base. It has to 'convert' people (and it often utilizes the terminology of 'salvation') into its fold, in order to sustain its public legitimacy.

On the other hand, traditional healing has a massive consumer base. It is estimated that 80% of South Africans utilize some form of indigenous healing (van der Linde 1997; Department of Health 2003; *Sunday Independent* 2004). However, its consumers are poor, and it cannot offer other forms of capital as rewards for subscription.

But 'traditional' capital has the added component of 'authenticity' or 'indigeneity.' This is important in a post-apartheid context.

> "Because the different positions in the hierarchized space of the field of production … correspond to tastes that are socially hierarchized, any transformation of the structure of the field involves a translation of the structure of tastes, that is, of the system of symbolic distinctions between groups …" (Bourdieu 1996a: 160).

Because of apartheid and the anti-apartheid struggle, biomedical science lacks legitimacy with the masses. Biomedical public health care was first introduced to the African population by the apartheid government. As a result, it is often associated with Western imperialism, and is certainly perceived as both 'white' and 'modern.' And traditional healing is understood to be synonymous with African identity. Therefore, 'traditional' healing does wield a particular form of cultural and symbolic capital. This 'distinction' is further buttressed by the symbolic struggle being waged in the public sphere between the denialist state and the proponents of biomedical hegemony. This is because the state utilizes a cultural capital of 'authenticity' to de-legitimize biomedical healing.

"[T]he exchange rate of the different kinds of capital is one of the fundamental stakes in the struggles between class fractions whose power and privileges are linked to one or the other of these types" (Bourdieu 1984: 125).[76] Within each field, the *tools* of domination include: the composition or conversion rate of particular forms of capital, the value of capital on the labor market, the changes in these two components over time (Bourdieu 1984: 114). All transactions of capital entail risk. Because of the arbitrariness

[76] The struggle in any field is "primarily over the exchange rate between different forms of capital" (Bourdieu 1996b: 265).

of appropriation, then, every reproduction strategy is also a legitimation strategy. In South Africa, the symbolic struggle over HIV/AIDS is, in part, a struggle over the valuation and legitimation of either 'indigenous' or 'biomedical' capital.

However, poor, Black South Africans actually don't wholly buy into one or the other 'tastes' for sale on the market. They strategically deploy both toward different ends. Michel de Certeau introduces the idea of 'bricolage' as a means of explaining the ways in which people, even in the most oppressive of social structures, change and subvert meanings through their powers of interpretation as "consumers." Borrowing from Foucault's study of how mechanisms of power are redistributed discursively in the operations of surveillance which are articulated in everyday life, de Certeau moves away from Foucault's concentration on the 'production apparatus' to explore instead, the anti-disciplinary tactics and strategies used by people in their "practices of everyday life" (de Certeau 1984). "Hence, the necessity of differentiating both the 'actions' or 'engagements' that the system of products effects within the consumer grid, *and* the various kinds of room to maneuver left for consumers by the situations in which they exercise their 'art' is *polemological* analysis of culture" (de Certeau 1984, xvii). The fact that poor South Africans are able to deploy 'bricolage' in their search for health care and in this way *play the field* without being wholly invested or incorporated into one or another healing paradigm is the primary puzzle of this project.

Autonomy

"The degree of autonomy of the field (and thereby, the state of relations of force established there) varies considerably according to periods and national traditions. It is related to the degree of symbolic capital which has been accumulated over the course of time by the action of successive generations … It is in the name of this collective capital that cultural producers feel the right and duty to ignore the demands or requirements of

temporal powers, and even to combat them by invoking against them their own principles and norms" (Bourdieu 1996a: 220-21).

Bourdieu never really explains what he means by autonomy. In *The Rules of Art* (1996a), in discussing the initial constitution of the field of art in the 18th century, he does mention that autonomy implies autonomy *from* the state and the market. Because of the inverted principles of hierarchization characteristic of all fields of cultural production, the autonomy from the market is complicated. Bourgeois art is *not* autonomous from the market, and is therefore situated at the pole of heteronomy. (In fact, *all* fields seem to be characterized by this polarized structure.) But even avant-garde art, or "art for art's sake," is partially dependent on the market in two ways. First, because the accumulation of cultural capital does eventually lead to economic profit (in the long-term), which is true of all forms of capital. And, because the freedom from necessity which characterizes the tastes of "art for art's sake" is only possible because the producers are (to varying degrees) economically secure. Therefore, the producers of "art for art's sake" occupy a dominant class position in the social sphere. Therefore, this 'autonomy' is only ever partial.

In addition, the chiasmatic structure of the fields of cultural production seems to be an important component of autonomization. It is because these fields have an inverted principle of hierarchization that allows those within the field to challenge both the economic field and the field of power (Bourdieu implies that autonomization is a necessary condition for politicization). I think this is only possible for two reasons. First, because those who are dominant in the fields of cultural production reinforce and reify the class hierarchies within the social field, and second, because the fields of cultural

production occupy a dominated position within the field of power. Thus, their political 'challenge' is not too threatening to the hierarchies that govern the field of power and the social field at large.

However, in *State Nobility* (1996b), all of a sudden the entire field of power is characterized by a chiasmatic structure, and as such, the field of education becomes 1) homologous to the field of power and economy; and 2) the greatest consecrators and reproducers of the status quo.[77]

Further, the autonomy of the field of cultural production seems mitigated by the fact that, it seems, *all* of the members of the field occupy dominant positions in the class structure. It is a field dominated by the dominant classes. This is an important point that Bourdieu never explicitly makes. The only place where he discusses the dominated classes' relationship to fields of cultural production is in *Distinction* (1984), where the dominated classes only seem to participate in the field as consumers. However, the point that the dominated classes have *neither* cultural nor economic capital is never made. This seems an important lack in Boudieu's formulations of hiearchization and autonomy.

However, all of these points are essential in understanding the role autonomy plays in the field of health and healing in South Africa. Struggles within the field of health and healing have broader repercussions for the fields of power and the social field at large for completely different reasons. In fact, this case will show that autonomy is not necessary for politicization, but then, the field and health and healing in South Africa constitutes a very different kind of field than those analyzed by Bourdieu.

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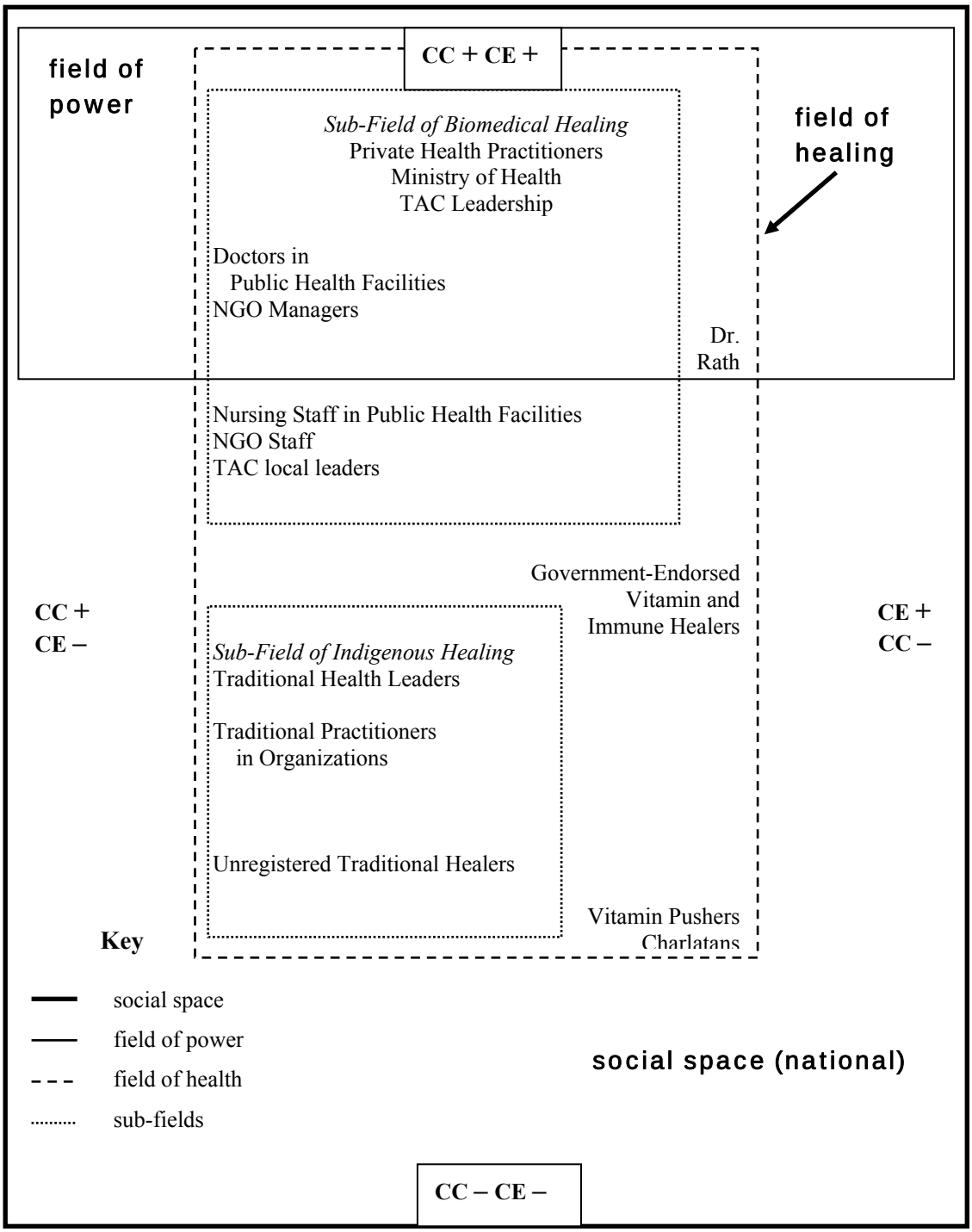
[77] The fields of cultural production would also seem to have a homologous structure to the field of power.

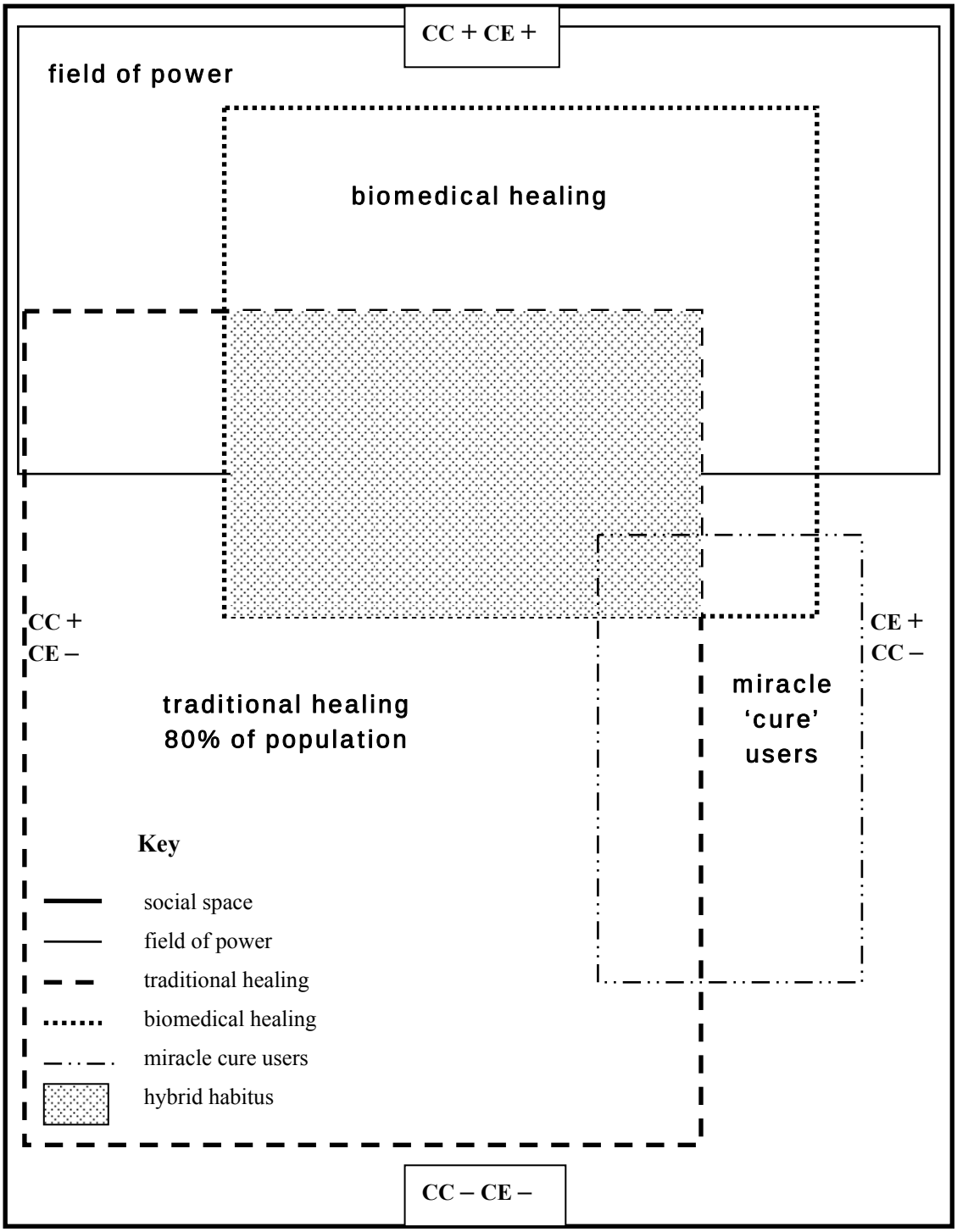
The Structure and Layout of the Field of Health and Healing

Diagram 2-1: South African Field of Health **Production** [78]



[78] This is based on Bourdieu's diagram of the field of cultural production (Bourdieu 1996a: 124).

Diagram 2-2: South African Field of Health **Consumption** [79]



[79] This is *loosely* based on Bourdieu's diagram of the social space of France (Bourdieu 1984: 128-129).

I have included diagrams of both the field of *production* and the field *consumption* of health care because it is only by illustrating and discussing the disjuncture between these two modes of participation in the field that we can begin to make sense of the distinctiveness of the field of health and healing in post-apartheid South Africa. Further, I would argue that such an approach needs to be resolved in any Bourdieuian field analysis. The field of health and healing is divided into two sub-fields, split between the practitioners and consumers of biomedical versus indigenous healing. The field is also unequally divided in social space. The producers *and* consumers envelop the entire range of classes in South Africa, and this plays an important role in the shape and distribution of capital in the field.

The dominant pole of the field is heteronomous (there is a direct homology between class hierarchies and capital accumulation in the social sphere and within the field). Those who control the sub-field of biomedical healing wield tremendous domination in the field of power and are endowed with economic, political and social capital. However, those who actually provide the majority of services to the public (nurses and NGO staff) and those who consume those services free of charge occupy a more intermediary position in the national social space. However, despite the fact that the dominant members of the field of health and healing have disproportionate control over both cultural and economic capital, the producers that are situated at this pole of the field have a much more limited consumer population (their profits are derived from the sale of extremely expensive products to a small and wealthy consumer base).

The dominated pole of the field is completely autonomous, except that it is occupied by those who have neither cultural nor economic capital (some members have a certain amount of social capital and 'authenticity' capital, but its economic conversion and therefore usefulness is mediated by the member's position in the class structure and geographical space). The sub-field of indigenous healing attracts the largest consumer base, and also employs the largest number of producers of health care. There are also other health care options (including charlatanry, immune boosters, faith healing, etc) which exist on the periphery of both sub-fields, at the lower end of the healing field. These peripheral forms of healing are produced and utilized by the poorest and most marginalized members of society.

Finally, directly in the middle of the field of the field of consumption are the healing consumers who utilize both indigenous and biomedical forms of healing, and thus possess a hybrid habitus. These consumers tend to live in semi-urban areas, and their hybridity reflect their ambiguous social position under apartheid. Their habitus is in hysteresis.

> "On the one hand, agents are not completely defined by the properties they possess at a given time, whose conditions of acquisition persist in the habitus (*the hysteresis effect*); and on the other hand, the relationship between initial capital and present capital, or, to put it another way, between the initial and present positions in social space, is a statistical relationship of very variable intensity" (Bourdieu 1984: 109; my emphasis)

Hysteresis occurs when a habitus, which was once fitted to its field, lingers on into a field with a new logic and structure. Such a habitus is 'out of place,' or perhaps more accurately, temporally disjointed (Derrida 1994/2006). A habitus in hysteresis literally manifests a previous embodied state. Therefore, the hybrid habitus of South

African health-seekers reflects a previous historical period because they occupied a position in-between the two fields of healing under apartheid. However, I will suggest that this hybridity is also 'out of joint' because it foreshadows a possible future configuration of the integrated field of health and healing.

The Bifurcated Structure of the Field

"The structure of the field is a *state* of the power relations among the agents or institutions engaged in the struggle, or … a state of the distribution of the specific capital which has been accumulated in the course of previous struggles and which orients subsequent strategies. This structure, which governs the strategies aimed at transforming it, is itself always a stake" (Bourdieu 1993b: 73).

Although the South African field of health and healing has merged into an integrated field, it remains tremendously bifurcated because of the legacy of apartheid *and* the obligations of 'development.' Biomedical science is invested with economic, social and symbolic capital from both national and international sources, *and* it plays a dominant role in the public health care system. Traditional healing exists largely as an informal and peripheral health care option for poor, Black South Africans. The dichotomization that structures the health field is institutional, geographical, economic and ontological.

Biomedical Healing

"[O]ur knowledge of the virus … is inevitably mediated through our symbolic constructions of them; biomedicine … is only one of many, but one with currently privileged status" (Treichler 1999b: 152).

Institutions that enforce neoliberal policies (like the World Bank, the IMF and the WTO), international funding and policy agencies (like the UN), and a whole host of international NGOs, serve to extend the international scope of biomedical hegemony. In

addition, the pharmaceutical industry, whose interests are promoted (and safeguarded) through the WTO and various "free trade" agreements, continues to reap titanic profits from the patented sale of its products. In 2001, the "US pharmaceutical industry had an annual turnover of nearly $200 billion dollars, much of it derived from patents" (Oxfam 2001). Because pharmaceuticals are one of the world's most profitable industries (*Fortune* 2004), the maintenance and expansion of international biomedical hegemony is largely driven by Western financial incentives.

NGOs occupy an intermediary position in the symbolic struggle over HIV/AIDS because they are forced to navigate between Western funding agencies, the national government, and the township populations they serve. NGOs receive most of their funding from large 'Western' (and most often US-based) institutions, and this money comes with ideological strings attached.[80] So, for example, with the Bush regime's insistence that all sexual education be couched in terms of abstinence as opposed to 'safer sex,' not only were all educational campaigns in the US affected, but any NGO throughout the world, funded by US public agencies had to follow suit. In addition to directives about abstinence-based prevention programs, these funding agencies encourage NGOs to impose western models of care and healing as well as complex systems of bureaucracy, and little regard for the ways in which poverty, landlessness, gender discrimination, unemployment, access to water, housing and electricity are mutually relevant issues to HIV prevention, care and support. Further, international funding is generally bestowed upon governments and NGOs, leaving very little support for grass-roots organizations and movements. The result of this international pressure is the

[80] For further information on the international politics of AIDS governance, see Swidler 2006.

increasing corporatization of NGO structures and programming, causing NGOs to replace any grass-roots initiatives they may have implemented with international models of "best practice."[81]

The influence Western funding agencies and governments have on health systems in the 'Third World' is not limited to NGO interventions. Bush's Emergency Plan for HIV/AIDS Relief (PEPFAR), the Gates Foundation, WHO and UNAIDS have all provided funding and support for the *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa*, which implements the roll-out of antiretroviral medication in the public health sector (Department of Health 2003). In addition, this roll-out would have been impossible were it not for particular pharmaceutical companies finally lowering the costs of their medications.[82] In general, HIV/AIDS in South Africa cannot be understood outside of a global marketplace where biomedical hegemony is backed by the interests of empire.

Though it has not yet secured *hegemonic* power in South Africa, biomedical science is invested with so much cultural, economic and social capital that its *orthodoxy* is incontrovertible (Bourdieu 1991). In South Africa, biomedical health care is provided by the private and public health care system, but its approach is further supported by the media, governmental regulatory institutions (like the MCC and MRC), all national prevention campaigns, and NGOs. The availability of antiretroviral medication in the

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[81] From December 1, 2004 – September 30, 2005, I conducted ethnographic research with a prominent national NGO, which offers many outreach services to people infected with HIV/AIDS in Johannesburg. This analysis is based on the ethnographic data and interviews I conducted during this time with the staff and clientele of this NGO, but also with other NGOs that collaborated with it on a variety of projects.
[82] The history and complexities around the ARV roll-out will be discussed in the next chapter.

public health sector has also served to strengthen its position within the field of health care.

The official health care system is divided between high quality private health care utilized by middle- and upper-class South Africans and miserably inadequate public health care provision for the working class and poor. The public sector serves 82% of the population but has only 27% of the country's general practitioners (*Equal Treatment* 2005c). "[E]conomist Alex Van den Heever reported that private medical scheme [83] expenditure was R43.4 billion compared to R42.4 billion for provincial departments of health, in 2005. The private system sucks resources, including nurses and doctors, away from the public system" (*Equal Treatment* 2007). Only 37.7% of the population possesses a medical aid scheme (Statistics South Africa 2006a).

> "The biggest problem is a shortage of staff. You know you'll be...you find yourself...Maybe in a department you will find that you are only two or three, and this is a 40-bed ward and there are so many patients and you cannot cope. And then, there's the problem with the equipment. Like for example, medicines, we find that maybe go to pharmacy ... there's no stock of this, there's no stock of that … Sometimes we can't give the patient what the doctor prescribed because it's not in the pharmacy."[84]

> "The biggest obstacle is too much workload and a shortage of staff. Every morning the clinic is full. It doesn't matter how many you are, you have to man this clinic, and the department is saying, don't turn away patients … And there are shortages, drastic shortages of resources, human resources, material resources … drugs, um...drugs are being ordered, but mainly because you cannot predict the number of patients that you can see. It's never enough. And even if you have ordered it, there is no guarantee that you...you will get what you have ordered."[85]

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[83] A medical scheme is similar to medical insurance in the US. It is a private corporate enterprise. Wealthier citizens simply pay for these schemes, or sometimes employers offer them to their workers.
[84] Female Nurse, Critical Care. Interview held on May 25, 2006 at the Chris Hani Baragwanath Hospital in Soweto.
[85] Female Matron, Dobsonville Clinic. Interview held on June 7, 2006 in Dobsonville, Soweto.

South Africa is suffering from a severe 'brain-drain' – more and more health workers (both doctors and nurses) are abandoning the public health sector for the private sector or they are leaving South Africa altogether. Nearly one in three public health positions are constantly vacant, and 300 nurses leave South Africa every month (*Equal Treatment* 2005c).

> "Nurses are moving from the public to the private health sector in droves. In the private sector, they are paid much better and their working conditions are much better. Their nurse to patient ratio is like 1:3, but here, at Bara, it's like 1:100! In the private sector, there's less hours, less stress, and more pay. There is no incentive to stay in the public health sector. The turnover for nurses in the public sector is only 3-6 months."[86]

> "I think the cause of the trouble starts because nurses are not paid enough. So we are not paid enough *and* people are now free to move. Unlike in the apartheid era, if you were a nurse, it was a blessing. You would stay there until you retired. Now people have got a right to move to wherever they want. Some go to private where they are better remunerated, some go overseas, and this is causing a shortage. And some are de-motivated because of a shortage of resources."[87]

Between 1996 and 2004, South Africa produced just over 34,000 nurses. But over 27,000 were "lost to the system" (*Equal Treatment* 2005c). It is estimated that there is a 54% shortage of nurses in all primary health clinics in South Africa (*Mail and Guardian* 2007a). In an effort to manage the severe nursing shortage in South Africa, The Minister of Health recently introduced a plan to bring nurses out of retirement to fill the gap (Department of Health 2006). All of the nurses with whom I spoke thought this was a horrible plan, given the high burn-out rate of nursing staff and the fact that these retired nurses would not be up to date on current conditions.

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[86] Female Nurse, HIV Clinic. Interview held on May 25, 2006 at the Chris Hani Baragwanath Hospital in Soweto.
[87] Female Matron, Dobsonville Clinic. Interview held on June 7, 2006 in Dobsonville, Soweto.

Public clinics and hospitals are not only understaffed and under-resourced, they are also immensely overcrowded – a problem made even more acute by the rising numbers of sick and dying AIDS patients.

Figure 2-2: Patient Queues at Public Clinics [88]

> "In my ward, people have full-blown AIDS. I think that 99% of my patients have HIV. I'm being honest. And I think it's getting worse instead of improving, despite these ARVs. There are more and more patients every day, and they are getting more and more sick. So the statistics are going up."[89]

Due to severe nursing shortages and growing numbers of patients, the nurse-patient ratio in the public health system is shocking. Gauteng enjoys a nurse/population ratio of 412:100,000 (*The Star* 2005a), and one of the nurses I interviewed told me that at Bara, it is common to have one nurse per 100 patients.[90] The burden the HIV/AIDS pandemic has had on the health sector also includes a high infection rate among nursing staff. A survey of health workers in four provinces by the HSRC found over 15% were HIV-positive (*Equal Treatment* 2005c).

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[88] *Equal Treatment* 2005c. Photo by Brenton Geach.

[89] Female Head Nurse and Unit Manager, Critical Care. Interview held on May 25, 2006 at the Chris Hani Baragwanath Hospital in Soweto.

[90] Female Nurse, HIV Clinic. Interview held on May 25, 2006 at the Chris Hani Baragwanath Hospital in Soweto.

On June 1, 2007, 700,000 public service workers (including health care workers) went on strike (*Mail and Guardian* 2007b). The strike lasted until June 27th, making it "the longest public-service strike in South African history" (*Mail and Guardian* 2007c). The workers (represented by a conglomeration of service worker unions) were asking for a 12% salary increase, and the government was offering 6% (*Equal Treatment* 2007). During the strike, 3,000 workers, mainly in the health sector, were given dismissal notices (*Mail and Guardian* 2007b). One of 12 nurses fired in the Eastern Cape had this to say: "We work with broken equipment, inadequate facilities, not enough drugs for our patients, and we're paid pathetic salaries. Thousands of qualified nurses are leaving the country, doubling our workload. And the only words our president has for us is to condemn vandalism and violence" (Emilia Maloi, quoted in *Mail and Guardian* 2007a). After almost a month of striking, the workers accepted a 7.5% wage increase (*Mail and Guardian* 2007c).

Biomedical health care is highly segregated – the most obvious line is between the private and public sectors, which very clearly means that if you can afford to pay for your health care (or have employment which provides you with a medical scheme), then you have access to a 'first-world' quality health system. But for those who cannot afford to pay, the health system available is dirty, overcrowded, and many patients complain of the treatment they receive from their over-worked and under-paid health care staff. There are some nurses who have dedicated their lives to the public health sector. The nurses I interviewed had served the system for at least twenty years, but in so doing, they make up

a *very* rare sample of nursing staff.[91] Most of the nurses that I met and observed while visiting the clinics and hospitals were disgruntled, uncaring and often discriminatory. And these are the nurses the patients are most likely to encounter. They were rude, impatient, and often treated the HIV-infected patients with contempt. In a survey of 771 HIV-infected households in South Africa, 40% of the respondents who utilized public health services complained of the "uncaring attitude of health workers" (Steinberg et al. 2002: ii).

> "They don't want us – those public health centers. Because the treatment that they give to us is not right. First, they shout at us. Then, they give us medication that is not correct – that does not assist us … They keep on shouting at those of us who are HIV-positive. This makes us even sicker. This is horrible treatment."[92]

> "I took my child to the clinic, and it was listed on the file that I was infected. This sister shouted at me, and said: 'this child is HIV+, so you need to get treatment for the child.' The nurse was shouting at me in front of everyone, and people stared at me. It made me feel horrible. She was exposing me in front of everyone."[93]

Accessing public health care is an extremely alienating, humiliating and discriminatory experience for most HIV-positive South Africans.

The Chris Hani Baragwanath Hospital is now the biggest hospital in the Southern Hemisphere. "The hospital was entered in the 1997 Guinness Book of Records as the largest hospital in the world" (Chris Hani Baragwanath Hospital 2008). If the corridors were put into a straight line, they would stretch over 10 kilometers (Ibid). The hospital has 3,400 beds, but due to financial constraints, only 2,865 are in use. Therefore, the

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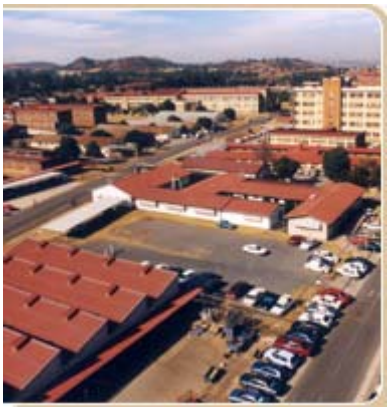
[91] This selection bias was caused by the hospital protocols for interviews. In order to interview public health nurses, I first was required to get ethical clearance from *both* the provincial and municipal Departments of Health. I also had to get clearance from the institution (I conducted interviews at the Zola and Dobsonville clinics as well as the Baragwanath Hospial). The clinic or hospital administration chose the nurses I was allowed to interview. They most often chose matrons who were unit managers.
[92] Female participant in FGD held on October 6, 2005 in Lawley 2.
[93] "Mary." Interview held on October 26, 2005 in Lawley 2.

hospital functions at a 65%-85% bed occupancy, but most of the critical care wards function on 95%-100% bed occupancy because of the HIV/AIDS pandemic (Ibid).

Figure 2-3: Main Entrance to Bara Hospital [94]

Figure 2-4: Bara Hospital Ward

Figure 2-5: Aerial Photo of Bara Hospital [95]



"This is an old building. According to my sight, it needs to be renovated. I'm not happy working under these conditions. You can look at the ceilings. This needs to be changed. There's very little that I can do to help that. I made a report to the Gauteng Department of Health. I took pictures of the ceiling (which is hanging down in some places), the quality of the beds, the toilets are leaking in the bathrooms, the paint is peeling off the walls, and the whole place is dirty. This is a hospital! Where people who are sick come to get better. But this is chaos. So, I made a report to the Department of Health. I heard nothing. Then, I made

[94] Photo taken by the author
[95] These two photos are taken from the Chris Hani Baragwanath Hospital Website. http://www.chrishanibaragwanathhospital.co.za/bara/article.jsp?id=161

> another report … and another. I just wanted them to send someone over here to look at these environmental conditions. But no one has bothered to come."[96]

I spent quite a bit of time at Bara because one of my primary informants, Pheello Limapo, was extremely ill for several months in 2005.[97] I was shocked at the conditions. The critical care wards, where most of the HIV-positive patients are given beds, are always packed to capacity. Sometimes, there are people lying on gurneys blocking the corridors – every available space is occupied. The patients are lucky to see a doctor for 5 minutes every day, and they rarely see the same doctor twice. The nurses do not spend quality time with the patients (probably because they are so few staff to cover so many patients), but they also treat the patients with indifference or overt hostility. The patients who could not bathe themselves were often left to steep in their own waste for hours if not all day.

In addition, the hospital bureaucracy was maddening and illogical. Patients are constantly being moved from one ward to another for no rational reason. Patients are very often misdiagnosed, or given a script for a particular medication which is not available, and then cannot get someone to prescribe them something else. And neither the doctors nor the nurses take the time to explain patients' conditions or diagnoses (they often do not even speak the relevant language). Pheello, for example, never had any idea what condition he had been diagnosed with, or what his medications were supposed to achieve.

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[96] Female Head Nurse and Unit Manager in Critical Care. Interview held on May 25, 2006 at Chris Hani Baragwanath Hospital, Soweto.

[97] I visited Pheello at Baragwanath 9 times in August and September 2005 when he was in and out of the hospital with TB and other opportunistic infections. I also visited him in June 2006 when he was admitted to the Johannesburg hospital.

> "There are more problems in the hospitals than in the clinics. When I was admitted most recently, they could not diagnose me immediately. They could not tell me what the problem was. I was taken from one ward to another. I was then released, but I still wasn't better. Then, later, I was readmitted. I tried to follow-up with the doctor who had originally seen me, and I was told he had left – he was still in training, and had gone to finish up. And then I explained to the new doctor what they had done to me before. This new doctor said that there is a problem with these trainee doctors. 'They have done you a disservice.' So, they did a wrong practice to me. The kind of treatment in the hospitals is not right."[98]

There are also very clear racial dynamics to health care treatment. Whenever I visited Pheello at the hospital, everyone (including the nursing staff) assumed I was a doctor because of my race. This is quite simply because the only white people at Baragwanath Hospital are doctors. I walked right into wards without being questioned, nurses and doctors often showed me Pheello's medical chart and talked to me, instead of him, about his condition. Pheello told me that he was more likely to see a doctor and have that doctor spend time explaining his condition when I was present. He also told me that the nurses treated him better if they had seen me visiting. And more than anything else, I was able to speak to the doctor about Pheello's condition, then explain it to Pheello, and I was also able to advocate for him in the hospital. In other words, by having a white visitor, Pheello received significantly better health care than his fellow patients. Therefore, in addition to economic divisions within the public health system, there are also very stark racial divisions.

The health care system is also geographically bifurcated (which is, in part, a function of economic divisions). There is one main public hospital inside the city of Johannesburg, but its wards seem racially segregated simply because the hospital is split between private and public care. However, in order to use this hospital, a patient has to

[98] Pheello Limapo. Interview held on October 5, 2005 in Lawley 2.

show proof of residency within the city limits. Therefore, most Black South Africans in the greater Johannesburg region, utilize Baragwanath Hospital, where there are very few non-African patients. Most of the informal settlements in Johannesburg are geographically distant from the city center, and there are no public health facilities available at all. So, biomedical health care is itself bifurcated between the public and private sectors. Quality care is reserved for the white, wealthy, urban populations – who are least likely to be infected with HIV.

> "It's about equality, because no matter what anyone says, it's those of us with money who can afford to buy life. It is those of us who are employed, who are, incredibly, allowed access to life saving medicine. But it's those of us who are poor who do not have access to proper health provision" (Achmat 2004: 76-77).

Traditional Healing

"[W]hile the medical doctor focuses on the symptoms of a disease, often in ignorance of the patient/client's broader social and psychological situation of state, the traditional healer treats the whole person, and understands the physical body in its social and spiritual context" (Thornton 2002b).

Given the obstacles and indignities associated with accessing public biomedical health care, traditional healers have remained an important source of healing for many poor South Africans. Traditional healers are often more available to sick community members, and they take patients' material social conditions and cultural beliefs into account. One respondent told me: "I have found that traditional healers are more in touch with peoples' realities."[99] Unlike nurses and doctors, traditional healers take the time to talk to patients about the way in which the economic and social hardships they

[99] Anonymous HIV-positive community member. Interview held in Zola, Soweto on September 12, 2005.

face impact their health. For all of these reasons, traditional healers are one of the most important sources of health care in post-apartheid South Africa.

However, it is also important not to romanticize the traditional health sector. It faces tremendous constraints and problems. The largest obstacle facing traditional healers is the ever-increasing rise of charlatanry. Because traditional healing is not nationally standardized or regulated, it is very difficult for patients to distinguish between legitimate healers and impostors. And there are innumerable con artists attempting to make a profit off the desperation of poor people facing an incurable disease. And given the despair in which many HIV-infected South Africans are engulfed, anyone offering the hope of a cure becomes worthy of the very minimal economic resources available to the family. In fact, the informal settlements of South Africa, which completely lack sustainable conditions let alone health care, are replete with every possible 'miracle cure' imaginable.

The media and many biomedical proponents sustain the association between charlatanry and indigenous healing. And the denialism of the state does not help matters. Given the fact that the state often equates its support for traditional healing with its peddling of various 'miracle' vitamins, it is no wonder that the general public often confuses the two. A further difficulty is the conflation of 'witchcraft' with divination, which is extremely pervasive. However, according to my informants, there is a very clear demarcation separating the two 'arts.'[100] An *igedla*, or 'witchdoctor' in common parlance, is a type of herbalist, who utilizes his/her advanced knowledge of *muti* to practice a kind of occult science of spells and curses. This may include love potions,

[100] This claim is further supported by Campbell 1998; Green 1999; Thornton 2002b.

hexes, or spells for protection. For example, under apartheid, guerillas often went to *amagedla* (plural) to receive spells that would render them invisible, so that the police would not be able to find them. Further, *intelezi* is an herbal antidote that is meant to ensure that bullets cannot penetrate the body, which was used in wars throughout history but also during the anti-apartheid struggle (Xaba 2005: 177). However, this form of conjuration is completely separate from divination. An *igedla* does not communicate with the ancestors and has not gone through *ukuthwasa*.

> "This person is not an *inyanga*, is not a *sangoma*, is not a faith healer. But he is *igedla* … his advantage is that he can take any *muti* at any given moment – no one can control him. But not so with the *inyanga* because there are certain *mutis* the *inyanga* is not allowed to touch. They've got a limit, in terms of what is sacred and allowed … an *inyanga* knows the correct way of doing traditional healing. But *igedla*, *igedla* moves freely, bends with the wind … and does whatever."[101]

In other words, the *igedla* does not follow the historical laws of indigenous healing. "In most cases … traditional healers assert that they are only connected with witchdoctors insomuch as they are responsible for healing the 'witchcraft' inflicted through witchdoctors' work" (Mills 2005: 151).[102]

Public sphere discourses often confound traditional healing with charlatanry and 'witchcraft,' which contributes to the profession's denigration and demonization. But this conflation is also happening in the townships. Many charlatans and *igedla* call themselves *sangomas* in order to garner community support and consumption. Therefore, without a regulatory mechanism in place, traditional healers are having a difficult time maintaining their professional codes and practices. This is the primary

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[101] Dr. Martha Mongoya. Interview held on April 8, 2005 in Orlando East, Soweto.
[102] Many researchers have discovered similar findings: Green 1996 and 1999; Niehaus 2001; Thornton 2002b.

reason why traditional healing organizations first emerged. However, these organizations are rarely recognized by the state, receive no remuneration[103] or tangible support, and they are rife with internal power struggles between different *mpande*.

A further problem traditional healers face due to their peripheral and informal status within the health care system concerns their remuneration. Traditional health care can only operate as a private enterprise. Because most of their patients are poor, many traditional healers provide their services for minimal costs, on a bartering system, or even free of charge. But traditional healers are not independently wealthy and cannot afford to purchase the resources and materials they need for healing unless they charge their patients fees. Therefore, a further attraction for state incorporation is public subsidy.

> Female FGD participant: "Why hasn't the government provided traditional healers with the equivalent of a clinic? We are left outside the health care system because we don't have a place to practice."
>
> Male FGD participant: "And we also need to be compensated for our services. If the government paid our salaries, like they do the nurses and doctors, then we could offer our services free of charge."[104]

In addition to institutional differences and the unequal distribution of capital between the two professions, indigenous and biomedical healing promote somewhat contradictory ontologies of the body. Before detailing these differences, it is important to explain the heterogeneity of indigenous healing and to then justify my generalized summary of indigenous ontology.

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[103] The only exception being the GTFMP, but their support is quite minimal.
[104] This exchange took place in a FGD held on May 2, 2005 in the Diepkloof Community Center in Soweto.

There are a wide variety of different kinds of indigenous healers in South Africa. In addition to diviners and herbalists, there are faith healers, traditional birth attendants, traditional surgeons, bonesetters and other specialists (RSA 2005; Abdool-Karim et al. 1994; Gumede 1990; Last and Chavunduka 1986). Most of these healers share a common ontological paradigm of the body. Faith healing deserves a bit of attention given its slightly different approach and prevalence in South African townships. It stems from African Apostolic Churches, which broke away from Western Christian churches (Freeman and Motsei 1992: 1183). African syncretic churches, which includes general Apostolic churches of different kinds, as well as the Shembe Church and the two branches of the Zionist Church of Christ (ZCC), have millions of members each, and all utilize some form of ancestral healing (Thornton 2002b). In fact, "most healers of all kinds in South Africa have a formal religious background in Christianity, even if they do not practice" (Thornton 2002b). Faith healers share a common theory of health and disease with other indigenous healers, but they synthesize Christian and traditional healing practices. Some *sangomas* are also faith healers. I held a FGD with a group of women who were trained as both faith and traditional healers. I asked them to explain the relationship:

> "You talk to your ancestors, but you pray to God."
>
> "The ancestors are closer to God than you are."
>
> "The ancestors are between us and God. So, the ancestors take the message to God. And when the answers come, God replies to the ancestors, and the ancestors will tell the traditional healer."[105]

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[105] Three female participants in a FGD held on June 13, 2005 in the Career Center Community Hall, Pimville, Soweto.

There are some differences between faith healing and divination. Faith healers utilize different mediums. They heal through prayer, the laying on of hands, and the application of holy water, ashes, and herbs (Abdool-Karim et al 1994). They also use candles and the Bible to channel the spirit of God (Staugard 1985: 74). Faith healers do not need to diagnose patients with a particular illness. Prophets simply pray with the patient and conduct private rituals which "cleanse them spiritually 'from inside' so that the illness might heal itself through the intercession of the holy spirit" (Thornton 2002b).[106]

In addition to different kinds of indigenous healers, there are some *historical* differences in healing paradigms emerging from disparate ethnic origins (Zulu, Xhosa, Tswana, Sotho, Pedi, etc). However, despite the segregation of ethnic identities under apartheid, these differences are quite minor today. This is particularly true in Johannesburg, given its unique history. As mentioned in the previous chapter, Johannesburg has been the site of mass migration from all over South Africa and Southern Africa more generally for at least a century. Although the neighborhoods in Soweto were segregated by ethnicity in the 1970s, this residential segregation was never completely actualized, due to intense resistance (Bozzoli 2000). And it never really served to undermine the hybridity of Sowetan identity. Medical anthropologists and sociologists who have studied indigenous healing throughout Africa find sufficient

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[106] Although some of the indigenous healers I interviewed and worked with were faith healers (including one of my primary informants, Dr. Martha Mongoya) and many of the HIV-positive patients I worked with utilized this form of healing, I did not conduct a lot of research on faith healing. This is a significant lack in my project, which was due to some practical ethnographic constraints. The ZCC and Shembe Churches, which have the largest membership and conduct the most interesting healing rituals are very secretive. It would have taken a great deal of effort to gain the trust of the leadership. I simply did not have time to invest in researching both indigenous and faith healing. However, I would be interested in doing so in the future.

similarities amongst healing ontologies in the Sub-Saharan region to make generalizations that cross not only ethnic lines, but vast geographical space (Lambo 1963; Janzen 1981 and 1992; Last and Chavunduka 1986; Makinde 1988; Gumede 1990; Feierman and Janzen 1992; Chavunduka 1994; Green 1999; Setel et al. 1999). Although they recognize certain social and historical contingencies, they also claim that there is a transhistorical "symbolic center" of African healing systems (Janzen 1981: 189). My research cannot possibly support or refute such generalizations and in general, this project will show that 'traditional' healing has undergone dramatic changes in response to social upheaval. However, in my research in Johannesburg, I did not find sufficient differences between *ethnic* group's ontological paradigms of indigenous healing. I found more differences amongst different generations and *mpande* of indigenous healers. I will discuss these differences where relevant. With this caveat in mind, I will now outline the general ontology of the body promoted by the indigenous healers I interviewed.

According to a traditional ontology, the body is comprised of four synchronized components. These are: the body itself or the flesh (*umzimba*), the spirit (*umoya*), the blood (*igazi*), and what is directly translated as 'charisma,' which can be understood as a person's 'aura' or 'presence' (*isithunzi*). The flesh is "the transient locus of the other substances that can be thought of as flowing through the body while, at the same time, constituting it" (Thornton 2002a).

Umoya means "air, breath, spirit and soul" – these substances are indistinguishable, or inextricably linked. The spirit is linked to the ancestors, and it is passed on to the next generation. Blood is also passed along to the next generation, but the medium and meaning of the transmission is different. Each individual's spirit is

"unique and yet connected to an ancestral village."[107] The *umoya* detaches from the body at death (Niehaus 2002). Different spirits can be 'activated' through ritual, they can have an impact on people in the community who are not even biologically related to them, and different spirits (from different families or even ethnic groups) can possess a particular *sangoma* (Thornton 2002a). In addition, spirits can be 'detained' in particular geographical regions (Ibid). This can happen at the site of traumatic accident or event, but also different spirits are connected to different material substances (water, earth, fire, etc). So, some *sangomas* are possessed by spirits of a particular river or mountain. This connects the ancestors with the land.[108]

The blood of a person carries his or her ancestors. The blood is the material base of the ancestors, and ancestral lineage is passed through the blood – but not only through procreation. It is also believed that blood is exchanged during sexual intercourse. In long-term and sustained sexual relationships, the ancestors of each partner communicate and learn to join together in new familial relationships. Therefore, the two peoples' families are introduced and intermingled. This is accomplished through the blood exchanged, over a long period of time, during sexual intercourse.[109]

The *isithunzi* is a complicated substance. It is something like a bodily projection or double, but like the spirit, it does not die. It can be identified with an individual's 'smell' or 'presence.' For example, if an absent family member is needed for a ritual, his/her clothes can stand in for him/her because the clothes still possess the person's

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[107] Dr. Robert Tshabalala. Interview held on July 22, 2005 in Orlando East, Soweto.
[108] Clarification of these characteristics was provided by Dr. Robert Tshabalala and Dr. Martha Mongoya in interviews held on July 22 and August 3, 2005 in Orlando East, Soweto.
[109] This information was provided by Dr. Moki in an interview held on November 1, 2005 in Evaton West, Dr. Mputhi in an interview held on July 18, 2005 in Evaton West, and by Dr. Robert Tshabalala in an interview held on August 3, 2005 in Orlando East, Soweto.

isithunzi (Niehaus 2002). When a person dies, his/her spirit will be detached from the body, but so will the *isithunzi.* So, a person might have a dream where a deceased family member appears. It is the deceased's *isisthunzi* that is appearing in the dream. It is also the *isithunzi* of the ancestor that appears to the *sangoma* during divination rituals.[110] But this can also happen to a living person. For example, a woman might be walking down the street and think she sees her husband. She calls out to him, but he does not hear her and continues on his way. When she gets home, her husband is there. She says she just saw him on the street, and he swears he has not left home. The woman ran into her husband's *isithunzi*.[111]

Diagram 2-3: Traditional Ontology of the Body [112]

	ENDURING	TRANSIENT
SUBSTANCE	**BLOOD (*igazi*)**	**BODY (*umzimba*)**
NON-SUBSTANCE	**SPIRIT (*umoya*)**	**AURA (*isithunzi*)**
	FLUID	PRESENCE

Healing the body involves a careful balancing of all of these components, "with excesses of blood or spirit being purged … and with deficits being made up through ritual

[110] Dr. Robert Tshabalala. Interview held on July 22, 2005 in Orlando East, Soweto.
[111] Dr. Robert Tshabalala. Interview held on July 22, 2005 in Orlando East, Soweto.
[112] Thornton 2002b. According to my informants, the "aura" is also enduring and not transient. This is the only correction I would make to this diagram.

treatments involving the 'calling' of the spirits (*pahla*) …" (Thornton, 2002a). Practices of amplifying the body (because of a bodily or spiritual insufficiency) might be done through the inhalation of herbal fumes, being washed with herbal remedies, or the rubbing of medicines into small incisions made on the body (Henderson 2005; Thornton 2002a). Cleansing or purging unwanted toxins or infections would call for drinking medicines that will induce vomiting or diarrhea, or steaming the body with herbal infusions to sweat out the infection (Henderson 2005; Thornton 2002a).

In order to diagnose an illness, a *sangoma* will 'throw the bones.' Unlike in Western medicine, patients do not report symptoms to the *sangoma*. It is the *sangoma's* duty to determine what ails the patient, through ancestral mediation. "The bones" are a set of divinatory objects, which are unique to the *sangoma*. They include bones from the animals slaughtered at the *sangoma's* graduation ceremony, objects that represent the *sangoma's* particular spiritual guides (i.e. if the *sangoma* is linked to a water spirit, there might be a rock from the river that spirit inhabits), or objects from deceased relatives who now possess the *sangoma*. In addition, there are a series of objects that help the *sangoma* narrate a story of illness. These include pieces to represent family members (brother, sister, mother, father, child, grandfather, etc.) and pieces to represent sex. There may also be pieces that represent good and evil. In addition, there are objects that serve as "adjectives" indicating degrees of importance, size, seriousness, distance, etc (Thornton 2002b). When one asks the *sangoma* to 'throw the bones,' one must place money on the mat in order to "open the mouths of the spirits" or to "make the spirits talk." The *sangoma* will give the patient his/her 'bones.' The *sangoma* will breathe on the set of bones, and then ask the patient to also breathe on the bones. Because the *umoya* (spirit)

is connected to breath, this invites the ancestors of both the *sangoma* and the patient to guide the bones. Then, the patient throws the bones onto the mat, for the *sangoma* to interpret.[113]

> "With these 'elicitation devices' then, the healers and the patient gradually work out a story or a narrative that simultaneously diagnoses the complaint and situates it within a social context. It is thus both a psychological and a physical diagnosis that relates the complaint to the social milieu of the client" (Thornton 2002b).

Another means of consulting with a *sangoma* entails direct communication with the ancestors, without the use of 'the bones.' The *sangoma* will burn *impepo* (a traditional herb) in order to facilitate a trance-like state the *sangoma* requires to communicate with the ancestors. This takes quite a bit of time and saps great energy from the *sangoma*. The *sangoma* will call forth the patient's ancestors and talk directly to them. Often, one or more of the patient's ancestors will actually appear before the *sangoma*. The *sangoma* will describe the person to the patient, so the patient can identify the ancestor. The patient can also ask questions, and is invited to tell the *sangoma* when s/he is incorrect.[114]

Both forms of divination might be used for any illness. The means of communication depends on the needs of the patient and the sense the *sangoma* has of the patient's illness.

Ontological Contradictions

"'We can cure the 'incurables.' We were doing it even before Western medicine" (*City Press* 1993).

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[113] I learned this by undergoing a consultation with Dr. Martha Mongoya on December 1, 2005 in Orlando East, Soweto.
[114] I learned this means of divination through a consultation with Dr. Robert Tshabalala on December 2, 2005 in Diepkloof, Soweto.

"Traditional healing does not just suppress illnesses, it cures them. It heals the body by purging infections – bringing them from the inside out. There has never been a disease we couldn't cure."[115]

There are actually several ways in which the traditional cosmology of the body contradicts a biomedical paradigm, which results in divergent and incompatible diagnoses and prescribed remedies. These incongruities are particularly acute and therefore problematic when it comes to preventing and treating HIV.

Adam Ashforth (2002) has argued that the very concept of a virus challenges the ontological basis of traditional forms of healing. An incurable, invisible and sometimes dormant agent hiding in an abstract location called the "immune system," and eventually spawning a whole host of other diseases, is not readily translatable or even comprehensible within a 'traditional' paradigm. Instead, traditional healers tend to describe HIV as an infection of the blood, and many claim that with the proper treatment, traditional healing should be able to cleanse and purge the pollutant. [116] "Purging the contamination that had been 'put' in the body was a common theme for traditional healers dealing with HIV … [One informant] talks of getting it to come to the surface of the skin" (Mills 2005: 138).

> "A 'virus' is a biological term … which was introduced by the biomedical doctors to scare traditional healers. They say it is a huge problem that cannot be dealt with. I want to differ with this kind of notion. We as traditional healers, we know viruses – they aren't serious problems, they can be dealt with … Western doctors take their ideas from theories – not practical and historical experience. They want

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[115] Female participant in FGD of the Soweto Traditional Healers Forum held on September 6, 2005 in the Career Center Community Hall, Pimville, Soweto.

[116] This definition of HIV was first explained to me during a series of focus group discussions I held with traditional healers in May and June 2005.

> to scare us with this notion of a virus … With us, our ancestors speak and guide us … they can tell us what to mix to treat these viruses."[117]

Healers I worked with also claimed that if they were given the proper amount of time and resources, they *might* be able to cure HIV because as I quoted above: "There has never been a disease we couldn't cure."

Ashforth (2002) has also argued that the 'traditional' paradigm of healing locates the cause of the disease firmly within the *social* world – a positive HIV diagnosis could be caused by witchcraft and can therefore be both diagnosed and cured through rituals of divination and herbal antidotes.[118] In fact, I found very little evidence to suggest that traditional healers believed HIV could be caused by witchcraft. Most agreed it was a sexually transmitted infection of the blood.

> "Even though many traditional healers are moving away from claiming they can cure AIDS, some still do. And hence they will clash with Western doctors. Or, their knowledge and mutis, which will help boost the immune system, to them, that's a cure. So, this also clashes with Western doctors – because they are not cured. And I think some don't understand the disease, but link it to being bewitched. This also clashes …."[119]

There are also more practical contradictions that can emerge in treatment. For example, if a doctor prescribes a medication to a patient, and then the patient visits a *sangoma* and is given a medicine to purge the body, the patient might vomit his/her biomedical remedy. This has been a rather constant concern expressed by biomedical health professionals regarding ARV treatment. In addition, the TAC has reported that "a

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[117] Male participant in FGD held with the Soweto Traditional Healer's Forum on September 13, 2005 in Pimville, Soweto.
[118] While Ashforth's work (2005) on the "spiritual insecurity" ideologies of witchcraft signify is hugely important and provides a crucial intervention in the scholarship on both AIDS and post-apartheid, I find his interpretation of traditional forms of healing somewhat problematic because of his tendency to conflate witchcraft and traditional healing.
[119] "Thandi." [NGO staff.] Interview held on April 15, 2005 in Soweto.

recent study shows that people taking antiretrovirals should not use the African Potato [a popular traditional remedy] because it lowers the levels of antiretrovirals in the body. This means that the HIV continues to multiply and you will get sick. It also increases the chance of resistance to antiretrovirals developing" (*Equal Treatment* 2005b).[120]

Another contradiction exists in relation to prevention strategies, as opposed to treatment. According to traditional cosmology, when men experience sexual desire, their blood becomes "hot" and their semen can become "backed up." The sexual act itself can restore equilibrium to the body because the man is able to purge the surplus of blood his desire produces.[121] Using condoms during intercourse or abstaining from sex can exacerbate a man's surfeit of blood which can then lead to illness.[122] In addition, because the ancestors (and the history they represent) are embodied, the sexual act is essentially one of historical and social exchange. Condoms, therefore, can also prevent communication with and between the ancestors. [123] This means that the use of condoms, as a preventative measure against sexually transmitted diseases, are sometimes (though not always) condemned by *sangomas*.

Finally, the biomedical and indigenous bodies are quite distinct from one another. Thus, treatment simply functions differently. "The traditional healing approach is holistic, whereas the biomedical doctor only treats the infected part" (Gumede 1990: 154). The biomedical body is atomized, autonomous and parts of the body are

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[120] The study they site is found in the *Journal of Alternative Complementary Medicine* 5, 6: 553-565, 1999.
[121] The gender dynamics such an ideology connotes will be one of the topics explored in Chapter 5. In classical traditional ideology, women's bodies are often the sites of 'pollution' (during menstruation, after an abortion, or recent widowhood). These various taboos will be explored in Chapter 6.
[122] Dr. Martha Mongoya and Dr. Robert Tshabalala. Interview held on August 3, 2005 in Orlando East, Soweto.
[123] Dr. Mputhi. Interview held on July 18, 2005 in Evaton West *and* Dr. Robert Tshabalala. Interview held on August 3, 2005 in Orlando East, Soweto.

extractable. The indigenous body functions as an organic whole, but it is also not the sole property of the individual. It is linked to a whole host of ancestral spirits who bestow the body with a unique cultural and familial identity, guide individuals' life choices, and use the body as a medium of communication with other ancestors. As such, the body is a site of spiritual mediation and is, in this sense, deterritorialized.

In conclusion, then, the field of health and healing in post-apartheid South Africa is bifurcated in two fundamental ways. First, there are institutional, ontological, and identitarian schisms between biomedical science and indigenous healing. The distribution of capital in the field is highly unequal – biomedical science is invested with tremendous amounts of economic, social and political capital (from both national and international sources), whereas traditional healing wields a particular kind of cultural and symbolic capital based on South African 'authenticity.' The definition of health capital, the *illusio* regarding the ability to effectively heal HIV/AIDS, and the boundaries of the field are all in dispute at this unstable moment in the constitution of the field. Second, though, the public *provision* of health care is dispensed along economic, geographical and racial lines. The population of South Africa is, therefore, divided between those who enjoy the rights of citizenship and those who have been abandoned on the outskirts of the body politic. Both of these field dynamics and their effects will be explored in detail throughout the rest of the dissertation.

Historical and Social Contingency

"More generally, although largely independent of them *in principle*, the internal struggles always depend, *in outcome*, on the correspondence that they maintain with the external struggles – whether struggles at the core of the field of power or at the core of the social field as a whole" (Bourdieu 1996a: 127).

In his analysis of the American sociological field post-WWII (Steinmetz 2005a; 2005b; 2005c; 2005d; 2007b), Steinmetz critiques Bourdieu's field theory for three primary limitations. First, he notes that Bourdieu focused his attention on the *internal* dynamics of a particular field, but did "not adequately theorize the relations between a specific field … and everything that lay outside the field" (Steinmetz 2007b: FN 2, 314).[124] Therefore, fields must be understood as *both* socially and historically contingent, and completely embedded within the social nexus in which they operate. Second, due to this limitation, Bourdieu was unable to "explain why specific definitions of distinction are more successful than others in any given time and place" (Steinmetz 2005a: 123). Finally, Bourdieu tended to focus his analysis on well-established, fully autonomous and completely "settled" fields (2005a: 123), but he did not articulate the specific dynamics that shape and structure "unsettled fields." "The opposite of a well structured field is an unsettled field, that is, an assemblage of practices in which no single definition of cultural capital holds sway" (Steinmetz 2007b: 321). These critiques and interventions are important to my analysis of the post-apartheid health system.

Instability

The South African field of health and healing is positively ravaged by disturbances and is harboring a symbolic warfare that will have wide-reaching

[124] Depending on Bourdieu's empirical object (and its historical specificity), he does discuss the influence various external factors have on internal field dynamics, such as: the state, the field of power, the field of the economy, and the class structure. In addition, in *The Rules of Art* (1996a) and his earlier work on the Kabyle (1997), Bourdieu highlights the historical contingency of the state of any field. Therefore, I would like to modify Steinmetz's first critique of Bourdieu by insisting that while Bourdieu is aware (and sometimes shows) that external forces influence the internal structures of fields, he does not spend time articulating *how* and *in what way*.

repercussions for the future of the field. One of the primary stakes about which the struggle is being waged is the composition and value of the various forms of cultural capital circulating within the field; the goal is to secure recognition (and eventually legitimation) for one dominant form, composition and value of cultural capital. In addition, the struggle is waged over the *boundaries* of the field and who qualifies as a legitimate *producer* of health care. The autonomy of the field is also insecure. "The *state of power relations in the struggle* depends on the autonomy of the field – this degree of autonomy varies historically and nationally – and it affects the whole structure of the field" (Bourdieu 1993a: 40; my emphasis). As such, the field of health and healing is in essence, unsettled.

The *causes* of this unsettledness are manifold. One of the primary reasons for its unstructured nature concerns the fact that the field of health and healing is still in its nascent stage of development, having been constituted during the transition to post-apartheid by synthesizing two previously isolated fields of healing: indigenous and biomedical healing. As Bourdieu notes in *The Rules of Art* (1996a), when a field is first emerging, it's principles of autonomy are not yet fully objectified in the logic of the field. A foreshadowing of the future 'settling' of the field can only be found in subjects' habitus. "[T]he state of the intellectual field in the phase of its formation … [is] a heroic period when the principles of autonomy that will later be converted into objective mechanisms, immanent in the logic of the field, still reside to a large extent in the agents' dispositions and actions …" (Bourdieu 1996a: 113). If this is true, further proof that the South African field of health and healing has indeed merged two previously disparate fields resides in the hybrid habitus of township residents, who incorporated two

segregated and in some ways contradictory systems of healing because of their intermediary position in the apartheid system. Bourdieu notes that writers like Flaubert and Baudelaire were able to constitute a new and autonomous 'taste' *because of* their position in *both* the literary and the economic field (1996a: 60).

In addition, the end of apartheid was marked by a conjuncture of upheavals – the political transition itself, the adoption of neoliberal economics, and the HIV/AIDS pandemic. The state and the South African society at large are reeling from this conjuncture of crises, and the field of health and healing is both the object and subject of a possible resolution. I would argue that all fields can become unsettled during times of historical crisis, which unhinges the homologies that exist between objective structures, schemas of perception and habituses (in any one field), but also the homologous relationship *between* the structure of a field and those that legitimate the hierarchies within the field of power. Again, *The Rules of Art* (1996a) is instructive. Flaubert was able to chart a new trajectory and logic for the field of art partially because of his ambiguous social position. But it was also facilitated by a particularly radical moment in history: the French Revolution overturned previous social hierarchies and introduced new ones. Without this social and historic break, the revolutionary shift in the field of art would have been impossible.

> "If the permanent struggles between the possessors of specific capital and those who are still deprived of it constitute the motor of incessant transformation of the supply of symbolic products, it remains true that they can only lead to deep transformations of the symbolic relations of force that result in the overthrowing of the hierarchy of [positions] … when *these struggles can draw support from external changes moving in the same direction*" (Bourdieu 1996a: 127; my emphasis).

Therefore, Bourdieu does offer some guidelines for analyzing an 'unsettled' field, and suggests that external determinations can have a traumatic impact on the logic and structure of fields. Bourdieu also takes factors external to fields into account in his conceptualization of the 'field of power.' In fact, one of the primary components of field analysis entails an articulation of the field's relationship to the field of power.

The Field of Power

> "The field of power is the space of relations of force between agents or between institutions having in common possession of the capital necessary to occupy the dominant positions in different fields (notably economic or cultural). It is the site of struggles between holders of different powers (or kinds of capital) which … have at stake the transformation or conservation of the relative value of different kinds of capital, which itself determines, at any moment, the forces liable to be engaged in these struggles" (Bourdieu 1996a: 215).

In post-apartheid South Africa, the symbolic struggles over the composition and definition of health capital are inextricable from struggles taking place in the field of power over the *nomos* of the entire social space. The politicization of the field of health and healing is actually most acute at the field's *heteronomous* pole (whereas for Bourdieu, politicization requires autonomy).[125]

In fact, the political stakes of the symbolic struggle in the field have extensive implications for the whole nation. The outcome of the struggle *could* impact state power, the economic system, the application and implementation of sovereign- and bio-power, and the signification of national identity.

> "A good number of struggles within the field of power are of this type, notably those aimed at seizing power over the state, that is, over the economic and

[125] However, political engagement is also occurring at the autonomous pole of the field. This political activity is carried out by social movements, which articulate their struggles in opposition to the state and the neoliberal economic system. I will discuss this political activity in Chapter 4.

> political resources that enable the state to wield a power over all games and over the rules that regulate them" (Bourdieu and Wacquant 1992: 99-100).

Therefore, it is not autonomy that determines the political capacity of those in the field, or the possible political reverberations the struggles that afflict the field might have for the field of power and the social field. Rather, the most pertinent components of the field are: field-disturbances (its unsettledness), the role the state is playing in the symbolic struggles within the field, identity and its relationship to cultural capital, vast discrepancies in class positionality and consumer populations, and factors external to the field itself.

External Determinations that Traverse Fields

While Bourdieu suggests that fields are always situated in relation to the field of power *and* that external dynamics can have an impact on the structure of the field, especially during times of crisis, I would like to argue (drawing on Steinmetz) that external forces are *always* impinging on internal field dynamics. And this external impact is not only momentarily traumatic at a particular historical period; there are external forces which have a sustained and constant impact on *all* fields within a social space. Although Bourdieu analyzed some of these forces (gender identity and neoliberalism in particular), he very rarely applied these analyses to his theory of fields. Therefore despite having the *intention* of illustrating the ways in which fields are historically and socially situated, Bourdieu's field, as an analytic framework, remains extremely insulated.

I would like to suggest that there are three kinds of forces that structure and inform *all* fields within the social space: 1) modes of regulation (neoliberal capitalism,

colonialism and post-colonialism); 2) forms of bio-power (both disciplinary and thanatopolitical); 3) structuring discourses, which are institutionally situated (race, gender, class, 'traditional,' 'modern'). These external forces share common features. First, they are *international* in scope. They have a similar structuring impact across all national social spaces (but are articulated differentially in particular social and historical settings). Second, these external forces *generate* subjectivities – they inform subjects' habituses. Because these subjectivities stretch *across* fields, one's habitus is less likely to be homologous to any one field.

> "Societies are based on practices that derived from many distinct structures, which exist at different levels, operate in different modalities, and are themselves based on widely varying types and quantities of resources. While it is common for certain range of the structures to be homologous … it is never true that all of them are homologous … [S]ocial actors are capable of applying a wide range of different and even incompatible schemas and have access to heterogeneous arrays of resources … To say that schemas are transposable, in other words, is to say that they can be applied to a wide and not fully predictable range of cases outside the context in which they are initially learn" (Sewell 1992: 16-17).

Habituses are, therefore, constituted by participation in *all* fields, but also by certain structuring logics (the market, state power, and identity) which are national in scope. Third, these external factors impinge upon schemas of perception and have an impact on the vision and division (*nomos*) of the social space. Because capital is allocated differentially based on these hierarchical significations, at least *some* of the objective structural relationships which characterize any one field are determined by these external forces.

Steinmetz argues that it is important to pay attention to "modes of regulation and societalization" (Steinmetz 2005a: 110), and specifically, the ways in which fields are influenced by the kind of social regulation Fordism and post-Fordism exercise. These

forces regulate economic markets and impact structural hierarchies, but they also generate subjectivities. "Post-Fordism [or, neoliberalism] has entailed a new set of demands on the individual personality, which is compelled to become more adaptable, flexible, self-promoting, and reflexive and to be able to read social practices hermeneutically, as texts, in order simply to function properly in everyday life" (Steinmetz 2005a: 136). The next chapter will detail the ways in which neoliberalism has impacted the post-apartheid nation, but also the field of health and healing. Given the fact that NGOs and Western governments provide South Africa with a great deal of economic support for health interventions and given the role the pharmaceutical industry plays in any epidemic, economic 'modes of regulation' play an essential role in structuring the field of health and healing in post-apartheid South Africa.

The state also possesses regulatory power, and in the case of South Africa, this regulation has been exercised according to both colonial and apartheid logic, both of which still have a profound impact on the objective structural hierarchies that mark the national social sphere. Although neoliberalism has, to some extent, fragmented subjectivities and social relations, regulatory power is still concentrated at the state level. "Even in the current period, the state (considered at all of its scalar levels) is still the superordinate coordinator for regulatory initiatives, and it continues to organize most of the familiar legal, infrastructural, and welfare-statist interventions" (Steinmetz 2005a: FN 47, 156). But it is equally important to note that sovereign power has been decentralized under the new neoliberal order. Therefore, in addition to the regulation exercised by the market and the state, there are a whole host of civil society organizations that all serve to "regulate the social" (Steinmetz 1993). "This is not to ignore shifts in emphasis and scale

since the 1980s, including the increasing importance of parastatal and nongovernmental centers as organizers of social regulation" (Steinmetz 2005d: 313).

In addition to regulation, however, the state also exercises *disciplinary* power aimed at the bodies of its citizens. And in the case of South Africa, this bio-power is both anatamo-political and thanatopolitical (Foucault 1978/1990 and 1997). It serves to circumscribe the body politic on the basis of a perceived threat of contagion. As such, certain populations are transformed into *hominess sacri*, relegated to zones of indistinction, where their bodies become the direct target of sovereign necro-power (Agamben 1998). But in fact, the state's use of both regulatory and disciplinary power is in part caused by the exigencies of neoliberal economics. Therefore, the state, the market and various civil society institutions all collude to some extent in the division of the population between those whose bodies are disciplined and regulated, and those who are abandoned to a "bare life" (Ibid).

I would like to suggest that race, gender, class and 'indigeneity' function as discursive practices, in a Foucaultian sense (1972; 1991a). They are material in the sense that they are institutionalized, structured, economized, embodied and performed. These particular discourses are also inscribed onto peoples' bodies, such that they become naturalized and often binarized. The vision and division of society relies heavily upon these signifiers of difference to justify hierarchical social relations. These discourses provide the basis for the apportionment of structural inequality, but they equally form an integral sense of peoples' identities.

Identity

One of the most important features of the field of health and healing in South Africa is the role *identity* plays in the internal dynamics of the field. Traditional healing is not simply a healing approach, an epistemology, and an ontology (like biomedical healing), but it is also an identity. It is related to, but does not operate in precisely the same way as race in South Africa. The habituses of those who utilize traditional healing are informed by an 'indigenous' identity that is not unique to the field of health and healing. Like any identity, it transcends the boundaries of any one field.

Given the complexity and detail of Bourdieu's analytic apparatus, it is perhaps surprising how limited his engagement with identity is in his broader theoretical framework. Class is very clearly an important and privileged hierarchizing and structuring mechanism for Bourdieu, but his analysis of class identity is perhaps less relevant here than his engagement with gender. In both his earliest work (on Kabylia and Béarn) and his latest work (on masculine domination), Bourdieu theorizes the way in which gender operates as a "naturalized social construction" (Bourdieu 2001: 22-23). Reviewing these theories, it is possible to tease out a possible Bourdieuian analysis of biologized identities.

Gender domination, while socially "arbitrary" is converted into "natural" differences. Male domination, consecrated, strengthened and protected over time is so well rooted that "it imposes itself as self-evident" (Bourdieu and Wacquant 1992: 171). Objective social structures form homologous relationships with subjective mental structures, so that masculinity and femininity are mapped onto bodies (Bourdieu 2001: 22-33). Bodily hexis refers to the process of socialization, which roots fundamental

structures of logic in the body by equating the physical and the social worlds. This occurs through an unconscious kind of 'mimesis,' which functions at the level of practice and therefore never passes through discourse or consciousness.

Drawing on Maurice Merleau-Ponty, Emile Durkheim, Erving Goffman, and Norbert Elias, Bourdieu develops this relational, improvisational and still deeply structured theory of gender. Bourdieu believed that case of the Kabylia unveils the fundamental "phallonarcisstic" cosmology that "haunts our own unconscious" (Bourdieu and Wacquant 1992: 171). Bourdieu is, thus, proffering a universal theory of gender domination, which he believes is the "paradigmatic form of symbolic violence" (Ibid: 170). "The case of gender domination shows better than any other that *symbolic violence accomplishes itself through an act of cognition and of misrecognition that lies beyond – or beneath – the controls of consciousness and will*, in the obscurities of the schemata of habitus that are at once gendered and gendering" (Ibid: 171-72; emphasis in the original).

The most controversial component of Bourdieu's theories of gender emerges out of his theories of bodily hexis. Because objective and subjective structures are so well aligned, women are complicit in their own subjugation and often justify their victimization (Bourdieu 2001; Bourdieu and Wacquant 1992). Bourdieu stressed that women adapt in this collusive way, in exchange for a healthy consciousness. He also explains that it is because these gendered distinctions are so firmly rooted in bodily practices and mental structures that resistance based on resignification is relatively useless.[126]

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[126] It is for this reason, Bourdieu has been harshly critiqued by Judith Butler (1997a).

Although there are similarities between Bourdieu's and Foucault's conceptualizations of identity (and its relationship to regulatory discourses or symbolic violence), I prefer the Foucaultian framework for two reasons. First, by insisting on a model of dual causality, Foucault avoids the structuralist determinism to which Bourdieu's theory of gender identity succumbs. For Foucault (and Butler), identities are *effects* of discursive regulatory practices (Butler 1990: 28). "The claim that a discourse 'forms' the body is no simple one, and from the start we must distinguish how such 'forming' is not the same as a 'causing' or 'determining,' still less is it a notion that bodies are somehow made of discourse pure and simple" (Butler 1997b: 84). Although Foucault often makes a causal argument whereby the regulating power of law precedes the productive power of the subject (especially in Foucault 1977/1995), what is important is the mutual dependency of the two forms of power (Foucault 1978/1990). In other words, regulatory discourses produce particular 'naturalized' bodies, but subjects also produce and thereby transform discourses and the inequalities upon which they are based. In other words, the causal arrow of production is bi-directional. "Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it" (Foucault 1978/1990: 101).

Second, despite the fact that identities are so often biologized and binarized, which suggests a strong, sustained and covert power at work, Foucault's analytic framework leaves space for instability and transformation. For Foucault, discourse is a "series of discontinuous segments whose tactical function is neither uniform nor stable" (Foucault 1978/1990: 100). Simple binaristic strategies of power do not capture the complexity of discursive effects and re-activations. There are "a multiplicity of

discursive elements that can come into play in various strategies," (Ibid), which are just as often contradictory as uniform. Bourdieu's theory of gender is so structured that it cannot account for shifts across time in ideological representations, the operations of structural inequality, subjective experiences of identity, or embodied practices. In South Africa, the symbolics and politics of identity shifted structurally and ideologically with the transition to post-apartheid, and yet huge schisms in the apportionment of resources are still drawn along the same lines of inequality. There are new formulations along with traces of old identitarian politics. Bourdieu's theory of identity cannot account for these complexities.

A third and final critique of Bourdieu's formulation of identity is that he does not relate it to field theory. The ways in which race, gender, and 'indigeneity' function as *both* structural inequalities that imbue habituses with hierarchized positionalities *and* embodied hexes that structure and are structured by social relations cannot be left out of a field analysis, especially in the post-colonial world. Identities (like modes of regulation and disciplinary power) are not field-specific, but they impact and are impacted by all of the fields in the national social space.

Conclusion

Perhaps due to globalization and the new 'neoliberal world order,' nationally circumscribed fields of production are becoming unhinged. Fields are no longer well-bounded (if they ever were). Modes of regulation, bio-power, and identitarian discourses and the causal power they wield cannot be ignored in field analysis. These external forces generate particular social epistemologies that are historically contingent and that

vary in their "conditions of plausibility" in each field (Steinmetz 2005a). But they also influence varying social ontologies generated and practiced in each field. These external dynamics exercise both regulatory and disciplinary power, but they are also consistently being refashioned and subverted through innovative consumption.

The limitations of field theory are no reason to abandon the framework. This project will show the usefulness of analyzing the post-apartheid health system with field theory. However, the project will supplement Bourdieu's theories in order to account for the ways in which various external determinations impinge upon the field. As such, the project will push field theory in new directions. As Bourdieu himself recognized: "Whenever one studies a new field … one discovers specific properties that are peculiar to that field, at the same time as one pushes forward our knowledge of the universal mechanisms of fields …" (Bourdieu 1993b: 72).

Chapter 3

The Symbolic Struggle over HIV/AIDS:

Circumscribing the Body Politic

The Neoliberal Pandemic

"The timing of its onset was uncanny: the disease appeared like a momento mori in a world high on the hype of Reagonomics, deregulation, and the end of the Cold War … Coming as it did at the time of radical restructuring of the axes of a bipolar world, of the liberal-democratic nation-state and the workings of capitalism itself, the disease served as both a sign and a vector of a global order-in-formation – and with it, a new sense of the nature and possibilities of the political" (Comaroff 2007: 197-198).

"To date, access to lifesaving medicines and care for people living with HIV and AIDS have been largely determined by race, class, gender and geography. AIDS thus points to more fundamental global inequalities than those involving a single disease, illuminating centuries-old patterns of injustice. Indeed, today's international political economy – in which undemocratic institutions systematically generate economic inequality – should be described as 'global apartheid'" (Booker and Minter 2001).

In an eerie coincidence of global proportions, AIDS and neoliberal economics share a common chronology and impact. The histories of these two pandemics are inextricably intertwined. Feeding off of one another, both served to exacerbate economic and social schisms of inequality. Their symbiosis created mass populations of 'expendable' people abandoned to the world's "zones of indistinction" (Agamben 1998). And due to its distinct dishonor of becoming the country with the highest prevalence rates of HIV/AIDS in the world, South Africa has played a key role in these processes of empire.

Practically overnight, the ANC was forced to transform from a militant revolutionary movement into a reputable governing body. In the 1990s, it was faced with a legacy of immense inequality, international pressure to abandon social democratic ideals in exchange for market competitiveness, and a disease that would become an epidemic of unparalleled proportions. This particular conjuncture of events – the transition from apartheid to democracy, the adoption of neoliberalism, and the AIDS pandemic – propelled the new developmental state immediately into a 'state of emergency' at its very moment of inception. As a result, the legitimacy of the post-apartheid state is tenuous, and the symbolic boundaries of its body politic are fragile. The relationship between the South African HIV/AIDS epidemic and the neoliberalization of the South African economy goes far beyond their shared inception in the history of the state – they are both the cause and panacea of the "state of exception" (Agamben 1998; 2005).

In the mid-1980s, the ANC began negotiations with the South African business elite – the outcome of which was the ANC's adoption of a neoliberal macro-economic strategy: a concession to help end apartheid rule.[127] South Africa became a signatory of the *General Agreement on Tariffs and Trade (Gatt*) – the precursor to the WTO – in December 1993. In 1994, the *Reconstruction and Development Programme* (RDP) was

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[127] Much scholarship has focused on the reasons for the post-apartheid state's adoption of neoliberalism, citing, to name but a few: the need to address severe economic disparity and uneven development, the crisis of over-accumulation, the rise of finance capital, the particularities of South Africa's own economic bases, etc. There was widespread fear that capital would flee the country along with the white elite if apartheid should fall. The post-apartheid state accepted the apartheid government's international debt of $20 billion because they were frightened that a refusal of the debt would scare away foreign investment, which South Africa was desperate to attract after the boycott and divestment campaigns of the 1970s and 1980s. In addition, the post-apartheid state wanted to sustain its dominant economic position on the continent. For further information on how the adoption of neoliberalism played an integral role in South Africa's transition to democracy, see: Marais 1998 and 2005; Bond 2000a, 2000b, 2002a, and 2002b.

passed. This program was meant to ensure the provision of basic services (housing, land reform, and water and electricity provision) through increases in government subsidies. However, in 1996, the ANC adopted the *Growth, Employment and Redistribution Macroeconomic Strategy (*GEAR*)*. The more progressive economic program, the RDP, was abandoned and replaced with GEAR, a World Bank-sanctioned macro-economic strategy, which fits squarely within a neoliberal framework of 'development' (Bond 2002b). "Indeed, not only were free enterprise and property rights enshrined in every major economic policy statement and the Constitution itself, full-blown neoliberal *compradorism* became the dominant (if not universal) phenomenon within the ANC policy-making elite" (Bond 2000a: 16). GEAR:

> "… has come to be known as South Africa's own, 'home-grown' structural adjustment programme. It prescribed measures for enhancing exports, trade liberalisation, fiscal restraint in the interests of servicing the national debt, tax breaks for big business, cuts in social spending, restructuring of the public service, privatisation of state assets, privatisation of basic services, flexible labour practices, job-sharing and lower wages for youth …" (APF 2004: 3-4).

The South African Constitution (RSA 1996), states that every citizen has the right to adequate housing, health care, sufficient food and water, and social security (Chapter 2, Bill of Rights, Sections 26 and 27). However, the utilization of neoliberal approaches to delivery has made it impossible for the post-apartheid state to provide and protect these basic rights of its citizens. The neoliberalization of housing and urban basic service delivery has had perhaps the greatest impact on South Africa's poor, but also provides the best illustration of the compromises the ANC made in adopting GEAR (Bond 2000a: 16). The land redistribution policy adopted is based on a World Bank-approved 'willing-seller, willing-buyer' principle, which fully protects private property rights, allows the

market to guide redistribution, and buttresses the commodification of land. Under this policy, landowners must volunteer to sell their land to willing buyers, and the state provided some small grants to qualifying groups and individuals. The assumption was that in a well-functioning market, land prices would remain competitive; however, in the case of South Africa, the price of land continued to rise.

> "[M]arkets are skewed towards meeting the desires of those with resources, able to pay for commodities. The result is an ever-greater concentration of resources in the hands of a few. Even where the state assists, this is no guarantee that 'effective demand' will be stimulated beyond the point at which state assistance is no longer available. For example, the state may assist to buy land and even to provide initial start-up support for agricultural production. But in a context of intense competition with large-scale landowners and producers these resources are likely to be depleted for most beneficiaries of assistance long before they are independently regenerated through the market" (Greenberg 2004: 4).

Although the government set a target to redistribute 30% of agricultural land to previously disadvantaged groups by 2004, in 2007 only 4% of land had been redistributed (*Mail and Guardian* 2007e).

The policy adopted for housing delivery was based on a "market-driven capital subsidy system," financed largely by the private sector. According to several scholars, this housing policy is at fault for the ANC's abysmal failure to reach delivery targets (Bond 2000b; Huchzermeyer 2004). In addition, the housing being provided falls far short of the "reasonable living space and privacy" defined as the norm according to the RDP (Huchzermeyer 2001: 306). "This subsidy requires home-ownership of a standardized housing unit, and has been translated into large-scale developments of uniform, free-standing, mostly one-roomed houses with individual freehold title in standardised township layouts located on the urban peripheries" (Ibid). Finally, the housing policy has failed to formulate concrete mechanisms for adequately addressing

the continuing proliferation of squatter settlements and therefore meeting the needs of the poor (Huchzermeyer 2001 and 2004). "The number of shack dwellings in South Africa rose from 1,45-million in 1996 to 2,14-million in 2003, according to Minister of Housing Lindiwe Sisulu … That was 417 new shacks a day on average between 2001 and 2003 and 210 shacks per day on average in the five years between 1996 and 2001" (*Mail and Guardian* 2006a). According to Statistics South Africa (2006a), 14.5% of South Africa's population lives in shack dwellings.

In 1995, fewer than one-third of Africans had access to internal taps, flush toilets, electricity and waste removal (RDP 1995). By 2006, according to Statistics South Africa (2006a), 60.6% of the population had refuse removal, 71.3% of South Africans had access to piped water in their dwelling or on site, and only 8.6% of households used bucket toilets or had no toilet facility. In ten years, the post-apartheid state has managed to radically reverse the poor's access to basic services. However, these statistics hide a more complicated reality. In a report released in July 2001, 10 million people had experienced water cut-offs due to non-payment, another 10 million also suffered electricity cut-offs, and 2 million South Africans were evicted from their homes for their failure to pay rent (Deedat 2002). The South African government managed to expand its service delivery capacities through the privatization of electricity and water, and specifically, through the implementation of pre-paid technology, which has meant that while service provision has improved, the *price* of basic services has become unaffordable for many of South Africa's poor.

> "Prepaid technology came to be seen as a way of ensuring payment for services delivered. With prepaid water [and electricity] meters, the objectives were to manage service arrears and to avoid the financial burden connected to the traditional means of water [and electricity] provision (disconnection, billing and

> collecting fees), thereby minimising management costs. In effect, the objectives were to ensure that private companies were able to make more money without the worry of people's needs and the hassle of chasing after people to pay" (APF 2004: 5-6).

In order for citizens to have access to water and electricity, they would have to pay. This system was at least partially implemented in order to combat a perceived 'culture of non-payment' – a legacy from the anti-apartheid struggle when millions of urban residents engaged in rent boycotts in order to resist financially buttressing the apartheid system. Township residents are still in debt to the state for housing rent and service delivery from both the apartheid and post-apartheid eras. The pre-paid system is meant to reverse this practice of accruing debt in two ways. First, by pre-paying, the accumulation of debt is prohibited. "[T]he responsibility for securing access would become the individual paying customer's and no longer that of the state and/or private company" (APF 2006a). In addition, however, due to widespread resistance to the installation of pre-paid technology, the government has introduced several policies that make pre-paid water and electricity meters practically impossible to resist. In many locations where pre-paid are being installed, there has been no previous service delivery. Therefore, if a resident wants electricity, piped water and flush toilets, pre-paid meters are their only option (Naidoo *Forthcoming*). Therefore, the quality of service delivery is determined by residents' acceptance of pre-paid technology. In addition, new indigency policies allow for the complete erasure of accumulated debt in exchange for an acceptance of pre-paid meters (Ibid). Further information on the effects of these measures will be explored later in this chapter.

The neoliberalization of South Africa's economy has buttressed and sustained *two* symbiotic pandemics. Today, South Africa vies with Brazil for the highest Gini

coefficient in the world (UNDP 2003; Human Sciences Research Council 2004), [128] and it is still plagued with one of the highest rates of HIV/AIDS infection in the world. Barnett and Whiteside (2002) have shown that countries with high Gini coefficients also have the highest rates of HIV infection. "In general, internationally, it can be said that relative wealth or poverty affects the vulnerability of individuals, households and societies to the impact of the epidemic" (2002: 276). Since 1994, 1.5 million jobs have been lost (Statistics South Africa 2004a). Unemployment has risen steadily over the past decade, and there is now an official 25.6% unemployment rate (Statistics South Africa 2006c), but this escalates to 40% when using an expanded definition of unemployment that includes those who have stopped looking for work (McKinley 2006). Fifty-seven percent of South Africans live below the poverty line, which is $98/month per person (Schwabe 2004). The adoption of neoliberalism and the accompanying transition from a Keynesian logic of welfare state responsibility to one premised on free market economics served to exacerbate the divide between rich and poor, healthy and sick, white and black.[129]

> "It is in South Africa itself that the unique combination of a modern industrial state characterised by a first-class infrastructure in specific economic and social sectors and inhabited, as it were, for the most part by people of European descent came to coexist with a set of Third- and eventually Fourth-world conditions that turned it into a kind of microcosm of the modern world … It has been remarked that the resultant demographic, economic and political (power) relations are a miniature version of North-South relations in the world." (Alexander 2002: 138-139)

[128] The Gini-coefficient rose from 0.596 in 1995 to 0.635 in 2001 (UNDP 2003: xvi).
[129] For scholars who argue that neoliberalism has exacerbated inequality in the post-apartheid era, see: Marais 1998; Terreblanche 2002; Bond 2000a, 2000b and 2002b; Hunter 2007.

There are a wide range of ways in which neoliberal economics negatively impacts access to health care and the ability of poor communities to maintain healthy lifestyles.[130] "Inequalities in distribution of services and treatments are not the concerns of free markets. Denial of care for patients who could not pay were not unknown in the past. But they were not legitimated as they are in a free market system … In this view, inequities are unfortunate but not unjust. Some simply are losers in the natural and social lottery" (Pellegrino 1999: 252; quoted in Farmer 2005: 162). Throughout the 1980s, global health activists and researchers launched negative publicity campaigns against the World Bank and the IMF, blaming Structural Adjustment Programs (SAPs) for the incapacity of developing countries to address the AIDS pandemic (Biehl 2004: 111). However, HIV/AIDS activists in South Africa, Brazil and Thailand shifted the terms of the debate from loans to intellectual property rights.

According to the WTO Agreement on Trade Related Intellectual Property Rights (TRIPS), patented medicines were protected from price-reducing competition for a period of 20 years. However, there were safeguards written into the TRIPS agreement which theoretically protected developing countries facing health crises. Under these safeguards, a country confronting an epidemic could implement one of three policies: 1) compulsory licensing, which allows the government to import or manufacture generic medication, so long as the state pays a 7% royalty on all sales to the patent holder; 2) voluntary licensing occurs when the pharmaceutical company holding the patent gives up its exclusive right to produce the drug, allowing other companies to manufacture or import generics during the period of patent protection; 3) parallel importing allows the government to find the

[130] For more global analyses of this connection, see: Farmer 2005; Fort et al. 2004; O'Manique 2004; Davis 2005; Petryna et al. 2006; Navarro 2007.

"cheapest *legitimate* international source" without permission from the patent holder; this means that the government can buy the drug from whatever country sells it the cheapest, but only from the same company that holds the patent (WTO 1994).

Up until recently, countries rarely, if ever, implemented these TRIPS safeguards because in doing so, they faced trade sanctions from the WTO Dispute Settlement Body, which "gives the WTO the legal tools to approve tough trade sanctions by one member against another, especially on nations which might disagree with the organization's interpretation of global trade rules" (Ellwood 2001: 34). More often than not, the US imposed "TRIPS Plus" agreements onto governments, in effect forcing countries to pass national laws that benefit multinational corporations (especially those based in the US). This legislation was "based on the most restrictive interpretation of TRIPS, shorn of the already-weak safeguards that TRIPS allows, and containing levels of IP protection that go well beyond anything mandated by TRIPS" (Oxfam 2001: 3).

> "Since a country in the WTO is obliged to offer similar trade terms to all member states (the principle of 'most favoured nation'), agreements reached in a bilateral deal with the US automatically become its global policy. In this way, the EU and other IP-rich countries free-ride on US agreements with other countries. EU bilateral agreements also oblige partner countries to strive for the 'highest possible standards' of IP protection, which acquires real meaning when standards are being ratcheted up around the world by the US" (Oxfam 2001: 10).

In 1997, the South African government passed the Medicines and Related Substances Control Amendment Act (RSA 1997), which provided the legislative framework for the issuing of compulsory licenses and parallel importing of medications. The Pharmaceutical Manufacturing Association (PMA), an organization representing 39 multinational pharmaceutical companies, sued the state of South Africa in an effort to remove the price reducing sections of this act. The PMA eventually withdrew its case.

The TAC has claimed victory for this retraction, due to their prominent and negative media publicity (Mbali 2004: 107-108; Comaroff 2007: 211-212). However, it would take several more years before the South African government would launch a Competition Commission (CC) case against pharmaceutical companies in order to secure low-cost treatment through the issuing of voluntary licenses. In other words, although the PMA withdrew its case, no steps were made to issue voluntary or compulsory licenses for several more years. Although not generally posited as a reason for the PMA's withdrawal, I do not think it coincidental that in 1999, South Africa signed a bilateral TRIPS Plus trade agreement with the US (GRAIN 2001; Oxfam 2001).

> "[W]hat keeps the system going is less rhetoric or discourse than … its own systemic logic: the idea that advanced capitalism works all by itself, that it doesn't any longer need to pass through consciousness to be validated, that it somehow secures its own reproduction" (Bourdieu and Eagleton 1994: 267).

According to Pierre Bourdieu, neoliberalism is quickly becoming doxic at an international level. The slogan Margaret Thatcher made famous, "There Is No Alternative" is now widely disseminated by not only the Western countries whose corporations and governments are growing rich from global neoliberal hegemony, but it is also parroted by newly democratized developmental states like South Africa as an *excuse* for failing to provide social welfare. "For neoliberal discourses is not a discourse like others … it is a 'strong discourse' which is so strong and so hard to fight because it has behind it all the powers of a world of power relations which it helps to make as it is, in particular by orienting the economic choices of those who dominate economic relations and so adding its own – specifically symbolic – force to those power relations" (Bourdieu 1998: 95).

In the US, where there is little tradition of the state as guarantor of citizens' welfare, there has been very little resistance to the imposition of a neoliberal hegemony (Bourdieu 1998). However, in South Africa, neoliberalism has not yet achieved doxic status – it is still the site of symbolic struggle and popular resistance. This is partially because of the make-up of the ruling party and its historical rise to power. The ANC is joined in a "tri-partite alliance" with the Congress of South African Trade Unions (COSATU) and the South African Communist Party (SACP). Both COSATU and the SACP have argued against the imposition of neoliberal economic restructuring and have historically proposed (and instituted) alternative economic models.[131] Though they have thus far been unable to slow its pervasive spread, it is significant that the source of critique of neoliberalism comes from within the ranks of the ruling elite. As well as from without.

Since the transition to post-apartheid, a number of social movement organizations have arisen to protest neoliberal economic restructuring: The Anti-Privatisation Forum (APF) struggles against the privatization of water and electricity and the use of the pre-paid delivery system; the Anti-Eviction Campaign (AEC) organizes against evictions, which are part of the state's strategy for privatizing housing allocation; and the Landless Peoples' Movement (LPM) has fought against the 'willing-seller, willing-buyer' strategy for land redistribution. The privatization of all basic services and the usage of pre-paid technology have become one of the primary instigators for public unrest. In 2005 alone, there were 5,000 basic service protests (FXI 2006). These social movements mobilize symbolic struggles, and even deploy the cultural 'authenticity' capital, against the

[131] The SACP and COSATU have always backed the more progressive RDP over GEAR; however, their resistance has been rather ineffectual.

discourses of development and democracy voiced (in self-defense) by the state. They have been labeled "ultra-left" by the ANC in an attempt to exclude their critiques from economic discussions taking place in the public sphere. This classification has, to some degree, succeeded in ostracizing the social movements from more active civic participation.

However, there has also been a rather unique shift in neoliberal hegemony regarding international health policy, largely initiated by treatment activists in Brazil, India, Thailand and South Africa. Utilizing immense public media campaigns highlighting the vulgar greed and disdain for human rights exercised by the international pharmaceutical industry, activists eventually convinced their governments and the pharmaceutical industry that a free market approach to health was unethical and unsustainable. Brazil was the first country to strike a compromise with the US and the WTO – it would not *violate* TRIPS nor pharmaceutical patents (without first getting the approval of the US), but it would issue compulsory licenses. With a loan from the World Bank in 1992, Brazil was the first 'developing' country able to offer ARVs within the public sector. Brazil's AIDS program has been hailed as 'proof that poor nations can do it' and 'a model for treating AIDS worldwide' (Biehl 2004: 105). Despite fears of losing capital, countries with high rates of HIV infection have become sources of profit for the industry.

> "As Brazilian adviser to the WHO explain: 'Pharmaceutical companies had already gained back their research investment with the sell-off of AIDS drugs in the United States and Europe and now with Brazil, they had a fixed market and even if they had to lower prices they had some unforeseen return. If things worked out in Brazil new AIDS markets could be opened in Asia and in perhaps Africa'" (Biehl 2004: 113).

Despite the pharmaceutical industry's fears about lowering medication costs in the 'Third World,' the magnitude of the problem and the amount of drugs states were forced to buy to accommodate their infected publics will eventually make up for the loss of individual costs. In a 2004 pharmaco-economic report on emergent HIV/AIDS pharmaceutical markets (including Brazil, Thailand, India, China and South Africa), it was estimated that these countries could provide a basic 3 ARV 'cocktail'[132] at 10% of the current US price, to 30% of the infected population, and the pharmaceutical industry would *still* make an $11.2 billion profit for the year (Biehl 2004: 112). "By 2010 the developing world is expected to account for approximately 26 percent of the world pharmaceutical market by value" (Ibid). In addition, these countries are invested in adding to the industry through generic manufacturing. Therefore, in some sense, HIV/AIDS activists in the developing world have *used* neoliberal economics *against* their states in order to secure ARV medication within the public sector. This battle has also served to radically transform international neoliberal health policy.

> "The success of the [Brazilian AIDS case] … is due to local activists' alliances with international organizations that have politicized patents as a question of fair global exchange and social justice … Indeed, much of the inventiveness and success of this policy is due to the encroachment of social mobilization within the state and its transnational ramifications. But this policy is as much social invention as it is state and market extension" (Biehl 2004: 112).

Therefore, South Africa continues to play a key role in global AIDS politics. TAC (and similar activist organizations in Brazil, Thailand, and India) have successfully transformed international IPR policy and forced the pharmaceutical industry to lower its prices on life-saving medications. However, this has *not* served to undermine the power

[132] The combination of treatments (3 different drugs from three different drug classifications) are often referred to as a 'cocktail.'

and scope of neoliberal economics. In fact, this chapter will argue that it has simply shifted the terms of the debates and perhaps further entrenched neoliberal hegemony. In the next chapter, I will present data to show the precise mechanisms by which the neoliberal approach to development undermines poor South Africans' ability to access health care and sustain a healthy lifestyle.

Symbolic Struggle

"One should never forget that language, by virtue of the infinite generative but also *originative* capacity … which it derives from its power to produce existence by producing the collectively recognized, and thus realized, representation of existence, is no doubt the principal support of the dream of absolute power" (Bourdieu 1991: 42; emphasis in original).

The AIDS crisis in South Africa has elicited what Paula Treichler labels an "epidemic of signification" (Treichler 1999a). It is impossible to read a newspaper, turn on the television, listen to the radio, or even walk down the street without engaging in and being informed by the various signifiers of HIV/AIDS. Foucault argued that discursive upsurges of this nature signal shifts in the "interventions of power" (Foucault 1978/1990: 30). The *symbolic struggle* raging in the South African public sphere over the meaning and significance of HIV/AIDS is more than anything a battle for hegemony. According to Laclau and Mouffe, "the openness and indeterminacy of the social … gives a primary and founding character to negativity and antagonism, and assures the existence of articulatory and hegemonic practices" (1985: 144-145).

Because AIDS, like any serious material crisis, threatens to upset the careful balance between the "objective social relations" and subjects' "habitus," the epidemic elicits wide-reaching doxic tremblings (Bourdieu 1977). If "it can even be said that the

production of a biopolitical body is the original activity of sovereign power" (Agamben 1998: 6), then how have nations which have been transformed into 'states of exception' by the epidemic, altered their boundaries of national incorporation, their interventions in the production of doxa, and their scope of power over "bare life" *because* of the threat posed by the disease (Agamben 1998; 2005)?

Discourses of healing inform subjects' corporeal practices and habitus and are therefore particularly valuable assets in the quest to secure hegemonic power at the national level. Controlling the processes of ideological incorporation is essential for institutional players whose domination relies upon the ability to define the boundaries of the South Africa body politic. The ability to impose neoliberal hegemony and to tame and contain the epidemic could ensure the stability and security of the post-apartheid state's legitimacy and symbolic power. The politics of inclusion and exclusion so integral to the imposition and legitimization of "doxa" become the essential stake over which the players in the symbolic struggle wrangle. Whoever wins the battle will reap the rewards of sovereignty.

In this section, I will explore the battle being waged in South Africa's public sphere between a denialist state and biomedical science. While the field of health and healing is bifurcated between biomedical and indigenous healing, the battle for hegemony within the field of power (articulated as a struggle over the HIV/AIDS epidemic) takes place between the state[133] and certain proponents of biomedical science. But the settling of the field of healing is a primary stake in the battle, and the 'irreconcilable' binary

[133] When I mention the 'state' in this chapter, I am referring to the state leaders that espouse a denialist ideology. As already mentioned, the entire post-apartheid state is not characterized by denialism, only its most powerful contemporary leaders.

between traditionalism and modernity is one of the weapons both antagonists wield in their effort to garner support from their various backers and constituencies.

Orthodoxy vs. Heterodoxy in the Field of Power

"Even the most constant combination of properties … are subject to variations in time so that their meaning, insofar as it depends on the future, is itself held in suspense and relatively indeterminate. This objective element of uncertainty … provides a basis for the plurality of visions of the world … *and it provides a base for the symbolic struggles over the power to produce and impose the legitimate vision of the world*" (Bourdieu 1989: 20; my emphasis).

For Pierre Bourdieu, symbolic struggle is a class struggle that takes place in the absence of doxic power. Each competitor in any symbolic struggle attempts to accumulate a maximum level of legitimacy for its own ideological framework, made possible by the accrual of different species of capital within the field. The ultimate sanction of legitimacy occurs when the domination ceases to be recognized for what it is, and is silently and therefore doxicly accepted by the subjects of the field. Doxa can only be achieved when a perfect homology exists between the objective social conditions and the subjective habitus; doxa is after all, the embodiment of common sense (Bourdieu 1996a: 334).

> "[T]he perception of the social world is the product of a *double structuring*: on the objective side, it is socially structured because the properties attributed to agents or institutions present themselves in combinations that have very unequal probabilities … On the subjective side, it is structured because the schemes of perception and appreciation, especially those inscribed in language itself, express the state of relations of symbolic power … these two mechanisms act to produce … a world of common sense" (Bourdieu 1989: 20).

After doxa has been established, only a material crisis can elicit a doxic rift, causing a disjuncture to emerge between the social field and subjects' habitus. If this radical moment is seized and symbolically interpreted by the dominated classes, then the

unspoken doxa has been broken. A "heretical break" presupposes *both* "critical discourse *and* an objective crisis, capable of disrupting the close correspondence between the incorporated structures and the objective structures which produce them" (Bourdieu 1991: 128). In order to safeguard against the revolutionary potential this moment permits, the elite, who benefit from the doxic system, are forced to *speak out* in defense of their disposition. A symbolic struggle ensues between the orthodoxy of the elite and the heterodoxy of the oppressed.

"What is at stake in the struggles over the meaning of the social world is power over the classificatory schemes and systems which are the basis of the representations of the groups and therefore of their mobilization and demobilization" (Bourdieu 1984: 479). Systems of classification are an object of struggle because it is only through recognition that a place within the field of perception can be secured (this is the only way that classes are recognized). When a certain system of classification wins the symbolic struggle over the worldview and is objectified and institutionalized, there is *orthodoxy*.

According to Bourdieu's framework, then, it is possible to interpret South Africa's "epidemic of signification" (Treichler 1999a) as a symbolic struggle for legitimacy taking place within the field of health and healing.

> "… the conflict around AIDS, in the context of an emerging post-apartheid state, represents a battle between certain state and non-state actors to define who has the right to speak about AIDS, to determine the response to AIDS, and even to define the problem itself" (Schneider 2002: 153).

The transition to post-apartheid required the merging of previous disparate fields of healing. However, the simultaneous inception of the AIDS crisis triggered a necessary and volatile symbolic struggle over the stakes and boundaries of the field. Because the

ability to successfully address the epidemic would fetch economic, cultural and symbolic rewards and because it would allow the victor to define South Africa's position within a geopolitical sphere, the symbolic struggle in which the field of health is embroiled also has more wide-reaching repercussions within the 'field of power.'

> "Th[e] struggle over the power to dictate *the dominant principle of domination*, which leads to a constant state of equilibrium in the partition of power, in other words, to a *division in the labor of domination* … is also a struggle over *the legitimate principle of legitimation* and, inseparably, the legitimate mode of reproduction of the foundations of domination. It can take the form of real face-to-face encounters … or symbolic confrontations" (Bourdieu 1996b: 265).

The field of power is made up of groups of people who possess significant quantities of capital and who therefore occupy dominant positions in various influential fields within the social space – especially in economic and cultural fields of production (Bourdieu 1996a). There are two primary stakes of the power struggles occurring within the field of power. The first concerns the ability to control the exchange rate between different forms of power (Bourdieu 1996b). The state possesses a kind of "metacapital" or *statist* capital which *usually* allows it to "exercise power over the different fields and over the different particular species of capital, and especially over the rates of conversion between them" (Bourdieu 1999b: 57-58). However, when the state has not yet achieved hegemony, or when the boundaries of the body politic are unstable, as in the case of a newly emergent state facing a crisis, this metacapital, the "capital granting power over capital" (Bourdieu 1996b: 265), is still up for grabs amongst the antagonists in the field of power.

The second stake in struggles within the field of power concerns the *nomos* of the social space, the capacity to control "schemas of perception" and "classificatory

systems," the vision and division of the body politic, the boundaries of sovereign inclusion and exclusion. "The struggles over definition (or classification) have boundaries at stake … and, therefore, hierarchies. To define boundaries, defend them and control entries is to defend the established order in the field" (Bourdieu 1996a: 225). Whoever has control over the *nomos* controls the "production and reproduction" of the "construction of social reality … where irrevocable differences are instituted between the chosen and the excluded" (Bourdieu 1999b: 68).

The post-apartheid state has not yet secured its own doxic legitimacy, so the "vision and divisions" the state endorses are not secure, meaning, they can be contested and subverted.

> "Using Bourdieu's (1986) typology of 'capitals,' contestation in the AIDS field, from the perspective of political leaders, is over symbolic capital: the legitimate right to hold and exercise power … Although key civil society actors in the AIDS field may not have been accepted by the state as serious contenders in the policy process, their ability to mobilise and convert 'capitals' into political and even economic power has forced an engagement with them" (Schneider 2002: 153).

Biomedical science and the denialist state have entered into a battle of orthodoxy versus heterodoxy. In terms of disease epidemiology and treatment, biomedical science enjoys hegemony throughout the world. However, in South Africa, biomedical proponents have been coerced into voicing their position and defending their ideologies against the 'heresy' of state denialism.

> "[D]ominant individuals, in the absence of being able to restore the *silence of the doxa*, strive to produce … a substitute for everything that is threatened by the very existence of heretical discourse … having an interest in leaving things as they are, they attempt to … restore the doxa to its original state of innocence and which, being oriented towards the naturalization of the social order, always borrows from the language of nature" (Bourdieu 1991: 131).

Biomedical science garners its greatest symbolic power by claiming an exclusive access to 'truth.' However, it is not quite this simple because the state is not without power, and it wields its own legitimacy through the articulation of cultural 'authenticity.' By calling biomedical science an 'imperialist' intervention and therefore making implicit claims about the legitimacy of science's ability to speak for and to 'Africans,' the state has turned health into a *political* issue. In contrast to the thorough medicalization of HIV/AIDS, Mbeki attempts, instead, to *politicize* it. "The President usurps the role hitherto confined to medical expert opinion" and therefore "affords scientific evidence a role secondary to that of political criteria in policy decisions" (Kistner 2003: 152, 136).

The prize over which these discourses contend is legitimacy for their own 'solution' to the epidemic. However, each seeks legitimacy from different sources: the global market, 'Western' institutions and governments, the populations within South Africa who are most affected by the disease. In other words, much of this debate is concerned precisely with South Africa's relationship to international capital, response to cultural imperialism, and ability to truly represent the needs and identities of its people. These debates starkly illustrate the stakes involved in both the symbolic struggle over the definition of AIDS taking place in the global public sphere *and* the stakes involved in setting the limits of South African identity and sovereignty. Therefore, these two proponents battle over four significant spoils of symbolic victory: 1) the ability to control the operations of bio-power because the ontology of the body is a primary stake within the field; 2) the imposition of a doxic acceptance of its capital and *nomos*; 3) the ability to set the terms of neoliberal engagement; and 4) to ultimately situate South Africa within a particular geopolitical configuration.

The odds of the discursive battle over HIV/AIDS are very clearly stacked in favor of biomedical science. Biomedical science is invested with tremendous amounts of cultural, social and economic capital from both national and international sources. However, the post-apartheid state, under President Thabo Mbeki, has sabotaged, to some extent, the hegemony of biomedical science. It does so by deploying a particular capital of 'authenticity' which relies upon the legitimacy traditional healing enjoys amongst the masses. As such, the denialism of the President is made possible by the habituses of the populations most affected by the epidemic. The popularity and prevalence of traditional approaches to healing within Black communities throughout South Africa disallows a homology to form between the structures and systems of the field and peoples' habituses. Therefore, even though biomedical science is 'winning' the symbolic struggle at the macro-level, at the micro-level (within communities), it is traditional healing which enjoys symbolic power. The state shrewdly manipulates the ideology of traditional healing in order to promote its own political agenda in an attempt to succor doxic control and therefore firmly secure the boundaries of the body politic and the circumscription of sovereignty.

Both the discourses of denialism and biomedical science attempt to interpellate the needs of the Black populations who are suffering from the dual pandemics of poverty and HIV/AIDS. In fact, the ability to secure legitimacy in the public sphere relies on the ability of the state and the proponents of biomedical science to promote a *simulation* of a homology between their vision of the world and peoples' lived experiences with the disease. As this paper will soon show, the rhetorical *use* of both discourses about poverty *and* racism feature prominently in the symbolic struggle over the epidemic. In the

meantime, the real needs of communities mired in abject poverty and disease play no role in the symbolic struggle.

The Myth of Incommensurability

"There's a fundamental conflict – either you're part of the system or you are not … The philosophical diversion between Western biomedical medicine and traditional medicine is something you can't overcome. Either you're going to believe in science or you're not. It's like religion. The way it pans out – it's going to just depend on the extent to which traditional healers and the traditional health system is going to be able to concede … because it's for their benefit as a community … Um, but you're not going to be able to get away from the fundamental conflict."[134]

Despite the integration of the field of healing, the state, biomedical scientists and traditional healers still insist on a fundamental incommensurability between indigenous and biomedical forms of healing. While the field is certainly bifurcated in many ways due to the legacy of apartheid and certain post-apartheid politics (as was illustrated in the previous chapter), the incommensurability insisted upon in public sphere debates is ideological and political in nature. It functions to (re)invent and then reify two mythical constructs, collapsing the symbolic struggle over HIV/AIDS into an epic confrontation between 'modernity' and 'traditionalism,' an anachronistic and colonial battle between the 'West' and 'Africa.' Because the boundaries of the field and of the national body politic are at stake, the traditional/modern binary becomes a valuable weapon wielded in the battle for hegemony. This binary played an important role in the construction of social divisions under apartheid, and it has remained a significant trope in the fashioning of a post-apartheid national identity. While my research will show that peoples' everyday experiences with health care undermine such a rigid binary, these dichotomous

[134] Anonymous AIDS Law Project lawyer and activist. Interview held on November 22, 2005 in Johannesburg ALP offices at the University of Witwatersrand.

analytic categories have social, historical, and political origins. Exploring the motives behind the production of this 'myth of incommensurability' will shed light on its function and meaning in the contemporary symbolic struggle over HIV/AIDS.

Terence Ranger has shown that African 'tradition' was an invention of colonial rule. Prior to colonization, there was no single 'tribal' identity: "most Africans moved in and out of multiple identities … Thus, the boundaries of the 'tribal' polity and the hierarchies of authority within them did *not* define conceptual horizons of Africans" (Ranger 1983/2003: 248). In precisely this way, 'tribal authority' was invented and sustained by the apartheid state in order to facilitate indirect rule.

> "To deepen and stabilize the rule of a racially defined minority, it was necessary to split the majority into compartmentalized minorities. But that division could not be an arbitrary invention. To be believable and to stick, it had to be anchored in a historical and cultural experience. To consolidate racial rule required that it be anchored in a tribal mode of control: by defining every native as a Bantu belonging to a particular tribe, subject to regulation under its own customary law, it would be possible to divide natives into a number of tribes, each a minority on its own, and thereby contain all within the parameters of separate tribal institutions" (Mamdani 1996: 96).

Ranger explains, then, that not only was African 'tradition' a *product* of modernity, but it was also *what made African modernization possible* (Ranger 1983/2003). Once this 'traditionalism' was firmly invented, applied to the Bantustans, and incorporated by chiefs (who benefited from the interpellation), then the 'myth of incommensurability' served to justify segregation by driving an essentialist wedge between a white, urban population interpellated as modern, and a rural population

imprisoned within the spatial confines of Bantustans and the ideological constraints of 'traditional authority.'[135]

Despite these complications, some historians and social researchers continue to conceptualize tradition and modernity as teleological stages of social development (Myers *Forthcoming*).[136] Not only was African 'tradition' an ideological construction of colonial rule, it was also never wholly embodied by the colonized. Those subjects most exploited by apartheid were actually forced to live in both worlds simultaneously. As such, apartheid initiated the co-existence and mutual dependency of various heterogeneous kinds of indigenous and 'modern' beliefs. For example, an oral history project in Durban townships revealed Zulu subjects' multiple identities, in which certain codes and beliefs associated with both 'traditionalism' and 'modernity' were spliced together in unique and varied patterns (Campbell et al. 1995). But this hybridity occurred not only in urban settings, where subjects were literally straddling the system of indirect rule, but it was also common in rural settings. Most South Africans (no matter their location) participated in the modern economy and were controlled by modern forms of governance.[137] Therefore, the cultural boundaries established by the apartheid regime between modernity and traditionalism were necessarily flexible and malleable.

Given the apartheid state's reification and exploitation of the myth of incommensurability, it is hardly surprising that the modernity/traditionalism dichotomy played an important role in the resistance struggles against apartheid. The ideologies of

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[135] Sources on the apartheid state's construction and use of the traditional/modern binary include Marks 1986; Ashforth 1990; Beinart and Dubow 1995; Mamdani 1996; and especially Myers *Forthcoming*.
[136] In fact, Mamdani is critiqued for precisely this error. See: Cooper 1983 and 1997a.
[137] For sources which highlight the way in which chiefs were forced to negotiate between the ideological and institutional constraints of both modernity and traditionalism in their occupations under the apartheid system in South Africa, see: Fallers 1965; Weinrich 1971; and Holleman 1969.

the ANC were framed within a modernist paradigm. Because the way in which apartheid system attempted to reserve the privileges of 'modernity' for the white population, the ANC's resistance sought to bring modern development and its rewards to the Black majority (ANC 1975; Lodge 1983; Mandela 1990). However, other resistance movements, most notably the Inkatha Freedom Party (IFP) considered this ideological framework to be a betrayal of 'African' identity. The IFP consistently (and sometimes successfully) used the trope of 'African tradition' to undermine the political legitimacy of the ANC.[138] Because the IFP's stronghold was in rural KZN (the Bantustan near the Natal province), whereas the ANC tended to concentrate its struggles in urban settings (most notably Cape Town and Johannesburg), the *ideological* distinction between the two groups was often translated into a rural-urban divide, thereby reinforcing the divisions constructed and forcibly policed by the apartheid government. However, because of these political and historical conflations, traditionalism came to be associated with ruralness – an assumed correlation that still operates in contemporary politics.

In addition to a spatial correlation, 'traditionalism' is also associated with economic divisions. The discovery of diamonds and gold around the turn of the 20th century initiated a shift in the colonial approach to the native population (Marks and Rathbone 1982). The industrialization of the South African economy was reliant upon the super-exploitation of Black labor. A previously undesirable population was now absolutely essential to the productivity of the quickly modernizing state. With the National Party's victory in 1948 and the subsequent establishment of the apartheid system, the class-race divisions of the colonial period were institutionalized, resulting in

[138] For analyses of the politics of the IFP, see: Southhall 1981; Mare and Hamilton 1987; and Mzala 1988.

the development of a polarized economic system, drawn along racial lines. Despite this entrenched system of racial capitalism, there was a small Black middle class which emerged in townships throughout South Africa (although the apartheid government attempted to eradicate class distinctions in the townships in the 1970s) (Bozzoli 2000). Certain chiefs also benefited financially from their service to the apartheid system (Myers *Forthcoming*). Despite these class ambiguities, the invented African 'tradition' is strongly associated with poverty.

The tendency to correlate traditionalism with *both* poverty and ruralness was most likely buttressed by the hostellization process in the townships. Hostels were built in the urban townships as a means of housing single men working in urban industries. In the 1970s, in response to growing resistance in the township regions, the apartheid government launched a legal onslaught against urban dwellers. As explained in the previous chapter, this included forced removals, harsher punishments for pass law violations, and hostellization (Bozzoli 2000). Most of the hostel dwellers were single, male migrants (recent arrivals from rural areas) and township residents (most of whom had lived in urban areas for decades) often discriminated against them. In addition, in Soweto, many of the hostels were strongholds of the IFP. "In its attempts to enhance its national and urban power base, the IFP used Zulu-speaking migrant workers in the hostels to ferment conflict, sometimes with state backing" (Beall et al. 2002: 186). This often led to violent conflict between township residents and IFP-affiliated migrants (Ibid). Given the IFP's constant performance of a reified 'traditional' African identity, these conflicts between hostel dwellers and permanent township residents may perhaps

provide one reason why a strong 'traditional' identity is still today associated with both poverty and ruralness.

These correlations remain prevalent in today's popular imaginary, but the usually derogatory stereotypes about 'traditionalism' are now associated with informal settlement residents *in addition to* hostel dwellers. For example, one nurse told me, with derision, that: "people from the informal settlements believe in witchdoctors because they are uneducated."[139] When I interviewed an HIV-positive resident of Sol Plaatje and asked him about why members of his community utilized traditional healing, he said: "There are many people in our informal settlement from the rural areas. They have strong customs there, and they only believe in traditional healing. They won't go to Western doctors. They don't trust them."[140] And an NGO member expressed frustration with some of her support group members: "Ack, some of these people are very poor and so they don't know better. They use those *mutis* and traditional healers and don't like to come to the clinics."[141] In addition, access becomes a justification for upholding this correlation. In an interview with a TAC leader, when I mentioned the pervasive use of traditional healing, the interviewee responded quickly and derisively: "but we have no evidence about the reason for this incidence. Perhaps it is only because of a lack of alternative treatment options."[142] However, my research unveils the falsity of these popular assumptions by showing that there is no significant difference in the usage of traditional healing based on class, educational attainment, or access to biomedical

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[139] Female Nurse, Maternity Ward. Interview held on May 25, 2006 at the Chris Hani Baragwanath Hospital, Soweto.
[140] Anonymous HIV-positive community member. Interview held on October 14, 2005 in Sol Plaatje.
[141] "Lily." [NGO Staff]. Interview held on October 19, 2005 in Soweto.
[142] Anonymous interview with TAC leader. Interview held on November 21, 2005 in Johannesburg.

facilities, and in fact, the usage of traditional healing in urban areas is much more common in formal townships than it is in informal settlements.

According to Eric Hobsbawm, traditions are often 'invented' for ideological purposes. While these invented traditions assume invariance and are symbolic in nature, customs are flexible and reflect "patterns of social interaction … pragmatically based on norms" (Ibid: 3). "[A]ncient materials" are used to "construct invented traditions of a novel type for novel purposes" and are often "readily grafted on old ones"; this process requires an "elaborate language of symbolic practice" (Ibid: 6). I would like to suggest that 'tradition' has been (re)invented in precisely this way by the post-apartheid state[143] in order to assert a certain cultural 'authenticity.' In adopting neoliberalism, the ANC was forced to abandon the social democratic banner under which it was voted into power. Because of this, the ruling party faces a certain anxiety over its legitimacy with the poor – especially because neoliberal economic restructuring has served to further exacerbate economic and racial divisions. In the next section, I will explain the way in which the state attempts to represent itself as 'Africanist' in order to purchase legitimacy from a population who was dispossessed of the promises of liberation.

In addition, however, the denialist state utilizes its invented 'traditions' in order to delegitimize biomedical science. The state's 'tradition' draws on the tropes of indigenous healing, but in so doing, it does the profession a disservice and locks it into an

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[143] Lucky Mathebe (2001) argues that the ANC in exile invented traditions to "symbolise the cohesion and collegiality of the organisation" (85). Because Mbeki was born into this invented "familial tradition," his policy decisions and role in the ANC reflect this emphasis on presenting a united party front (Mathebe 2001: 84-110). I do not think this analysis I still valid, given the fact that Mbeki has often surrounded himself with cronies he can control, against his perceived enemies within the party. These fragmenting inner-party struggles have played a role not only in his controversial AIDS policies, but also in his relationship with Jacob Zuma. However, I mention the analysis in order to illustrate the ways in which Hobsbawm's theories have informed other analyses of Mbeki's reign as President.

anachronistic past. Further, the proponents of biomedical science defensively combat the state's invented 'tradition' by swathing its own ideological orthodoxy in signifiers of progress, modernity and human rights. And as a result, the symbolic struggle over HIV/AIDS is reduced to a tired and obsolete "clash of civilizations."

And in order to buttress their own ideological positions, both dominant discourses assert that indigenous and biomedical healing are incommensurate. They each promote a kind of monotheism of treatment, insisting that healing approaches cannot (ontologically) and should not (scientifically) be combined. Therefore, the users/consumers of healing are asked to *choose* one or the other disposition, and told that a failure to do so could lead to further illness or even death.

Many of the biomedical practitioners and activists with whom I worked believed that there were a variety of incommensurate practices that emerged out of the combined usage of healing methods, which ultimately undermined the biomedical treatment. "If traditional healers believe that diseases are caused by witchcraft, there is not much you can do with them, from a biomedical perspective. They belong, as one doctor who worked in a district hospital in Africa put it, to a 'system that is irreconcilable with our own'" (Steinglass 2001: 36). The TAC, for their part, promote the testing of traditional herbal remedies in order to ensure their safety, but also to determine whether the combined usage of particular herbal remedies will counteract or undermine the effects of various biomedical treatments.[144] However, this approach implicitly promotes the

[144] I heard this suggestion again and again in the interviews I conducted with the leadership of the TAC. To be fair, the leadership of the TAC does not advocate for an eradication of traditional healing. They are aware that this would seriously undermine not only their case, but their ability to speak to (and for) the masses of HIV-infected South Africans. Therefore, they are very careful in their political stance on this issue. On the one hand, if you push some of them (in interviews), they do show abundant frustration in

orthodoxy of biomedical science (though the TAC believes it is being culturally sensitive in making such a suggestion) because it insists that only biomedical science is capable of measuring the effectiveness and safety of any and every drug – including those that have been used by traditional healers for centuries.

On the other side, the Minister of Health insists that vitamins are more in keeping with African beliefs and dispositions (because they are supposedly 'natural'), and should be used *in the place of* antiretrovirals which are not only understood as 'foreign' but also 'toxic' (Dr. Rath 2005b). "Manto Tshabalala-Msimang, Minister of Health, believes that South Africans are dying as a direct result of the toxic side-effects of antiretrovirals and wants the health department to back this up with statistics" (*The Star* 2005b).

Therefore, both of the competitors in the struggle for hegemony rely on incommensurability in order to better vie for domination. In order to gain hegemonic power within the field of health and healing, alternative approaches must be de-legitimated and vilified, if not wholly squashed. Or, alternatively, these alternative approaches can be incorporated into and therefore subsumed under the control of the dominant approach. In analyzing the specifics of the symbolic struggle raging in the public sphere, both of these positions on alternative methodologies will be illustrated. But what remains completely clear is the insistence that amalgamating the approaches bastardizes healing to a dangerous degree. Therefore, there is an assumed ontological

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even having to engage in this debate at all (because it is so obvious to them that biomedical science is the only relevant and effective option for addressing the pandemic). But on the other, they officially recognize the important role traditional healers play in addressing the pandemic and even the historical oppression traditional healers have faced in South Africa. Therefore, they take what they believe to be a culturally relativist position by suggesting that the MCC test all traditional *muti*. For an example of this carefully orchestrated political stance on traditional healing, see: *Equal Treatment* 2005b.

and epistemological impossibility of hybridization that underlies both of the dominant approaches vying for legitimacy in the symbolic struggle over HIV/AIDS.

It is in the field of power that the myth of incommensurability circulates. It is in the *interest* of those in dominant positions to maintain segregation between the healing approaches, and they use the myth as *political* capital. For biomedical science, the reward offered for accepting and embracing biomedical 'distinction' is the continued accrual of 'modern' forms of capital (both economic and cultural). State denialism, on the other hand, *utilizes* the cultural capital of 'authenticity' in order to purchase legitimacy. Therefore, 'traditionalism' becomes its own *symbolic* reward. Instead of offering economic or cultural rewards for adopting their position, the state is *using* the material conditions and beliefs of the population *against* the populations' actual interests. Therefore, biomedical science offers the capital of 'modernity' as a reward to those who adopt its disposition, whereas the state *uses* the fear of imperialism and the importance of 'traditionalism' in order to keep the dispossessed majority from claiming the rewards of 'modernity.'

Incommensurability is the language used to make political claims about South Africa's position in the global market, relationship to Western states and institutions, and ability to fulfill the promises of liberation. The binary between traditionalism and modernity sustains and reinforces other dichotomous divisions, which still operate with force in contemporary South Africa: urban/rural, white/Black, healthy/diseased, rich/poor, male/female. In many ways, the binary between traditionalism and modernity operates as a mechanism of control. Although the state denialists utilize the trope of traditionalism in the public sphere, their brand of African nationalism actually seeks to

invent a new form of African *modernity*. Therefore, Mbeki circumscribes certain portions of the population within the delimiting boundaries of 'traditionalism' in order to justify their exclusion from the national imaginary, while simultaneously speaking the language of 'traditionalism' in order to garner support from these self-same masses. Ordering post-apartheid subjects into two autonomous categories concretizes the boundaries of citizenship. These binaries matter, because sovereignty is doled out and withheld on their basis.

The State in Denial

"There is this kind of illogical contrariness which celebrates so-called questioning of accepted truths when it comes to HIV and medicine, but doesn't see any contradiction in … [embracing] the orthodox when it comes to economic policies." (Mark Heywood, TAC National Treasurer)[145]

Thabo Mbeki, the current President of South Africa, will be most remembered throughout the world for his "AIDS denialism." The first symptom of Mbeki's unorthodox views on HIV/AIDS emerged in 1997 when he threw his weight, as then Deputy President, behind clinical trials on a new experimental drug, Virodene – a powerful industrial solvent (Myburgh 2007*; New Yorker* 2007). Despite the eventual scandal and subsequent abandonment of the drug, it was originally touted as a possible 'cure,' and the ANC government (under the leadership of Mbeki) went to extraordinary lengths to promote the drug and to support the possibility of extensive human trials (Myburgh 2007). Eventually, the MCC blocked clinical trials in South Africa (Ibid). In 1999, Mbeki questioned the safety of AZT in a speech given to Parliament (Mbeki 1999). Then, in 2000, Mbeki convened a Presidential Advisory Panel on AIDS that included

[145] Interview with Mark Heywood, Head of AIDS Law Project, and National Treasurer of Treatment Action Campaign. Interview held on November 24, 2005, in Johannesburg ALP Offices.

notorious AIDS denialists, including Peter Duesberg, the inventor of the international AIDS dissident movement (Mbali 2003 and 2004; *New Yorker* 2007).[146]

However, it was not until the International AIDS Conference (held in Durban in late 2000) that Mbeki fully outed himself as a denialist to the whole world when he insinuated that rather than HIV, it is poverty that causes AIDS.

> "The world's biggest killer and the greatest cause of ill-health and suffering across the globe is listed almost at the end of the International Classification of Diseases. It is given the code Z59.5 - extreme poverty … As I listened and heard the whole story told about our own country [as presented by the WHO], it seemed to me that we could not blame everything on a single virus … what is to be done, particularly about HIV-AIDS? One of the questions I have asked is are safe sex, condoms and antiretroviral drugs a sufficient response to the health catastrophe we face! … We remain convinced of the need for us better to understand the essence of what would constitute a comprehensive response in a context such as ours which is characterised by the high levels of poverty and disease to which I have referred … The world's biggest killer and the greatest cause of ill health and suffering across the globe, including South Africa, is extreme poverty" (Mbeki 2000).

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[146] Peter Duesberg was one of the first scientists who uncovered some of the key properties of retroviruses in the 1970s, for which he received international acclaim and recognition from the scientific community. Then, in 1987, he wrote a paper arguing that HIV is a mere 'passenger' virus that causes no harm to the body. Since this time, he has led an international AIDS dissident movement, which gained new strength when Mbeki discovered Duesberg's work on the Internet and began to reiterate his theories publicly. Mbeki wrote in 2000: "By resort to the use of the modern magic wand at the disposal of modern propaganda machines, an entire regiment of eminent 'dissident' scientists is wiped out from public view, leaving a solitary Peter Duesberg alone on the battlefield, insanely tilting at the windmills" (*New Yorker* 2007).

Figure 3-1: Zapiro cartoon - World AIDS Conference [147]

Figure 3-2: Zapiro cartoon on Mbeki's Advisory Panel [148]

[147] Cartoon by Jonathan Shapiro, see Zapiro 2000. Originally published in the *Mail and Guardian* 2000b.
[148] Cartoon by Jonathan Shapiro, see Zapiro 2000. Originally published in the *Mail and Guardian* 2000a.

In a *Time* magazine interview (*Time* 2000) and during several Q&A sessions during parliamentary sessions (Schüklenk 2004), Mbeki has claimed that HIV could not cause AIDS "because a virus cannot cause an immune deficiency syndrome" (Mbali 2004: 106). Since this time, the ANC government, under his rule, has consistently denied HIV-positive South Africans access to antiretroviral treatment.[149]

The Western media has never attempted to complicate or explain the dissident views held by Mbeki and other government officials. In fact, he situates his anomalous views about the science of AIDS within an extremely intelligent social critique. First and foremost, Mbeki's views on HIV/AIDS are "a defense of Africans against racism and neoimperialism" (Mbali 2004: 106). Mbeki's dissident views and harsh critiques of biomedical science offer a biting critique of Western imperialism disguised as universalism (in the case of biomedical science) and good intentions (in the case of policy interventions). The "Western way of fighting AIDS will not transfer to Africa" ("Castro Hlongwane" 2002). In addition to highlighting the role colonization played in creating the conditions for the epidemic, Mbeki has consistently reminded South Africans not to forget the history of scientific racism they have faced throughout the colonial period – from being guinea pigs for biomedical clinical trials to the eugenics activities of the apartheid government (Fassin 2007).[150]

> "I speak of courage because there are many in our country would urge constantly that we should not speak of the past … The story of Sarah Bartmann is the story of the African people of our country in all their echelons … It is an account of how it came about that we ended up being defined as a people without a past,

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[149] For summaries and discussions of Mbeki's denialist stance, see: Schneider and Stein 2001; Schneider 2002; Johnson 2004; Mbali 2002, 2003 and 2004; Heywood 2004b; Fassin 2007. For more celebratory sources on Mbeki's term in office, see: Mathebe 2001; Roberts 2007; Gevisser 2007. For critical accounts of Mbeki's economic and political policies, see: Jacobs and Calland 2002; Bond 2004a; and Gumede 2005.
[150] For a history of scientific racism in South Africa, see Dubow 1995.

> except a past of barbarism, who had no capacity to think, who had no culture, no value system to speak of, and nothing to contribute to human civilisation - people with no names and no identity … The legacy of those centuries remains with us, both in the way in which our society is structured and in the ideas that many in our country continue to carry in their heads …" (Mbeki 2002).

In his long and detailed exploration of Mbeki's 'denialist' stance, Fassin (2007) argues that Mbeki's views on HIV/AIDS are informed, more than anything else, by history, but that his critics have become amnesiatic. He refers to Benjamin's version of history, and insists that we follow his example of "brushing history against the grain," by understanding that the present sheds new light on the past (Fassin 2007: 169-170). It is only through this type of reading that we can begin to make sense of Mbeki's 'ghosts' (Mbali 2002).

Though posted to the ANC website anonymously, there has been widespread speculation that the now infamous "Castro Hlongwane" article, which is generally interpreted as the manifesto of South African denialism, was actually penned by Mbeki himself. In it, Mbeki presents a compelling critique of Western representations of the African AIDS pandemic – particularly racist connotations about Black sexuality (Fassin 2007; "Castro Hlongwane" 2002).

> The answer lies in the reality that the hypotheses about ourselves, that are presented as facts, rest on an age-old definition, by others of what and who we are as Africans … For their part, the Africans believe this story, as told by their friends. They too shout the message that – yes, indeed, we are as you say we are!
>
> Yes, we are sex-crazy! Yes, we are diseased!
>
> Yes, we spread the deadly HI Virus through our uncontrolled heterosexual sex! In this regard, yes we are different from the US and Western Europe!
>
> Yes, we, the men, abuse women and the girl-child with gay abandon! Yes, among us rape is endemic because of our culture!

> Yes, we do believe that sleeping with young virgins will cure us of AIDS! Yes, as a result of all this, we are threatened with destruction by the HIV/AIDS pandemic!
>
> Yes, what we need, and cannot afford, because we are poor, are condoms and antiretroviral drugs!
>
> Help! ("Castro Hlongwane" 2002)[151]

Since most of the international funding available for HIV/AIDS services, treatment and support comes from the West, racist assumptions about African behavior and identity which underpin policy interventions have very real implications for both prevention and treatment paradigms in South Africa. After all, it was not so long ago that George W. Bush's Director of USAID, Andrew Natsios, claimed, without any sense of irony, that Africans cannot take antiretrovirals because they "don't know what Western time is."[152]

Much of Mbeki's stance on HIV/AIDS makes use of a rather academic cultural critique of the social constructedness of science. In fact, one might mistake Mbeki's claims for those of cultural analysts who have long attempted to break open the "black box" of scientific hegemony.[153] For example, several cultural theorists have brought to light the fact that HIV was too quickly posited as the one and only cause of AIDS, before sufficient research could be conducted, because political-economic concerns and the

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[151] "No longer will the Africans accept as the unalterable truth that they are a dependent people that emanates from and inhabits a continent shrouded in a terrible darkness of destructive superstition, driven and sustained by ignorance, hunger and underdevelopment, and that is victim to a self-inflicted 'disease' called HIV/AIDS."

[152] On June 7, 2001, Andrew Natsios, the Bush administration's Director of the U.S. Agency for International Development (USAID), stated publicly in both the *Boston Globe* and in testimony before the House International Relations Committee, that antiretrovirals should not be promoted in the African context. "Ask Africans to take their drugs at a certain time of day, said Natsios, and they 'do not know what you are talking about'" (*Washington Post* 2001).

[153] For example: Knorr-Cetina 1981; Knorr-Cetina and Mulkay 1983; Latour and Woolgar 1986; Latour 1987; Haraway 1989a, 1989b, 1991. For cultural analyses of HIV/AIDS specifically, see: Watney 1987; Sontag 1988; Crimp 1988; and Treichler 1999a and 1999b.

expert status of biomedical research was at stake (Treichler 1999b). In the 1980s, a Canadian scientist, Nicholas Regush, contended that the US scientific mafia would stand to gain if HIV was simply accepted as the correct answer to the many mysteries that still surrounded AIDS: "I felt that a reasonable argument that HIV could be the cause – *could* be the cause of AIDS – was being translated all too quickly by science and the media as *the* cause of AIDS, and no one seemed to give a damn about really questioning whether in fact that was true or not" (Quoted in Treichler 1999b: 164-165). Although these cultural analysts do not, like Mbeki, question the years of scientific research that have since proven these initial theories on HIV correct, nor do they claim ARVs are toxic; however, it is important to note that Mbeki's critiques are certainly informed by the social constructionist theories of cultural studies. The "Castro Hlongwane" article brands biomedical science the 'omnipotent apparatus,' and lambastes the international pharmaceutical industry for its corporate logic and greediness in the face of such a humanitarian crisis.

> "Stridently and openly, the omnipotent apparatus disapproves of our effort to deal with the serious challenge in our country of health, poverty and underdevelopment. It is determined that it will stop at nothing until its objectives are achieved. What it seeks is that we should do its bidding, in its interests. In this respect, all of us are obliged to chant that HIV=AIDS=Death! We are obliged to abide by the faith, and no other, that our immune systems are being destroyed solely and exclusively by the HI Virus. We must repeat the catechism that sickness and death among us are primarily caused by a heterosexually transmitted HI Virus. Then our government must ensure that it makes antiretroviral drugs available throughout our public health system" ("Castro Hlongwane" 2002).

Mbeki's critiques of the international AIDS industry deserve serious attention and debate. However, because they are used to buttress a denialist stance which has proscribed millions of South Africans access to life-saving medications, these important

critiques about the role cultural imperialism plays in global AIDS politics go unheeded. And ultimately, denialist ideology serves to mask a fundamental contradiction in the government's approach to HIV/AIDS. The ANC's adoption of a neoliberal macro-economic strategy has: 1) undermined its ability to adequately address the poverty which Mbeki himself believes fuels the epidemic; *and* 2) opened South Africa's national borders to international capital, which has ushered in the cultural imperialism he condemns.

By emphasizing the *causal* role poverty plays in the epidemiology of AIDS, Mbeki is speaking directly to the needs of the population (Mbeki 2000), for whom abject poverty and deplorable living conditions offer more of a threat to survival than the disease itself. However, addressing poverty as a causal factor of HIV/AIDS infection and providing comprehensive care to those infected (including the provision of proper nutrition, access to water, land and electricity) would require the abandonment of privatization, a refusal to cut government spending on social welfare programs to attract foreign investment, and a complete restructuring of the public health care system. Patrick Bond has similarly argued that there are three "structural impediments to ARV access," including: 1) neoliberal fiscal policy – which has privileged the slashing of corporate taxes, the use of state resources to enhance the arms industry, and the repayment of apartheid-era debt over state spending on health care and treatment; 2) compliance with the international pharmaceutical industry's profiteering and the WTO and US trade policies that privilege corporate development over public spending on health care, and 3) the large size of South Africa's 'reserve army' which allows for a perpetual replenishment of workers who die of AIDS (Bond 2004b).

The doubt that the denialists, such as Mbeki, have cast on the effectiveness and safety of antiretroviral medication is little more than sophisticated abracadabra. While distracting the population with promises of poverty alleviation and equal opportunity, and duping civil society organizations into arguments over disease epidemiology and causality, the backstage workings of neoliberalism go unnoticed. "[D]enialism may be a smokescreen for the government's adoption of poverty sustaining neoliberal policies, which may be blocking further public spending on AIDS" (Mbali 2004: 105).

Daniel Herwitz has argued that a "smokescreen" becomes essential when a state is faced with a "stark" "Malthusian" choice: "either one denies antiretrovirals to pregnant mothers, guaranteeing an early death to their children, or one floods the society with motherless children for whom nobody can care" (Herwitz 2006: 2). In fact, Parks Mankahlana, the late Presidential spokesperson made this argument in no uncertain terms during the national debates about funding Mother-to-Child-Transmission Prevention (MTCTP). He insinuated, publicly, that it cost less state resources to let HIV-infected children die, than to have them become dependent upon the state as orphans (*Independent Online* 2000; Mbali 2004: 110). Denialism is quite simply a convenient excuse for the failure to provide adequate health care to an undesirable population.

While on the one hand, then, Mbeki is a cold and calculating economist, who seeks the imposition of neoliberal doxa. On the other hand, biomedical science is not at odds with neoliberalism. Quite the contrary. Internationally, the hegemony of biomedical science is garnered *through* neoliberal economics. As already explained, the WTO protects patent rights on pharmaceuticals to insure the growing revenue of the world's most profitable industry. Therefore, providing a smokescreen for the

advancement of neoliberalism is not the *only* causal explanation for state denialism. Mbeki's critique of biomedical science shows that he is ideologically invested in the promotion of an anti-imperialist and Africanist agenda. This could simply be because of his interests in promoting South Africa as the economic leader of an African alliance.[154]

But Mbeki does go to great lengths to undermine and side-track the biomedical establishment. For example, the internationally controversial Dr. Rath, whose foundation touts mass dosages of multi-vitamins as a cost-effective 'cure' to HIV/AIDS,[155] has been allowed to advertise and distribute his vitamins, and even conduct 'clinical trials' in poor communities throughout South Africa. He first announced his presence in South Africa in early 2005 through a series of advertisements he placed in national newspapers, which not only promoted his own vitamin products as an 'answer' to the ravages of the AIDS pandemic, but also defamed antiretrovirals, the pharmaceutical corporations that sell them, and the TAC itself which, according to Rath, acts as "the running dogs of the drug cartel in South Africa" (Dr. Rath Foundation 2005b).

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[154] The New Partnership for Africa's Development (NEPAD) promotes free trade relations throughout the continent, and Mbeki plays a key role in securing agreements favorable to the South African economy.

[155] Please see the following sources for further information: Treatment Action Campaign 2005a and 2005b; Rath Foundation 2005a; ASASA 2005; South African Medicines Control Council 2005.

Figure 3-3: Dr. Rath Advertisements [156]

Though he has been kicked out of multiple countries, including his own Germany, for his fraudulent claims, he has been welcomed by the South African government. The Rath Foundation has been given private interviews with key Department of Health officials, the MCC investigation into its vitamin products was secretly and furtively called off, and the TAC has recently launched a court case to undercover the extent to which the government has supported the Rath Foundation for its own covert purposes. The Minister of Health has made the following public statement, which was published by several newspapers: "I will only distance myself from Dr. Rath if it can be demonstrated that the vitamin supplements that he is prescribing are poisonous for people infected with HIV" (*Mail and Guardian* 2005).

[156] *Mail and Guardian* 2004 and *New York Times* 2004.

The Rath Foundation employs a discourse similar to that of Mbeki's (and there have been consistent insinuations that certain members of the organization have Mbeki's ear),[157] which highlights poverty, the social construction of science, and the greed of the pharmaceutical industry.

> "We focus on health care, which is monopolized by the pharmaceutical industry. When people are sick, in a capitalist system, then the market works only when people stay sick. Some illnesses (like high blood pressure, etc.), which are really part of the natural life course, are created by the pharmaceutical industry in order to create new markets for their drugs. The more people who are sick, the more they make a profit … Disease is therefore in their interest, and they fight against anything that actually prevents or cures the diseases on which they make their profit … We are here to reform primary health care, to promote affordable therapies and cost-effective natural products."[158]

In addition, the Rath Foundation shares the economic contradiction inherent in Mbeki's stance on HIV/AIDS. While publicly stating that the real issue is the profiteering of the international pharmaceutical industry, the Foundation markets and sells its own patented vitamins for tremendous profit over the internet. Rath also is the CEO of his own multinational vitamin company.[159]

Since it's arrival in South Africa, the Rath Foundation has promoted its own vitamins as the most natural, cost-effective approach to HIV (which they claim to be distributing in South Africa free of charge but which have not been approved by the national regulatory institution, the MCC).[160] "Denialism is not the issue. The real issues are the toxicity of drugs and the fact that nutrients are the cost effective means of dealing

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[157] Anthony Brink, an employee of the Rath Foundation, told me in an interview that his work on the toxicity of AZT was what caused Mbeki to "order an inquiry into the safety of the drug in Parliament on the 28 October 1999." Interview held on May 20, 2005 in the Rath Foundation offices in Cape Town.
[158] Interview with Rath Foundation spokesperson held on November 16, 2005 in the Rath Foundation offices in Cape Town.
[159] Interview with Fatima Hassan, ALP advocate in the court case between TAC and the Dr. Rath Foundation. Interview held on November 14, 2005 in the ALP offices in Cape Town.
[160] Ibid.

with the disease … Poverty does cause AIDS. We are bringing the science to support the power of the nutrient."[161] Given the fact that the Minister of Health has utilized this exact same discourse in defense of her promotion of vitamins over antiretrovirals (*The Star* 2005b), it seems the Foundation has found its public proponent. When asked "why South Africa?," the spokesperson for the Rath organization responded: "Because of the progressive approach of the South African government. They recognize the importance of nutrients."[162]

In addition to sharing a common AIDS denialism, contradictory economic stance, and ideology which promotes 'natural' health options over 'toxic' pharmaceuticals, the Rath Foundation deploys a racial critique that is uncannily similar to Mbeki's:

> "Why did HIV/AIDS, as an item, seize the public imagination and particularly the white imagination (liberal and conservative) … after 1994? AIDS was nothing, in the public consciousness, until the revolution – when the old order had been displaced. So, I have explored AIDS as a manifestation of mass epidemic hysteria. This notion that, lets be frank about this, the thinking is: African people are rife with AIDS … There is a phenomenon of 'othering' in play. I find that very interesting. I have set about flushing out, quite brutally – by that I mean, uncompromisingly – the inarticulate, enduring racist preconceptions that fuels this kind of thinking."[163]

But Anthony Brink, a well-known AIDS dissident who is now employed by the Rath Foundation, does not stop with a critique of the racist and colonialist assumptions that have historically underwritten medical discourses. He suggests that AIDS in South Africa was constructed and turned into a "mass epidemic hysteria" by "white liberals" who needed to find a sense of belonging after the fall of apartheid.

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[161] Interview with Rath Foundation spokesperson held on May 20, 2005 in the Rath Foundation offices in Cape Town.
[162] Ibid.
[163] Interview with Anthony Brink held on May 20, 2005 in the Rath Foundation offices in Cape Town.

> "White liberals lost their voice with the revolution in '94 … Now that they're suddenly bereft of a function, they need something, they need a cause. You know, so AIDS has become a cause … But it's driven by a tremendous residual racism … It's based on a deeply engrained cultural chauvinism … They need HIV and AIDS to have a cause. But also, HIV and AIDS ideology gives them a continuing sense of superiority. A continuing reason to regard the other as a diseased lot."[164]

Therefore, in addition to offering an 'alternative' to antiretrovirals (supposedly backed up by 'science'), in the Rath Foundation, the denialist government has also found ideological support for its political agenda. In fact, most of the critiques put forward by the Rath Foundation were already made by Mbeki in the early years of the transition (Heywood 2004b), so when he withdrew from public debate on HIV/AIDS, the Rath Foundation was there to continue his legacy. I will return to this important point when I discuss the TAC (who is implicitly being targeted in Brink's comment), but it is important to recognize the way in which race functions as an ideological trump in this symbolic struggle over HIV/AIDS.

This is also why traditional healing has been dragged into the denialist game. Because of its connection to an essentialist ideology of indigeneity, traditional healing is bandied about in public sphere discourses on HIV/AIDS. In fact, the government routinely discusses *both* poverty and traditional healing in conjunction with HIV/AIDS. Not only are these "issues" equated in the state's interpellation of Black South African identity and experience, but they are also strategic devices manipulated to avoid discussing public health care and antiretroviral treatment. Just as denialism allows state functionaries to avoid financing public health care, arguments about the "authenticity" of

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[164] Interview with Anthony Brink held on November 16, 2005 in the Rath Foundation offices in Cape Town.

traditional healing allows the state to avoid spending money on antiretroviral drugs. Strategically, the state pits traditional healing against biomedical science, thereby maintaining an ideology of incommensurability that ultimately serves the interests of the post-apartheid, neoliberal state.

Over the last few years, the state has made steps toward incorporating traditional healing into the public health sector, culminating in the adoption of The Traditional Health Practitioners Act, 2004 (RSA 2005) which claims to bring South Africa closer to achieving a holistic health plan which supports *African* notions of health. But mostly, the legislation subjects traditional healing practices to mechanisms of control and surveillance. In fact, the Act has attempted to placate traditional healers by making an important public statement about the state's support for traditional healing while it actually squashes the autonomy of traditional healers by forcing them to serve the current health structure, under the watchful gaze of biomedical science and without remuneration from the state.

The traditional healing legislation was constructed with extremely minimal feedback from traditional healers, and since it was formally passed in early 2005, none of the policies and guidelines it enacted has been implemented. On the subject of the legislation, Dr. Tshabalala told me: "I appreciate the fact that Mbeki supports traditional healing, but I don't see any major changes. If there were changes, then people wouldn't come to traditional healers with already made solutions … with briefcase solutions to our problems."[165] At the request of some of the traditional healers with whom I worked, I sat on a task team formed by the Gauteng Department of Health to strategize around the role

[165] Dr. Tshabalala. Interview held on April 8, 2005 in Orlando East, Soweto.

traditional healers should play in the AIDS pandemic (GTHTT 2005).[166] While the traditional healers were concerned with whether or not they would have a role in implementing the legislation, they wanted to debate its policy implications and have a voice in the professionalization and institutionalization of their profession, the Department of Health was only concerned with providing workshops to traditional healers to explain to them the biomedical definitions of HIV, STIs and TB. In terms of their service to the state, the Department of Health wants them to be part of their home-based care initiative – which provides funding to lay volunteers to provide palliative home-care. In other words, traditional healers' knowledge and expertise on healing is completely disregarded, and they are only considered valuable as HBC volunteers who can help ease the financial and human resource burden on the public health sector.

> "In practice, when policy makers devise plans for the health system, they have mostly ignored traditional healing entirely or else have situated nonmedical healers in a clearly subordinate role. Generally, such plans call for programs to train healers to recognize symptoms of AIDS and illnesses such as tuberculosis, as well as other sexually transmitted diseases, in order to facilitate referrals to biomedical practitioners; they treat traditional healing as a subsidiary activity to Western medicine" (Ashforth 2005: 299).

Some members of the Department of Health are trying to act on the government's mandate to incorporate traditional healing, but they have not been given any directives or a budget, and they have no idea what will happen with the legislation. In fact, the

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[166] The Gauteng Traditional Healer's Task Team is a joint traditional healing and Gauteng Department of Health (DOH) initiative. The Gauteng DOH invited members from different prominent traditional healing associations based in Gauteng Province to meet with representatives of the DOH on a regular basis to attempt to build collaborative initiatives and to respond to the needs of the traditional healing community – in regards to HIV/AIDS, TB and STI's. I was an active member of the Task Team for 6 months, and attended their bi-monthly meetings and met with DOH and traditional healing representatives individually. This provided me an opportunity to observe the relationship between the government and traditional healing in the province in which I was working.

Gauteng Department of Health is quite proactive;[167] however, without any national government support or direction, and with so many complications involved in the process, even those with the best of intentions, are forced to resort to "briefcase solutions." Therefore, both my ethnographic and textual data suggest that the government is content to use traditional healing as an ideological weapon in the symbolic struggle over HIV/AIDS, without making any significant efforts to change the current state of affairs in which traditional healing subsists as a peripheral and informal health care option for poor, Black communities.

In addition to confusing messages issued by the government on traditional healing, indigenous healers face another major problem of national significance. The Traditional Healer's Organisation (THO) has joined forces with the Dr. Rath Foundation. In part, this relationship developed out of a mutual dislike of the TAC. According to the TAC representatives I interviewed as well as Phephsile Maseko (the acting chair of the THO), the TAC and THO held a joint workshop in the fall of 2004 to discuss their positions on treatment and possibilities of collaboration. The THO walked away feeling as though the TAC was patronizing them by using the opportunity to educate traditional healers on the benefits of ARVs without listening to the healers' own concerns.[168] On November 24, 2004, the THO staged a massive rally against the TAC, in which they claimed that TAC only promotes antiretrovirals for HIV/AIDS treatment and that TAC ignores traditional medicines and nutrition. The TAC responded: "The TAC believes that

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[167] Dr. Liz Floyd, Director of the Intersectoral HIV/AIDS Unit, Gauteng Department of Health for example really attempts to promote traditional healing, and the Gauteng Task Team was her own initiative. But she is a rare example within a much broader public health care system.

[168] Phephsile Maseko, acting chair of the THO. Interview held on May 15, 2005 in the THO offices in downtown Johannesburg.

there are traditional medicines that work but proof of their safety and efficacy requires scientific data" (*Equal Treatment* 2004).

When the Dr. Rath Foundation arrived on the scene, it formed an immediate alliance with the THO, united together by a common enemy. And thus the circus began. In 2005, the media could barely keep up with the rallies and counter-rallies, the court cases, the public statements – shooting back and forth between the TAC and the Rath/THO alliance. The TAC sued the Rath Foundation for defamation,[169] and the TAC and the South African Medical Association (SAMA) sued Rath for breaches of the Medicines and Related Substances Act (including the conduct of unauthorized clinical trials and the distribution of untested substances).[170]

Figure 3-4: Zapiro cartoon - TAC vs. Rath Court Case [171]

[169] This court case, between TAC and the Rath Foundation/THO was settled, in TAC's favor in the Cape High Court on 3 March, 2006 (See: TAC 2006).
[170] The TAC and SAMA just won this Cape High Court case on June 13, 2008. On the day of the judgment, the TAC issued a statement claiming: "This judgment unequivocally establishes the duty of the state to enforce the scientific governance of medicines as defined in the … Medicines Act … This judgment is effectively a stern warning to all purveyors of untested and unregistered medicines, especially those selling so-called "cures" for HIV/AIDS" (*Equal Treatment* 2008).
[171] Cartoon by Jonathan Shapiro. *Sunday Independent* 2008a. In this cartoon, Zackie Achmat and Mark Heywood from the TAC sit on the lower left hand corner, and Rath is sitting at the desk with his vitamin cure. Manto, the Minister of Health is outside the court, acting as Rath's *imbongi*, his "praise-singer."

And the Department of Health and the President simply sat back and watched, as the public health policy and ARV roll-out was delayed by all of the bickering.

It is important to note that the THO does not represent the interests or ideologies of traditional healers in South Africa, and its participation in this scandal has certainly done a disservice to the already damaged reputation of the traditional health sector. In fact, in interviews with *both* THO and TAC *members*, it became clear that this was a battle of the leadership. Although masses of traditional healers and HIV-positive community members were bussed to various rallies during this time, neither groups really understood who Rath was or what the issues were. And in fact, several TAC members with whom I spoke left the organization at this time, frustrated that the TAC was so concerned with its own good name and with fighting denialism, that it was becoming distanced from community issues.[172] Similarly, THO members abandoned the organization and joined others in the region.[173]

Although the Department of Health was not 'officially' involved in these scandals, state denialism was still in the public eye, this time in the guise of the Minister of Health, Manto Tshabalala-Msimang, who has become a very controversial figure in South African politics. Since 2002, Mbeki has been reticent in discussing the pandemic at all in any kind of public forum (SAPA 2002; Mbali 2004). It is widely believed that "Manto" (as she is derisively called by civil society organizations) has become the public face of denialism, at Mbeki's bidding. It is not only the Rath scandal, which has exposed the recent denialist tendencies of the South African government. Manto has promoted

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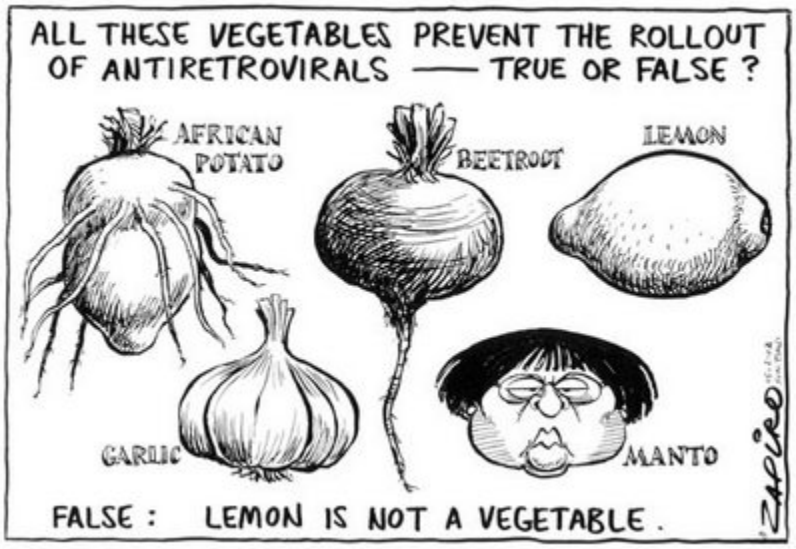
[172] Interviews with Pheello Limapo and Thulani Skhosana. Interview with Pheello held on November 23, 2005 in Lawley 2. Interview with Thulani held on June 11, 2006 in Sol Plaatje.
[173] Anonymous THO leader. Interview held on August 1, 2005 in Johannesburg.

(through a variety of different programs and channels) a health paradigm that highlights the importance of micro-nutrients and a healthy diet and lifestyle. Perhaps the most striking illustration of this point occurred in early 2005, when the Minister of Health stated publicly that garlic, olive oil, beetroot and lemon can delay the onset of AIDS (*Health-E News* 2005).

Figure 3-5: Zapiro cartoon representing Manto's vegetable remedy [174]



The Ministry of Health campaign is at least partially motivated by the government's critique of its own public sector roll-out of antiretrovirals by highlighting first of all the 'toxic' side-effects of the drugs, which Tshabalala-Msimang claims are killing people. "When we were being pressured to use ARVs, we did warn about the side-effects, and when I get reports about the people on ARVs, nobody presents to me how many have fallen off the programme or died because of the side effects … We need this information" (*The Star* 2005b). A second and related issue is a concern with the

[174] Cartoon by Jonathan Shapiro in Zapiro 2007. Originally published in *Sunday Times* 2002.

dangers in taking the treatment without proper nutrition. The Minister of Health recently explained the campaign in the following way:

> "There is this notion that if you haven't treated patients with ARVs (antiretrovirals) then you have not done anything …With a population which has high levels of micronutrient deficiencies caused by food insecurity, as well as health system challenges means adopting a model which focuses exclusively on ARV therapy would not solve the problem" (*South African Press Association* 2006).

Mbeki also clearly shared this concern:

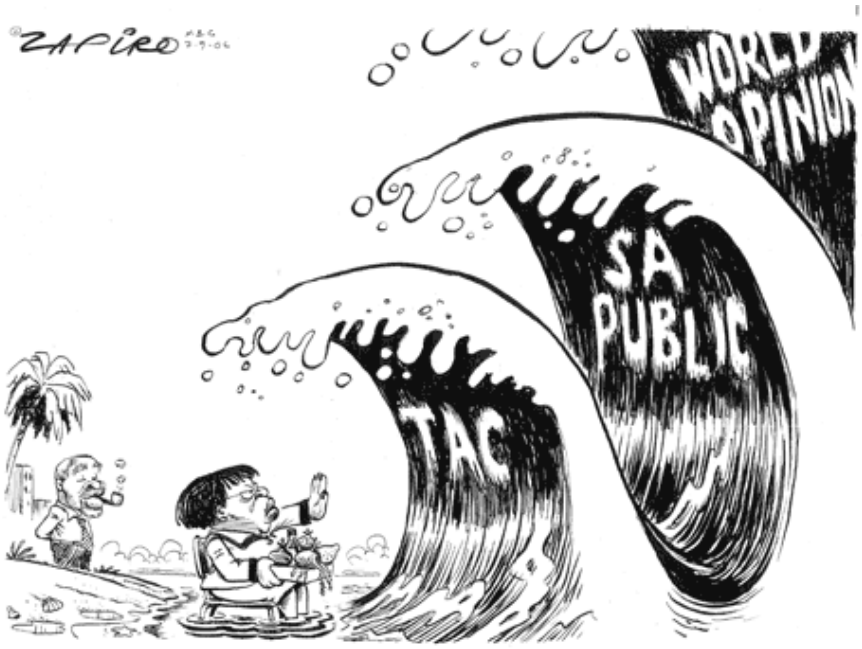
> "You can't say the response to an unhealthy human body is drugs. Your first response is proper feeding. The Minister of Health repeats this thing every day and what do they do, they mock her. It's like she's some crazy person from the moon!" (Mbeki 2004).

In fact, this is a very important intervention in the debates about sustainable treatment strategies in South Africa (a point to which I will return later in my analysis). However, like Mbeki's critiques about Western cultural imperialism, the importance of this policy intervention is undermined by the denialism it cloaks. If the government were simply attempting to ameliorate an already existing antiretroviral treatment program by insisting that it be accompanied by attention to micro-nutrients, sustainable food sources, and access to water, electricity and housing, then Manto's interventions would be a valuable contribution. Instead, it acts as an excuse for failing to provide adequate treatment.

It is worth noting, in brief, that there have been some recent controversies over Manto's status in the Department of Health. In early 2007, there was widespread speculation that the government's position on HIV/AIDS was changing. The Minister of Health received a lot of negative international attention because during the International

AIDS Conference, held in Toronto in August 2006, the South African government's stall, which was designed by Tshabalala-Msimang featured beetroot, lemons and garlic, but not antiretrovirals. "The South African government's position on Aids was denounced as 'wrong, immoral and indefensible' by the United Nation's top official on Aids, Stephen Lewis" (*Mail and Guardian* 2006c).

Figure 3-6: Zapiro cartoon, "Manto against the World" [175]



After this debacle, Tshabalala-Msimang was less visible in the public sphere. Rumors circulated that "Manto [had been] muscled out in a palace coup" (*Sunday Times* 2006), but her absence was actually due to a prolonged illness and hospitalization. The press seemed to imply that Manto's illness was allowing the 'real work' on HIV/AIDS to progress unchallenged.

[175] Cartoon by Jonathan Shapiro in Zapiro 2007. Originally published in *Mail and Guardian* 2006b.

Figure 3-7: Zapiro cartoon on Manto's sick leave [176]

On May 2, 2007, the cabinet approved the National Strategic Plan for HIV/AIDS and STDs "as a strategic framework that will guide the national response to HIV and AIDS over the next five years" (Cabinet 2007). Deputy President Phumzile Mlambo-Ngcuka, Deputy Health Minister Nozizwe Madlala-Routledge and acting Health Minister Jeff Radebe have all been lauded by civil society organizations and the media for taking HIV/AIDS seriously. Last year, several articles in the mainstream press asked: "Is AIDS Denialism Dead?" (*Health-E News* 2007). And then Mbeki broke his silence. On August 8, 2007, Mbeki fired the Deputy Health Minister who had come to enjoy a kind of super star status amongst civil society organizations.

> "[T]he consensus is widespread in South Africa that he fired the wrong minister. And that in so doing he has laid bare the willful ignorance and criminal neglect with which he has responded to a humanitarian crisis of such vast proportions that any half-decent leader anywhere else would not hesitate to flag as his country's overwhelming national priority" (*The Observer* 2007).

[176] Cartoon by Jonathan Shapiro, *Mail and Guardian* 2006d.

Figure 3-8: Zapiro cartoon on Madlala-Routledge [177]

This was the naked baring of state capital, a blatant exercise of symbolic violence. I believe the message is that AIDS denialism is far from dead in post-apartheid South Africa.[178]

> "Symbolic systems owe their distinctive power to the fact that the relations of power expressed through them are manifested only in the misrecognizable form of relations of meaning (displacement) … the labour of dissimulation and transfiguration (*euphemization*) … secures a real transubstantiation of the relations of power by rendering … misrecognizable the violence they objectively contain and thus by transforming them into symbolic power, capable of producing real effects without any apparent expenditure of energy" (Bourdieu 1991: 170).[179]

I would like to suggest that Mbeki's denialism operates as a form of symbolic capital. In promoting an ideology of 'indigeneity' and using race politics to undermine

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[177] Cartoon by Jonathan Shapiro. *Mail and Guardian* 2007d.
[178] In fact, according to a new biography of Mbeki written by Mark Gevisser (2007), evidence from interviews with Mbeki show that he still subscribes to dissident beliefs about HIV/AIDS, and that he "regrets bowing to pressure from his cabinet to 'withdraw from the debate'" (*The Guardian* 2007).
[179] The exact same quote appears in Bourdieu 1979b: 83.

the legitimacy of the TAC and other biomedical proponents, he is attempting to disguise his economic motives behind a kind of 'authenticity' capital. South African citizens (and even the TAC) *misrecognize* Mbeki's attempt to secure neoliberal hegemony, as an irrational critique of biomedicine. And he is so successful, in part, because he borrows from the language of the struggle and voices the real concerns of the people. In this way, he is capable of "talking left" and "walking right" (Bond 2004a).

> "Our understanding of the difference in the manifestation of this challenge in Africa as opposed to the North is that Africa has high levels of poverty and underdevelopment affecting the vast majority of its population. There are serious health system challenges in our continent, including shortage of human resources and inadequate infrastructure. Access to affordable and quality medicines and limited social security support for the poor, who constitute the majority of our populations, remains a challenge. With all these challenges, and the fact that we have significantly higher numbers of people estimated to be living with HIV and AIDS than Europe, adopting a model which focuses exclusively on antiretroviral (ARV) therapy would not solve our problem" (Mbeki 2006).

Overall, the state's contribution to the symbolic struggle over HIV/AIDS is contradictory, but it serves a dual function. First, denialism masks the state's neglect, which has created a surplus population, pushed out of the boundary of sovereign responsibility – a neglect that is required by neoliberal economic restructuring. Second, this discourse allows the state to purchase legitimacy in the eyes of the population and to therefore stave off critique and resistance. In this way, state actors are attempting to gain legitimacy in the public sphere by speaking a language that mimics community ideology but ultimately serves its own political interests.

Figure 3-9: Zapiro cartoon – Playing the Dissident Fiddle [180]

Treatment Activism

"When we started TAC, we didn't think there was going to be this battle of denialism. There were two things in our mind. One was about community mobilization and de-stigmatization and the other was a campaign against profiteering by pharmaceutical companies. We didn't think we were going to have to fight the government every step of the way. And it's been a big waste in many respects, because it takes us away from the real issues. I mean, we're still not on the real issues around ARVs. We shouldn't be having to establish that ARVs are safe and effective. That shouldn't be the national debate. The national debate should be how do we manage the bad parts of ARVs, like the side effects? How do we deal with adherence issues? What do we do to monitor ARVs better? … But instead, we were drug into debates about toxicity and stuff. And so, there hasn't been space for nuance. We've had to take a hard line, and that has its disadvantages."[181]

The dominant representation of AIDS politics circulating in the South African public sphere pits the TAC (and its most nationally recognized member, Zackie Achmat)

[180] Cartoon by Jonathan Shapiro, see *Sunday Times* 2001.
[181] Mark Heywood, Head of AIDS Law Project, and National Treasurer of Treatment Action Campaign. Interview held on November 24, 2005, in Johannesburg ALP Offices

against Mbeki and Manto in a duel for symbolic and political control. As Mark Heywood points out in the quote above, fighting denialism was not anticipated by the original activists that formed the TAC. Instead of battling against international capital and working to repair an unequal and sorely inadequate health infrastructure, the TAC was drug into a *national* battle against its own government. The government's denialism has presented the TAC not only with an extreme obstacle, but has negatively impacted and framed their struggles over the last 10 years.

For example, as an AIDS activist from the United States, I was shocked by the rhetoric employed by the TAC when I first arrived in South Africa. A large part of AIDS activism, in recent years in the US has been aimed at the way in which pharmaceutical companies advertised ARV medication as manageable. Signs and leaflets published by the pharmaceutical industry insist that ARV's make HIV/AIDS a 'manageable disease' and often equate HIV with diseases like asthma. Part of the struggle, in the US anyway, has been to combat this imagery and honestly portray the side-effects of the drugs. As one HIV-positive activist in the US has explained: "Yeah, the drugs are keeping us alive, yeah, this is a manageable disease, but the drugs are just killing you in different ways … You have to make the decision: do you want to keep your viral load down, which is keeping you from getting an opportunistic infection, or, you know, or do you wanna kill your heart and end up dying of a heart attack (chuckling) … It's always a trade-off. Do I do this or do I do that?"[182] Therefore, when I arrived in South Africa in late 2002, I was genuinely surprised to see the TAC advertising ARVs as a cure-all, mentioning in fact,

[182] Interview with HIV-positive US activist. February 2001. This interview was part of a research project I conducted in 2001-2002 (University of Michigan Institutional Review Board #6099 and #6584), which culminated in a journal article which is *forthcoming* in *Sociological Theory*, entitled "The Specter of AIDS: Testimonial Activism in the Aftermath of the Epidemic."

their ability to transform HIV into a manageable illness like asthma. Of course, I quickly understood their strategy – given the denialism with which they were faced, but in retrospect, many TAC activists recognize this down-playing of side-effects as problematic.[183] Dr. Liz Floyd, Director of the Intersectoral AIDS Unit, in the Gauteng Department of Health, recently pointed out three primary failures of the TAC's approach: down-playing the side-effects of the ARV's, ignoring nutrition, and marginalizing traditional healing.[184] I will touch on each of these points as I explore the complicated politics of the TAC's relationship to the government. But first, some background.

During its 10 years of work, the TAC has fought and won tremendous victories in the field of HIV/AIDS prevention and treatment, and has successfully mobilized tens of thousands of community activists to fight for access to health care and treatment of HIV/AIDS. Almost single-handedly, it has managed to radically transform the health system of post-apartheid South Africa and secure low cost treatment for MTCTP (Mother-to-Child-Transmission-Prevention), PEP (Post-Exposure Prophylaxis), and public and private sector roll-out of ARVs.

In addition to acting as a friend of court in a court case between the South African government and the PMA, which was discussed earlier in this chapter, in 1999, TAC launched a MTCTP campaign encouraging the government to provide AZT and Nevirapine to pregnant women. Mbeki's 1999 Parliamentary speech in which he questioned the safety of AZT was a direct response to TAC's campaign (Heywood 2004b). After a long and vigorous struggle on the part of the TAC, in 2001, Parliament's

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[183] Interviews with TAC and ALP leaders in Johannesburg and Cape Town in November 2005.
[184] Interview with Dr. Liz Floyd, Director of the Intersectoral HIV/AIDS Unit, Gauteng Department of Health. Interview held on November 1, 2005 in Gauteng Department of Health Offices.

Joint Monitoring Committee on the Improvement of the Quality of Life and Status of Women ruled that "under South African law, women had a right to treatment and to antiretroviral drugs to reduce the risk of MTCT and HIV infection after rape" (Heywood 2004b) – eventually leading to South Africa's first ARV program, targeted at preventing HIV transmission to newborn infants and victims of sexual assault. In 2000, TAC engaged in a Defiance Campaign, in which Zackie Achmat and other TAC leaders went to Brazil to purchase and then illegally import three ARVs: Zidovudine (AZT), Lamivudine and Nevirapine (TAC 2000). In the same year, TAC threatened Pfizer with a legal battle over patent abuses for its anti-fungal treatment, Fluconazole, used to treat thrush, a common opportunistic infection. Eventually, the company donated the drug, which significantly reduced the price the government paid to provide it free of charge in the public sector.

From 2002-2004, the TAC pursued action against industry abuse of patents through the Competition Commission, essentially suing GlaxoSmithKline (AZT and 3TC) and Boehringher Ingelheim (Nevirapine) and eventually securing seven compulsory licenses issued to generic manufacturers (Heywood 2008). By drastically reducing the cost of ARV treatment and thereby obliterating the last logical rationale the Department of Health had presented to providing ARVs through the public health system, a reluctant government was forced to finally adopt a National Treatment Plan that included a mass-scale roll-out of ARV medication (Department of Health 2003). The TAC has shown the

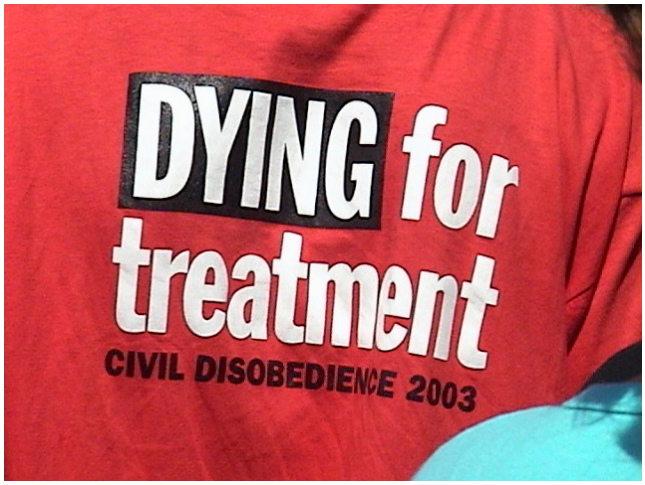
power of civil society to mobilize against not only a denialist government, but the international pharmaceutical industry.[185]

In addition to these triumphs, however, the TAC has also worked extensively to transform the body politic, so that it envelops and represents the needs and interests of people living with HIV/AIDS. It has utilized a variety of strategies to do so: from encouraging public disclosure, through the use of mass mobilization of poor people living with the virus, to their renowned t-shirts, which declare in large purple letters, "HIV positive." They have thus waged, not only legislative battles, but symbolic ones.

Figure 3-10: TAC Civil Disobedience Rally - April 24, 2003 [186]

[185] This history of the struggles of the Treatment Action Campaign has been gleaned from sources available on their website. Please see: TAC 2008.
[186] Photo taken by the author.

Figure 3-11: TAC Civil Disobedience Rally - April 24, 2003 [187]



The TAC is run and operated largely by intellectuals, lawyers, and some prominent HIV-positive activists. Its leadership is mostly drawn from a particular social class in South Africa – the intellectual bourgeoisie. This social class occupies key positions in the media, in academia, and in professional careers. As such, they have the capacity to mobilize tremendous economic and symbolic capital. The TAC has been rather aggressively rebuked by the government and other social movement organizations for maintaining a white leadership[188] while its volunteer and activist base is made up of largely poor, Black HIV-positive community members. In April 2003, Mark Heywood (one of the original TAC leaders, an ALP advocate, and current National Treasurer) was attacked in a public speech by Manto Tshabalala-Msimang who accused him of being a "white man misleading black people in TAC to demonstrate against the government"

[187] Photos taken by the author. The man pictured in the white "HIV Positive" T-Shirt is Zackie Achmat, TAC's long-term National Chairperson.
[188] In fact, the most famous TAC leader, Zackie Achmat, is not white, but is part of the so-called 'Indian' population. Despite the ideal of Black Consciousness, many South Africans do not consider 'Indians' to be Black.

(Heywood 2004a). The TAC was similarly critiqued by the National Association of People with AIDS (NAPWA) who criticized the TAC in an AIDS Consortium General meeting held in March 2004: "we are sick of white people sitting at the front of the meeting; it causes us pain." (Heywood 2004a).

The critique made is that TAC simply uses its grassroots base for legitimacy, while its mission and goals are decided by the vanguard and imposed from above. To its credit, the TAC leadership recognized this disjuncture as problematic. There is, Mark Heywood acknowledges, "a tension between the profile of the leadership and the base" (Friedman and Mottiar 2004: 11). Recently, the TAC has changed its public face (Zackie Achmat was replaced by Nonkosi Khumalo as the National Chairperson), and it has also attempted to incorporate community activists into its leadership at all levels – from the national to the provincial (Heywood 2004b; Jacobs and Johnson 2007). Despite these shifts in its leadership, however, because the TAC's mission is to transform legislation and health care policy, it is still reliant on the skills and experience of the lawyers, doctors, academics and policy-makers that hold key positions in the organization. This class background of TAC's leadership influences its ideological stance on HIV/AIDS, and in fact, makes it impossible for the organization to conceptualize alternatives to biomedical hegemony.

But more than anything else, this allows the government to continue to use race as a means of undermining the TAC's legitimacy.

Figure 3-12: Zapiro cartoon - Race Card [189]

And the TAC has actually facilitated this process in other ways. First, it failed to engage the racial critique inherent in the government's denialist stance.[190] Similarly, Fassin (2007) criticizes the TAC for ignoring the history of scientific racism and for failing to join Mbeki in his critique of the racist and colonialist representations of Black Africans which not only circulate in international AIDS discourses, but which also underpin some Western policy initiatives on the continent. This misstep also contributes to the public image TAC's enemies have promoted of the white liberal TAC acting as pimps of Black community activists (i.e. accusations have been made that the TAC pays its Black members to attend rallies in order to boost their public image).[191] By staying silent on the race critique implicit in Mbeki's denialism and by allowing non-African

[189] Cartoon by Jonathan Shapiro, see Zapiro 2000. Originally published in *Sowetan* 2000. Across from Mbeki sits Tony Leon, the former leader of the Democratic Alliance, the primary opposition party in South Africa, which is considered to be the party that best represents 'white liberals.'
[190] In an interview with Mark Heywood held on November 24, 2005, he admitted to this misstep. However, both he and Edwin Cameron have attempted to engage this critique more seriously since that time. See: Cameron 2005 and Heywood 2004b.
[191] Isaac Skhosana, Gauteng Provincial Chairperson, admitted this was a popular critique he had heard in an interview held on November 9, 2005 in TAC Johannesburg offices. In my interviews with community activists and people living with HIV, I often heard this insinuation.

leaders to be the public face and voice of TAC for so many years, the state has been able to convert the cultural capital of racial identity and 'authenticity' into symbolic capital, wielded to undermine the TAC's public legitimacy and buttress its own popularity with the masses.

But the TAC's complete disavowal of the important role traditional healing plays in Black South Africans' sense of identity and health ideologies plays an equally important role. By eschewing traditional healing, the TAC often alienates the communities hardest hit by the pandemic. The TAC's approach is ideologically embedded in a "stridently secular and scientific cosmology" (Robins 2004: 669 FN34). Because of the need to undermine denialism and to educate the population about its health rights, the TAC has become an almost fanatical advocate of biomedical science. In its efforts to sustain its privileged access to 'objective truth,' Paula Treichler claims that biomedical discourse jettisons *the cultural* "in order to identify and maintain a sense of what is real and universal … At rare moments, however, medicine's narration of the real is interrupted long enough to glimpse other narratives" (Treichler 1999b: 161-162). South Africa's state denialism has served precisely this function. Because biomedical hegemony is so doxicly obvious to TAC members, they are frustrated that denialism has forced them to pander to traditional healing, a health care option they understand to be so intrinsically inferior that conceptualizing a world in which it would hold an equal position with biomedical science in an integrated health system is inconceivable to them. As expressed by Heywood in the quote that opened this section, TAC activists expected to be simply fighting for access to treatment from the pharmaceutical companies, not having to defend the legitimacy of biomedical health care.

> "For the Minister to say, we as a government are not going to prescribe to people and tell them what to do. People have choices. You can have this, you can have that. For me, that's not on. A state has to act rationally and reasonably. We have a constitution that must be abided. The state has to develop its health care policy on the basis of evidence. It has to be evidence based. We couldn't possibly develop an economic policy on the basis of the throwing of the bones. We couldn't do that. We have to monitor what we are putting into peoples' mouths – those *muti* have to be scientifically tested … there's no getting around that. Because there is no equivalence between the systems, so the state can pretend there is when there isn't. It has to be responsible."[192]

Given the fact that the TAC is being delegitimized in the public sphere through the state's creative manipulation of a symbolic capital of 'authenticity,' one would think that the TAC would attempt to garner greater support from the communities they are most dedicated to helping. And they have to some extent. Khayelitsha is a township outside of Cape Town, where TAC's main offices are. Khayelitsha is a strong-hold of TAC's community base. However, this is the only site in the nation where TAC has such a base. And the TAC leadership is aware of this limitation and is attempting to become more nationally grass-roots based, especially now that its primary role will be to monitor the roll-out of ARVs.[193] However, another one of the primary ways in which TAC's approach alienates the communities hardest hit by the pandemic is its inability or unwillingness to directly engage with economic disparity.

The TAC *could* expose the contradiction inherent in the government's position on HIV/AIDS by pointing out that neoliberal economic restructuring has exacerbated South Africans' impoverishment and that while the government recognizes poverty's impact on

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[192] Jonathan Berger, Head of the Law and Treatment Access Unit, AIDS Law Project. Interview held on November 24, 2005 in the Johannesburg ALP Offices.

[193] In interviews with Isaac Skhosana (Gauteng Provincial Chairperson) and Xolani Kunene (Gauteng Provincial Organizer), both discussed the obstacles to implementing this new strategy, especially in the Gauteng region where TAC has very weak community representation. Interviews with Skhosana were conducted on November 9, 2005 and May 18, 2006 in the TAC Johannesburg offices. Interview with Kunene was held on December 12, 2005 in Johannesburg.

the epidemic, it has no intention of addressing it. However, because the government cloaks its economic interests (to avoid financing public health care) in a rhetoric that both critiques Western imperialism and sites poverty and inequality as *causal* factors for infection, the TAC has been cornered out of the rhetorical market on poverty. Because Mbeki has claimed the symbolic copyright on discussions of poverty's role in the pandemic, the TAC – which is supposed to represent those who cannot pay for private health care – has eerily avoided all discussions of the way in which poverty contributes to disease vulnerability and erects obstacles for accessing health care. When asked about this silence in interviews, members of the TAC – from the leadership all the way down – reiterate the same defensive explanation: "We as TAC, really, we need not to lose focus, which is on treatment and not poverty. We will support other organizations' campaigns against poverty, but that is not our mandate."[194] The Department of Health has launched a very public campaign, led by the Minister of Health, on the dangers of taking high dosages of antiretrovirals (which are extremely difficult drug regimes to endure) without proper access to nutrition, clean water, and sustainable development. While these claims are valid and extremely significant, they are used to buttress a denialist position. In their attempt to combat denialism, the TAC has failed to seriously confront the complex obstacles poverty poses to sustainable treatment options.

Because the TAC has taken on significant battles against the post-apartheid government *and* the international pharmaceutical industry, they are often portrayed as leftist, global justice activists. But in fact, the TAC situates its struggle squarely within a

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[194] Isaac Skhosana, Gauteng Provincial Executive Chairperson of the TAC. Interview held on November 9, 2005 in the TAC Johannesburg offices. I heard this exact same response from the national leaders, provincial leaders and grass-roots members of the TAC. It is clearly an ideological stance they have agreed upon and regularly need to reiterate.

nationalist, rights-based paradigm, fighting legislative battles and pushing the government to live up to the ideals promised in the Constitution. "The TAC is not an opposition party seeking to destabilize or bring down the government … It is *their* government and constitution; they are still proud of both" (de Waal 2006: 36-37). The TAC has been hesitant to critique the government's adoption of neoliberalism because that critique is associated with a group of community-based social movements, which the ANC has labeled the "ultra left" and demonized in the South African public sphere.

> "I feel that a lot of the organizations that define themselves as social movements are using the social issues to pursue a political and ideological agenda. So primarily they're jumping on water or electricity to show that the ANC has sold out. Or that capitalism is ... is bankrupt ... but TAC and the TAC leadership don't think that that's the way to go. Not because we think that capitalism is a good system or that capitalism can ... deliver jobs or medicines or quality healthcare services, or whatever. But because we think that in South Africa, and not just in South Africa, in fact, globally, and some people will say we're naïve, but we think there is a space for mobilization and for winning social improvements through democratic, constitutional reform."[195]

In fact, the TAC has vociferously defended its allegiances with the ANC. TAC has insisted on "a political strategy that always preferred collaboration with government rather than conflict." (Heywood 2004b: 19). Zackie Achmat, one of the founders and long-term Chairperson of the TAC, who has become world-renowned for his decision to refuse antiretroviral treatment until it was made available in the public health sector, has consistently insisted in a very public fashion that he is a "loyal, card carrying member of the ANC" (Mbali 2005). In fact, some of the most iconic images that make up the visual landscape of HIV/AIDS politics in South Africa show Achmat and Nelson Mandela with their arms around each other.

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[195] Mark Heywood. Interview held on November 24, 2005 in the Johannesburg ALP offices.

While the TAC has won significant battles for health care and treatment, their reception at the community level is surprisingly ambiguous. In fact, on the ground, antiretrovirals become yet another possible treatment option in a long line of available sources of health care. In the interviews I held with community members, antiretrovirals are understood to be manufactured and produced *by* the TAC.[196] Vitamins, traditional *muti*, micro-nutrients, and antiretrovirals are *all* touted as miracle cures in townships throughout South Africa, so why is the TAC so surprised that there is 'confusion on the ground'? They engage in a similar strategy of 'selling hope' to the masses, and as such, for community members, all treatment options become a matter of *ideological* choice. What the TAC fails to understand is that their unwillingness to engage the issues most relevant to *poor* South Africans is the real reason why antiretrovirals are considered a less viable (or at least equitable) treatment option to Dr. Rath's vitamins. I conducted a series of interviews with people living in Khayelitsha – which is both TAC's community stronghold *and* the site of Rath's so-called 'clinic' – from which his followers dispense the untested vitamins.[197] In these interviews, it was obvious that the symbolic struggles between the two organizations are indeed causing strife and confusion amongst the population. And yet Rath still has legitimacy because his organization has managed to heed the thus-far unanswered needs of poor communities suffering from high rates of HIV infection. I am in no way celebrating Rath's criminal activities in poor communities, but I believe that his presence in South Africa has lay bare and exposed some of the silences and failures lurking beneath the vociferous symbolic struggle

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[196] I conducted a series of interviews with people living in Khayelitsha on Saturday, November 12 and Friday, November 18, 2005.
[197] Interviews held with various Khayelitsha residents on Saturday, November 12 and Friday, November 18, 2005.

between the TAC and the government. On the one hand, the depth and degree of the government's continued devotion to an irrational and immoral denialism has once again been confirmed, and on the other, this scandal has unveiled the extent to which the TAC has thus far failed to respond to the needs of poor HIV-infected populations.

As a result, in many poor communities throughout South Africa, people believe in Rath's vitamins and Manto's "healthy lifestyle" campaign *more* than they believe in antiretovirals because the symbolism used to promote the products recognizes their beliefs and takes their material social conditions into account. This reveals the extremely intelligent "bare life" strategies (Agamben 2005) of the post-apartheid state – it has managed to convince people, whose very lives depend on accessing quality health care in the public sector, to disavow it and instead wait for the government to fulfill their liberation promises and deliver them from poverty. And because the TAC refuses to point out the hypocrisy of this promise and engage in public campaigns explaining the role neoliberal economics has played in this epidemic, people will continue to eschew antiretroviral treatment.

Circumscribing the Body Politic

"… the epidemic represents a crisis for what can be understood as the well-being of the state: HIV/AIDS affects and infects the body politic just as it affects and infects the bodies of individual citizens. Because the HI virus is generally transmitted sexually and can be passed from mother to child, people living with the virus are represented as a threat to the reproduction of the body of the nation itself" (Thomas 2001).

Perhaps ironically, given his own fate, Michel Foucault's ground-breaking theoretical work on the operations of bio-power is an essential epistemological starting point for analyzing the effects the epidemic has had on symbolic struggles over national

identity, the circumscription of the body politic, the ways in which the diseased body functions as a primary stake in disciplinary struggles over the politics and practices of healing, and the processes for inscribing the bodies of those suffering from the disease. In this section, I will draw on Foucault and Agamben's theories of bio-power in order to present an analytic framework for understanding the forms of power aimed at the bodies of HIV-positive South Africans. Overall, I will suggest that because the AIDS body poses a particular ideological and bio-political threat to the fragile, nascent post-colonial state, it has been foreclosed from national incorporation. Those South Africans whose bodies defy disciplinary power are literally inscribed with the sovereign exception and are abandoned to the zone of indistinction at the threshold of South Africa's body politic.

For Foucault, modernity has been defined by a transformation of the state and state power. Although often overdetermined in theory, states have no essence and are only defined by their practices (Gordon 1991). "What is really important for our modernity … is not so much the *étatisation* of society, as the 'governmentalization' of the state" which is what has "permitted the state to survive" (Foucault 1991b: 103). The governmentalization has led to a form of political sovereignty in which the state is now capable of *both* totalizing mechanisms *and* individualizing practices (technologies of the self), which has become the core antinomy of the modern state (Foucault 2000b: 404). As such, the state is only concerned with individuals if they can produce either a negative or positive change in the state's strength. "And sometimes what he has to do for the state is to live, to work, to produce, to consume; and *sometimes what he has to do is to die*" (Foucault 2000b: 409; my emphasis).

> "If genocide is indeed the dream of modern powers, this is not because of a recent return of the ancient right to kill; it is because power is situated and exercised at

> the level of life, the species, the race, and the large-scale phenomena of population" (Foucault 1978/1990: 137).

For Foucault, modernity ushered in a new form of power, *bio-power*. As knowledge about biological processes advanced and so did techniques for controlling famine and disease, new techniques of control and discipline over the body's functioning were brought into the sphere of political techniques (Foucault 1978/1990: 141-142). There are two primary forms of bio-power in operation in modern societies with governmentalized states: anatomo-politics, which is disciplinary in nature and serves to produce docile bodies and bio-politics, which is regulatory in nature and is concerned with subjects as members of a population (1978/1990). Death becomes the limit of bio-power which is exercised against "those who represent … a kind of biological danger to others" (Foucault 1978/1990: 138). Ancient sovereign power was concerned with *taking* life or *letting* live, which was replaced, in modern societies with the power to *foster* life or "*disallow* it to the point of death" (Ibid).

There are a few ambiguities in Foucault's theories on bio-power. First, sometimes thanatopolitics is a form of bio-power, and sometimes it is "its limit." A related vagueness concerns the relationship between bio-power and sovereign power. The bare exercise of the ancient sovereign right to take life has been replaced in modern society, but sometimes Foucault claims that the two can coexist and that contemporary society is characterized by a triangle of government-discipline-sovereignty (1991b:102). However, in other places, he insinuates that their coexistence is "extraordinary," for example when he is describing the Nazi state (1978/1990; 1997; 2000a).

> "We have, then, in Nazi society something that is really quite extraordinary: this is a society which has generalized biopower in an absolute sense, but which has

> also generalized the sovereign right to kill. The two mechanisms – the classic, archaic mechanism that gave the State the right of life and death over its citizens, and the new mechanism organized around discipline and regulation, or in other words, the new mechanism of biopower – coincide exactly" (Foucault 1997: 260).

Agamben (1998; 2003) will claim that this 'extraordinary' coexistence, this exception, becomes the rule in contemporary societies. In fact, Mbembe (2003) and Kistner (2003) also argue that this conflation was common in colonial (and even post-colonial) rule.

In fact, Foucault's explanation of thanatopolitics and bio-power merge in his analysis of race, which he directly links to colonization. "I think that, broadly speaking, racism justifies the death-function in the economy of biopower by appealing to the principle that the death of others makes one biologically stronger insofar as one is a member of a race or a population … So racism is bound up with the workings of a State that is obliged to use race, to exercise its sovereign power" (1997: 258). For Foucault, this form of racism first began in the colonies, which then became a model for the Holocaust. Ann Stoler critiques Foucault for not linking bio-politics and colonial power more explicitly and for failing to consider the relationship between technologies of sex and colonial racism (Stoler 1995 and 2002). Ulrike Kistner critiques *both* Stoler and Foucault for conflating fascism with colonial racism. Because "hegemony was never achieved in the colonial state," both colonial and post-colonial states "have different versions of bio-politics to contend with" (Kistner 2003: 144). I will return to this issue after I have summarized Agamben's contribution to the debate.

A final critique I would like to make of Foucault's theory concerns the fact that although he studied the mad, the criminal, the homosexual, the sick, his theories never accounted for bodies that *cannot be* disciplined. He notes that biological risks like

famines and epidemics have not ceased to exist, despite our greater knowledge, but they represent "thresholds of modernity." "It is not that life has been totally integrated into techniques that govern and administer it; it constantly escapes them" (1978/1990: 143). However, because Foucault was concerned with emphasizing the totalizing way in which the state and various institutions of power/knowledge served to invade all bodily integrity, he did not allow for the impossibility of corporeal discipline. He does insinuate (1978/1990) that even when the body is 'out of control,' it is still the *target* of a power/knowledge nexus. I think this is another ambiguity upon which Agamben seizes because it illustrates the ways in which *hominess sacri* represents a kind of interiorized exclusion. I would like to suggest that "thresholds of modernity" represents moments *when the body escapes all attempts to discipline and control it*. Those who are dispensable and expendable are banned to the zone of indistinction *because* their bodies and subjectivities cannot be disciplined. They are still the target of bio-power (in the form of thanatopolitics) and are thus still interior to the *nation* but exist within "zones of abandonment" (Biehl 2001 and 2005) at the threshold of the body politic.

Unlike Foucault, Agamben analyzes the *intersection* of sovereign power and bio-power. He argues that sovereignty is founded on the 'state of exception,' when 'bare life' is incorporated into the political order. As the politicization of bare life increases, the state of exception becomes the rule, and sovereign and bio-power become indistinguishable. Because bare life is politicized, it is internal to the political order, while simultaneously being excluded through the exception (1998: 18). "In truth, the state of exception is neither external nor internal to the juridical order, and the problem of defining it concerns precisely a threshold, or a zone of indifference, where inside and

outside do not exclude each other but rather blur with each other" (2003: 23). This zone of indistinction is the boundary between fact and law. "[T]ransgression seems to precede and determine the lawful case … In this sense, the exception is the originary form of law" (1998: 26). *Homo sacer* (who can be killed without punishment but cannot be sacrificed) is banned – he does not exactly sit outside of law, nor is he indifferent to it, but he is *abandoned by it* (1998: 28). "*The originary relation of law to life is not application but Abandonment*" (1998: 29; emphasis in original).

There is an important slippage between the referents of *homo sacer*, indicating that there may be two forms of bio-power in operation in Agamben's theories. The first encompasses Foucault's own definition of bio-power, which is a composite of three forms of power: anatamo-politics (of the body) = disciplinary power; bio-politics (of the population) = regulation and governmentality; and technologies of the self. Bare life is based on the Aristotelian notion of *zoē* (natural life), and was originally characterized as everything *excluded* from political life. For Agamben (as for Foucault), in modernity, more and more aspects of bare life (sexuality and reproduction, healthiness, food consumption) are politicized, which leads to an inclusion of the excluded. Therefore, the scope of bio-power increases exponentially, and impacts all of those in the social body (the People).

The second form of bio-power targets *homo sacer* (the people), those who are excluded from the body politic (the poor, the sick, the criminal, and especially racial others). *Homo sacer* lives in a zone of indistinction, at the threshold of the juridical order. He does not enjoy the rights of citizenship, but is also outside of the law.

However, he is included in the juridical order because its very existence is premised on the exclusion, on the exception.

> "It is as if what we call 'people' were in reality not a unitary subject but a dialectical oscillation between two opposite poles: on the one hand, the set of the People as a whole political body, and on the other, the subset of people as a fragmentary multiplicity of needy and excluded bodies; or again, on the one hand, an inclusion that claims to be total, and on the other, an exclusion that is clearly hopeless; at one extreme, the total state of integrated and sovereign citizens, and at the other, the preserve – court of miracles or camp – of the wretched, the oppressed, and the defeated. In this sense, a single and compact referent for the term 'people' simply does not exist anywhere … 'people' is a polar concept that indicates a double movement and a complex relation between two extremes … bare life (people) and political existence (People), exclusion and inclusion, *zoē* and *bios*. The 'people' thus always already carries the *fundamental biopolitical fracture within itself*" (1998: 177-78; my emphasis).

In advanced capitalism, sovereign power is defined by the decision. "Here the decision is not the expression of the will of a subject hierarchically superior to all others, but rather represents the inscription within the body of the *nomos* of the exteriority that animates it and gives it meaning (1998: 26). But not the decision to institute the exception (which has become de facto – law and fact are indistinguishable), the decision made on the value of life – to decide whose life is "unworthy of being lived." The decision to move from bio-politics to thanatopolitics. In this way, the concentration camp becomes the political paradigm of modernity because it is the materialization of the state of exception (1998: 174).

In early modern societies, when a state of exception was instituted and rights were temporarily suspended (Schmitt 1922/1985), the threshold between *homo sacer* and those inside of the body politic was drawn along the lines of citizenship. Under advanced capitalism, more and more actors are imbued with sovereign power – not just heads of state or politicians, but also doctors, priests, prison guards, the police, scientists, etc.

Sovereignty is decentralized. In addition, thresholds of the body politic are multiplied and the line between those whose lives are worthy of being lived and those who are dispensable are drawn along many more axes than citizenship. So it is not simply foreigners or traitors who are 'banned' to the life of *homo sacer*, but it is also those whose bodies are undisiplinable in a variety of ways. *Homo sacers* are the included exclusion because they are those against whom sovereign power acts, but also because they are born into the state (they *are* citizens). The dividing line between those inside the juridical order (the body politic) and those who are excluded becomes fragmented, so that zones of indistinction proliferate and are scattered throughout the social space. "If there is a line in every modern state marking the point at which the decision on life becomes a decision on death, and biopolitics can turn into thanatopolitics, this line no longer appears today as a stable border dividing two clearly distinct zones. This line is now in motion and gradually moving into areas other than that of political life …" (Agamben 1998: 122).

For Foucault, sovereignty is to let live or make die, and bio-power is to make live or let die. According to Agamben, in advanced modernity, to make or to let die are indistinguishable, and so too, then are sovereign power and bio-power. Foucault would characterize the actions of the state in a concentration camp or during a military occupation as brute sovereign power – the naked and exposed exercise of state power. However, this project would force us to ask whether the state is exercising its power differently when it denies the sick and the poor health care, medication, water, and housing? Isn't this still sovereign thanatopolitics?

> "And in a different yet analogous way, today's democratico-capitalist project of eliminating the poor classes through development not only reproduces within

> itself the people that is excluded but also transforms the entire population of the Third World into bare life" (Agamben 1998: 180).

There are a variety of pertinent critiques to be made of Agamben's reformulation of Foucualt's theories of bio-power, many of which I will attempt to correct as I apply them to post-apartheid South Africa. First, it is too blanketed and abstract; it requires empirical application (Comaroff 2007: 208-209). Second, sovereignty, bio-politics and governmentality are not indistinguishable. They still operate as a set of power relations, sometimes in concert with one another and sometimes not. For Foucault, sovereignty and bio-power are distinct, and Agamben collapses the two. But not all bio-power is sovereign (as Agamben seems to imply), and sovereign power can be bio-political, but not always. Bio-power can still be regulatory, governmental or thanatopolitical, and it is *not* always imposed from above. There is a play of interaction between the state, global capital and civil society. Although Agamben allows for a decentralization of sovereignty, he still overdetermines the sovereign state. Achille Mbembe makes an important theoretical intervention on this point:

> "The claim to ultimate or final authority in a particular political space is not easily made. Instead, a patchwork of overlapping and incomplete rights to rule emerges, inextricably superimposed and tangled, in which different de facto juridical instances are geographically interwoven and plural allegiances, asymmetrical suzerainties and enclaves abound. In this *heteronymous organization of territorial rights and claims* it makes little sense to insist on distinctions between 'internal' and 'external' political realms, separated by clearly demarcated boundaries" (Mbembe 2003: 31-32; my emphasis).

Although Mbembe is describing the colonial world, the post-colonial political space is also heteronymously organized. Third, states still exercise juridical control. According to Malcolm Bull, by suggesting that states are always 'in exception,' Agamben disavows

normalized state violence, which can be exercised not only non-juridically but juridically (2004). Bull also notes that while states have not relinquished their monopoly on violence, the 'exception' is a *site of struggle*, or at least a product of it.

> "Agamben gives little indication that *the state of exception is usually only one side of a social confrontation*, or that, rather than creating a void in the law, the exception is often made in an attempt to close a space opened up by someone else … it is not the state of exception itself that carries the power of real life so much as the crisis with which it attempts to deal, or the crisis that it provokes" (Bull 2004: 6; my emphasis).

The ability to revise existing norms (through legal or social frameworks) is essential to state-making because reformation allows state power to be renewed (Bull 2004). Both Bull and Jean Comaroff (2007) insist that Agamben's disavowal of "constituent power"[198] is misplaced (see Agamben 2003: 34-36). Constituent power can *use* the law, and is therefore not extra-juridical (Bull), and can also be biopolitical (Comaroff). Bare life is not the only entity against which sovereign power acts. It still engages in governmentality and because of this and because sovereignty is decentralized, it is a site of struggle and resistance. Finally, and this is a point to which I will return in the next chapter, agency becomes completely impossible within Agamben's zone of indistinction. However, Comaroff points out that exclusion also leads to the production of new political subjectivities (2007: 211).

Several theorists have suggested that the squatter camps of the Third World are the spaces of exception under a neoliberal world order (Biehl 2001 and 2005; See also Scheper-Huges and Bourgois 2004; Inda 2005). I will argue that in order to protect the "nation's biological body" (Agamben 1998: 142) from moral, economic and physical

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[198] On 'constituent power', see Negri 1999 and Hardt and Negri 2000.

contagion – from undisciplinarity, those in South Africa's informal settlements have become the target of thanatopolitics. "[S]overeignty means the capacity to define who matters and who does not, who is *disposable* and who is not" (Mbembe 2003: 27). The government relegates those who are dispensable, those who fail to "produce, work and consume" (Foucault 2000b) and who represent a "biological danger to others" (Foucault 1978/1990) to "zones of abandonment" (Biehl 2001 and 2005), on the outskirts of the city, on the margins of the body politic.

> "The colonial world is a world cut in two … The zone where the natives live … is a place of ill fame, people by men of evil repute. They are born there, it matters little where or how; they die there, it matters not where, nor how. It is a world without spaciousness; men live there on top of each other … The native town is a hungry town, starved of bread, of meat, of shoes, of coal, of light. The native town is a crouching village, a town on its knees, a town wallowing in the mire" (Fanon 1963: 38-39; also quoted in Mbembe 2003: 26-27).

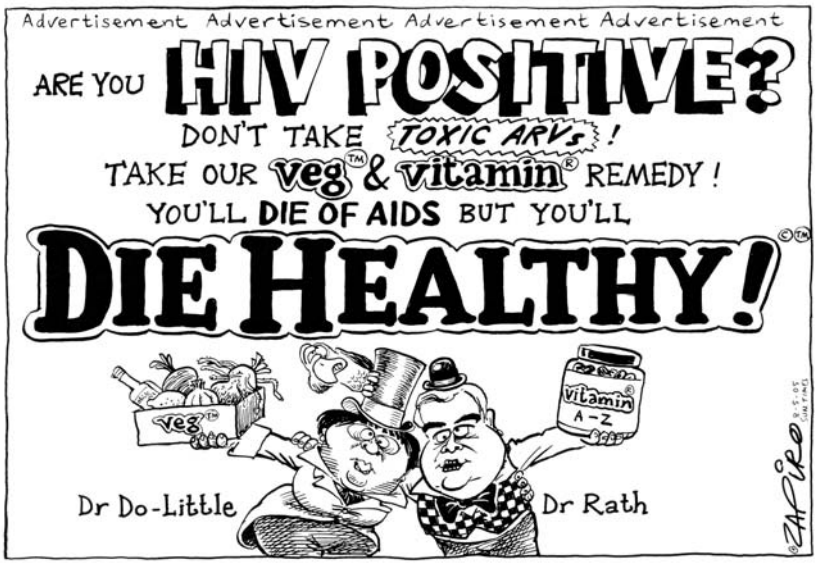
Fanon might as well be describing South Africa's *contemporary* squatter camps – where there is no water, no electricity, no sanitation services, no health care, no proper housing … and no hope.

In the rest of this chapter, I will show *how* the state shifted its bio-political strategies after the National Treatment Plan was passed and ARVs were now available in the public sector.

Figure 3-13: Zapiro Cartoon on National Treatment Plan [199]

The state denialists speak through Manto and Rath, in order to continue to vocalize a discourse that encourages distrust of ARVs so that people who now have access will continue to eschew treatment.

Figure 3-14: Zapiro cartoon: Manto and Rath's Veg and Vitamin Remedy [200]



[199] Cartoon by Jonathan Shapiro, originally published in *Mail and Guardian* 2003.
[200] Cartoon by Jonathan Shapiro, originally published in *Sunday Times* 2005.

But it also maintains and strengthens an economic system that undermines effective treatment and healing which further plunges the disposable in abject poverty. In addition, they have also passed certain public policies that force the poor to choose between health and economic sustainability, damning them to death one way or the other. This shows that the state's thanatopolitics is enacted through *both* juridical and extra-juridical strategies.

And for those who are not yet considered disposable, for those who can still (if only barely) access their rights of citizenship, both the state and certain non-state actors save their strategies of governmentality and discipline – investing their livelihoods and bodies in complex systems of control and regulation until their habitus becomes self-governing and docile. Biomedical health plays an important role in this anatomo- and bio-political scheme. Through the use of a complex system of rules and regulations about treatment regimens, hygiene, hospital and clinic protocols, etc. and by insisting on single-course treatment, biomedical science attempts to reconfigure the habituses of the poor, as a condition for access to 'public' health care.

Do-It-Yourself

"Iketsetseng means 'do it yourself,' it means self-reliance – not begging and not depending on anyone else to do it for you. People in South Africa suffer from a dependency syndrome, all the time thinking that other people should do things for them … It started under apartheid, this syndrome, but even in post-apartheid, people are finding it hard to change their mentality."[201]

"Vukuzenzele means 'wake up and do it yourself.' People waited for the government to deliver, and the government did not. Now, it's a wake-up call. Now, stand up and do it yourself because no one will ever do it for you."[202]

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[201] Pheello Limapo. Interview held on December 8, 2005 in Lawley 2.
[202] Thulani Skhosana. Interview held on June 11, 2006 in Sol Plaatje.

"We need to start owning our programmes and move towards self-reliance … We need to strengthen the spirit of volunteerism amongst our communities" (Tshabala-Msimang, Minister of Health, 2003).

The ideologies of "self-reliance" and "do-it-yourself" are foundational to both neoliberal economics and grass-roots social movements. As Mike Davis points out in a recent book on neoliberal housing policy (2006), the "intellectual marriage" of these strange bedfellows was clinched in the 1970s when the then World Bank president Robert McNamara and a former English anarchist, John Turner, collaborated to construct a World Bank policy on urban poverty. This policy incorporates many now commonplace factors of neoliberal restructuring, including: privatization, the termination of welfare state responsibility, and the introduction of "micro-entrepreneurial solutions" in order to "enable" the poor (71). "Community-orientated discourses, however, can also take a markedly self-help, entrepreneurial flavour which emphasizes the importance of self-reliance as an alternative to dependence on government spending" (Barchiesi 2005). Every other small (and oftentimes radicalized) community-based group in South Africa is called "Iketsetseng" or "Vukuzenzele," both of which mean "do-it-yourself."[203] Self-sustainability has become the most-often reiterated maxim for those who have become thanatopolitical targets of neoliberal restructuring. Whether or not this is an anarchist revolution or simply an expression of successful ideological interpellation (an interesting question that is beyond the scope of this project), the pervasiveness of this discourse reflects a reconfiguration of power.

Because neoliberal economics requires the dismantling of the welfare state and the privatization of the public sphere, newly emerging democratic states facing economic

[203] 'Iketsetseng' is Sotho, and 'vukuzenzele' is Zulu.

crises *and* vast legacies of economic inequality were disallowed from implementing social democratic reforms. "Any hint of return to the Keynesianism that had for so long saved capitalism from its own excesses would have betrayed the ideals of the new personal responsibility and independence from the state so valorized by the neoconservatives" (Somers 2005: 258). The individualization of blame for the spread of HIV (popularized and hegemonized by the international AIDS industry) parallels an individualization that underpins neoliberal market logic, which serves to shift the obligation of economic welfare from the shoulders of the state to its citizens – their ability to survive now rests solely on their capacity to embody entrepreneurial tactics and engage in aggressive competition over scarce, commodified resources. According to Bourdieu, neoliberalism insists on a "radical separation … between the economic and the social" (1998:31). The social is rejected, therefore, and replaced with an atomistic fiction of individuals guided only by conscious choice in a 'free' market. "The return to the individual is also what makes it possible to 'blame the victim,' who is entirely responsible for his or her own misfortune, and to preach the gospel of self-help, all of this being justified by the endlessly repeated need to reduce costs for companies" (Bourdieu 1998: 7). And governments.

Ironically, Peggy Somers (2005) notes that World Bank neoliberal policymakers and economists have engaged in an epistemological imperialism by co-opting Bourdieu's concept of 'social capital' in order to transform civil society into a market economy. Bourdieu's use of 'capital' does reflect a certain kind of economic determinism. Although capital takes multiple forms, it is *capital* in the sense that when invested or put to use, the agent (in whom it is endowed) is able to mobilize resources and accrue (or

maintain) legitimacy. Often investment does eventually lead to economic profit (as in the case of symbolic capital). However, Bourdieu went to great lengths to avoid theorizing capital and investment in a utilitarian fashion. Agents, in his theoretical model, are not consciously and rationally calculating their individual investments, and interest is not measured by an abstract "aggregate of individual agential intentionalities" (Somers 2005: 242). "[T]he concept of interest as I construe it has nothing in common with the naturalistic, transhistorical, and universal interest of utilitarian theory … Far from being an anthropological invariant, interest is *historically arbitrary*, a historical construction that can be known only through historical analysis, *ex post*, through empirical observation …" (Wacquant 1989: 41-42; emphasis in original).

Bourdieu's concept of *social* capital is compatible with utilitarianism only when it is divorced from his macro-theoretical framework. For Bourdieu, one doesn't simply *own* social capital, but one is also equally *possessed* by it (Somers 2005: 246). And it is through this extraction of social capital from its embedded relationship to habitus that allows neoliberal policymakers to re-appropriate the term to forward their own agenda (Ibid). The World Bank defines social capital as: "a set of horizontal associations between people, consisting of social networks and associated norms that have an effect on community productivity and well-being. Social networks can *increase productivity by reducing the costs of doing business*" (World Bank 2008; quoted in Somers 2005: 239; my emphasis). According to Somers, the conceptual tool of 'social capital' provided neoliberal policymakers with a community-based discourse to veil its market-driven objectives. By employing the term to describe its policies, the risks of the market were displaced onto families and communities (261-262), making the poor bear the heavy

burden of not only the abject indigency the policies sustained but also the fault for its persistence. In this way, "[t]he terrain of citizenship has been reconstituted as a form of capital" (235).

President Thabo Mbeki declared 2002 the Year of the Volunteer for reconstruction and development, an eerie reminiscence of the "Volunteer Week" instigated in 1987 by one of the primary leaders of neoliberal ideology, Ronald Reagan. This is only one example of the way in which the South African post-apartheid state has eagerly deployed not only neoliberal economic restructuring, but the ideologies that buttress and sustain it. These ideologies are absolutely essential for the continued legitimacy of a regime which gained power by espousing social democratic ideals and whose economic policies make addressing rampant racial and economic inequality impossible. In its discourse, the state has begun to use terms like "self-reliance" and "individual responsibility" in order to abdicate its responsibilities towards the poor, and privatize and commodify life itself.

Because the HIV/AIDS pandemic poses perhaps the most striking threat to the legitimacy of the post-apartheid state, health care is one of the primary sites for the deployment of neoliberal ideology. Recently, the Department of Health has launched a new media campaign asking citizens to 'take responsibility for their own health care' in an effort to outsource its responsibility for the provision of resources to civil society. The state's home-based care strategy, which provides extremely minimal resources to women who essentially 'volunteer' to provide basic palliative care to victims of the HIV pandemic, is a perfect example of the neoliberal approach to health care. The government sees this as an "investment in social cohesion" (Cullinan 2000). Through

home-based care, the government insists, "disease may become normalized within society, expensive institutionalized care is avoided, and social networks are maintained and even strengthened" (Ibid). Traditional healers are also part of this social response to the disease.

> "Community-based care is the care that the consumer can access nearest to home, which encourages participation by people, responds to the needs of people, encourages traditional community life and creates responsibilities … Care in the community must become care by the community" (*National Guideline on Home-Based Care and Community-Based Care*: ANC 2001).
>
> "Home and community based care is a very important component of our response to HIV and AIDS, TB and other debilitating conditions … it is geared towards community empowerment. It takes a holistic approach to the challenge of diseases related to poverty that is affecting our people and takes into account the cultural beliefs and values of individuals … HIV and AIDS as well as TB … [have placed] a heavy burden on our formal health care and social security system. Hospitals are seeing increased bed occupancy rate and average length of stay putting additional pressure on our human and other resources. Partly as a result of all these factors, Cabinet prioritised home and community based care and support as a key intervention to mitigate the impact of HIV, AIDS and TB" (Tshabalala-Msimang 2003).

The way in which the government borrows and co-opts community-based values of care (i.e. *ubuntu*), operates in a similar fashion to the World Bank's appropriation of 'social capital,' because it takes advantage of community ideals in order to justify its outsourcing of care *and* to gain the community's consent for it. And the government also encourages its citizens to move away from its dangerous and anti-nation-building "dependency syndrome." As such, the Department of Health encourages communities to form support groups, develop community gardens, and practice home-based care because, it argues, health care should be everyone's responsibility. NGOs help to disseminate this ideology. On numerous occasions I have heard NGO staff members

complain that: "people do not want to help themselves because they think the government owes them something."[204]

And this supposed "culture of non-payment" is precisely the justification provided for the post-apartheid state's privatization of basic services. The government's role has shifted from directly delivering services to "enabling" service delivery through increased privatization, the construction of ideologies of "self-reliance," allowing market forces to determine access, and commodifying life itself (water, electricity, air, and health care). Beginning in 2003, Johannesburg Water, a para-statal organization, was created by the South African government to implement the wide-scale corporatization of water delivery in the city. Johannesburg was the first national target, and Phiri, a township in Soweto, became the site of the flagship project entitled Operation Gcina 'Manzi (Operation 'Save Water'). Up until recently, the government provided residents with 6,000L of water each month. Depending on family size, this lasts between 1-2 weeks. When this water runs out, the resident must purchase a pre-paid water card at a local shop and then either punch the number or insert the card into pre-paid meter installed in every resident's home. Actually, the City of Johannesburg very recently announced that it will no longer provide *any* free water. "The city has withdrawn the provision of 6 free kilolitres of water, meaning that the poor will now have to fork out [the additional] R15 a month for the 6 kilolitres" (*The Star* 2008).

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[204] "Tebogho." [NGO staff.] Interview held on October 19, 2005 in White City, Soweto.

Figure 3-15: Electricity Sold Here [205]

Figure 3-16: Pre-paid water meter [206]

Electricity has been similarly privatized (the para-statal is called Eskom).

The ideology used to promote the pre-paid system was 'water conservation.' Poor people were told that they wasted water, and that these systems would allow them to become better consumers and to utilize water in an environmentally responsible fashion. "The prepaid system was sold to residents as the only means by which they would be able to fix their leaking pipes and/or to get flush toilets, and as a necessary means of encouraging residents to 'budget properly' and to 'make efficient use' of water" (APF 2006). As a result, poor township residents are having to use the same water to wash themselves, their clothes, their houses, water their gardens, etc.

Even though there has been large-scale resistance to the installation of these meters (especially staged by the Phiri Concerned Residents, which is one of the many

[205] Photo taken by Andy Clarno
[206] Photo taken by Andy Clarno

community organizations represented by the Anti-Privatisation Form),[207] some residents have begun to not only accept pre-paid technology as inevitable, but to adopt their accompanying ideologies of 'conservation' (von Schnitzler 2006). As such, not only has pre-paid technology transformed citizens' practices of water consumption and conservation, and thus reconfigured their bodily hexis, but the prevailing "neoliberal governmentality" has also been incorporated into subjects' habituses (Ibid).

Biomedical Citizenship

"The political economy of AIDS, spanning both national and international institutions, creates an environment within which individuals and local AIDS organizations are codependent and simultaneously recraft positions and possibilities with each exchange. Their transactions are legitimated by a humanitarian and pharmaceutical discourse of life saving and civic empowerment. In adhering to a regimen of life-extending drugs and making new and productive lives for themselves, patients are – in this discourse – saved. *However, merely guaranteeing existence in such dire contexts, amid the dismantling of institutions of care, involves a constant calculus that goes well beyond number of pills and the timing of their intake*. Even as they search for employment, patients work hard to remain eligible for whatever the state's paternalistic politics have made available – renewal of disability benefits, free bus vouchers, and additional medication at local health posts, to name a few …" (Biehl 2006: 459; my emphasis).

During the 2003 court case the TAC launched against two major pharmaceutical corporations for patent abuse, the TAC gained international support and admiration from global justice activists who situate their own struggles within an anti-neoliberal framework. However, the TAC was criticized for the way in which the court case was settled – the two pharmaceutical companies granted voluntary licenses to South Africa, allowing them to produce or import generic medications. Global justice activists

[207] "The Johannesburg High Court today ruled that the City of Johannesburg's practice of forcibly installing prepayment water meters in Phiri, Soweto is unconstitutional" (Centre for Applied Legal Study 2008). This court case presents a victory for activists who have resisted the installation of pre-paid water meters. The city is now no longer able to coerce residents into accepting pre-paid technology, but they will continue to pressure them in the ways mentioned above.

believed that the implementation of compulsory licensing would have better served the global struggle against international capital and better provided for *all* countries in the global south struggling against the pandemic.

> "While encouraging to those concerned with closing the access gap, these voluntary arrangements have thus far only involved one or two South African generic manufacturers and have been limited to a handful of antiretrovirals. Thus their impact is limited to a single disease (HIV/AIDS) in a single country (South Africa), and because they permit a limited number of generic manufacturers they appear likely to reduce prices as much as open competition between generics would" (Love 2005).

The TAC responded by stating that it was never their intention to fight capitalism – it was simply trying to secure low-cost treatment for its own population.[208]

In his work on Brazil, which underwent a similar global justice struggle and subsequent bargain with the WTO, the US government, and several pharmaceutical companies, João Biehl argues that these new social movements actually forged *both* a new relationship to the state *and* a reconfiguration of neoliberal policy on health care. "These committed AIDS professionals and activists were well aware of how to maximize equity within the neoliberalizing state. The AIDS initiative is thus seen as a kind of tool of new democratic politics and ethics" (Biehl 2004: 111). South African biomedical activists couched their struggle in two paradigms. First, they attempted to *use* neoliberalism against the international industry and the developmental state – in the end fortifying neoliberal hegemony.

> "You can't reverse globalization. You can't, as an economic or a social process. So therefore the question of social movements that are anti-capitalist is how do we check the excesses, how do we try to make sure that there's a global

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[208] Interview with Fatima Hassan – AIDS Law Project. November 14, 2005. Held in ALP offices in Cape Town.

> movement of poor people that constructs agendas that turn this irreversible process to the advantage of ... of the people who are being cut out of it."[209]

And so, instead of fighting against the neoliberal order, the TAC has attempted to "exploit its incoherences … finding productive footholds within the aporias of the market system" (Comaroff 2007: 214). This is different than being "in the pockets of Big Pharma," which is a commonly reiterated critique made by the Rath Foundation (and Mbeki), and it is more honest than the denialist strategy of speaking the language of the poor while abiding by the most anti-poor neoliberal development policies available.

Second, the TAC deployed a politics of human rights, but did so in a way that never alienated the state, but rather incorporated its constitution and ideological framework thereby constituting a "new epistemic community within the state" (Biehl 2004: 108).

> "[The TAC] has shifted the debate firmly to one of fundamental human rights and utilized the human rights machinery established by the same government to force its hand on the ARV issue" (Heywood 2008).

> "The struggle of TAC is, in the first and the last instance, a struggle about our *constitutional rights to life* … Why do we say life? Life because without medicine, and also of course according to the Minister of Health, without food, people die … So life is the first thing to think about" (Achmat 2004: 76).

Ulrike Kistner has argued (utilizing Agamben's theories) that in utilizing a human rights paradigm, the TAC deploys its own bio-political strategy, thereby unveiling the bare, naked sovereign power which has served to turn all citizens into 'bare life' (2003: 156-157). Comaroff has critiqued Kistner's formulation of the TAC's struggles and claims that they are, instead, a form of 'constituent power.' I think the problem is the

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[209] Mark Heywood. Interview held on November 24, 2005 in the ALP offices in Johannesburg.

unquestioning use of Agamben's somewhat totalizing paradigm. While the TAC certainly engages in some 'bare life' strategies, it also utilizes governmental and regulatory strategies. While many of its members are the target of thanatopolitical power (coming from various different sources), the TAC attempts to bring all of the poor into the body politic and subject them to governmental and disciplinary forms of power.

Of course, Foucault was the first to point out the role that biomedical science played in processes of governmentality (1973/1994; 1978/1990). Biomedical science amplified its scope of control by classifying risk behaviors, codifying 'healthiness,' disseminating knowledge about disease transmission, capitalizing on treatments, gathering statistics on infection and mortality, etc. Definitions needed to be made, so that crises could be contained within the comforting and rational logic of science. In addition, however, the micro-technologies of the self needed to be bolstered, and emphasis was thus placed on the atomized individual.

Biehl notes that the reconfiguration of the state and neoliberal health policy that global health activists enacted was accompanied by the rise of "biomedical citizenship" (Biehl 2004 and 2006). In order to implement wide-scale treatment delivery within an ailing and bifurcated health system that was being further undermined by cuts in social spending, *pharmaceutical* care was individualized and new demarcations of inclusion and exclusion were being drawn. "These new mechanisms of governance mediate the emergence of selective forms of biomedical citizenship" (Biehl 2004: 114). Therefore, access to treatment and care, as well as certain supplementary rewards of citizenship, are only available to those who are willing to submit to the governmental logics of health care. Just to survive, patients must adopt certain survival discourses, adhere to

disciplinary bodily practices defined and policed by a wide range of health care professionals, and they must also constantly calculate the costs they must be willing to pay in order to adhere to these difficult health regimens. "To get that to which they are legally entitled, these individuals must not only identify themselves as belonging to the class of those served but also constantly seek out services. To retain services, furthermore, they must behave in certain ways" (Biehl 2006: 472).

In post-apartheid South Africa, the TAC plays a key role in promoting and regulating this 'biomedical citizenship.' First, it advocates a certain discourse of 'positive living,' which means, at least as a first step, publicly disclosing one's status. In this way, as Biehl notes, people identify themselves as a population that needs servicing. "In these contexts, claiming positive identity can be tantamount to a conversion experience: quite literally, a path to salvation, since identification can being access to medication and material support" (Comaroff 2007: 204). But this 'salvation' has ideological strings attached. One has to adopt the wholly rigid and totalizing ontology and bodily hexis prescribed by biomedical healing. Only when people have converted to their cosmology, will biomedical science dole out its life-saving treatment and care. Steven Robins explains that "TAC members have been unambiguously 'converted' to biomedicine" (2004: 668). In a somewhat celebratory and uncritical fashion, he also notes that "conversion rituals" are a primary way in which TAC reaches out to isolated HIV-positive South Africans and provides them with a means of joining an activist community (if they are willing to convert to the biomedical cosmology for 'sale'), which also serves to create a body of "responsibilised citizens" (Robins 2006: 321). And, the new neoliberal order the TAC activists have played a role in creating (by striking a

powerful bargain and subsequent alliance with the pharmaceutical industry), also serves to economize the social. ARVs are the real salvation, according to the TAC, but given their expense (both in terms of drug price and human resource cost), they are only available to the worthy and the wholly converted. And yet another aspect of 'bare life' is commodified.

> "[A] crucial feature of AIDS activism – at least in the global south – is that it focuses ever more overtly on 'biocapital' … For healing is increasingly vested not merely in corporate bioscience but in the drugs as ur-community … Drugs have come to embody ever more succinctly the means of life itself: the means to control qualities of body and mind and hence to subject them to the terms of the market … The independent hold of biotechnology and the pharma-industrial complex over significant dimensions of the life process makes them consequential forces in the operation of sovereignty in our world" (Comaroff 2007: 213).

Thanatopolitics

"Modern democracy does not abolish sacred life but rather shatters it and disseminates it into every individual body, making it into what is at stake in political conflict" (Agamben 1998: 124).

Nicoli Nattrass (2003) compares the management of AIDS in South Africa with warfare triage, where resources are first allocated to those who have a good chance of recovery. The dividing line between thanatopolitics and bio-politics is the decision on the exception – the decision between those whose lives are still worthy of state incorporation and those who can be abandoned to social exclusion and subsequent death. These decisions are often made on the basis of productivity. "*The ones incapable of living up to the new requirements of market competitiveness and profitability are socially included through their dying in abandonment*" (Biehl 2001: 139; emphasis in original). And, in fact, decisions on the ability of HIV-positive patients to successfully meet the

requirements of biomedical citizenship plays a role in this "moral economy of triage" (Nattrass 2003).

The state, the market and science actually merge together in the making of this decision on 'bare life.' "[T]here is a contradiction between a generalized culture of human rights and emergent exclusive structures through which these rights are realized, biologically speaking, but only on a selective basis … In this context, 'letting die' is a political action, continuous with the biomedical and political power that 'makes live'" (Biehl 2001: 137-138). Biomedical proponents and TAC in particular are actually attempting to fight against the thanatopolitics of the state. The power biomedical proponents exercise is more regulatory and disciplinary; however, those excluded from biomedical citizenship ultimately meet the fate of thanatopolitics. In this unanticipated and unintentional way, biomedical activists and health care workers are still engaged in making that sovereign decision separating those who are worthy of living from those who are banned. Because sovereignty is decentralized and the other side of biomedical citizenship is thanatopolitical, both state and civil society constantly make the sovereign decision on the exception. And this decision is ultimately a stake in the symbolic struggle, and so to, then, is sovereignty.

> "The overall rationale at work here is the following: specialized health care is provided to those who dare to identify themselves as AIDS cases in an early stage of infection at a public institution and who autonomously search (they literally have to fight for their place in the overcrowded services) for continuous treatment – those whom I call biomedical citizens. As the country's pharmaceutical policy successfully controls the mortality of some, letting die remains an active capacity of the local state, medical profession, and communities" (Biehl 2004: 120).

Despite this ambiguity, it is the denialist state that has decided that there should be a line between those worthy of life and those banished to the zone of indistinction, and it carries out its deadly work through two primary strategies.

First, it utilizes the 'do-it-yourself' ideology in order to manifest an insidious process of 'letting die.' The state not only outsources its health care through the ideology of 'self-reliance,' it also actively undermines ARV treatment by attempting to convince people that vitamins, nutritious food, and a "healthy lifestyle" are the salvation for AIDS.

> "We introduced the Healthy Lifestyle campaign that promotes regular physical activity and encourages people to avoid health risks … To deal with the broader problem of the poor nutritional status of our population, we introduced interventions that encourage intake of necessary micronutrients …. Vitamins and minerals are now added to staple foods like maize meal and wheat flour and communities are encouraged to produce and eat fruits and vegetables. These interventions are aimed at strengthening the body's ability to fight infections and maintain good health for a longer period" (*ANC Today*, "Understanding South Africa's Approach to AIDS." See: Mbeki 2006).

The state has managed to convince poor HIV-infected South Africans who now have access to ARV treatment which could extend and improve their lives, to rely instead on immune boosters, vitamins, and nutritious food (which they cannot even access in informal settlements). This is the true baring of "necropower" (Mbembe 2003). I also believe that this policy of non-intervention, which can only lead to death, is often utilized in order to convince people to accept their status as *hominess sacri*. The state also deploys the language of 'positive living.' For the TAC, this is related to disclosure and a biomedical health regimen. But for the state, 'healthy living' is simply having a positive outlook on life and believing in the body's 'natural' capacity to fight infection, with the right micronutrient support. And many of the people with whom I worked believed in this state-sponsored ideology:

> "Positive living should be encouraged more than ARVs. Yes, there are cases that they will need ARV's, but it shouldn't take priority over everything else – over proper nutrition and living positively over exercise."[210]
>
> "People need to think positively or else nothing will work. If you have the wrong mentality, then your body will simply give up. I think the most important thing for better health is a positive attitude."[211]
>
> "If you think positively and eat right – you can get better."[212]
>
> "I haven't used ARV's. For me, I believe in positive living. Because what's the use of taking a tablet, when you are going through stress and denial. Start with positive living. Start with loving yourself more, and taking care of yourself. You'll see. Without ART's, you'll cope. I've been HIV+ for 8 years now. I haven't used ARVs; I use positive living and thinking. Whatever stresses me, I talk about it … Because I believe that HIV needs you to think positively, and offload, ventilate. If something hurts you, talk about it. And eat healthy, and you'll live longer. A lot of people who live longer never used ARVs. I know someone who's been HIV+ for 20 years, and has never used them. I'd rather use these garlics and these gingers, then using tablets."[213]
>
> "I don't need ARVs, and I don't believe in them. I've seen a lot of friends who died while using them. I have 5 friends who are on ARVs now. They come to me and say, 'aish, this is hard.' You know we used to be a team, and we wanted to prove to people we could do it without drugs. But they got scared because their CD4 count dropped below 100 and they thought they were dying. So, they went on the ARVs. But you know what? Your CD4 count can drop and then go back up. This is why you need to understand the disease. You need to understand all the cells in your body. It's not only ARVs that can help you. *You can help yourself*."[214]

In addition to this "healthy lifestyle" campaign, the state has shifted its thanatopolitical strategies since the introduction of the National Treatment Plan. It has implemented several policies that coerce people to make a maniacal choice about the instrument of their own death. People living with HIV are eligible for a disability

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[210] "Thandi." [NGO staff]. Interview held on April 15, 2005 in Soweto.
[211] Thulani Skhosana. Interview held on May 20, 2006 in Sol Plaatje.
[212] Anonymous HIV-positive community member, Phiri. Interview held on May 26, 2006 in Phiri, Soweto.
[213] "Nhlanhla." [NGO staff]. Interview held on October 19, 2005 in Soweto.
[214] Anonymous HIV-positive community member, Zola. Interview held on September 12, 2005 in Zola, Soweto.

grant[215] if their CD4 count is under 200. Since the National Treatment Plan was passed in 2004, antiretrovirals are now available in the public sector free of charge. When a person begins taking antiretrovirals and her immune system is strengthened, her CD4 count will rise. When this happens, she is no longer eligible for continued social assistance and the government will cancel her disability grant. This exact situation occurred for one of my respondents, Pheello. Pheello's disability grant was the only income he earned, in order to support himself and his HIV-positive wife and daughter. Pheello decided to continue taking his medication, and since then, his disability grant has been cut.[216] He was forced to choose between economic survival (for both himself and his family) and life-saving medication.[217] This is one of the reasons why HIV-positive South Africans are turning down the opportunity to take antiretrovirals.

> "There's this one person I know who is HIV+, and who was supposed to go and collect his medication. Because his disability grant was cancelled, he cannot afford the transport money to go and get the medication. I don't see the difference between low and high CD4 count. The government is just tricking people. They give the grant to people who are just 5 minutes from dying. They only give you a grant if you are about to die. This is [the government's] plan to kill people instead of supporting them."[218]

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[215] The South African Department of Social Development provides a series of social welfare grants (pensions, child dependency, disability, etc.) to which poor South Africans can apply. The process is complicated, convoluted and biased, and there are a variety of bureaucratic measures in place to minimize the number of people able to access the very negligible monthly stipends. The grants are dismally inadequate to cover families' costs of living (the highest grant available only amounts to R780 per month = $130).

[216] Field notes, June 2006, Lawley 2.

[217] According to a female participant in the FGD held on October 20, 2005 in Lawley 2, the disability grant was not initially linked to a person's CD4 count. She had applied and received a grant, which was then cut not because her CD4 count went up, but because it was still too high to be eligible under the new cut-off point. This provides evidence to support my argument that the post-apartheid state changed their policies after the National Treatment Plan was passed.

[218] Female participant in FGD held on June 10, 2006 in Sol Plaatje.

Figure 3-17: Zapiro cartoon - Mbeki and the AIDS Crisis [219]

Those whose bodies bear the marks of having been on the "wrong side of history" (Fassin 2007) and who are still undermining the post-apartheid, liberatory, imaginary, are the ones most likely to be the target of thanatopolitics. Certain people are banished from the "field of visibility" (Biehl 2005: 41), and it is only when one visits the squatter camps that the "moral economy" (Nattrass 2003) of the South African body politic is rendered visible. But despite its inscrutability, this is "socially authorized death" (Biehl 2001: 134). Those who reap the benefits of biomedical science's promise to 'make live' and those who are completely untouched by AIDS (or believe themselves to be), sanction the abandonment of those who bear the mark of *homo sacer*. And in fact, the citizenship

[219] Cartoon by Jonathan Shapiro, originally published in *Sowetan* 2004.

rights of those who are considered worthy of state incorporation consent to and profit from this circumscription of the body politic.

Conclusion

"On the one hand, the nation-states become greatly concerned with natural life, discriminating within it between a so-to-speak authentic life and a life lacking every political value … On the other hand, the very rights of man that once made sense as the presupposition of the rights of the citizen are progressively separated from and used outside the context of citizenship, for the sake of the supposed representation and protection of a bare life that is more and more driven to the margins of the nation-states, ultimately to be recodified into a new national identity" (Agamben 1998: 132-33).

The politics of HIV/AIDS in South Africa is often represented as a boxing match between the government and the Treatment Action Campaign. Imagine Manto Tshabalala-Msimang in one corner, with Mbeki silently coaching her from the wings, and traditional healers ululating in order to encourage the ancestors to intervene in her favor in the ring. In the other corner, we have Zackie Achmat, who is joined by some trade union activists and more left-leaning ANC politicians. But the biggest supporters in the TAC corner are the proponents of biomedical science because TAC activists and their biomedical allies believe wholeheartedly that with the adoption of a stridently scientific health cosmology, HIV/AIDS will finally be brought under control in South Africa. While this dichotomous boxing match fails to capture the real complexity of struggles and actors engaged in the macro-politics of HIV/AIDS and health care more generally in post-apartheid South Africa, the image I have just painted quite accurately captures the dominant (and even hegemonic) representation of AIDS politics circulating in the South African public sphere. However, the communities most impacted by the disease are

nowhere to be seen. While they are certainly used as pawns of political warfare, they have no voice or presence in the symbolic struggle taking place in the public sphere.

Given the cataclysmic socio-economic and health conditions in post-apartheid South Africa, it is no surprise that discussions of poverty's relationship to epidemiology, access to health services, sustainability of certain courses of treatment, and the viability of prevention methods figure prominently in policy and legislative debates about efficient and successful prevention and treatment interventions. However, this paper argues that "poverty" is often used simply as an important rhetorical device in the symbolic struggle for state power and legitimacy, and that most often, the needs and interests of the people these discourses interpellate and exploit are marginalized and ignored. The discursive attention obscures an inability or refusal to attend to the material realities of poverty and disease. More than anything else, I was told by HIV-positive community members that they felt abandoned by *both* the state and civil society.

The existence of a large number of people living with HIV/AIDS undermine the post-apartheid state's attempts to actualize the promises of liberation and forge a new national imagination. There is, therefore, no space for the AIDS body in the imagination of the "new" South Africa. AIDS has become the focus of state power for precisely this reason – the pandemic threatens to expose the terms and conditions of exclusion by painting the boundaries of sovereignty in stark relief. People living with HIV/AIDS are occluded from the national imagination. In a way, the poor are always outside of citizenship, and the only way they are able to purchase sovereignty is to accept the new material constraints imposed by the state and adopt the state's corporeal inscription. However, in the case of South Africa, the state has abandoned those living with AIDS,

condemning them to a life (and death) outside the body politic. According to one of my respondents, Thulani Skhosana: "We are not good business according to the government. The poor in this new South Africa, they don't have a space … The statistics of people infected in poor communities is ripe – also where I live. Not giving HIV+ people health care is one strategy that the government uses to get rid of the poor. We are a stress to the government, and they don't want to deal with us."[220]

Figure 3-18: Graffiti in Orange Farm [221]

[220] Thulani Skhosana. Interview held on June 5, 2006 in downtown Johannesburg.
[221] Orange Farm is an informal settlement near Lawley 2. This photo was taken by Andy Clarno.

Chapter 4

Ancestors and AntiRetrovirals:

The Politics and Practices of Healing

"In the complex interweaving of pasts, oppressions, identities and the ambivalent intermingling of institutions associated with modernity and those associated with custom, we begin to see a mercurial disease within the social web of understandings … [and] … the multiple ways in which individuals may associate themselves with both [indigenous] … medicine and bio-medicine" (Henderson 2005: 42).

"Ellen" is a traditional healer, and she also owns and operates a *shebeen*, or tavern, from her home – making her both a business and community leader in Alexandra, a township located in the heart of Johannesburg. Both Ellen and her husband are HIV-positive. Ellen's husband has a full-time job which provides him and his entire family with comprehensive private health care – which is a very rare privilege in African townships. Following the advice of his doctor, Ellen's husband began anti-retroviral treatment during the time that I was conducting in-depth interviews with her. She was very wary of the course of therapy he had chosen to follow – especially when he began refusing Ellen's traditional herbal remedies because his doctor had told him they would interfere with his drug regimen. She informed me that she surreptitiously infused his tea with *muti*. Then, at the urging of her husband, she also visited the doctor he was seeing. She had her blood work examined to find out her viral load and CD4 count, and the doctor suggested she begin anti-retroviral treatment as well. She was very conflicted, and

she was scared. Ellen had always trusted in her own herbal remedies, but the doctor had told her that her CD4 count was low enough, that he would strongly encourage her to start ART.[222] She called me to get my advice, she spoke with her husband, she consulted her colleagues, and she communicated with her ancestors. In the end, she did begin triple cocktail therapy which she took in conjunction with her own traditional remedies. When I asked her what finally made her decide to mix the two kinds of methods, she said that she had spoken with her ancestors and that they had guided her toward this hybrid approach. "In an ideal world, everyone would take both kinds of treatment."[223]

"Tebogho" works as a project manager for a respected NGO where I conducted ten months of participant observation research.[224] Tebogho earns her living by trying to convince HIV-infected people in her township to follow the regimens prescribed by their doctors and health care professionals, including promoting the use of anti-retroviral medication. Due to the relatively middle-class lifestyle her NGO job affords her, Tebogho often parrots common Western ideologies about "traditionalism," equating traditional healing with ruralism, backwardness, and lack of education. However, I realized after some time that she was engaging in what Homi Bhabha might refer to as performative mockery (Bhabha 1994). Because of my own identity, Tebogho was

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[222] Antiretroviral Therapy. In South Africa, people with a CD4 count of 200 are encouraged to begin ART; and in fact, patients using ARVs in the public sector are not allowed to begin before then. The U.S. government's Department of Health and Human Services HIV Treatment Guidelines recommends that people begin HIV treatment if people are suffering from a serious OI (opportunistic infection), or *before* the T-cell count falls below 350 (DHHS 2008). A CD4 count (or t-cell count) measures the number of white blood cells per mL of blood. A healthy person has between 800-1,600 T-cells.

[223] "Ellen." Female Traditional Healer. Interviews held on April 22, August 8, and September 29, 2005 in Alexandra, Johannesburg. This quote is taken from an interview held on August 8th, 2005.

[224] I volunteered with this organization from December 1, 2004 – September 30, 2005. In order to protect the identity of my informants, I will not provide the name of the NGO. I worked most extensively with support groups in Zola, Dobsonville and Orlando East, Soweto. 'Tebogho' was my guide and closest research informant during this field work.

performing her 'Western-ness' and therefore proving her ability to do her job well; however, as time progressed and we got to know each other better, I came to find out that she refuses to take anti-retrovirals herself. She believes, instead, in 'positive living.' She told me that she exercises, she eats right, and she has a healthy lifestyle. "This is the best medicine for me. Those drugs have so many side-effects and sometimes they don't even work. I don't need them. I'd rather stick with natural remedies and *muti* than put all those toxins into my system."[225]

Figure 4-1: Pheello and Elizabeth [226]

Pheello was diagnosed with HIV in 2003, but believes he has been HIV-positive since at least 1994. His wife and baby are also HIV-positive. From the time I first met Pheello, he was a strong advocate of biomedical treatment and rejected traditional healing completely. "I believe that traditional healing is part of our culture. I do believe that. I'm just not convinced that traditional healers can deal with HIV/AIDS, especially at the

[225] I conducted interviews with 'Tebogho' on April 6 and October 19, 2005; however, she would never talk about herself during an official interview. She told me this in the car, during one of our many trips to and from support groups in the Soweto area. Field notes, February 2, 2005, Soweto.
[226] Photo taken by the author

present moment. They've got no knowledge of this disease… it's a problem." [227] Instead, Pheello is a firm believer in the power of anti-retroviral therapy.

This photograph of Pheello and his wife, Elizabeth, is taken in their home in Lawley 2. The wallpaper they have chosen consists of posters from the TAC's Defiance Campaign, in which the TAC engaged in a radical media and activist campaign that captured the world's imagination and eventually led to the public sector roll-out of ARVs. Biomedical health care is *the* signifier Pheello and Elizabeth have chosen to epitomize their deepest beliefs.

Pheello expended a great deal of his energy and resources trying to get onto the ART program. It took six months and a near-death health emergency to get a referral to one of the roll-out sites, in which he finally enrolled. But he was unable to get his wife or baby onto the ART program because neither of them are South African citizens. Pheello was very sick, and in and out of the hospital for most of the time that I knew him, but his wife and child remained quite healthy. Suddenly, however, they both became quite ill and Pheello's wife almost died. After a harrowing few months when Pheello's every bit of energy and money was spent visiting them both in the hospital every day, they all returned home. His wife's CD4 count was 10. When I next saw him, he pulled me aside and whispered, "Claire, remember how I told you I don't trust traditional healers? Well, I'm using them now." When I asked him why, he said: "Because I need help, and I don't know what else to do."[228]

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[227] Pheello Limapo. Interview held on October 5, 2005 in Lawley 2.
[228] Field notes, May 17, 2006 in Lawley 2.

Three years ago, Thulani fell ill and told no one.

Figure 4-2: Thulani Skhosana [229]

He hid his sickness as long as he could, but his HIV status was disclosed to his community by a lengthy hospitalization. After two terrifying months in the hospital, he returned home to find he had lost his job and his wife. He has not worked in three years. In the fall of 2005 (while I was conducting research in Sol Plaatje), a rash began to develop on Thulani's hands, feet and face. He visited his local *sangoma* to determine the cause of the infection and was then prescribed a traditional unguent which he rubbed into his skin every day. However, he also spent the money, time and energy to travel to the closest clinic, wait in line all day, and visit the doctor. He walked away with antibiotics, aspirin, and vitamin supplements dispensed by the Department of Health.[230] To treat this one rash, Thulani combined no less than three varieties of treatment: bio-medical,

[229] Photo taken by the author.
[230] Field notes, September 16, 2005 in Sol Plaatje.

traditional, and the intermediary therapy proffered by the government. Thulani stores all of the numerous remedies he has received and taken over the last three years in a box. In it, an entire cornucopia of treatments lie side by side: natural herbs and roots, bio-medical prescriptions, spiritual amulets and candles, aspirins, several miracle cures, immune boosters, and the government-endorsed vitamins. Thulani's medicine chest is a material incarnation of the hybrid nature of South Africans' healing regimens and ideologies.

Figure 4-3: Hybrid Habitus

This picture perfectly symbolizes the complexities of the hybrid habitus I am arguing has emerged in post-apartheid South Africa. It portrays a traditional healer who is wearing a t-shirt made famous by the TAC – a group which was able to win a treatment campaign against a denialist government because of their devotion to biomedical doxa – a devotion which required the wholesale denigration of traditional healing. And yet, this *sangoma* is subverting TAC's zealous conviction in the myth of incommensurability. This picture reveals the way in which peoples' practices undermine the binaries constructed and maintained within the broader field of health and healing.

The case studies provided above are just a few examples of the hybridity which has come to mark the landscape of healing politics and practices in post-apartheid South Africa. Several nurses at the Chris Hani Baragwanath Hospital commented on the various ways in which patients continue to use indigenous healing during their hospitalizations – from the surreptitious usage of *muti* to boldly inviting their *sangomas* to conduct rituals at their bedsides.[231] At the very apex of the Rath scandal, Khayelitsha – the site where the Rath Foundation set up its clinic, most likely because it is also a strong-hold of the TAC – was a virtual war zone between the two camps. However, many of the community members with whom I spoke were using both Rath's vitamins *and* anti-retrovirals. And when I asked them about this, they seemed nonchalant, as if it only made sense to try them both.[232] Traditional healers often discuss the way in which current Black leaders and doctors have betrayed their culture by "passing over to the side of Western medicine."[233] According to many traditional healers, Black government officials, business owners, legislators, etc. disavow traditional healing and attempt to suppress its influence in an effort to thrive in the new 'modern' South Africa. While this is understood to be the worst kind of betrayal, these very same Black elite "secretly come knocking on our doors at night to get treated."[234] Therefore, what seems from the outside like incommensurable paradigms of the body is custom in most townships in South Africa, and people traverse these multi-vocal and discordant ideologies for a wide range of purposes.

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[231] Female Nurses in the Maternity Ward, Critical Care Wards, and HIV Clinics conducted in May 2006 at the Chris Hani Baragwanath Hospital in Soweto.
[232] Khayelitsha residents. Interviews held on November 12 and November 18, 2005 in Mandela Park, Cape Town.
[233] Anonymous Female Sangoma. Interview held on April 20, 2005 in Mapetla Extension, Soweto.
[234] Anonymous Male Sangoma. Interview held on April 13, 2005 in Diepkloof Extension, Soweto.

This bring me to the most important research question this project addresses: given the vociferous reiteration of the myth of incommensurability, the unequal distribution of capital in the field, and the fact that traditional healing and biomedical science promote contradictory ontologies of the body, why do most Black South Africans utilize *both* traditional healing and biomedical science simultaneously and without experiencing any radical sense of incongruity?

The health itineraries and community-based health initiatives of HIV-infected community members reveal South Africans' ability to navigate a fractured (and often contradictory) field of health services and ideologies, suggesting that certain post-apartheid subjects have incorporated a *hybrid* habitus. But given the fact that this hybridity reflects a profound disjuncture between the discourses circulating in the public sphere and peoples' lived realities, this hybrid habitus is in *hysteresis*. In these two ways, peoples' habituses are surprising, given the layout and structure of the field of health and healing in post-apartheid South Africa.

Incorporating Incommensurability

"In spite of the development of 'White' medical services for Africans, the African belief in the 'isangoma,' witchdoctors, is increasing" (*The Star* 1964).

It has been estimated that, with over 300,000 traditional healers, the indigenous health sector in South Africa has fifteen times more health practitioners than the biomedical sector (Liddell et al. 2005). Therefore, accessibility is certainly one explanatory factor for the continued popularity of indigenous health care. However, the demographics of indigenous health care usage are unexpected. Part of the assumption under which international and national health policy operates is that there are class,

geographic, and access differentials in peoples' health-seeking behaviors. Under this assumption, one would expect residents of informal settlements (who are most likely to be migrants from rural areas, represent the lowest economic strata of society, and be most isolated from public health care facilities) would utilize indigenous healing more than residents of formal townships. The selection of research sites for this project allowed for the investigation of the validity of this assumption. The study found that residents living in formal townships, who had immediate access to public health care and even anti-retroviral medication, were from a more working- or middle-class background and who were second- or third-generation Sowetans were *more* likely to utilize indigenous healing (in addition to other healing options).[235] "Traditional healers are themselves distributed throughout South African society and at all economic levels, so it is not possible to generalise about the economic or social status of their clientele" (Thornton 2002b).

Informants in both Sol Plaatje and Lawley 2 – the two informal settlements where I conducted research – tended to harbor a profound distrust for indigenous healers, despite their prevalence in the regions.

> "We do have a lot of them. Lawley is their kingdom, but I, for one, don't trust them and never use their services."[236]

> "Sangomas cannot tell you how long you have been sick what your status is, and this is what you must do, and so on. Sangomas mostly they lie, they say you have been poisoned, and others will say your ancestors are punishing you. So, they don't have a straight answer when it comes to HIV/AIDS."[237]

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[235] Tebogho and Ellen's cases show us that despite the common assumption that traditional healing is associated with poverty, class status is not a true indicator of peoples' proclivity for traditional healing methods.
[236] Female participant in FGD held on October 20, 2005 in Lawley 2.
[237] Female participant in FGD held on June 10, 2006 in Sol Plaatje.

In a survey conducted in 2006 in Sol Plaatje, it was found that only 12.5% of the respondents surveyed ranked traditional health care an "effective strategy for fighting HIV/AIDS" (APF 2006: 28). However, it is also estimated that on average, between 70 – 80% of the South African population utilizes indigenous health care (van der Linde 1997; Campbell 1998; Department of Health 2003). So what accounts for this unexpected trend in urban squatter camps?

Informal settlements are characterized by a lack of social cohesion. Whereas residents of formal townships have lived together for several generations and have built up a sense of community, informal settlement residents are an amalgamation of migrants, people who were forcibly removed from other communities (through evictions), and people who have lost their families and economic support systems. In this way, squatter communities are extremely unstable, and residents often compete over the same very scarce resources. Although community members often build social movements or form CBOs, these tend to create cliques rather than bring the whole community together. Strife between differently-aligned political factions is quite common. There are four primary effects of this divisiveness that helps to explain the lack of trust squatters exhibit toward traditional healers. First, charlatans of all shades have a tendency to feed off the most desperate – this makes shanty towns their primary target.

> "These impostors … they target the people who are really, really vulnerable. You won't find these signs advertising 'cures' in the wealthier areas of town. The people who use this kind of 'treatment,' I think are low class, or who are, you know … desperate."[238]

[238] Thulani Skhosana. Interview held on September 30, 2005 in Sol Plaatje.

> "You cannot find charlatans everywhere – they target the places where they see people need health care, and where they see people who are desperate. They target those people – mostly the poor."[239]

But in fact, some shanty town residents were more likely to try the random remedies packaged and sold by a million different "fly-by-night" dealers, than use traditional healers. These various tonics and mixtures include 'immune boosters,' miracle vitamins, and hundreds of mysterious powders and liquid remedies which claim they can treat everything from asthma and low blood pressure, to impotency and, as always, HIV. At one of the Iketsetseng Support Group meetings I attended in Lawley, a representative from a random organization touting a powder formula as an effective treatment for HIV/AIDS was given space to sell her product.[240] In addition to the sales representative, there were two women who served as witnesses, testifying to the formula's potency and miracle qualities: "Before I took this treatment, I was wasting away, and now look at me! I've gained 20 pounds, I have so much energy, and I've never felt better!" On the bottle, it claims to be an 'herbal cure for AIDS.' But then it also lists the following:

Diabetes
TB
Kidneys
Arthritis
Back Pain
Boosts Erection
Flu
Joints and Inflammation
Period Pains
High Blood
Ulcers
Digestion

[239] Male participant in FGD held on October 14, 2005 in Sol Plaatje.
[240] This occurred in a support group meeting held on Thursday, September 15, 2005 in Lawley 2.

Dizziness
Purifies Blood
Sore Bones
Eyes
Ears
Kills Worms
Gives Appetite
Rheumatic
Diarrhea
Sweating

I expected Pheello to tell these people to stop exploiting the support group members, but instead, he tried the treatment and then forked over the R80 for the 'first bottle.' As per usual, the remedy is packaged as one of a series of treatments which get progressively stronger. In order to buy the whole package, one would need R240 – this is an incredible amount of money for people who are *lucky* to earn a R500-R700 grant to support their entire family for a month. When I asked Pheello why he tried this product, when he was such an adamant believer in biomedical treatment, he shrugged and said with a bit of embarrassment, "well, it couldn't hurt."

In addition to being the primary target for miracle cures, informal settlements are characterized by so much distrust and desperation, accusations of witchcraft abound. Ashforth (2005) argues that economic and social instability leads to "spiritual insecurity," which can sometimes take the form of obsessive fears of the supernatural and outright terror of those who supposedly wield occult powers. As already mentioned in Chapter 2, it is quite common to confuse traditional healers and those who practice witchcraft.

> "People have norms that traditional healers are associated with wrongdoings. That's why there might be stigmas of traditional healers. But also, some people don't want to use them because they will then be accused of bewitching their neighbor."[241]

[241] Thulani Skhosana. Interview held on September 30, 2005 in Sol Plaatje.

> "Sangomas will tell you that you are sick because your neighbor is using some *muti* to bewitch you, so they are misleading people."[242]

More than anything else, there are no regulatory mechanisms for ensuring the quality and legitimacy of traditional healers who work in informal settlements. In formal townships, organizations of traditional healers have developed to precisely protect the profession against charlatans and *igedla*. But further, people *know* each other. They know family histories, they know their local *inyanga*, they know when a particular *sangoma* received his/her calling and probably attended his/her graduation. In informal settlements, people cannot rely on history or reputation. And because there are no regulatory institutions, impostors, fronting as traditional healers, would fare far better in an informal settlement than in a formal township.

> "I think that there are some sangomas who are only doing business. Those who will judge you according to the way you dress. If you wear expensive shoes, then you will pay R1,500 to get cured."[243]

> "We respect the fact that in other communities, they are standing up and helping the community as best they can. In Lawley, they don't do that. They still haven't come out to the community to let us know what they know about HIV and how they might be able to help. They also don't seem to have any training on the disease at all – and traditional healers in other communities maybe do … In their own respective practice, we believe they are not taught in a right way. I say this because when a new sangoma graduates, sometimes we go to that graduation. During the ceremony, we are supposed to hide something that they will find, through their communication with the ancestors. But they battle to find that hidden object, and sometimes they fail completely. This is why we say they are under-trained."[244]

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[242] Female participant in FGD held on October 20, 2005 in Lawley 2.
[243] Female participant in FGD held on June 10, 2006 in Sol Plaatje.
[244] Pheello Limapo. Interview held on August 18, 2005 in Lawley 2.

In addition, there might be a kind of sampling bias in operation. In other words, it is possible that residents of informal settlements, who are recent migrants from other regions in South Africa, have come to the city not only in search of work, but in search of 'modern' forms of healing.

Despite these trends, some informal settlement residents do utilize traditional healing as their primary form of health care – this is true for Thulani, for example. Others only distrust particular healers, not the entire profession. I also found that when residents did choose to utilize a form of indigenous healing, they often chose *faith* healing over other forms. For example, when Pheello finally decided to try indigenous healing, he attended a prophet healer from the ZCC. While I believe my findings on squatters' health-seeking behaviors are valid, there is so little research conducted on informal settlements, further data would be helpful and elucidating.

Therefore, my research suggests that hybrid healing strategies may be more common in formal townships where life is more structured, there is greater social cohesion, and people are better integrated into the body politic and therefore face less economic scarcity. However, this does not mean that the habituses of squatters lack hybridity altogether. It may simply mean that the hybridity expressed in informal settlements is more varied and complex – reflecting greater instability. In informal settlements, necessity dictates all behavior, meaning that often peoples' strategies for survival are at odds with their professed ideologies. This is a point to which I will return.

In addition to access and social cohesiveness, there are a few other obvious explanatory factors that account for Black South Africans' hybrid healing strategies. There is a certain functional division of labor some people heed. If one breaks her leg,

she will have the bones set by a biomedical doctor,[245] but will go to her *sangoma* to understand *why* she broke her leg. It is very likely that such a mishap is an ancestral message of some kind. "While biomedicine asks what caused the condition and how, traditional healing asks 'who' and 'why'" (Abdool-Karim et al. 1994: 6). In addition, traditional healers cannot 'look inside' the body; therefore, they often ask their patients to go to biomedical facilities to get X-rays or blood work (including CD4 counts), to simply verify their diagnoses.[246]

In addition, the disease itself inspires a kind of indiscriminate response. Because of its pervasiveness and incurability, it is only rational that people seek a panacea in every possible source. Pheello's decision to finally utilize traditional healing was certainly motivated by desperation. In addition to these rather obvious reasons why people mix contradictory paradigms of healing in their efforts to treat HIV/AIDS, many of the most important and often under-explored reasons for the deployment of a hybrid healing strategy concern the epistemology and ontology of indigenous healing itself.

Flexibility, Multiplicity and Permeability

"The way in which illness is understood and experienced, whether it is through personal signification, cultural category, biological disorder or a combination of the above, informs the kind of treatment that is sought to heal the illness. However, the way in which one understands illness is itself informed by numerous factors, not least public policy, the media and epistemologies drawn on by health practitioners to support their various forms of health care practices. Therefore, the epistemology that informs and supports a particular form of treatment will in turn reproduce, or challenge the individual's understanding of his or her illness, continuing or reconstituting the cycle" (Mills 2005: 129-130).

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[245] There are 'traditional' bonesetters, so not all people heed such a structured division of labor.
[246] Many of the healers I interviewed and spoke with in FGDs relied on biomedical technology in this way. This evidence is further supported by Mills 2005: 141-143.

In his study of the history of anthropology, Fabian (2002) notes that Time is often used to construct, situate, and study the Other of colonial epistemology. Indigenous healing has often been de-temporalized in precisely this way by social scientists who rigidly circumscribe it within a fixed and static past, where it can be comfortably signified as a leftover from the precolonial days of yore. Against this historical tendency, this project seeks to highlight the flexibility of the profession and to recognize the historical and social contingency of its structure and ideologies.

Thokozani Xaba has studied the history of the profession of traditional healing (1844-2002) in KZN (2005). According to Xaba, apartheid radically distorted the structure of indigenous healing when it declared divination illegal and yet allowed herbalists to continue to ply their trade. These two professions were historically segregated by function. *Sangomas* diagnose and *inyangas* serve as natural pharmacologists. However, under apartheid legislation, herbalists began to divine on their own, in order to prescribe remedies, despite the fact that they had not been 'called' or trained in divination and were therefore unqualified to make such prognoses (Xaba 2005: 185). In addition, *sangomas* often registered as *inyangas* in order to avoid attracting the penalizing gaze of apartheid authorities (Ibid: 163). The professions of *sangoma* and *inyanga* were also historically segregated by gender. Women were most often diviners and men were the more often herbalists.

> "Part of the reason why there are more women sangomas is because women are more likely to answer their calling and believe in the ancestors. Men are more invested in the material world, and they believe they control their own destinies. Many men will prefer to die without answering his call. But women, they trust the ancestors and answer their calling."[247]

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[247] Dr. Tshabalala. Interview held on September 3, 2005 in Orlando East, Soweto.

The gendered division of indigenous healing was also transformed under apartheid.

Inyangas relied on knowledge of herbs passed down from generations; however *sangomas* would also collect their own herbs through the intervention of the ancestors. For both, the process involved prayer, rituals, and entailed a complex and selective harvesting process. However, under apartheid as more and more women joined the informal economy due to dire financial constraints, one of the most readily available and lucrative trades in which women began to participate was trade in indigenous herbs (Xaba 2005: 184). This rise in an informal trade in indigenous herbs as well as extremely restrictive property laws and pass laws completely transformed the profession of *inyangas*. Now, women, who lacked all training and indigenous knowledge, were most likely to supply the entire traditional health sector with their various *muti.* Today, indigenous healers of all shades are now forced to buy their herbs at sanitized market places where untrained female gatherers sell natural herbs and roots, and animal bones, skins and unguents.

> "Today, it is difficult for the traditional healers. It used to be that if my patient came to me, and the ancestors gave me a prescription for my patient, then I would go immediately to the veld, [248] and harvest that plant or muti myself. But today, I need to have a permit. Because if I come with a bunch of branches, you know, of muti, they will ask me, 'Where's your permit?' So, apartheid has had a really long-term effect on our profession."[249]

> "I hate being forced to use Faraday market to buy my herbs. They aren't fresh, and the people who sell them don't even know anything about where they came from. They weren't collected with prayer, and so it's not even the correct process [i.e. harvesting was done incorrectly]. And the herbs are so expensive. But we don't have any other choice."[250]

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[248] Afrikaans word for a rural plain.
[249] Dr. Tshabalala. Interview held on July 22, 2005 in Orlando East, Soweto.
[250] Dr. Mongoya. Interview held on July 22, 2005 in Orlando East, Soweto.

Figure 4-4: Faraday Market, Johannesburg [251]

Therefore, traditional healing has managed to survive the apartheid system through adaptation. And it continues to adapt to present day constraints, not least of which is the AIDS pandemic itself.

Traditional beliefs, ideologies and practices around HIV/AIDS exhibit some etiological traces from previous historical periods (Green 1994 and 1999; Setel et al. 1999; Delius and Glaser 2005), and are simultaneously mediated by contemporary social circumstances. Like any paradigm of knowledge, both traditional and biomedical forms of healing reflect structural (social, economic and cultural) transformations and

[251] Photos taken by the author.

inequalities. They are each socially constructed and historically contingent. As such, it is important to note their *current* systematic confluences and contradictions in an attempt to promote health policy and interventions that combine both global and local strategies and beliefs. "It is the present belief system – not an imagined pure system of the past – that needs to be understood by those in public health who would influence popular health beliefs and practices in ways deemed compatible with public health (Green 1999: 202).

However, in order to make sense of the present status of indigenous healing and its relationship to biomedical science, it is important to note *both* its social embeddedness and certain durable characteristics which have survived the transformations the profession has undergone over time in response to structural change. Despite its historical and social contingency, therefore, there are certain enduring ontological premises, epistemologies, and customs which characterize indigenous healing and make it amenable to hybridity. In fact, as Janzen notes, "therapeutic pluralism" is facilitated by the dynamism of African healing 'traditions' (1981).

First, indigenous healing is inextricably linked to Africans' sense of identity. One respondent told me that apartheid stole his identity and history from him, and that traditional healing has taught him who he is again. "When I was growing up, I would wish I was a white person … [After apartheid], learning about indigenous knowledge systems and traditional healing … broadened my understanding of who I am and where I come from."[252] It is possible, therefore, that embracing one's indigenous identity has become more important over time as a means of resisting colonialism, apartheid and racism.

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[252] Torong Ramela. Interview held in Parktown, Johannesburg on June 10, 2005.

> "It's true that after 1994, everybody started searching for indigenous origins. They wanted their identity and they wanted to know where they emanate from. Even those who went toward Western civilization or who went to get educated in the Western way, they came back … Because people now started to reclaim who they are. And they wanted to know their origin, their sense of origin, you know."[253]

During one interview I conducted in 2003, a nurse who worked at Bara told me that the use of traditional healing was declining; she was convinced that once anti-retrovirals became readily available to the public, traditional healing would become obsolete.[254] However, community members find this prediction absurd. As one community activist explained, "People will never stop going to traditional healers. That would be like suddenly abandoning your name because you are taking a new medication."[255] In other words, traditional healing is synonymous with the ideological make-up of Black South Africans' identities.

But this sense of identity is not simply individual, it is communal. "It enacts a form of social identity that insists on shared qualities between the living and the dead in particular clans; a strand of identity in which it is impossible to extract the individual utterly from their embedding within a body of kin" (Henderson 2005: 38). Healers are *mediums* between the natural and the social, between the living and the dead, between the individual and the community. As such, traditional healers occupy multiple social roles. Green notes:

> "Traditional healers are priests, religious ritual specialists, family and community therapists, moral and social philosophers, teachers, visionaries, empirical scientists, and perhaps political leaders in addition to being healers in the more restricted Western sense" (1994: 36).

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[253] Dr. Mongoya. Interview held on July 22, 2005 in Orlando East, Soweto.
[254] Female Nurse. Interview at the Chris Hani Baragwanath Hospital, Soweto. January 2003.
[255] Female Community activist. Interview held in White City, Soweto. February 2003.

In a study conducted between 1999-2000 in Hlabisa, KZN, patients' responses to indigenous versus biomedical care were surveyed (Colvin et al. 2001). Traditional healers were incorporated into a tuberculosis directly observed treatment (DOT) control program. Fifty-three patients were attended by traditional healers and 364 were supervised by either clinic workers or lay community members.

> "Overall, 89% of those supervised by traditional healers completed treatment, compared with 67% of those supervised by others (P = 0.002). The mortality rate among those supervised by traditional healers was 6%, whereas it was 18% for those supervised by others (P = 0.04). Interestingly, none of the patients supervised by traditional healers transferred out of the district during treatment, while 5% of those supervised by others did" (Colvin et al. 2001).

The reasons provided for the success of supervision by traditional healers included the following: patients and indigenous healers have established long relationships of trust, and traditional healers spend more quality time with their patients and exhibit much greater care and nurturance than health workers. In addition, traditional healers live locally and were familiar with the patients' social settings (Colvin et al. 2001). Green's research (1994) also supports these findings.

Kleinman (1988) made a now famous distinction between the psychosocial aspects of an *illness* and the biological or physical *disease*. The most successful healing strategies incorporate both conceptualizations, healing the body must be accompanied by attention to the experiential and social aspects of illness (Ibid). Whereas the biomedical approach assumes an autonomous, independent and mechanistic body, traditional healing helps us *situate* illnesses and recognize them as composites of cultural, social, environmental, historical, economic *and* biological factors.

Thornton (2002b) and Gumede (1990) also note that indigenous healers' approach is far more comprehensive and holistic. For indigenous healers, treating the body means understanding its social and material embeddedness. As mentioned in Chapter 2, biomedical health care workers (in part due to human resource constraints) rarely spend time explaining patients' symptoms and treatment options, indigenous healers not only explain the problem, but do so in a language and conceptual framework the patient can immediately grasp. Finally, Thornton notes:

> "[W]hile the medical doctor views the patient as a (temporarily) malfunctioning biological system, the traditional healer interacts with the patient/client with his/her own body and spirit. The traditional healer is both sympathetic and empathetic with the patient/client. The traditional healer diagnoses the patient's problem intuitively by 'feeling' the patient's own symptoms, in part, and through insight into the patient's social context and psychological state" (Thornton 2002b).

Therefore, indigenous health care is holistic, communal, and takes patients' material and social conditions into account. In addition, however, there are certain characteristics of an indigenous ontology that allow for hybridity in such a way that 'incommensurabilities' become livable.

I would like to specifically address the ontological contradictions I outlined in Chapter 2, drawing on Ashforth's (2002; 2005; Ashforth and Nattrass 2005) analysis that AIDS may be the downfall of indigenous healing practices. To review quickly, he claims that: 1) the concept of a virus is foreign to traditional healing; 2) because AIDS is associated with witchcraft, its origin is *social* as opposed to biological in nature; and 3) that traditional healing and biomedical science posit such contradictory ontologies of the body that they cannot complement one another without radical transformation. Ashforth's notion that viruses are incompatible with indigenous ontology may be based

on previous anthropological studies which claimed that "germs and infections" are "alien concepts" (Asuni 1979: 33; quoted in Green 1999: 11). In addition, he is also consistent with an anthropological tradition which assumes that the causes of illness are personalistic and that "everything boils down to witchcraft" (Pool 1994; See also Murdock 1980 and Foster 1983). However, against both of these trends, based on research conducted in multiple countries throughout Africa, Green has found that "when it comes to diseases that account for greatest morbidity and mortality (i.e., those biomedically classified as infectious and contagious), the indigenous and biomedical etiological models are, in fact, not very different in fundamental and important ways" (1999: 12). He believes that there are four primary etiological causes of illness: 1) naturalistic, which is a form of "folk germ theory"; 2) pollution; 3) environmental dangers; and 4) taboo violation (Ibid). He spends the bulk of his *Indigenous Theories of Contagious Disease* (1999) discussing theories of pollution because he believes they have been misunderstood as having a personalistic or supernatural causality (i.e. witchcraft). Against this tradition, he argues that "[p]ollution and other indigenous contagion beliefs [including 'germ theory'] therefore are an area of potential interface between African and Western medicine. But this potential has not been realized" (Green 1999: 17).

Thornton (2002b) also notes that South African traditional healing contains a germ theory, but he finds that this concept of a pathogen was not generally utilized by the indigenous healers he studied to explain HIV. My research suggests otherwise. In two of the FGDs I held with traditional healers in Soweto, I asked them very specifically about whether or not indigenous healing contains the concept of a virus and whether or not they

believed HIV was a virus. They were indignant and horrified that 'Westerners' would continue to undermine them by misunderstanding their belief system.

> "We know many viruses – not just HIV."[256]
>
> "Bio-medical doctors really undermine us if they say we don't know anything about viruses. Viruses live inside the human body. We have many different kinds of viruses we have always treated."[257]
>
> "I don't know why they say we don't know viruses: We can heal diseases that develop from the inside."[258]

As one traditional healer explained:

> "The idea of a virus does exist in traditional healing. It is sometimes referred to as insects, worms, parasites, or microbes, but it is the same idea. And it can be caused from simply environmental factors. It can be caused from pollution, or it can be caused from witchcraft. The causation theories differs, but the idea of germ and that kind of thing doesn't. And HIV is generally understood as one of these 'germs' – at least by most of the traditional healers I know … The idea of microbes, for sure it exists. The causation is different than biomedicine, but absolutely … And you can have something in your body and still be sick, particularly, and it may manifest, not in a physical problem. So you could have a worm in your body that's caused or related to something that...that isn't tangible [so the idea of an asymptomatic virus is also part of the indigenous ontology]."[259]

Causation theories are generally categorized as either proximate or ultimate, the former referring to physical symptoms of disease, and the latter to ancestral, social and sometimes mystical origins. Traditional healing provides both theories of causation when diagnosing and treating illness (Evans-Pritchard 1937/1976; Ingstad 1990; Green 1994).

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[256] Female participant in FGD held with the Soweto Traditional Healers Forum on September 13, 2005 in the Career Center Community Hall, Pimville, Soweto.
[257] Male participant in FGD held with the Soweto Traditional Healers Forum on September 6, 2005 in the Career Center Community Hall, Pimville, Soweto.
[258] Female participant in FGD held with the Soweto Traditional Healers Forum on September 6, 2005 in the Career Center Community Hall, Pimville, Soweto.
[259] Dr. Rogerson. Interview held on August 19, 2005 in Melville, Johannesburg.

However, these notions of causality are often "hierarchically nested" (Rödlach 2006: 172).

One of the primary points of contention between the two healing systems concerns the 'cure.' When Ashforth mentions that indigenous healers do not allow for a virus in their cosmology, he is not referring to 'germ theory,' he is referring to incurability (Ashforth 2005; Ashforth and Nattrass 2005). And indeed, as I mentioned in Chapter 2, while many of the healers I worked with believed that HIV was a virus, they also believed that indigenous healing has the capacity to heal the body 'from the inside out.' And when I asked, at a FGD, whether there had ever been a disease traditional healers could not cure, they all answered in unison: "Never." But in fact, the point about the 'cure' is often misunderstood. The traditional cosmology of healing concerns targeting the infected or damaged part, and purging or cleansing it. While healers understand that HIV is a virus, this does not imply incurability for them. In fact, there is no such thing, and on this point, Ashforth has hit on a primary contradiction. But it does not necessarily imply irreconcilability. Most of the healers with whom I spoke did not yet think there was a cure for HIV, nor did they claim to have the answers, but they did think that a cure was not just possible but eventual. In the meantime, however, they treat opportunistic infections, provide counseling and other forms of psycho-social support, and they try to boost or at least maintain the immune system of their patients as long as possible. In all of these ways, the indigenous healing approach to HIV precisely parallels the biomedical approach.

In contradistinction to Ashforth's work, my research shows traditional healers' willingness to incorporate biomedical explanations and treatments into their own health

practices and diagnoses.[260] In fact, traditional healing has proven itself to be much more fluid and flexible than biomedical science.[261] And this finding is supported by numerous other authors who have worked closely with traditional healers (Green 1999; Thornton 2002b; Mills 2005). "Traditional healing is going to have to change. Because of HIV/AIDS for one thing. We have to change some of our beliefs and practices in order to help prevent its spread and to take better care of people who are infected."[262] However, traditional healers do not simply want to be integrated as lay people into an already structured biomedical health system either. They want their professionalism and knowledge to be not only respected, but accepted as equitable.

> "These doctors are not honest or straight-forward … Our knowledge is so important, but they always refer to us as illiterate and tell us we don't know anything. They have been to school for so many years, but we have also been in school – but in a different form of education. There are a lot of things we are doing that they don't want to recognize. Tablets are made out of muti and herbs – that's where pharmaceuticals come from. They just give them fancy names – to market them and sell them. But they can't take our knowledge from us. But if they were honest, we could share some of our knowledge with them. If they are open, we can share knowledge better – and heal people better … All modern medicines have their roots in traditional healing … *Before it was modern, it was traditional*."[263]

In fact, Thornton notes that although power and cultural identity is rooted in African 'tradition,' and the 'Western' or 'modern' is often conceptualized as a danger or at least an imposition, this opposition is neither absolute nor mutually exclusive (2002b).

> "Rather, traditional healers see this as an opposition of categories that can be combined, but that must be 'balanced' in order to achieve well-being for the

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[260] This was obvious from all of the FGDs I conducted with healers and most of the interview as well.
[261] Further proof of this is traditional healers' willingness to follow the Department of Health training programs on HIV, TB, and STDs. Even though these training programs patronize traditional healers and refused to admit their own expertise in healing, traditional healers continue to attend because they care about their patients.
[262] Dr. Mongoya. Interview held on September 3, 2005 in Orlando East, Soweto.
[263] Anonymous Female Sangoma. Interview held on August 29, 2005 in Orlando East, Soweto.

> African person. They seek to incorporate both sets of ideas and knowledge into a single system of healing, while maintaining the opposition of 'modern' and 'traditional' as separate potentials whose interaction yields power … Achieving the proper balance between the 'African' and the 'Western' is essential. This makes it possible for healers to remain completely open to Western medical practice while at the same time placing equal value on African healing practices and treatment with herbs" (Thornton 2002b).

Many modern concepts, ideologies, signifiers, and technologies are consistently incorporated into 'traditional' healing practices.

There are two primary reasons for this accommodation of dualism. First, because illness has many different causes and origins from multiple different domains, including the social, spiritual and physical, treatments must also be multiple. "The biopsychosocial model challenged the single domain approach of the biomedical paradigm … the onslaught on health can therefore be from various entry points or even from various interactions. Interventions can similarly, within obvious limits, be performed at any of the interacting domains or even from a combination of entry points (Viljoen *et al.*, 2003: 332). In addition, HIV actually brings on *other* diseases. AIDS is a syndrome, which refers to a set of symptoms that only collectively signify disease. The danger of HIV is that it breaks down the immune system, so that the body is at risk from multiple infectious agents, or *opportunistic* infections. Therefore, AIDS is not really *one* disease at all. Traditional healers recognize that a hybrid approach to healing, one which combines *both* biomedical and traditional methods may be the most effective means of treating a disease as complicated and complex as HIV/AIDS.

In addition, according to a 'traditional' ontology, the boundaries of the body (and of subjectivity) are permeable.

> "Although modern personhood tends to posit an autonomous agent, free from external sources and individualized to an every-increasing degree; however,

> 'traditional' notions of personhood understand the self as 'permeable and partible.' They believe their bodies impart substances to and incorporate substances from other bodies" (Niehaus 2002: 189).
>
> "Being inhabited viscerally by a voice of an ancestor, and submitting to its instructions, suggests a state of being radically different from privileged, rationality within the context of modernity. It is a voice that contests a predominant notion of discrete subjectivities" (Henderson 2005: 36-37).

This alternate view of subjectivity incorporates a certain recognition of fragmentation. Peoples' bodies and selves are constantly being incremented by various different gifts (material, social and spiritual) and flows (bodily and ancestral), making them "compound sites of [the] relations that define them" (Niehaus 2002: 190).[264] In this way, one cannot possibly heal the body without also situating that body within a social, material and communal context.

In order to illustrate all of the varied complexities of the hybrid nature of indigenous ontology, but to also show how the fundamental split between traditionalism/modernity is both maintained and yet incorporated within an indigenous paradigm, I would like to provide a case study of one of the healers I met during my research. Rebecca Rogerson is a white, Canadian *sangoma*, trained in Soweto. I included her story about being 'called' in Chapter 2. Dr. Rogerson claims that the traditional healing community in South Africa has been nothing but supportive of her, in part, because they accept the simultaneity of modernity and traditionalism and in part, because they understand subjectivities to be necessarily multiple.

> "But this idea of being able to have these kinds of simultaneous cultures and backgrounds is embraced by traditional healing. So ... so my work, ultimately, I've been received well, and that's part of the reason that I do what I do. Because

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[264] For more information on the difference between a 'dividual' and an 'individual,' see Wagner 1986; Lambeck and Strathern 1998; Taylor 1990.

> of how exceptional traditional healing is. Because for traditional healers, identity is always, yeah, fluid. And multiple … It's like a multiplex hybridity."[265]

She explains that she only faces difficulties surrounding her identity when she is back in 'Western' society.

> "What's been the most challenging for me is going to North America where there isn't that fluidity. Where things are very much left or right, black or white, you know. North Americans think that I'm a contradiction. They think modern health care and being a *sangoma* is like trying to be two races. You know, like totally conflicting ideologies."[266]

According to Dr. Rogerson, then, South African traditional healers accept contradiction as a lived reality. She mentions that it is a 'Western' practice to segregate and isolate different healing paradigms, but also to segregate healing from social networks (of the family and the community), spirituality and religion. Here is an excerpt from her website, where she describes the different approaches:

> When I first returned to Canada from South Africa I was overwhelmed with what I can only describe as a sort of a spiritual poverty in the health care industry … I saw dis-connectedness, isolation and fragmentation with regards to health care. The cerebral approach to the industry in general really struck me.
>
> Though Western medicine is vital and important to the world at large, there is a real lack of education on this continent on divergent medical systems, and the cultural values or beliefs that sustain them. All too often, vast bodies of knowledge are condensed into marketable courses designed for convenience, with little or no regard for history …
>
> In Africa, individual health is the responsibility of everyone – the families, and the community at large. Healings draw heavily on the concept of collectivism, and communal prayer is an integral part of the process. On a similar note, when a person is ill all aspects of their being are taken into consideration: mental, emotional, physical and spiritual. Rather than isolating obvious symptoms, the indigenous view on illness is one of relationships; of finding and restoring an overall connectedness. There is no separation made between mind, body and the spiritual realm …

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[265] Dr. Rebecca Rogerson. Interview held on August 19, 2005 in Melville, Johannesburg.
[266] Dr. Rebecca Rogerson. Interview held on August 19, 2005 in Melville, Johannesburg.

> Traditional African medicine is serious, and practitioners assume responsibility for both preserving community wellness and upholding its most sacred cultural values. It is a system based in science – not science as its known in the West, but a science deeply rooted in rich and ancient ethnomedical knowledge.[267]

Therefore, hybridity is an important feature of the ontology of indigenous healing; however, this is only one of the varied factors that accounts for the hybrid habitus that been incorporated by certain subjects in post-apartheid South Africa. Because the field of healing's bifurcation is sustained by an unequal distribution of capital in the field and a prominent discourse of incommensurability iterated by powerful actors including the state and an international biomedical industry *and* because indigenous healing occupies a *dominated* position in the field, its sanction of hybridity cannot fully explain how disempowered subjects who are at the mercy of incredible structural and ideological forces are able to straddle a field so wholly dichotomized or how they are able to use this hybridity to circumnavigate the material strictures erected by neoliberal economic restructuring and the pandemic itself. Because those who have embodied hybridity are subjects of a legacy of apartheid and an equally oppressive post-apartheid thanatopolitics, both of which split populations into structurally segregated and hierarchized groups, the hybrid habituses of HIV-infected subjects are indeed surprising. This cultural hybridity unveils a radical disjuncture between the field of health and healing and subjects' lived experiences – thereby becoming an example of what Bourdieu labels the hysteresis of ideological habitus (1977). "In short, the ongoing dialectic of subjective hopes and objective chances, which is at work throughout the social world, can yield a variety of

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[267] Dr. Rogerson's website is no longer on the internet, but she has given me permission to reprint this brief description here.

outcomes ranging from perfect mutual fit … to radical disjunction" (Bourdieu and Wacquant 1992: 130).

Hybridity

"[T]he colonial discourse has reached that point when, faced with the hybridity of its objects, the *presence* of power is revealed as something other than what its rules of recognition assert" (Bhabha 1994: 112).

Combining a Derridean framework of symbolic analysis with Lacanian psychoanalysis, Homi Bhabha (1994) argues that colonial translation necessarily enacts an alienating displacement of meaning, which gives rise to a "Third Space" of interpretation that is always already hybrid in nature. "It is that Third Space, though unrepresentable in itself, which constitutes the discursive conditions of enunciation that ensure that the meaning and symbols of culture have no primordial unity or fixity; that even the same signs can be appropriated, translated, rehistoricized, and read new" (37). The ambivalence inherent in this Third Space creates the conditions for a symbolic struggle over meaning, between the colonizer and the colonized. One of the most powerful discursive strategies Bhabha explores is that of "mimicry," which is replete with colonial desire for "a subject of difference that is *almost* the same, but not quite" (86). The strategic objective of mimicry is to camouflage colonial power and therefore maintain these important margins of difference. However, it is possible to unveil mimicry in the making. At this important "site of interdiction" (89), the authority inherent in mimicry is unmasked. "Mimicry *repeats* rather than *re-presents*" (87-88), but the repetition is metonymic and threatens to destabilize colonial subjectivity. As such, mimicry can act as more of a "*menace*" than a "resemblance" (86), more of a rupture than

a consolidation. "[It] is a mode of contradictory utterance that ambivalently reinscribes across differential power relations, both colonizer and colonized" (95).

When the colonized repeat, in this metonymically menacing way, they hybridize colonial identity and inscription. "Hybridity is the revaluation of the assumption of colonial identity through the repetition of discriminatory effects" (112). And in so doing, the power of colonial representation is subverted, its authority disavowed, and its rules of recognition transformed (113-114). Differing cultures – hybrid cultures – are the *effect* of colonial discrimination, but in their new articulation, they undermine the value and rules of colonial representation. "The display of hybridity – its peculiar 'replication' – terrorizes authority with the *ruse* of recognition, its mimicry, its mockery" (115).

Mockery, is therefore, a strategy of resistance, in which the colonized subject engages in order to performatively flaunt colonial desire and control. Hybrid performances of the colonized unveil the simultaneous partiality and doubleness of colonial signification.

> "Both colonizer and colonized are in a process of misrecognition where each point of identification is always a partial and double repetition of the *otherness* of the self – democrat and despot, individual *and* servant, native and child. It is around the 'and' – that conjunction of infinite repetition – that the ambivalence of civil authority circulates as a 'colonial' signifier that is *less than one and double"* (97).

Colonial desire is "less than one" because identification is always only partial (the colonized is "*almost* the same, but not quite"), but it is also "double" because it embodies the ambivalences of power – the subjects of colonization incorporate the contradictions inherent in the system – they are both citizen and subject, both civilized and barbaric, both modern and traditional.

> "The metonymic strategy produces the signifier of colonial *mimicry* as the affect of hybridity – at once a mode of appropriation and of resistance, from the disciplined to the desiring. As the discriminated object, the metonym of presence becomes the support of an authoritarian voyeurism, all the better to exhibit the eye of power. Then, as discrimination turns into the assertion of hybrid, the insignia of authority becomes a mask, a mockery" (120).

For Bhabha, then, hybridity is a discursive strategy that can be deployed differentially by both the colonizer (mimicry) and the colonized (mockery), producing a space of ambivalence in the interstices of this interpretive encounter. However, both forms of hybridity put the signifiers of colonial authority on display, which ultimately undermines their success through perpetual re-inscription and metonymic slippage.

Both Ella Shohat and Arif Dirlik criticize post-colonial scholars for their romanticization of the revolutionary potential of hybridity (Shohat 1992; Dirlik 1996). For them, the 'post'-colonial obsession with 'hybridity' and the concordant desire to superimpose a certain multiplicity and in-between-ness over the subaltern experience, enacts a misrecognition of the various forms of domination that continue to operate in a global capitalist system. The very concept of 'post' is problematic because its teleology disavows contemporary cultural and economic imperialism,[268] which seriously undermines the possibilities for resistance: "While capital in its motions continues to structure the world, refusing it foundational status renders impossible the cognitive mapping that must be the point of departure for any practice of resistance and leaves such mapping as there is in the domain of those who manage the capitalist world economy" (Dirlik 1996: 315). I mention this critique of post-colonial theory, not because I think it is particularly applicable to the theories or scholars I am utilizing, but because I think it is

[268] See also: McClintock 1992 and 1995; Coronil 1992.

important to heed three important warnings inherent in this critique in my own analysis of hybridity.

First, it is important to recognize the various forms of coercive power operating both overtly and covertly in post-apartheid South Africa, whether they be symbolic, cultural, economic or physical, and the role these violent operations of oppression play in subjects' capacity to embody healthiness. Because these forms of bio-power operate at the level of "bare life" (Agamben 1998), subjects' itineraries of access and possibilities of resistance are not only severely circumscribed, but a failure to navigate this complicated social field often ends in death. Second, both socio-economic conditions and the materiality of the body impact concretely on the construction and performance of discursive strategies. Bourdieu would remind us that it is through *action* and *practice* that actors engage in social and symbolic reproduction (1990). Finally, putting different discursive strategies into one of two boxes – subversive or collaborative – is overly simplistic and fails to take into account the multiple ways in which power operates.

While I agree with certain points raised by these critics of 'post'-colonial studies, I disagree with their disavowal of hybridity. The concept is definitely worth salvaging because of its *increasing* relevance to any analysis of the operations of symbolic power in a global capitalist system. However, one must pay attention to structural hegemony, corporeal and social materiality, and the multiple methodologies of power in any responsible application of the theories of hybridity. As Ong reminds us, "[o]nly by weaving the analysis of cultural politics and political economy into a single framework can we hope to provide a nuanced delineation of the complex relations between transnational phenomena, national regimes, and cultural practices in late modernity"

(Ong 1999: 16). Different forms and nexuses of power produce different kinds of hybridity – which are wielded by a variety of actors for a wide range of reasons. Consideration of these various modalities and causalities of hybridity will push our 'post'-colonial theories in new and important directions.

Overall, the available theories on discursive strategies fail to account for multiply inscribed habituses, created by a situation in which people live within and between contradictory discourses of the body. Bhabha theorizes a 'third space' of interpretation that is created by a disjuncture between forces of domination and resistance (1994). However, the dominant discursive strategy is always singular and hegemonic. If subjects are interpellated by multiple and incongruous discursive authorities, then what kind of space is produced? And what is made possible by these symbolic spaces of interpretation?

In contemporary South Africa, there are in fact *two* authoritative discourses, two imperialist inscriptions (informed by two forms of bio-power) with which the subjects of post-apartheid must contend. Post-apartheid hybridity, then, involves playing each off the other, performing them both ineptly, and strategically embodying the contradictions in this dual inscription in order to undermine and expose post-colonial authority. And as such, a new form of disruptive hybridity is created, embodied and performed. In the townships, where people are targeted with both governmental and disciplinary power, subjects engage in a form of mockery, made possible by their in-between status in the field of social space. As Bourdieu suggests in *The Rules of Art* (1996a), positionality in the field is integral for the development of new, subversive tastes. It is a particular position in the field that allows for an "inclination to independence" to develop (Bourdieu

1996a: 60). However, in South Africa's zones of abandonment, different and more varied forms of hybridity develop because of the greater material constraints and insecurity that mark the lives of the *hominess sacri*. In this next section, I will describe the forms of hybrid strategies that are deployed in response to different mechanisms of power. I will chart the ways in which HIV-infected residents of South Africa's Black townships and squatter camps incorporate, reconfigure and resist both post-colonial discourse and bio-power.

Governmentality

Since the end of apartheid and the subsequent adoption of neoliberal economics, state governmentality has been leveled at the reconfiguration of habitus, such that citizens are forced to subscribe to new strategies of self-governance if they are to survive. The state has deployed a series of governmental tactics, including the privatization of basic services, the outsourcing of health care to community volunteers, and the appropriation of 'do-it-yourself' logic in order to shift its welfare responsibilities onto the shoulders of the poor themselves. However, each of these new tactics is met with an equally forceful strategy of resistance and reinscription.

In Phiri, where the pre-paid water meter has been installed, water has become so expensive, residents are forced to not only conserve water, but reuse the same water for different purposes. HIV-positive residents require greater water supplies – both in terms of consumption and sanitation. Not only does this directly impact their ability to stay healthy, but also contributes to ill-will and stigmatization by family and community

members. Water is also unavailable for home-based care services or projects like community gardens.

In response, some community members have begun to 'mimic' in precisely Bhabha's terms, the water conservation rhetoric the city and the state are utilizing to 'sell' this pre-paid system to communities. However, many others have engaged in outright revolt. First, people flatly refused the systems, and staged mass protests against the government.

Figure 4-5: SECC Protest, May 11, 2005 [269]

But then, the community activists began to get sneakier. Because some residents were worried about the consequences of blatant subversion (especially given that their water and electricity were at stake), the Soweto Electricity Crisis Committee, SECC, (a branch of the APF) arranged for out-of-work electricians and plumbers to illegally by-pass the installed meters through a complicated alternative system of piping. In addition, the SECC engaged in symbolic warfare. Because the discourse used to advertise the new

[269] Photo taken by the author.

technology deployed a 'water conservation' tactic, SECC activists began highlighting the contradictions inherent in the approach. They began showing pictures of the vast swimming pools and fountains that pepper the horizons of Johannesburg's richest (and whitest) suburbs, demanding to know why only the poor needed to be concerned with conserving water. Just recently, a major victory was won in the courts, when the forcible installation of pre-paid meters in Phiri was declared unconstitutional (Centre of Applied Legal Studies 2008).

In terms of health care, the government has deployed a different strategy of privatization, and home-based care has become its newest means of governmental 'enabling.'

> "It's true, the Department of Health is shifting its responsibility to ... to the community itself, you know [laughs], yeah. And how ... how can we have clinics, hospitals in our own homes. Yeah, I think that they are, you know, they're just trying to get rid of these HIV/AIDS patients, you know, because of maybe … they don't want to improve the health care sector."[270]

However, this state strategy has equally ambivalent effects in application. First of all, it has provided women with salaries for previously unpaid labor, but it has also served to undermine biomedical hegemony. Traditional healers have begun to undergo training to become officially recognized home-based care workers.[271] While the HBC system is only meant to provide disposable populations with palliative care, in order to ease the burden on the public health system, by providing state resources to traditional healers

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[270] Thulani Skhosana. Interview held on June 11, 2006 in Sol Plaatje.

[271] I conducted a series of FGDs with the Soweto Home Based Care Givers on August 10, September 14, and October 4, 2005 in their offices in White City, Soweto. Three of the 15 members were traditional healers. Dr. Martha Mongoya is also a state-recognized HBC worker. Unfortunately, I have not been able to explore the complexities of HBC in any detail in my dissertation and instead, have chosen to simply provide the basic contours of this state strategy. This is an oversight I hope to correct in the future.

(who then supplement the HBC with indigenous healing), this governmental program allows for the channeling of public health funds toward the remuneration of traditional healers.

The final governmental strategy the state deploys involves the appropriation of 'do-it-yourself' ideology. On the one hand, it is a neoliberal effort to replace the welfare state with community 'social capital.' However, community members also utilize this discourse in order to mobilize for self-sustainability. The contradiction is that these communities have absolutely no resources to become self-sustainable. Therefore, when groups like Pheello's support group calls itself, 'iketsetseng,' they mean that they want to initiate their own programs, on their terms, carried out in a communal fashion, but they still demand the state supply the funding. "It means also we can actually force the government to give us things so that we can do things ourselves. But even if it refuses, then it means we have to go and take it, you know, by force, in order for us to do it. This is included in the concept of itketsetseng."[272]

In Orange Farm, an informal settlement near Lawley 2, the community has developed a different strategy of 'do-it-yourself.' With support from international NGOs and the Catholic Church, the local Orange Farm Community Crisis Committee[273] has created its own autonomous health structure. Nurses and laypeople trained in basic HBC volunteer their time to distribute ARVs (donated by the church) to the population, ensure their proper usage, and provide support and counseling to people taking the medications. In addition, the community has a support group and a prevention program – all

[272] Pheello Limapo. Interview held on December 8, 2005 in Lawley 2.
[273] Participant observation of the Orange Farm Community Crisis Committee initiatives and interviews with Bricks Mkolo, the organization's chairperson. July 2005.

community operated and facilitated. The community is able to access nutritious food through a communal garden, and through various income-generation projects, many of the residents now have sources of income to fund trips to the clinics, hospitals, etc. This example shows us that poor South Africans, who have been neglected by state sovereignty, are actively and creatively navigating the social field, and in fact, utilizing geopolitical relations, in order to implement community sustainability projects. As such, they are resisting not only hegemonic corporeal inscription, but exercising agency in their performance of habitus.

Biomedical Discipline

"Now using AIDS drugs and on their own, these patient citizens face the daily challenge of translating medical investments into social capital and wage-earning power. At every turn, they must consider the next step to be taken to guarantee survival. Back in the world, they refuse the position of leftovers and break open new trajectories. Life is in transit" (Biehl 2006: 472).

Many HIV-positive community members join the TAC or other NGOs precisely because it gives them access to material resources and social and cultural capital. As such, people purchase social mobility by becoming involved in an organization and rising through its hierarchical positions. One of the most important jobs NGO volunteers and staff have is to disseminate the ideologies of the organization, which expands the scope of the international and national orthodoxies these organizations promote. But one of the most important purposes of NGOs is to enable people to access the rights ensured by 'biomedical citizenship' (Biehl 2004 and 2006), so long as they can embody the regulatory and disciplinary strategies biomedical science requires.

> "Look, I'm concerned about the programs that the TAC implements on the ground … Support is given to the people who can access their offices that date, and be organizers doing, whatever, doing important jobs. For many people, joining the TAC is a money-making scheme. People get into the organization hoping they will be hired, that they will find employment. But there is also some prestige. Some members get to travel to Cape Town … and they help people get things from the government. If you are a member of TAC, though, you have to follow their mandate. You have to agree with their rules. Because they don't listen to the communities. They don't respond to what we suggest because they think they already have all the answers."[274]

Pheello was converted to biomedical cosmology, and believed wholeheartedly, that by following the self-disciplinary requirements of biomedical citizenship, he would earn the salvation of survivorhood. When Pheello was first diagnosed with HIV, one of his closest friends was dying from AIDS. As he watched his friend die in silence and isolation, Pheello realized that the only way he could survive the disease would be to disclose his status, so that he could ask for help and support. He believes disclosure saved his life, and has become an adamant proponent of the "positive living" ideology. He joined the TAC and became one of their community organizers. He began attending workshops to understand the biomedical explanation of the disease and the various treatment strategies he could pursue. He also got help from the TAC and the AIDS Consortium (an ally of the TAC, that acts as an umbrella NGO for all AIDS service organizations in Johannesburg) to start his own support group in Lawley 2, and he uses TAC's resources to help disseminate biomedical knowledge about HIV/AIDS in his community.

When he is sick, Pheello follows the advice of his doctors to the letter, so long as it has been explained to him (which is rarely the case). But he does the best he can, and

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[274] Thulani Skhosana. Interview held on June 11, 2006 in Sol Plaatje.

he spends inordinate and extremely precious resources to follow the regimens biomedical science prescribes. After nearly dying from an illness that was never properly diagnosed, Pheello went through tremendous feats in order to get onto an ARV roll-out program, and he used his connections at TAC in order to do so. Pheello would use the hospital wards to mobilize other patients to oppose the government's denialism and neglect and become activists in the struggle for quality public health care. Often when I visited him, when he wasn't too sick, he would be holding court at another patient's bed. When I asked him what he was discussing, he said that he was trying to inspire hope in them. He was telling them not to give up, but to demand better health care, and together, they could fight for their lives.

But it takes a great deal of time and energy to simply access state resources, let alone follow all of the exhaustive requirements of biomedical citizenship. For example, in order to go onto ARVs, one must first get a doctor to provide a blood test to check the CD4 count. One cannot have a count of over 200 T-cells, but it also cannot be too low, or else the subject is too risky. If the CD4 count is acceptable, the patient must sign onto the waiting list at one of the various roll-out sites. And when it is one's turn, another CD4 count must be taken to ensure the patient still qualifies (given the conditions in South Africa, peoples' CD4 can lower dramatically and quickly due to various opportunistic infections and lack of proper environmental conditions and health care.) Next, the patient undergoes both pre-treatment counseling and adherence counseling. Then, s/he must go through a series of physical exams: blood tests, TB tests, pap smears, etc. The patient must select an adherence partner (a family member, friend, etc) who will help the patient take the drugs on time and monitor the progress. There are a series of

follow-ups (every two weeks and then every month) the patient is required to attend, at which point, the patient will see a doctor, fill out more paperwork, go through more blood tests, and receive counseling. The doctor will also check into side-effects, adherence, etc. The patient must attend these follow-up appointments to receive the next month's supply of ARVs.[275]

For those people who live in informal settlements, *one* trip to the hospital or clinic is both time-consuming and expensive. Pheello received his ARVs at the Lilian Ngoyi Clinic, which is housed in the same complex at Bara Hospital and is the closest roll-out site to Lawley 2. It takes him 2 hours, each way, to get there in a taxi, and it costs about R20 round trip. Pheello's entire family survives on his disability grant, and at the time that he began ARV treatment, he was receiving R700 a month. But in addition to attending all of these appointments, exams, and workshops, he needed to do most of the household work, which is itself exhausting and time consuming without clean water or electricity, because his wife was so sick she could not get out of bed. I provide all of this information simply to illustrate how difficult it is for poor South Africans to abide by the requirements of biomedical citizenship. Many do not begin to try because they do not have the resources to make it possible. Thulani told me that only one person in his community was taking ARVs (as of late 2005) partially because the price of transport was too great an obstacle. "But they don't even know that they're oppressed because they don't have ARVs [laughs] because they don't know ARVs exist!"[276]

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[275] Interview with Female Matron who is in charge of the ARV roll-out program at the Zola Clinic in Soweto. Interview held on June 7, 2006 in Zola, Soweto.
[276] Thulani Skhosana. Interview held on September 2, 2005 in Sol Plaatje.

Although biomedical science wields tremendous power and many submit to its authority since they believe their lives are at stake. Most people who utilize biomedical healing don't follow it prescriptive orders and surreptitiously engage in hybridity. This is an example of Bhabha's performative mockery. On the surface, they ascribe to biomedical citizenship and even engage in proselytizing its benefits, but in their own practices, they fail to live up to its stringent conditions, which undermines biomedical authority and flaunts its hegemony. For ten months, I volunteered with a very large international NGO that provides services and support to people living with HIV/AIDS in Soweto. On our way to visit a support group, three managers within the organization (all HIV-positive themselves) were discussing an advertisement sponsored by the Dr. Rath Foundation which ran in a local newspaper, the *Sowetan* (Dr. Rath 2005b), in which Dr. Rath claimed that the TAC was receiving millions of rand from the pharmaceutical industry to promote anti-retrovirals. These highly positioned NGO managers are all implicitly encouraged to advertise and advocate bio-medical hegemony, including outright suggestions that support group members sign onto the waiting list for anti-retroviral medication. However, amongst themselves, these NGO workers supported Dr. Rath's claims. Not only were they derisive of the TAC's agenda, but expressed their beliefs that vitamins and a 'healthy lifestyle' were the most effective and cheapest solution to the epidemic. And all three concurred when one emphatically exclaimed, "I will never use those anti-retrovirals!"[277]

[277] Field notes, March 30, 2005 in Soweto.

In the Zone of Abandonment

"The government recognizes that poverty causes AIDS, but I am poor and I'm HIV-positive, and in my community, we have no houses, no water or electricity, and no clinic. So what is the government doing to eradicate poverty? Nothing."[278]

"I want Manto [the Minister of Health] to come and try to survive in the squatter camp where I live. Just for one week – because if she stayed for a month, she would die. No, just for one week. And I want to see her fight for water, for food, for health care every day, just to, you know, make it. Just to live. This is the only way she will understand what people are going through."[279]

"It's not that the government has got no capacity or no money to assist people living with HIV. There is a lot of money that is there for AIDS. A lot of this money is donated from different countries all over the world … And the government is only the custodian of that money. But instead of the government using that money where it is supposed to be used – like in the squatter camps, it uses this money to make millions of condoms and millions of fancy pamphlets. Spending a lot of money on things that are secondary and not primary … But it's the people in the squatter camps who are vulnerable. The government does not even try to go to the squatter camps to find out what is needed. It is the people with the nice lives who are deciding on the money. People are struggling as we speak – in different squatter camps. But the government does not want to help *us*."[280]

"It seems like what the government is doing is waiting until we are on the brink of death before offering any help. *Or maybe the government is just waiting for us to drop dead*."[281]

Sol Plaatje is referred to as DRD by local residents. DRD stands for Durban Roodepoort Deep, the mining company whose workers were housed in what has become the squatter camp. In other words, the community lives in and around a disused mining compound. The DRD mine, like most of the mines in South Africa, became unprofitable once the natural resources became so scarce that the available technology and labor power cost more than the mined gold would yield on the market. The squatter camp "is

[278] Thulani Skhosana. Speech given at a community meeting in Sol Plaatje/DRD on June 10, 2006.
[279] Isaac Skhosana. TAC Provincial Chairperson. Interview held on May 18, 2006 in the TAC offices in Johannesburg.
[280] Pheello Limapo. Interview held on Decemer 8, 2005 in Lawley 2.
[281] Female participant in FGD held on October 20, 2005 in Lawley 2.

bounded by forest and mine-slag dumps on one side and by mine-buildings, sinkholes and heavily polluted ground on the other" (Mandelaville Crisis Committee 2005).

> "There are still enormous holes in the area, since it used to be a mine. Kids often play around them and many have died falling in. On rainy days, kids play in the water that pools at the bottom, but there are snakes and the water is surely contaminated by who knows what."[282]

Mines have become iconic signifiers of the post-colonial world. The former site of immense wealth and white power, once no longer productive, now house those who are rendered expendable in a neoliberal world order. Disused land for disposable people. This would be a perfect metaphor if it weren't so painfully literal.

Urban informal settlements house South Africa's 'poorest of the poor,' and although there is not a lot of demographic information available on squatter camps, "HIV prevalence rates tend to be at their highest in these spaces" (Hunter 2006: 161). In Sol Plaatje and Lawley 2, the lack of social services as well as substandard housing contributes to ill-health. For example: water is often contaminated; informal electricity sources like paraffin cause pollution and congestion; lack of sanitation services leads to higher exposure to opportunistic infections; and extreme heat and cold due to lack of proper shelter has a profound effect on people with compromised immune systems.[283]

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[282] Female participant in FGD held on June 10, 2006 in Sol Plaatje.
[283] For more general information about the deleterious effects on squatters' health, see: Stillwaggon 1998; United Nations Human Settlements Program 2003; Farmer 2005; Davis 2006.

Figure 4-6: Welcome to Sol Plaatje [284]

"We need proper housing right away, but people die in a queue – waiting to be housed." [285]

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[284] Photos taken by the author.

Figure 4-7: Sol Plaatje Energy Sources [286]

"Not having electricity affects people living with AIDS. We normally use paraffin which people suffocate from – it is not healthy for people who are HIV positive."[287]

"The paraffin smoke is really bad for you – it destroys peoples' lungs – even worse for people infected with HIV/AIDS."[288]

"The gas stoves are made for poor people, but I'm surprised to see that the prices go up each and every month … People cannot afford them, and the prices still increase."[289]

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[285] Male participant in FGD held on October 14, 2005 in Sol Plaatje.
[286] The photograph on the left was taken by the author. The photograph on the right was taken by Andy Clarno.
[287] Male participant in FGD held on October 14, 2005 in Sol Plaatje.
[288] Female participant in FGD held on June 10, 2006 in Sol Plaatje.
[289] Male participant in FGD held on June 10, 2006 in Sol Plaatje.

Figure 4-8: Toilets in Sol Plaatje [290]

"The toilets are dirty because there is no water. There are germs there." [291]

"The pipes are leaking and the toilets are blocked. There is sewerage coming into the houses." [292]

Figure 4-9: Leaking sewerage in Sol Plaatje

[290] Photos taken by the author.
[291] Female participant of FGD held on October 14, 2005 in Sol Plaatje.
[292] Female participant of FGD held on June 10, 2006 in Sol Plaatje.

In Lawley 2, the conditions are just as desperate.

> "People don't have any form of income. We are very poor in this community. There is no hope whatsoever. There is nothing we are expecting any time soon, from anywhere."[293]

> "One of the biggest problems in Lawley is the fact that we are living in shacks. They are very cold. Most of the ailments we are facing, because of this disease, our bones – especially in the legs – get very sore, which is worse because of the cold in the shacks. There is also a lot of dust. Sometimes there is not enough space. We keep on having to drink contaminated water. We also don't have electricity or any social services."[294]

Figure 4-10: Lawley 2 [295]

> "One of the biggest problems we are facing is: we stay in shacks. There are all kinds of weather here. If it is windy, then the wind goes straight through the house. This is why so many people in Lawley have TB – our illnesses are reflective of our living conditions. But the treatment is not reflective of our environmental conditions."[296]

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[293] Female participant in FGD held on October 6, 2005 in Lawley 2.
[294] Female participant in FGD held on October 6, 2005 in Lawley 2.
[295] Photo taken by the author.
[296] Female participant in FGD held on October 20, 2005 in Lawley 2.

Figure 4-11: Housing in Lawley 2 [297]

"I think that first of all, if you look at the conditions of the people living in squatter camps. First, look at the issue of water or sanitation. That is where you get germs and other diseases. The kind of water that we drink stays in drums for weeks. It gets contaminated. They never clean the drums of water – to change it and clean it."[298]

Figure 4-12: Water source in Lawley 2 [299]

[297] Photo taken by the author.
[298] Male participant in FGD held on October 20, 2005 in Lawley 2.
[299] Photo taken by the author.

Frédéric le Marcis discusses the way in which HIV-positive South Africans re-fashion urban space in their constant quest for treatment and support (2004). By tracing the routes of the 'suffering body,' le Marcis also highlights the way in which peoples' trajectories get caught up in and sometimes reconfigure markets of exchange, circuits of exploitation, and the boundaries of the polis itself (Ibid). Inspired by this approach, I will discuss the energy and tremendous creativity it takes to simply survive in South Africa's zones of abandonment, and the routes and strategies used to do so. There are not only ideological constraints, but extreme geographic and economic obstacles for people whose very lives depend on their achievement of biomedical citizenship.

Neither Lawley 2 nor Sol Plaatje has a health clinic, and due to the geographical isolation of these communities, transport to local clinics and hospitals is both expensive and time consuming. For example, for residents of Sol Plaatje to attend the closest clinic in Dobsonville, it takes 30 minutes in two different taxis and costs R8 ($1.50). To reach the hospital in Soweto, one must take several taxis, spending 2 hours each way. The cost is R17 round trip ($2.80). These costs are prohibitive for people without steady income, and for many people the cost is only worth paying if their condition is life-threatening.[300]

> "We don't have a clinic as a primary health care. People need to have money to go to the clinic, which is always a problem for people in our community because unemployment is so high."[301]

> "The problem we're facing is that sometimes we don't have R8, and someone is seriously sick. And so we can't afford health care. Many people die before they get to the clinic or hospital."[302]

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[300] This information was provided by participants of a FGD held on October 14, 2005 in Sol Plaatje.
[301] Male participant in FGD held on October 14, 2005 in Sol Plaatje.
[302] Female participant in FGD held on June 10, 2006 in Sol Plaatje.

Members of the FGD also told me that community members are in debt to the ambulance companies, which are privatized. Although it is illegal for the company to deny services based on debt, this is precisely what residents fear will happen. Therefore, the community has taken up a collection to raise money to pay off the company. But Thulani told me they would never pay it off because they accrue debt far faster than they can pay it off. The roads in Lawley 2 are inaccessible to the ambulance, so residents have to walk sometimes as far as 2 miles to the main paved road, which is a ridiculous expectation since ambulances are meant to transport people who are too sick to transport themselves.

In addition, as mentioned in Chapter 2, attending the clinics and hospitals is often an extremely humiliating and alienating experience.

> "When you are HIV positive, sometimes the nurses are reluctant to treat you. They don't want to treat people with HIV/AIDS. That's where you get them referring you to organizations that are doing home-based care."[303]

> "The government has really pushed its responsibility to incapable organizations. Taking the very same tax payer's money and give it to the people who are not capable to do the primary health care that is supposed to be done by the hospitals."[304]

> "Often there is no room at the clinic – it is so packed. I've seen people sitting on the floor. I went to see my mother, and she was on a bed in the middle of a hallway once I finally found her. I asked her how long she had been there, and she said all day. The hospitals are horrible."[305]

Even if squatter camp residents *could* access quality health care, their material social conditions undermine their abilities to sustain healthy lifestyles. For example, Pheello's wife, Elizabeth, is also HIV-positive, which means that she cannot breast feed

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[303] Male participant in FGD held on October 14, 2005 in Sol Plaatje.
[304] Female participant at FGD held on October 20, 2005 in Lawley 2.
[305] Female participant in FGD held on June 10, 2006 in Sol Plaatje.

her baby without risking the child's health. While I was conducting field work, their daughter, Nthabiseng, was under a year old. Often, a child born to an HIV-positive mother will test positive for HIV for the first year of his/her life, but will then turn out to be HIV-negative. It was important for Pheello and Elizabeth to avoid infecting their daughter through breast milk, just in case Nthabiseng would test negative after her first year. Therefore, they were required to purchase formula milk, which costs them close to a third of their disability grant each month. Sometimes they are able to get donations from clinics or NGOs, but this is hardly sustainable. The formula must be mixed with water, but the water in Lawley is often contaminated, so it must be heated up before it can be used. Residents must purchase paraffin in order to heat up their water. The degree to which people must toil simply to survive borders on the absurd.

Many informal settlement residents are not citizens of South Africa, and this makes their survival even more precarious. Non-citizens cannot access social welfare programs of any kind, nor can they attend the clinics and go onto ARV therapy (Henderson 2005: 47). Some residents *are* South African, but do not have ID documents. One very old woman in DRD told me that her ID papers were confiscated when she went to prison briefly for violating a pass law under apartheid, but when she was released, they failed to return the papers to her. Once apartheid ended, she could not prove she was South African, even though she has never lived anywhere else. Her daughter told me that they had been to every government office they could think of, but to no avail. She had simply slipped through the system. This woman was in a wheelchair (which was very difficult to maneuver in the squatter camp), and she would qualify for several welfare

grants as well as health care. However, because she has no proof of her citizenship, she has been transformed into the perfect example of Agamen's *homo sacer*.

Neither Pheello's wife nor Thulani's girlfriend are citizens, which means that they cannot apply for social grants to supplement the family income, but they also have even more limited options for health care. When Elizabeth, Pheello's wife became suddenly extremely ill, she was accepted at the hospital, where she stayed for a month. But her options were very limited in terms of treatment. This was the point at which Pheello began to lose hope and faith in biomedical citizenship.

> "My greatest fear is death, to be honest, simply because I'm worried what my family will survive on. Also taking into cognizance the fact that my wife, she's got no ID as a South African … And then also my daughter has got no birth certificate, and I'm worried that if I die, they won't be able to survive. Who will provide for them? Who will give them meals? So, that's the bottom line – my death."[306]

Access to water, electricity, proper housing, and primary health care is an essential prerequisite for pursuing an anti-retroviral regimen. From my field research, I have found that the provision of anti-retroviral treatment is undermined by community members' unemployment, the paucity of social welfare grants, and a subsequent inability to access nutritious and sustainable food sources. Therefore, even if anti-retroviral treatment is available to poor community members, it is at best difficult and at worst dangerous to endure ARVs in these conditions.

> "I don't even know when I'm going to have a healthy meal from one day to the next. How can I take these ARVs when I can't even afford to eat right?"[307]

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[306] Pheello Limapo. Interview held on November 9, 2005 in Braamfontein, Johannesburg.
[307] Thulani Skhosana. Interview held on September 20, 2005 in Sol Plaatje.

> "How do you give someone ARVs when they don't even have money for food? It clashes completely. So, to me, I'm more for, let's give people better nutrition. Better nutrition, and then they'll live healthy."[308]

> "How are people who are sick going to afford nutritious food, if they are not given grants? So, I suggest that food parcels with the right food should be given to the communities – especially those who are infected."[309]

Unfortunately, this is the precise critique the government forwards in order to avoid financing public expenditure for ARVs. However, these community members would prefer to have both quality public health care (including ARV treatment) *and* sustainable environmental and economic conditions. The government's thanatopolitics makes people choose between ARV treatment and poverty alleviation.

A further public health complication concerns drug resistance. The usage of multiple methods can lead people infected with the disease to take their anti-retroviral medication only intermittently – especially because the drugs are very difficult to sustain. When these medications are not taken on a regimented schedule, the likelihood of developing a drug resistance becomes more likely. The spread of multiple drug-resistant strands of HIV would be cataclysmic in a country with the highest rates of HIV infection in the world. Therefore, the government's denialism is not the only reason universal treatment programs are failing on implementation.

In response to these overwhelming obstacles residents of South Africa's zones of abandonment face, many end up *waiting* – for salvation or death.

> "A world founded on stable principles of redistribution is a predictable world … By contrast, absolute arbitrariness is the power to make the world arbitrary … Absolute power is the power to make oneself unpredictable and deny other people any reasonable anticipation, to place them in total uncertainty by offering no scope to their capacity to predict … In the extreme situations where uncertainty

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[308] "Thandi." [NGO staff]. Interview held on April 15, 2005 in Soweto.
[309] Female participant in FGD held on June 10, 2006 in Sol Plaatje.

> and investment are simultaneously maximized, because, as in a despotic regime or a concentration camp, there are no longer any limits to arbitrariness and unpredictability, all the ultimate stakes, including life and death, are brought into play at every moment" (Bourdieu 2000: 228-230).

When faced with this extreme arbitrariness of power, subjects' response is often to simply wait. For many, waiting is the only response they can muster in the face of such random and absolute oppression. Auyero and Swistun (2007 and *Forthcoming*) utilize Bourdieu's theories on the relationship between power and time to highlight the ways in which uncertainty functions in Brazil's toxic shanty towns. "Domination works … through yielding to the power of others and it is experienced as a waiting time: Waiting (while becoming hopeful and then frustrated) for others to make decisions over their lives; surrendering themselves, in effect, to the authority of others" (Auyero and Swistun *Forthcoming*: 4). In South Africa's informal settlements, I noticed three forms of waiting. First, there is certainly the kind Auyero and Swistun describe in which peoples' uncertainty about their daily survival encourages them to simply wait for the ANC to finally deliver on their promises of liberation. There is also the kind of waiting Biehl describes (2001 and 2005), a waiting *with* death, which refers to the state of abandonment in which they are trapped. Finally, there is waiting for AIDS to finally attack and kill. Because the virus lies dormant and asymptomatic for years, one waits with dread for the hidden virus to finally rear its ugly head and expose itself to the whole community, bringing on stigma along with an excruciating death. Bourdieu notes that "waiting implies submission" (2000: 228). Because the form of power in operation is thanatopolitical in nature, this waiting with and for death unveils peoples' incorporation

of abandonment. Their habitus is perfectly homologous to their position on the margins of the body politic.

But other people refuse to simply wait for their necropolitical fate and choose instead to fight against abandonment.

> "Every power relationship implies, at least *in potentia*, a strategy of struggle, in which the two forces are not superimposed, do not lose their specific nature, or do not finally become confused. Each constitutes for the other a kind of permanent limit, a point of possible reversal" (Foucault 2000a: 346).

During my field work, Pheello was supporting his wife and child with a disability grant. However, a disability grant only lasts for one year, and then must be renewed. The labyrinth of bureaucracy ties up the process for three months. So even those who will qualify for renewal are without any funding while they wait. Pheello became extremely ill during the time his grant was in hiatus. He was in and out of the hospital, and couldn't then work to find money to support his family at home. They diagnosed him with TB, but he refused the treatment because he would have had to stay in the hospital longer, and he didn't think his family could survive that.[310]

> "I was actually faced with a very difficult period in my life. And I thought maybe it was finished, had it not been for the handouts I received from my comrades. Otherwise, there was no way, no avenue whatsoever, where I could access anything. I thought maybe it was the end of my life. It was really difficult during that past three months that coincided with the stopping of the money."[311]

In South Africa's zones of abandonment, residents are reduced to competition over extremely scarce resources which also destroys *ubuntu* and their communal sense of responsibility to care for one another. Pheello faced a bit of scorn from the members of

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[310] This all occurred in August and September 2005.
[311] Pheello Limapo. Interview held on October 5, 2005 in Sol Plaatje.

the support group he began because people thought it unfair that his family would reap the various rewards that came with participation in my research project. When he discussed this with me, I suggested that any benefits be divided amongst the group. He said very quietly and dejectedly, "I try to help them when I can, but I have to think of my own family first. If it hadn't been for my work with you, my family wouldn't have survived these last few months. I can't afford to share with the whole group."[312]

Throughout this harrowing illness and lack of funds, Pheello's trust in biomedical citizenship was not shaken; he kept his eye on the prize. He used his hospitalization and connections at TAC to jump the ARV queue, and get onto the medications immediately. He believed his salvation had finally arrived, especially when his disability grant was reinstated. But then, as explained in the previous chapter, it was cut – when the ARVs caused his CD4 count to rise above the 200 cut-off. He had heard rumors this would happen, but he had believed he could fight the system, through his biomedical connections. He could not. He also believed he had the right to access food parcels while on the roll-out program. He had even organized his support group members to demand these rights, but after many expensive trips to town and many long days wasted waiting in queues and filling out paperwork, he finally gave up. He was on treatment, but had absolutely no economic income to buy food, formula milk, or paraffin, or to cover transport costs to even go to the clinic for his ARV check-ups. Despite his many efforts to claim his rights as a biomedical citizen, he was denied access to the body politic. And then his wife and child fell ill. Elizabeth was close to death. And this is when he finally

[312] Field notes, October 6, 2005 in Sol Plaatje.

lost hope in biomedical salvation not because it wasn't helping him, but because the obstacles for someone living in the zone of abandonment were simply too great.

One of Pheello's fellow support group members once described him to me as a "little ball of energy," and when he isn't too sick, this is an apt description. When I visited him in the hospital and he could see that I was quite concerned about his condition, he used to say to me, "Claire, don't you worry. I'm a fighter." And Pheello is a fighter. He wouldn't have survived if he weren't. He never gave up fighting. When he realized biomedical support was not going to fulfill all of his needs, he began searching for other options. This is when he started using traditional healing. But he never stopped taking his ARVs. His new life strategy was hybridity.

> "But this structure always includes a share of indetermination, linked in particular to the fact that, above all in a field as little institutionalized as this one, agents, no matter how strict the necessities inscribed in their position, always dispose of an objective margin of freedom … and that these freedoms augment each other in the billiard game of structured interactions, thus opening a place, *especially in periods of crisis*, for strategies capable of subverting the established distribution of chances and profits in favor of the available margin of maneuver" (Bourdieu 1996a: 238-39; my emphasis)

In both Agamben and Biehl's work, those abandoned to the zones of indistinction have no agency. While I found that some people embody abandonment, others resist their *homo sacer* status. Some join social movements, some use biomedical citizenship to re-claim a position within the body politic, and others are simply embedded in community politics. The difference between waiting and fighting is in part a function of the levels of arbitrary oppression one experiences, but also depends on the disease's progression. As people get closer to the threshold of death, indeterminacy overpowers. But habitus is not simply structured and imposed from above. It is a complex

interweaving of history, structure, experience and belief. Pheello shows us that even when faced with the most powerful forces of neglect and abandonment, there are always "margins of maneuver" to exploit.

Ambiguity marks the habitus of those who live on the threshold of life and death, but also of political subjectivity or objectivity. While all embody a certain 'taste for necessity' due to the very practical strategies deployed to survive, a profound indeterminancy is also incorporated. My ethnography shows that peoples' practices and beliefs do not simply reflect any one hegemonic discourse. They resist disciplinary and regulatory power – partially because AIDS and poverty create unruly bodies, but also because urban subjectivities are hybrid. This is why it is essential to situate peoples' health-seeking behavior within its social context.

Habitus in Hysteresis

"In situations of crisis or sudden change, especially those seen at the time of abrupt encounters between civilizations linked to the colonial situation or too-rapid movements in social space, agents often have difficulty in holding together the dispositions associated with different states or stages, and some of them, often those who are best adapted to the previous state of the game, have difficulty in adjusting to the new established order. Their dispositions become dysfunctional and the efforts they may make to perpetuate them help to plunge them deeper into failure" (Bourdieu 2000: 161).

In order to make sense of the hybrid healing strategies deployed by HIV-infected South Africans, my research requires a theory of practice which can make sense of the emergence of cultural hybridity despite tremendous structural constraints, the imposition of concretized notions of race, class, and gender, and a living legacy of colonial bifurcation. As mentioned in the introduction, theories of practice have a tendency to err either by imposing a rigid and totalizing structural determinacy or by uncritically

celebrating flexibility and agency. They very rarely succeed in establishing a multi-directional causal relationship or in showing the constant push and pull between these two poles. It is for both of these reasons – the need to pay heed to the mutual dependency of structure and agency *but* to also account for the way in which disjunctures can arise between structural forces and practices that I have selected the theories of Pierre Bourdieu to make sense of this post-colonial hybridity.

What sets Pierre Bourdieu's work apart from the other theorists exploring the relationship between structure and agency is that his theory of habitus was developed through field research in colonial Algeria (Bourdieu 1958/1962; 1979). "It was not by chance that the relationship between structures and habitus was constituted as a theoretical problem in relation to a historical situation in which that problem was in a sense presented by reality itself, in the form of a permanent *discrepancy* between the agents' economic dispositions and the economic world in which they had to act" (Bourdieu 1958/1962: vii).

In Bourdieu's early writings, the 'clash of civilizations' was used to denote the "confrontation between two social systems locked in asymmetrical relations of material and symbolic power" (Wacquant 2004: 393). But this 'clash,' the bifurcation caused by the colonial encounter, was also incorporated into the very bodies of the colonized, leading to "incongruent logics of action" (Wacquant 2004: 392).

> "In all realms of existence, at all levels of experience, one finds the same successive or simultaneous contradictions, the same ambiguities. The patterns of behavior and the economic ethos imported by colonization coexist inside of each subject with the patterns and ethos inherited from ancestral tradition" (Bourdieu and Sayad 1964/2004: 464).

This incorporated ambivalence has a life much longer than colonialism itself, because it will be consistently reiterated and re-incorporated through unconscious mechanisms of cultural reproduction (Bourdieu 1990). "The peasant can be liberated from the colonist without being liberated from the contradictions that colonization has nurtured in him" (Bourdieu and Sayad 1964/2004: 471-72).

In Bourdieu's theories, habitus refers to the embodiment of schemas of perception and structural hierarchies. "[B]odily habitus is what is experienced as most 'natural,' that upon which conscious action has no grip" (Bourdieu 1962/2004: 584). In his early theories, he argued that part of the function of the habitus, if not its entire purpose, was to incorporate and therefore synthesize the binaristic ontologies of the social world. "Bourdieu initially mobilized the idea of habitus to make sense of this seemingly magical integration of the disparate experiences that make up a biography" (Steinmetz 2006: 457). Bourdieu refers to the habitus as a "synthetic unity" (Ibid: 582). And in fact, he argues, that colonialism cannot be overcome until the contradictions it left behind in the habituses of its subjects are grasped and then surmounted (Bourdieu and Sayad 1964/2004: 470). However, in combining Bhabha's theory of hybridity with Bourdieu's concept of habitus, I am suggesting that embodied structural ambivalence and contradiction do not necessarily reconcile over time, and that habituses can remain more permanently "cleaved" (Bourdieu 1999a; Wacquant 2004: 382; Steinmetz 2006: 457). I will return to this point in a moment.

I have shown, in this chapter, that despite the bifurcated nature of the field of health and healing *and* the powerful bio-political strategies in circulation in post-apartheid South Africa, certain HIV-positive South Africans exhibit a hybrid habitus.

While the ontology and epistemology are themselves inflected with hybridity, several important questions still remain. Given the particularities of the South African field of health and healing, how exactly can we account for subjects' ability to straddle two opposing poles of the same field? How do we make sense of the emergent hybridity, and what does it tell us about the possible future of the field? But I have also discovered two different versions of hybridity: residents of formal urban townships present a habitus structured over a long period of time and residents of informal settlements embody a much more radically ambivalent and indeterminate habitus. How, then, do we make sense of these differences?

There are two options for analyzing the hybrid habitus that has emerged in post-apartheid South Africa using a Bourdieuian conceptual framework: dominated taste (a taste for necessity) or hysteresis.

Dominated Taste

> "Although all members of the settled field agree on what counts as symbolic capital, the dominated may still hold proudly to a dissonant set of 'values' and even developed a taste for necessity, a taste for their own cultural domination. We should not exaggerate the importance of dissidence or difference, which are as likely to reproduce power hierarchies is they are to disrupt the operations of a field" (Steinmetz 2007b: 323).

The dominated are rooted in their material social conditions, and as such, their 'tastes' are oriented toward products and symbols that have a direct correlation to or use-value in the material world (Bourdieu 1984). "Perhaps the most ruthless call to order, which in itself no doubt explains the extraordinary *realism* of the working classes, stems from the closure effect of the homogeneity of the directly experienced social world" (Bourdieu 1984: 381). This is partially *because* of the needs they require in order to survive, but Bourdieu notes that the refinement of these 'tastes for necessity' also serve to

reify their own subjugated class position. In this way, Bourdieu's theory of 'dominated taste' is reminiscent of Marx's 'false consciousness.'

Homologies between habitus and class positions, between taste and goods production, are always the result of class struggle, which nonetheless tend to reproduce the same social hierarchies *because* the dominant classes change the rules of the game to benefit their structural position of power, but also because the dominated are tied to their conditions of existence and relish their dominated tastes (misrecognition). "Adapting to a dominated position implies a form of acceptance of domination" (Bourdieu 1984: 386). Entrenched historical hierarchies and the tastes and habitus they produce are difficult to overturn, not only because the processes of their reproduction are misrecognized or hidden, but because the dominant classes are *not* reliant on economic necessities and are therefore free to invest in their own continued legitimation.

In a certain sense, the working class is 'free' from the confines of culture and their collective tastes serve to bind them together as a class-in-itself. However, the very tools that they would require to resist the dominant classes (which are more internally fractured) are controlled (economically, culturally and symbolically) by the dominant classes. This is because it is in the area of education and culture where the dominated classes have the least opportunity in discovering their objective interests. In these fields, the dominated are not only excluded from the symbolic struggles over capital and its conversion, but they are also the target of symbolic violence.

Resistance is possible, however. Revealing his debt to Marx, Bourdieu notes that the dominated would first have to *recognize* their own domination, and then engage in symbolic struggle for recognition and legitimacy. In order to change the world, one has

to "change the ways of world-making" (Bourdieu 1989: 23), meaning, one needs power to legitimate a particular vision of the world and have control over the practical operations by which certain groups are produced and reproduced. Because of the realities of poverty and exclusion, this is difficult, but never impossible for the dominated classes. The habitus "is a virtue made of necessity" for the working classes – a "deep-seated disposition which is in no way incompatible with a revolutionary intention" (Bourdieu 1984: 372).

In post-apartheid South Africa, we could understand Black South Africans' insistent usage of indigenous healing as a form of 'dominated taste.' Both the epistemology and the ontology of indigenous healing reflect the realities of subjugation because healing the body involves situating it within a social, historical and economic context. Further, indigenous healing accommodates hybridity. For all of these reasons, it is very definitely a 'taste of necessity.'

However, this particular 'dominated taste' is not without cultural capital, nor is it misrecognized as subjugated. Meaning, both the producers and the consumers of traditional healing are fully aware of its dominated position in the field, and are currently engaged in a symbolic struggle for recognition. As explained in the previous chapter, Mbeki and Tshabalala-Msimang utilize the cultural capital of 'authenticity' that traditional healing possesses in order to advance their own political objectives. And traditional forms of healing do wield a special kind of capital that the producers and users of biomedical healing covet: the ability to speak for and to the masses. Some traditional healers are also organizing and mobilizing for greater legitimacy and voice. Unfortunately these struggles are fragmented and replete with inter-personal squabbling.

But it is significant that such a dominated form of healing, utilized by only those who lack all forms of capital, would be playing such a prominent role in the symbolic struggles in which the field itself is embroiled.

In addition, however, dominated taste plays a crucial role in the habituses of informal settlements dwellers, whose every movement is bounded by the quest for survival. Their position at the nadir of the social order is reflected in their arbitrary tastes for healing because objective structural hierarchies are often replicated and reinforced through subjects' habituses. "Habitus of necessity operates as a *defense mechanism* against necessity" (Bourdieu 2000: 232-233).

However, the concept of dominated taste cannot account for the reasons *why* people would *mix* methods in a field bifurcated by the myth of incommensurability, and it also does not offer an explanation for *how* certain informal settlement residents are able to refuse to embody their own subjugation. Therefore, it is equally important to revisit Bourdieu's theory of hysteresis.

Hysteresis

> "[I]t can happen that, in what might be called the Don Quixote effect, dispositions are out of line with the field and with the 'collective expectations' which are constitutive of its normality. This is the case, in particular, when a field undergoes a major crisis and its regularities (even its rules) are profoundly changed. In contrast to what happens in situations of concordance when the self-evidence linked to adjustment renders invisible the habitus which makes it possible, the relatively autonomous principle of legality and regularity that habitus constitutes then appears very clearly" (Bourdieu 2000: 160).

In conditions of sustained, systemic disjunction (as in the case of colonialism), Bourdieu notes that a suspension of habitus (its ideological "hysteresis") is likely (Bourdieu 1977 and 1990; Bourdieu and Wacquant 1992). For Bourdieu, *hysteresis* is "necessarily implied in the logic of the constitution of habitus" (1977: 78), and it

represents a kind of "structural lag" (1977: 85) between the "exertion of a social force and the deployment of its effects" (Wacquant 2004: 392). In other words, there is a delay between the imposition or inculcation of particular structural dispositions and subjects' capacity or willingness to grasp and then practice them.[313] Hysteresis refers to a habitus that *once* was fitted to its field, but has somehow managed to survive despite the structural changes the field has undergone. In this way, it is a habitus that is "out of joint" with the present (Derrida 1994/2006) and is thus no longer reflective of the field in which it is situated, which is why Bourdieu labels it a "Don Quixote effect" (Quoted above; See also Bourdieu 1996a).

Hysteresis entails "*allodoxia* ('misapprehension')" which makes those who inhabit a habitus in hysteresis "accomplices in their own mystification" (Bourdieu 1984: 142). Therefore, hysteresis is a form of mystification, but one that is markedly different than having a taste for one's own domination. In hysteresis, the misrecognition arises from a refusal (sometimes unconscious) to acknowledge one's dominated position and thus entails a *denial* of subjugation. It represents a kind of embodied resistance to the revaluation of capital in the field (Bourdieu 1984).

For Bourdieu, the state of hysteresis has several possible outcomes. First and most often, hysteresis will simply be resolved by the eventual re-positioning or re-adjustment of habitus over time. However, it could also have more radical and prolonged effects if the hysteresis is shared by a collectivity. Second then, it is possible that a group whose habitus is "out of joint" will be able to successfully struggle to transform the value of capital and thus the hierarchies within the field, so that the field will be re-ordered

[313] The reason for this "structural lag" is that the process of embodiment takes time.

until subjects' habituses in hysteresis will now be perfectly fitted to the field. Finally, hysteresis can evoke an "anti-institutional cast of mind" which "points towards a denunciation of the tacit assumptions of the social order, a practical suspension of doxic adherence to the prizes it offers and the values it professes, and a withholding of the investments which are a necessary condition of its functioning" (Bourdieu 1984: 144). This can result in simply a detachment from the world and its rewards, but it can equally become "a showdown over the very foundations of the social order" (Bourdieu 1984: 147).

In his work on colonialism, Bourdieu explains that it is the economic transformations colonialism enacted which brings about a habitus in hysteresis. "Being both a consequence and the precondition of economic transformations, this transformation [of the system of cultural models and values] takes place only through the mediation of the experience and practice of individuals differently situated with respect to the economic system" (Bourdieu 1963/1979: 1). The culture of the Algerian peasantry was radically transformed with the introduction of capitalist modes of production and exchange. Before colonialism, the relationship between work and its product was veiled by agricultural cycles, certain communal welfare strategies, etc. But the colonialist intervention and their immiseration by it, makes the peasantry recognize the need for productivity and the absolute necessity for work to survive. People have discovered its scarcity, which was inconceivable in an economy which was not oriented toward productivity (Ibid: 33). They have had to comply with calculation. This produces an incommensurability when comparing the two systems (Ibid: 41-44): "necessity can only appear as such to a consciousness for which other possibles exist" (Ibid: 44).

In the case of colonialism (and other historical moments of radical disjunction), only *half* of the habitus is in hysteresis. "Remnants" of the pre-capitalist mode of production and "ancestral tradition" adhere to the peasants' habituses, but certain aspects of the colonial-capitalist ethos have also been incorporated, such that the pre-colonial and colonial reside together in subjects' habituses, "as if these societies were not contemporary with themselves" (Ibid: 5; See also Bourdieu and Sayad 1964/2004: 464). "In reality, like an ambiguous *Gestalt*, each practice lends itself to a dual reading because it contains reference to the two logics imposed by necessity" (Bourdieu 1963/1979: 49).

> "Habitus is the *mediating category*, straddling the divide between the objective and the subjective, that enabled Bourdieu to capture and depict the troubled and double-sided world of crumbling colonial Algeria. In this turbid world, social and mental structures were not only out of kilter with each other but also themselves composed of a motley mixture of ingrown tradition and colonial imposition, and the strategies of the autochthons prone to vacillating between two antinomic principles … Deracinated peasants and urban subproletarians were thus revealed to be bifurcated beings, disoriented and discultured by the combined experience of war and the capsizing of established social relations" (Wacquant 2004: 391-92).

Bourdieu suggests that this lived duality causes not only personal suffering and turmoil, but also disallows these colonial hybrid subjects the capacity for developing a revolutionary consciousness (Bourdieu 1963/1979; 1964/2000).

> "Habitus is not necessarily adapted to its situation nor necessarily coherent. It has degrees of integration … Thus it can be observed that to contradictory positions, which tend to exert structural 'double blinds' on their occupants, there often correspond destabilized habitus, torn by contradiction and internal division, generating suffering" (Bourdieu 2000: 160).

But then sometimes, Bourdieu implies that this embodied contradiction may help the colonized survive the inconsistencies of colonial rule (as opposed to simply being another effect of them): "And the inconsistencies are perhaps what enables them to bear (if not

overcome) the contradiction of which they are a product" (Bourdieu and Sayad 1964/2004: 467-468). And later in his career, Bourdieu does sometimes suggest that a habitus may be permanently *clivé* (Bourdieu 1999a and 2004; Wacquant 2004; Steinmetz 2007), but because the integrating capacity of habitus seems to be so important to his theory, Bourdieu cannot explain permanent hybridity.[314] I have chosen the term hybridity (despite its faults) because unlike 'syncretism,' it suggests an embodied contradiction and ambivalence. Indigenous and biomedical healing are not reconciled or dialectically synthesized into a new third form, they remain somewhat autonomous and incongruous paradigms, which happen to reside, alongside one another, in certain peoples' habituses.

Hybrid Habitus in Hysteresis

"[P]eople are able to move between, and often straddle, multiple treatment cosmologies. Working with bounded dichotomies in which 'traditional' and 'biomedical' knowledge systems are rooted in 'local' or 'global' epistemologies respectively is thus misleading" (Mills 2005: 129).

The emergent hybrid habitus in South Africa does reflect a previous historical period. As explained in Chapter 2, due to the strict geographical and cultural segregation required by the apartheid system, indigenous and biomedical healing compromised two separate fields. One of the primary locations where the healing methods mixed was in urban townships (where it was necessary to provide biomedical health care in order to maintain a healthy Black workforce). Therefore, in this sense, those whose habitus is informed by the dual logics of both indigenous and biomedical healing represent a certain kind of hysteresis. In other words, the colonial bifurcations of the apartheid system where indelibly marked on the habituses of township residents. Because township

[314] I will return to this point in the final chapter.

residents were stuck in the middle of these two segregated fields of healing (and actually between the two economies and systems of indirect rule), their habituses served to bridge the two forms of healing before they were structurally bridged during the transition. Because bodies serve as "memory pads" (Bourdieu 2000: 141), hybridity is a leftover of the colonial period, but it also foreshadowed the merging of the fields. This 'incongruent' habitus is *legitimated* by the integration of the field that accompanied the transition to post-apartheid.

Therefore, the hybrid practices of HIV-infected South Africans first emerged out of apartheid segregation policies. However, the conditions and implications of this hybridity are different in a *post*-apartheid system. The HIV/AIDS pandemic has not only given a privileged structural position to bio-medical science, it has insured the political potency of a myth of incommensurability. Those in dominant positions in the field of health and healing are deeply invested in maintaining segregation between the forms of healing. Their very domination and legitimacy is based on their ability if not to squash competing paradigms, at least to wholly and completely dominate, define, and thereby contain them. If hybridity is possible, then their legitimate (and therefore doxic) vision of the world is impossible. This is true for both biomedical healing and state denialism. The dominant insist that the merging of the fields result in the symbolic annihilation of alternative approaches; therefore, the myth of incommensurability operates in order to attempt to secure the hegemonic legitimation of one approach, at the wholesale expense of the other. Whereas those whose habitus is hybrid unveil a different possibility for the future structure of the field. This comprises a second way in which the hybrid habitus is 'out of joint' with the present. Further, there is a structural disjuncture (no homology)

between the realities of consumption within the field of health and healing and the logic of the field as it is articulated in the symbolic struggle raging in the field of power. This is made possible by the conjuncture of crises that marked the transition from apartheid to post-apartheid.

In fact the intermediate position of those in urban townships is an integral feature of this hybrid habitus in hysteresis. In *The Rules of Art* (1996a), Flaubert is able to constitute a new position/disposition through a double refusal which is only possible because he is situated in an ambiguous position within the field of power.

> "… *it is from the very particular position that they occupy* in the literary microcosm that writers such as Flaubert, Baudelaire … become aware of a political conjuncture which, grasped through the categories of perception inherent in their dispositions, allows and encourages their inclination to independence" (Bourdieu 1996a: 60; my emphasis).

It is through the process of objectifying the whole space of positions in which he is situated, that Flaubert's own mental structure takes form (Bourdieu 1996a: 104). It is only for this reason that Flaubert is able to reconcile the incompatabilities of the social world, which are also instituted in the mind "in the form of principles of vision and division" (Ibid).

I would like to suggest that it is the inhabitants of the in-between spaces of *both* the apartheid and post-apartheid system, the residents of formal urban townships (like Soweto) – those stuck *between* two economies, two logics of distinction (modernity and traditionalism) and two classes (the wealthy and the poor) – who are the only ones capable of envisioning and embodying a new hybrid disposition, which marks what I think is the *future* of the field of health and healing. And in this way, it is actually the

denialist state and the promoters of biomedical hegemony who are "out of joint" with the realities of the field.

> "In social universes in which the dominants must constantly change to stay the same, they necessarily tend to be divided, especially during periods of rapid transformation in the current mode of reproduction, according to the 'degrees' (and the forms) of reconversion of their strategies of reproduction. The agents or groups best equipped with the forms of capital giving access to the new instruments of reproduction, who are thus the most likely and most able to undertake a reconversion, are opposed to the agents or groups most closely linked to the threatened form of capital" (Bourdieu 1996b: 278)

In Bourdieu's theories of colonialism, it is also those who occupy a more intermediary position in the colonial system (the urban proletariat as opposed to the peasants) who develop a revolutionary consciousness and who can therefore articulate new tastes or habituses. A margin of maneuver requires freedom from necessity.

> "Before individual practices – not least, economic acts – can be organized in accordance with a life-plan and before a systematic, rational awareness of the economic system *as* a system can be formed, there has to be some relaxation in the pressure of the economic necessity which forbids that suspension of fascinated adherence to the present 'given' without which no 'lateral possible' can be posited" (Bourdieu 1963/1979: 50).

The peasants, on the other hand, are confined to arbitrariness and the uncertainty and waiting it inspires. The sub-proletarian have given way to "resigned surrender or to the magical impatience of those who are too crushed by the present to be able to look to anything other than a utopian future, an immediate, magical negation of the present" (Ibid: 63). According to Bourdieu, they cannot grasp their positionality, or recognize their situation within a broader context, and as such, "their aspirations, their demands, and even their revolt are expressed within the logic the system imposes on them … In short, absolute alienation annihilates even awareness of being alienated" (Ibid: 61).

> "The 'causality of the probable' which tends to favour the adjustment of expectations to chances is no doubt one of the most powerful factors of conservation of the established order. On the one hand, it ensures the unconditional submission of the dominated to the established order that is implied in the doxic relation to the world, an immediate adherence which puts the most intolerable conditions of existence … beyond questioning and challenge. On the other hand, it favours the acquisition of dispositions, which, being adjusted to disadvantaged, declining positions, threatened with disappearance … leave agents ill-prepared to face the demands of the social order, especially inasmuch as they encourage various forms of self-exploitation" (Bourdieu 2000: 231).

This formulation would help to explain why the hybrid habitus, which potentially augurs a new direction for the field of health and healing, would develop in the townships as opposed to the squatter camps of the 'new' South Africa. After all, the ability to generate new strategies is always bound by the "limits of structural constraints of which they are the product and which define them" (Bourdieu 2000: 138). However, while my research does show a much more structured hybridity in the habituses of township dwellers, the residents of informal settlements do not *necessarily* lack revolutionary potential, nor are they without hybridity. It is true that their habituses are mostly aimed toward survivorhood and necessity, which sometimes produces despondency and "resigned surrender," but it is equally true that some of the poorest of the poor are developing new hybrid strategies through their circumnavigation of the material strictures imposed by abject poverty and AIDS.

Because most of Bourdieu's work and his field theory in particular were developed out of analyses of an ever-hegemonizing and neo-liberalizing France, Bourdieu privileged stasis and hegemony over radical transformation. As a result, the concept of habitus increasingly suffered from the imposition of structural determinism. However, as noted in the Introduction, Bourdieu insisted that hegemony is secured

through constant transformation, always leaving open the possibility for not only agency, but radical systemic disjuncture. For Bourdieu, the agential component of 'habitus' emerges from the structural indeterminacy offered by subjects' participation in more than one field. There are various matrices formed by the interconnection between the schemes of perception (discursive formations) and objective structural relations, so that the result of subjects' practical itineraries is always already peripatetic and improvisational. Habitus is "the strategy-generating principle enabling agents to cope with unforeseen and ever-changing situations … a system of lasting and transposable dispositions which, integrating past experiences, functions at every moment as a matrix of perceptions, appreciations and actions and makes possible the achievement of infinitely diversified tasks" (Bourdieu 1997: 72, 95; Also quoted in Bourdieu and Wacquant 2002: 18). Therefore, in some sense, Bourdieu recognized that peoples' habituses were conflictually inscribed and practiced though he did not always explore the implications of this multiplicity.

I have argued that because urban township dwellers occupy in-between positions in the social field and in the field of health and healing and also have some freedom from necessity, they are better able to objectify the field of position-takings and thus to find room to maneuver. However, squatter camp residents are also in-between the rural and the urban, the modern and the traditional, the body politic and the zone of abandonment. They live on the threshold, and although they are limited by their material conditions and exhibit a taste for necessity, the ambivalence of their habitus and the multiple healing options available, *can* afford them radical agency. Because of the ambiguity maintained in the field of health and healing and sustained by the symbolic struggle raging in the

public sphere, people in even the most oppressive social conditions still have options. And this allows them to (consciously or unconsciously) select or disavow different discourses based on their personal experiences, needs and beliefs. In their navigation of a multi-vocal discursive field, these subjects create new spatial, material and symbolic tactics because more possibilities (and more radical kinds of interpretation) are possible.

> "… habitus helps to determine what transforms it. If it is accepted that the principle of the transformation of habitus lies in the gap, experienced as a positive or negative surprise, between expectations and experience, one must suppose that the extent of this gap and the significance attributed to it depend on habitus" (Bourdieu 2000: 149).

But in addition to opportunities for individual or collective agency, Bourdieu suggests there are certain conditions that could instigate more radical structural transformation. Resistance or the ability to radically disrupt the homologous relationships between objective structures, schemas of perception, and subjective embodiment requires three interrelated conditions. First, radical rupture is much more likely in times of crisis, but only if agents are positioned in such a way to seize upon structural indetermination (1996a: 238-239). And the more authority and legitimacy the actors within the field wield in the field of power or in the structured social space, the more wide-reaching reverberations field rupture can have. This is because "however great the autonomy of the field, the chances of success of strategies of conservation and subversion always depend in part on the reinforcement that one or another camp can find in external forces" (Bourdieu 1996a: 234). Because the field of health and healing is unsettled, bemired in crisis, and its dominant players are engaged in a symbolic struggle with the state, radical transformation is imminently possible, which is why the stakes of the game are so high.

However, before agents can seize upon the opportunities social upheaval affords them, they must occupy a particular position/disposition in the field and they must be able to recognize their domination and symbolically interpret it. In other words, heterodoxy is provisional until the dominated have both the material *and* symbolic capacity to subvert the "real that is imposed on them" (Bourdieu 1977: 169). "It is only exceptionally, *especially in moments of crisis*, that certain agents may develop a conscious and explicit representation of the game as a game, one which destroys the investment in the game, the *illusio*, by making it appear what it always objectively is … that is, a historical fictions, or in Durkheim's terms, a 'well-founded illusion'" (Bourdieu 1996a: FN 19, 382; my emphasis). In order for the field of health and healing to be truly integrated, hybridity must become a new 'taste' which is consciously recognized and advocated for in the form of heterodoxy. Indigenous healers would need to organize and so too would HIV-infected South Africans, to demand that hybridity become a taste in its own right, as opposed to simply a strategy performed in order to survive and navigate structural inequality. The battles in the field of power, and their future configurations, will also play a role in the future settling of the field, which at this point, is still indeterminate.

Conclusion

Bourdieu's theories are so compelling partially because of the attention he gives to both discursive and material causal mechanisms. In the context of this project, it is vitally important to recognize the role 'objectifying operations' and the materiality of the body play in subjects' navigation of a multi-vocal discursive field. The abject poverty

with which the majority of HIV-positive South Africans must contend offers more of a threat to survival than the disease itself. The role neo-liberal economic restructuring, ever-increasing levels of poverty, and peoples' limited access to basic services (water, electricity, housing, education, health care), seriously impacts peoples' strategies of survival, their conceptualizations of the disease, and their habituses. Therefore, while drawing on Bourdieu's theories, I have also suggested four interventions. First, habitus does not necessarily require the integration of contradictory logics. Second, in addition to reflecting a *previous* structure of the field, hysteresis can equally augur its future configuration. Third, those whose habituses are informed by necessity are not necessarily without agency or revolutionary capabilities.

Finally, and this is a point I have not yet articulated in detail, Bourdieu's theories underestimate the impact the materiality of the body can have on these processes. This is because he fails to account for the habitus of a diseased body. His theories assume a certain physical mobility and corporeal vitality which flouts the experiences of a diseased or dying body.[315] The diseased bodies of people living with HIV/AIDS in South Africa force us to consider the way in which the material limitations of the body trace, in important ways, the contours of the body politic.

In post-apartheid South Africa, the people whose lives have been hardest hit by the dual pandemics of poverty and HIV/AIDS, engage in practices which undermine and contradict the dominant discourses which name and contain the virus, the forms of capital invested in the AIDS industry, and the operations of bio-power practiced by international health agencies, health care institutions and the post-apartheid state. The field of health

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[315] See le Marcis 2004 for further discussion of this exclusion.

and healing has merged but remains politically, economically and culturally bifurcated. And in fact, there is a bifurcation of subject's doxic understandings of the world. This doxic dichotomy is in part a legacy of apartheid, but it is maintained by the symbolic struggle between biomedical science and a denialist state, differential techniques of power, and geographical, economic and racial segregation. The disjuncture between the field of health and healing and the habitus of people affected by HIV necessitates the bodily incorporation and preservation of a fundamentally contradictory logic of practice. Because of this, the hysteresis continues, but it is also being re-fashioned as both resistance and life strategy under post-colonialism. I have shown that this hybridity occurs in part because indigenous healing accommodates hybrid practices and beliefs and in part because those whose habituses are more historically and structurally hybrid (long-term residents of formal urban townships) occupy an important in-between space in the field. However, I have also uncovered a more ambiguous and indeterminate hybridity amongst the residents of informal settlements. All of these subjects' habituses are to some extent cloven (because they straddle binary systems in both the past and the present), but this maintains an ambivalence that disrupts inscription. In the end, it is only by revisiting Bourdieu's initial development of the theory of habitus, constructed out of the wreckage of colonialism in Algeria, that we can make sense of the bio-politics of HIV/AIDS in post-apartheid South Africa.

Chapter 5

The Crisis of Liberation:

Phobogenic Masculinity, 'Women's Rights,'

and the Political Economy of Sexuality

The Crisis of Masculinity

"Liberal versions of sexuality, which mark South Africa's new democracy, have had a number of highly contradictory consequences for women and men, as old notions of masculinity and male privilege have been destabilized. *The transition to democracy has precipitated a crisis of masculinity*. Orthodox notions of masculinity are being challenged and new versions of masculinity are emerging in their place. Some men are seeking to be part of a new social order while others are defensively clinging to more familiar routines" (Walker 2005:1; my emphasis).

According to both academic and popular analysis, the dehumanization of Black men under apartheid and the high rates of unemployment inaugurated by deindustrialization have triggered a 'crisis of masculinity,' causing men to act out their frustrations on women's bodies. This theory is used to explain everything from high rates of rape and violence against women, to stigmatizing behaviors, and even vindictive promiscuity. The 'crisis of masculinity' analysis is widespread, taking up significant space in popular newspapers, in academic work, and in the discourses on gender promoted by NGOs and social movements.

From the end of apartheid through the early years of the new democracy, public discussions about gender and sexuality were slowly on the rise, peaking in 2001-2002

with a very public discussion of the pervasiveness of rape and domestic violence triggered by a spate of 'baby rapes' (Posel 2005). In October 2001, a case of an infant who was sexually abused by six adult family members became the source of national moral outcry, which turned into national panic and horror, when subsequent news footage began uncovering the pervasiveness of the sexual abuse of children in post-apartheid South Africa (Ibid).

The most prominent and scandalous explanation given for this national trend was that men believed that they would be cured of AIDS if they had sex with a virgin (Leclerc-Madlala 1997; *Sunday Times* 1999; *Sunday Independent* 2005). "I don't know where the myth that if a man slept with an infant he could be cured of AIDS came from, but I do think it explains the rise in rapes in recent years."[316] While it is certainly questionable that this myth is actually a causal factor for the high incidences of sexual violence in South Africa,[317] the 'baby rape' controversy marked the beginning of a very public debate about sexuality and violence. "The most vociferous of these outbursts were preoccupied with sexual menace on the part of men, which was typically not diminished by insinuations about any complicities on the part of their female victims" (Posel 2005: 240). According to Posel, these public debates about sexuality unveiled a widespread fear about the moral state of the nation.

Then Deputy President Jacob Zuma commented: "there is a consensus that there is something seriously wrong in our society. We are still haunted by the news of six adult

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[316] Pheello Limapo. Interview held on November 9, 2005 in Braamfontein, Johannesburg.
[317] In an effort to show that this 'baby rape' discourse is not unique to South Africa, Helen Epstein (2007) has uncovered the 'myth about the myth,' situating its antecedent in 19th century America, where rumours were circulated about recent European immigrants who were said to believe they could cure themselves of syphilis if they had sex with a virgin.

men having raped a 9 month-old baby, and there are many other cases, which display barbarism and moral decay of the worst kind" (Zuma 2001, quoted in Posel 2005: 247).[318]

> "We look into the past not to excuse or explain away the violence but to interrogate the many ways in which it continues to shape and condition the present … As for apartheid's dehumanisation, how do black people recover their dignity? How do black men recover their manhood? In times of crisis, how does masculinity deal with a community? One such crisis is the HIV/Aids scourge. It has been alleged that fear of that illness has contributed to the rape of infants, because of the myth that sexual intercourse with infants cures Aids. What does this say about a concept of manhood, which privileges men and gives them the right to seek their own protection and cure at the expense of others?" (*Star* 2002).

This national fear that post-apartheid South Africa is plagued by a "moral decay," acted out through unbridled male sexuality, shifted from an historical moment of crisis, into a prolonged, hegemonic narrative about the 'crisis of masculinity' more generally defined. From 2002 through 2006, *The Star* newspaper, Johannesburg's most popular daily, published on average 20 articles a year deploying this 'crisis of masculinity' argument to explain everything from high rates of violence against women to the infrequency of condom usage.

> "[T]he era of conflict from which we have just emerged so damaged South Africa's psyche that we find it difficult to distinguish between right and wrong. So we have man-beasts roaming our streets and homes, raping and beating women at will" (*Mail and Guardian* 2002b).

> "Men, especially black men, found themselves diminished by the system, which caused them to be called 'boys' and to be unable to take up responsible positions, so the only place to be the 'boss' was in the home" (*The Star* 2003).

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[318] In an ironic twist of fate, Zuma's own acquittal on rape charges will spawn a new public controversy on sexuality five years later. This court case will be discussed briefly later in this chapter.

But this discourse on masculinity is also quite prevalent in academic analyses of HIV/AIDS, gender violence and stigma. Following in part a more global trend in gender and sexuality studies (Connell 1995; Frosh *et al* 2002; Whitehead 2002), there has also been a turn towards masculinity studies in contemporary South African academia, resulting in several edited volumes (Morrell 2001; Ouzgane and Morrell 2005; Reid and Walker 2005) and conferences devoted to the topic. I will only provide a small sampling of these analyses here in order to highlight not only the frequency of the reiteration, but also to further explain the *causal* argument being made about masculinity in contemporary South Africa.

Liz Walker (whose quote introduced this chapter) claims that liberal versions of sexuality, embodied in the constitution and popularized by public discourses on rights, have come in conflict with 'traditional' notions of gender and sexual relations, thereby destabilizing masculinity. Walker conducted an ethnographic project with men who have joined the "Men as Partners"[319] project in the Alexandra township in Johannesburg. In being encouraged to embrace rights-based 'liberal' definitions of gender, these men now view their previously held 'traditional' ideologies as "wrong" (Walker 2005). Suzanne Leclerc-Madlala has argued that while women in South Africa are more likely to celebrate changes in gender dynamics brought by the proliferation of 'liberal' feminist ideology, men are more likely to pine for the strictness imposed by 'tradition.' She notes that this differentiation in men and women's abilities and willingness to adapt to

[319] The "Men as Partners" program was developed by EngenderHealth, an international NGO focusing on gender equality and HIV/AIDS. Through the Men as Partners Project, "EngenderHealth works with individuals, communities, health care providers, and national health systems to enhance men's awareness and support for their partners' reproductive health choices … [and] mobilize men to take an active stand for gender equity and against gender-based violence" (EngenderHealth 2008). There are many Men as Partners projects, usually situated in partner NGOs, throughout South Africa.

ideological shifts has brought on a crisis of gender politics (Leclerc-Madlala 2001a). Isak Neihaus (2000 and 2003) has noted the way in which the loss of freedom under apartheid seriously undermined masculine identity. Due to contemporary post-apartheid politics (including massive rates of unemployment, continued racial oppression, the greater availability of jobs to women, and HIV/AIDS) masculinity is in crisis, and too often, women become the targets of confused and frustrated aggression. Mark Hunter (2002; 2004; 2005) outlines the ways in which neoliberal economic restructuring has impacted the ability of men to "assert their manhood through traditional avenues" resulting in a rise in concurrent sexual partnerships and the spread of HIV/AIDS.[320] Epstein (2007) suggests that because sex is increasingly 'transactional,' a man with nothing material to offer a potential sexual partner will engage in coercion in order to salvage his reputation and self-esteem.

The point of this chapter is not to discredit the 'crisis of masculinity' thesis as a causal argument to explain the catastrophic rates of sexual violence in South Africa or the gendered nature of the HIV/AIDS pandemic. In fact, as this chapter will show, my own research supports these academic analyses that link shifts in gender ideologies and sexual practices *to* shifts in the political economy of post-apartheid South Africa. However, is it not significant that the discourse bewailing the moral depravity that AIDS and sexual violence evidently represent, which is so often iterated that it has become commonplace, concentrates and trains the public's indignation onto the poor, Black, male body? With the notable exception of Deborah Posel's work (2004 and 2005), none of these academic

[320] From her work in East Africa, Silberschmidt (2001 and 2004) has argued that economic shifts have negatively affected men's self-esteem, and that it is only through sex with multiple partners and exercising gender violence that they can express their manliness.

analyses of masculinity take the discursive proliferation of the 'crisis of masculinity' thesis as a phenomenon in and of itself.

This chapter analyzes the 'crisis of masculinity' thesis as both a public discourse and a causal argument. It will begin by presenting the social ills the discourse is meant to explain. Next, the chapter will argue that through its pervasive circulation in the public sphere, this discourse exercises disciplinary power, which aims to produce particular 'technologies of the self' (Foucault 1978/1990; 2000a; 2000b). However, the discourse also has purchase in township communities where it is articulated as a critique of 'modernity' and the forms of cultural imperialism that the discourse about 'women's rights' signifies. The chapter will utilize archival and ethnographic research in order to show that the 'crisis of masculinity' thesis serves different purposes for those who brandish it and plays a significant role, then, in the symbolic struggle taking place within the public sphere of post-apartheid South Africa, between the tenets of 'traditionalism' versus those of 'modernity.'

After engaging with the 'crisis of masculinity' thesis as it operates as a discourse, I will explore the "materiality of everyday sex" (Hunter 2002)[321] by examining the link between transformations in the political economy of post-apartheid and shifts in sexual ideologies and practices; as such, I will engage with the 'crisis of masculinity' thesis as a causal argument. The chapter will end by arguing that the proliferation of the 'crisis of masculinity' discourse reflects widespread anxiety about the post-apartheid national

[321] It is important to note that although this chapter is concerned with exploring the complex and shifting ideologies associated with gender identity and practices of sexuality, it only considers *hetero*sexuality and will not explore dynamics associated with same-sex relations in South Africa.

imagination, suggesting that it is not masculinity that is in crisis, but rather, the promises and ideals of liberation itself that are in crisis.

The 'Gendered Epidemic'

> Women's vulnerability to HIV infection "… is a result of *structural violence*: neither culture nor pure individual will is at fault; rather, historically given (and often economically driven) processes and forces conspire to constrain individual agency. Structural violence is visited upon all those whose social status denies them access to the fruits of scientific and social progress" (Farmer 1999: 79).

Throughout the world, HIV/AIDS is a 'gendered epidemic' (Roth and Hogan 1998) for a variety of reasons. First, women are more vulnerable to infection because of the biological mechanics of transmission as well as structural and ideological conditions which put them at greater risk. Further, because women are often portrayed and blamed as vectors of the virus, they carry the added burden of stigma. This cloaks their plight in silence. In addition, due to the gendered division of labor, women take on the tremendous responsibility of caring for the victims of this epidemic – both the living and the dead.

Throughout Sub-Saharan Africa, women are disproportionately infected with HIV. At the end of 2006, women accounted for 48% of all adults living with HIV worldwide, and for 59% in sub-Saharan Africa (UNAIDS 2006). Young women (aged 15-24) bear the brunt of new infections in sub-Saharan Africa: 76 percent of HIV-positive young people are female (Quinn and Overbaugh 2005). There are on average 36 young women living with HIV, for every 10 young men (UNAIDS 2004a). Throughout the world, more than four-fifths of new infections in women result from sex with their husband or primary partners (UNFPA 2007). These more general trends in sub-Saharan

Africa are also relevant to the South African AIDS pandemic. From an HSRC study (2005), out of the national prevalence rate of 10.8%, women had a higher prevalence (13.3%) than men (8.2%). Among the 15-24 age-group, women have almost four times the HIV prevalence of males, 16.9% compared to 4.4%.

> "If you consider the statistics, it shows that women are more infected than men. So, I think people get the idea that this is a woman's disease."[322]

Over and over again, respondents told me that "AIDS is a woman's disease." "Thandi" and Thulani[323] both pointed out that this is also because women attend antenatal clinics,[324] and are therefore more likely to find out their HIV status *before* their male partners. This convention also contributes to the gendered apportionment of blame and subsequent stigmatization. Rachel Snow (2007) has found evidence suggesting that South African women *are* more likely to test for HIV, and not just because they attend antenatal clinics. They are also more likely to utilize national VCT (Voluntary Counseling and Testing) services (Snow 2007; See also UN IRIN 2005).[325]

But in addition to this, women are associated with HIV because they are taking on the burden of caring for the victims of the pandemic. As Dr. Tshabalala notes, "women are taking a leadership position when it comes to HIV/AIDS."[326] Two thirds of primary caregivers in households surveyed in Southern Africa are female, and one quarter of these

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[322] "Tebogho." [NGO staff.] Interview held on April 6, 2005 in Soweto.
[323] "Thandi." [NGO staff.] Interview held on April 15, 2005 in Soweto; Thulani Skhosana, interview held on September 30, 2005 in Sol Plaatje.
[324] Antenatal clinics provide pre-natal care for women, including HIV tests.
[325] Snow is currently conducting research on whether women's greater likelihood to use VCT services is part of a more general differential in men and women's health-seeking behavior – specifically, whether women utilize public health services to a greater extent than men. Several of my respondents believe this to be the case. In fact, they believed women were more likely to utilize biomedical treatment, whereas men were more likely to use the services of traditional healers. And they thought this differential in health-seeking behavior was associated with women's use of antenatal services.
[326] Robert Tshabalala. Interview held on April 8, 2005 in Orlando East, Soweto.

are over 60 years of age (UNAIDS 2004b: 38). A South African national evaluation of home-based care found that 91% of caregivers were women (Akintola 2005). These caregivers are most often grandmothers and children because the pandemic has claimed the lives of so many South Africans of child-bearing age (UNAIDS 2000).

> "Both groups of caregivers are especially vulnerable as they are not in the traditional income earning age bracket, and are frequently not protected by policies or support programmes, as they are often 'invisible' to authorities. In addition, while they can be excellent providers of love and support, they are often frail or simply young and inexperienced; and usually cannot provide adequate medical care" (Voluntary Services Overseas 2006).

It is important to note that because the prevalence of HIV is so high, people do not always change their sexual behaviors to avoid infection because they think of it as almost inevitable. Again and again in interviews, when I asked why people who watch their fellow community members die every day do not use condoms or avoid multiple partners, the reply was:

> "Many people think that HIV might kill them in 10 years, but poverty or violence will kill them first, so why worry about it?"[327]

> "People are dying all the time in my community, so many people just accept that as … you know, their future. So, they aren't careful about HIV 'cause they expect to die anyway. They don't care what kills them."[328]

> "People have reached a point where they aren't afraid to die."[329]

When people live with the constant possibility of imminent death, fear of infection does not serve as a deterrent for engaging in unsafe sex or sexual violence.

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[327] Field notes. This was said by a community member from Phiri, Soweto on December 19, 2005.
[328] Thulani Skhosana. Interview held on May 20, 2006 in Sol Plaatje.
[329] "Nhlanhla." [NGO staff.] Interview held on April 15, 2005 in Soweto.

Sexual Violence

Another gendered pandemic plaguing post-apartheid South Africa is sexual violence.[330] Police reports suggest that in 2004-2005 there were at least 55,114 cases of rape in South Africa, which is most likely a very low estimate given the fact that rape is the crime most likely to go unreported (Crime Information Analysis Centre 2005).

> "Women don't feel comfortable reporting rape. There are so many cases of rape that go unreported. Children especially are scared to report."[331]

> "The issue of rape is very serious. Children and women are being raped. And the thugs get arrested, but only for one day. You see them back in the community the next day."[332]

In a 2006 study of 1,370 South African men, nearly one fifth revealed that they had raped a woman (Medical Research Council 2005). Thirty percent of girls say their first intercourse was forced, and 71 percent have experienced sex against their will (UNAIDS 1999).

> "Rape is normal. It's very, very normal. But, there are no official *charges* of rape. You can go to the local police station. No one is getting a rape charge. But it is happening. It is happening daily … And some, they even beat their girlfriends to death … You know one reason I know it is happening? Because these really young girls, younger every year, are getting pregnant. They aren't old enough to decide to have sex. They're babies – babies having babies. So, obviously they are getting raped."[333]

High rates of sexual violence are also a leading factor in women's greater vulnerability to HIV infection.[334] The association between control in sexual relationships

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[330] Violence against the LGBT community is particularly acute in South Africa. The WHO reports that this form of violence is often of a sexual nature (2002). For further information, see: Gevisser and Cameron 1995; WHO 2002; Long 2003; and Anyamele et al. 2005.
[331] Female participant in a FGD held on June 10, 2006 in Sol Plaatje.
[332] Female participant in a FGD held on June 10, 2006 in Sol Plaatje.
[333] Thulani Skhosana. Interview held on May 20, 2006 in Sol Plaatje.
[334] On the connection between sexual violence and HIV prevalence, also see: Karim et al. 1995; Zierler and Krieger 1997; Wood et al. 1998; Wood and Jewkes 2000; Jewkes et al. 2001; MacPhail and Campbell

and STI/HIV risks was supported by research conducted in a township in Cape Town (Kalichman and Simbayi 2004). Women who had been sexually coerced (a total of 40% of the women surveyed) were significantly more likely to have exchanged sex to meet survival needs and to have had multiple male sex partners, greater rates of unprotected vaginal intercourse, lower rates of condom use, more sexual contacts involving blood, and greater rates of STIs. Women who had been sexually assaulted were also more likely to have been physically (non-sexually) abused by relationship partners and were more likely to be afraid to ask sex partners to use condoms.

Stigma

> One day when I arrived in Sol Plaatje, Thulani said he had been waiting impatiently for me and that he needed my help. He took me into one of the hostels, down the dark and narrow hallway, and then into one of its tiny rooms, where a family of four lived on top of one another. In a bed (the only one in the room), lay a young woman who was very clearly dying of AIDS. Her body was emaciated, and she was completely despondent to words or touch. It was also very obvious that in addition to suffering from the illness, this young woman was suffering from neglect. She was lying in her own bodily waste, she had oozing bed sores, and the whole room smelled of death. The woman's mother was busy preparing dinner and barely looked at us as she spoke quickly with Thulani. I asked (through Thulani) if she wanted us to take her daughter to the hospital. The mother responded abrasively and irritably, "I don't care where you take her – just get her out of here."[335]

In a survey conducted in the early years of the pandemic in Soweto, 38% of adults believed that people living with HIV should be separated from society, 6% believed that they should be killed and only 34% said that they should be cared for by their families (cited in Webb 1992; Chapter 3).[336] In December 1998, after openly declaring her HIV-positive status on a local Zulu television program, Gugu Dlamini was stoned to death by

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2001; Jewkes et al 2002; Dunkle et al. 2004a and 2004b. For a broader analysis of the relationship between structural violence and health in Africa, see Schoepf et al. 2000.

[335] Field notes, December 20, 2005 in Sol Plaatje.

[336] Reviews of the vast literature on stigma literature can be found in Deacon et al. 2005.

her neighbors in her home town, KwaMancinza, in the KwaZulu-Natal province (*Sunday Times* 1998; *New York Times* 1998; *Mail and Guardian* 1999). Although the level of violence Gugu Dlamini experienced is rare and is perhaps indicative of a particular moment in the history of AIDS in South Africa, it does reveal the level of fear this pandemic inspires. As the story I told about the young woman in Sol Plaatje reveals, stigma often leads to neglect and isolation, both of which can contribute to the earlier onset of death from AIDS.

According to my informants, stigma is still extremely prevalent, derives from a variety of sources, and varies in the form it takes. For the most part, respondents told me, the behaviors associated with stigma include: gossiping, socially ostracizing, and refusing to touch or eat with someone who is believed to be infected. Pheello told me that when he attends the mobile clinic in his informal settlement, the nurses will not touch him when drawing blood. They make him swab his own skin, and then when they insert the needle, they avoid touching him in any way – they only touch the needle itself. "She won't touch me, she just holds the needle and sticks it in my arm, without judging if it is the right spot or going in deep enough. That's stigma – right there among the nurses."[337] He also told me that when he first openly disclosed his status, people in his community would not look him in the eye, gossiped behind his back, and he once saw some young women point to his house and whisper: "there is AIDS there."[338]

South Africans go to great lengths to maintain silence about their status due to fears of stigmatization. In the support groups in which I conducted 10 months of

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[337] Pheello Limapo. Interview held on October 6, 2005 in Lawley, Extension 2.
[338] Pheello Limapo. Interview held on August 18, 2005 in Lawley, Extension 2.

participant observation in Soweto, most of the participants traveled vast distances to attend a support group in a neighborhood where no one knew them.

> "The treatment in the hospital is much nicer than the treatment at the clinic. But the...the nice...the nicest thing about it is that it's far away from … from where I stay. Because I thought I'm all alone from DRD, but, wow, I saw two people, you know, from my area, seeing *me* now, and we're all in the HIV ward [laughs] … But really, that's a horrible feeling. This is why I hate going to the clinics and hospitals."[339]

Because HIV/AIDS is often conceived of as a "woman's disease" and because women are more likely to *know* their status, they are also more common targets of discriminatory actions based on fear and stigmatization. "I want to say something about stigma … there is a stronger stigma for women who are infected."[340]

Given these shocking trends in post-apartheid South Africa, it is hardly surprising when the media declares that the "male population is waging a war against the country's women" (*Mail and Guardian* 2002). These staggering levels of infection, violence and stigma are testament to a crisis plaguing the post-apartheid state, and certainly explain the impulse to ascribe them to a 'crisis of masculinity.' Perhaps the legacy of apartheid and the current dramatic rates of unemployment *have* robbed South African men of dignity and every possible means of self-expression save unimpeded sexual promiscuity and violence. However, as the 'crisis of masculinity' discourse becomes more and more prevalent in public sphere debates, the causal argument highlighting *structural* violence and inequality tends to be obscured by an indicting and disciplinary gaze trained on the poor, Black, male body.

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[339] Thulani Skhosana. Interview held on September 30, 2005 in Sol Plaatje.
[340] Female participant in FGD held on June 10, 2006 in Sol Plaatje.

The Construction of a Phobogenic Object

"The Negro is a phobogenic object, a stimulus to anxiety … This object does not come at random out of the void of nothingness … This object is endowed with evil intentions and with all the attributes of a malefic power … For the sexual potency of the Negro is hallucinating. That is indeed the word … What is important to us here is to show that with the Negro the cycle of the *biological* begins … it is in his corporeality that the Negro is attacked. It is as a concrete personality that he is lynched. It is as an actual being that he is a threat" (Fanon 1952/1967: 151-163).

The 'crisis of masculinity' thesis asserts a generalized crisis of manhood, but in application, this masculinity is qualified – it is both racialized and classed. It is also 'traditional,' because there is an implicit teleological assumption that progress is based on the ability of the nation to incorporate and fully embrace modernity and liberal individualism – a goal it can only achieve by stripping itself of the encumbrances and obstacles towards development that 'traditionalism' has come to signify.

In the 'crisis of masculinity' discourse, economic conditions are listed as a primary causal factor for high rates of violence against women and their greater vulnerability to HIV infection. However, in many cases, when this thesis is espoused in public sphere debates and especially when possible policies are suggested, the focus is shifted from economic reform to solutions aimed at 'modernizing' gender norms.

Supplanting structural critiques of the economic, cultural and bio-political obstacles, the poor, Black man acts as the defining causal mechanism of social ills. The focus is trained on the 'uncontrollable' and 'depraved' Black male sexuality. The symptom of the problem replaces the disease. As such, the 'crisis of masculinity' discourse becomes a *disciplinary* force.[341] Foucault would remind us that a "discursive

[341] It is important to note that this fear is also expressed in the spatial dynamics of post-apartheid cities, which reflect in a very material way the entrenched segregation of black/white *and* poor/wealthy spaces.

explosion" signals a shift power relations, inaugurating new disciplinary strategies aimed at the bodies of citizens (Foucault 1978/1990: 17, 30), and in this case, aimed at regulating 'unruly' sexuality.

> "Broadly speaking, at the juncture of the 'body' and the 'population,' sex became a crucial target of a power … We … are in a society of 'sex,' or rather a society 'with a sexuality': the mechanisms of power are addressed to the body, to life, to what causes it to proliferate, to what reinforces the species … power spoke *of* sexuality and *to* sexuality; the latter was not a mark or a symbolic, it was an object and a target" (Foucault 1978/1990: 147).

But if the sexuality being targeted by the discourse on masculinity is the one most likely to be practiced by poor Black men, against whom the sovereign exception is exercised, then why would this discourse be *disciplinary* in nature? Why would it be concerned with regulating a population condemned to a bare life in a zone of abandonment? Because this sexuality is contagious and the boundaries of the body politic must be policed in order to safeguard the nation not only from an infectious disease, but also from a moral contamination that threatens the very identity of the state. Biopower is a "politics concerned with subjects as members of a population, in which issues of individual sexual and reproductive conduct interconnect with issues of national policy and power" (Gordon 1991: 5) The 'crisis of masculinity' is an "intervention and a regulatory control" to protect the *species* body (Foucault 1978/1990: 139) – the body of the nation. As such, sex is given a "fictitious unity" and *causal* power: "sex was thus able to function as a unique signifier and as a universal signified" (Foucault 1978/1990: 154).

The latter is most obviously illustrated by the high security walls that mark the landscape of wealthy neighborhoods throughout South Africa. This spatial manifestation of the fear of poor, Black men is the subject of a forthcoming article by Andy Clarno (Clarno 2009).

The Production of Tradition

"All this suggests that AIDS in Africa – as a fetish or taboo, disputed truth or irreducible reality – has been *prolifically productive*. I use this last term in the manner of Marx and Foucault to imply that it has given birth to significant forms of sociality and signification …" (Comaroff 2007: 203).

Post-apartheid South Africa has been widely celebrated for the various ways in which its democratization has been marked by a transformation of the relationship between the state and sexuality (Niehaus 2000). South Africa's constitution, ratified in 1996, was the first in the world to outlaw discrimination on the basis of sexual preference (BBC 2005). On December 1, 2005, the Constitutional Court ruled in favor of same-sex marriages, and exactly one year later, they became legal (BBC 2005; See also *Washington Post* 2005 and 2006). The state has also legalized abortion and seriously considered decriminalizing sex work (Niehaus 2000). "These steps seemingly signal the advent of more open-ended medical discourses about sexuality in the era of AIDS" (Niehaus 2000: 387).

However, along with a laudatory effort to challenge patriarchal gender scripts and institutionalize the rights of all women and sexual minorities, has come the demonization of alternative gender ideologies and sexual practices. Adopting liberal definitions of sexuality and medicalized sexual practices ('safer sex,' monogamy, etc) have become requirements for state representation and claims to citizenship in post-apartheid South Africa. In other words, embracing and incorporating 'modern' subjectivity is a requirement for state protection and the rights of citizenship. And, as evidence presented throughout this dissertation has shown, 'modernity' is often posited as the *only* answer to the AIDS pandemic.

The 'crisis of masculinity' discourse, then, becomes yet another symbolic tool wielded in the symbolic struggle over HIV/AIDS. But in order to achieve the prize of hegemony, an 'other' against which 'modernity' can be distinguished and celebrated is essential. And public debates about sexuality and 'women's rights' are one of the most important sites for the construction and subsequent criminalization of 'tradition.' Therefore, the myth of incommensurability is not only sustained through the symbolic struggle over healing, it receives perhaps its greatest support from the monotonous reiteration of the 'crisis of masculinity.' "That the media is so quick in seizing upon stories of multiple-partners, sex for money, and sugar daddies makes it imperative to challenge any static representations of 'promiscuous' African sexuality" (Hunter 2004: 123).

Foucault, of course, was the first to point out that disciplinary power is also *productive* of subjectivity (1977/1995; 1978/1990; 2000a). Techniques of power construct subjects: "subject to someone else by control and dependence, and tied to his own identity by a conscience or self-knowledge. Both meanings suggest a form of power which subjugates and makes subject to" (Foucault 2000a: 331). I would like to suggest that one of the most understudied aspects of sexuality in post-apartheid South Africa is the role that discourses about sexuality play in the construction of 'traditional' subjectivity – a subjectivity marked, literally stigmatized, as 'unruly,' licentious, and contagious. "What is important to us here is to show that with the Negro the cycle of the *biological* begins … It is in his corporeality that the Negro is attacked" (Fanon 1952/1967: 161, 163).

It is not as if these representations of African sexuality are new. AIDS has simply become a means of reinvigorating colonial scripts about primal and untameable desire. In fact, Nuttall and Mbembe claim that Western representations of AIDS in Africa have surpassed "even the archetypes of otherness implied in Said's Orientalist paradigm" (2004: 348).[342] Intriguingly, this equation of 'tradition' with unruly sexuality is precisely one of the causal mechanisms for the development of Mbeki's denialism. He denied HIV in part because he feared the pandemic would somehow lend credence to these ancient racist discourses about 'African sexuality':

> History "… created an image of our Continent as one that is naturally prone to an AIDS epidemic caused by rampant promiscuity and endemic amorality" (Mbeki 2001:7).

Or perhaps he feared the proliferation of discourses like the 'crisis of masculinity':

> "We [black people] are germ carriers, and human beings of a lower order that cannot subject its [sic] passion to reason. We must perforce adopt strange opinions, to save a depraved and diseased people from perishing from self-inflicted disease...convinced that we are but natural-born promiscuous carriers of germs ... They proclaim that our continent is doomed to an inevitable mortal end because of our devotion to the sin of lust" (Thabo Mbeki, *Mail & Guardian* 2001).

Mbeki has actually served as a staunch supporter of constitutionally-defined and protected, liberal 'women's rights.'

> "[T]he women of our country carry the burden of poverty and continue to be exposed to unacceptable violence and abuse. It will never be possible for us to claim that we are making significant progress to create a new South Africa if we do not make significant progress towards gender equality and the emancipation of women" (Mbeki 2002).

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[342] For other sources that deconstruct Western representations of 'AIDS in Africa,' see: Rigby 1996; Treichler 1999c; Patton 2002; Comaroff 2007; Fassin 2007.

And so, Mbeki switches sides in the discursive debates on sexuality.[343] While in the symbolic battle over healing, Mbeki attempts to *use* the discourse of traditionalism in order to advance his opposition to biomedical imperialism, Mbeki does *not* take up a 'traditionalist' position in an attempt to thwart the 'crisis of masculinity' proponents; he does not celebrate 'African' sexuality; but Jacob Zuma does.

Jacob Zuma was Mbeki's Deputy President until June 2005, when he was implicated in corruption charges and was asked to resign, but he maintained his position as Deputy President of the ANC. In addition to his corruption charges,[344] Zuma was accused of raping an HIV-positive woman who was a long-time friend of the Zuma family. Zuma admitted that he had unprotected sex with the woman, but claimed it was consensual. Although the court case became a source of ironic and bitter laughter (as the cartoons included can testify), it was widely believed to be evidence of a serious political and moral crisis. First, Zuma, who used to have the position of chairperson of the South African National AIDS Council (SANAC), claimed that he reduced his chances of being infected with HIV because he took a shower after intercourse.

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[343] Some TAC analysts and leaders claim that the TAC approach has always sought to depathologize *all* forms of sexuality (Lewis 2001; Robins 2004; Berger 2004; Cameron 2005). However, they are still adamant advocates of 'safer sex' and have failed to truly engage with the racial critique Mbeki is making. In this way, TAC has not attempted to deconstruct the 'traditional' sexuality put on display by these discourses on masculinity. I will return to this point in the next chapter.

[344] These initial charges were dropped, but Zuma may be re-charged and stand trial later this year (*Mail and Guardian* 2007g).

Figure 5-1: Madame and Eve Cartoon, "Great South African Lies and Myths" [345]

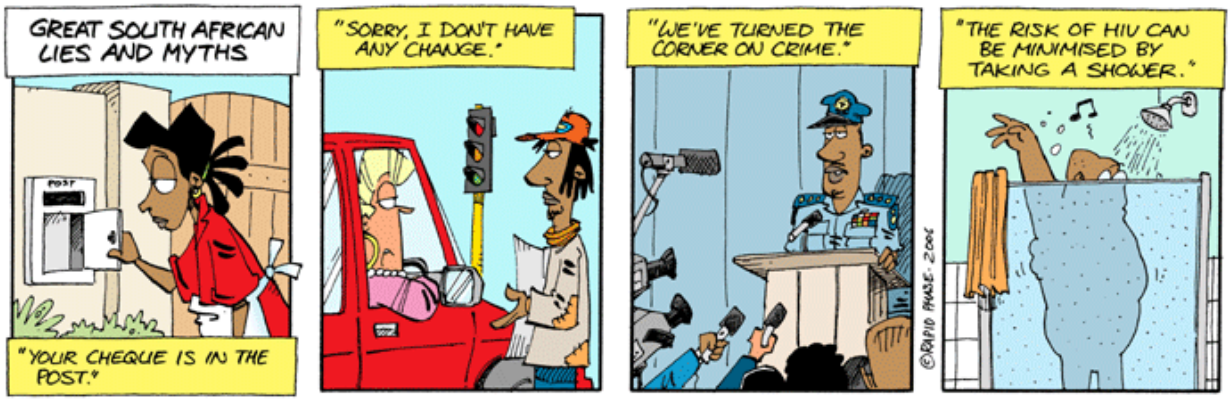

Figure 5-2: Zapiro cartoon on Zuma [346]

In addition, the court case itself made a mockery of the feminist movement's gains in rape litigation. The sexual and personal history of the woman who accused Zuma of rape was used as evidence to delegitimize her charge. He claimed she led him on, and was engaging in sexually provocative behavior because she wore a mini skirt. But perhaps most importantly, for the purposes of this chapter, he *used* his Zulu culture to

[345] Madame and Eve. April 8, 2006. Cartoon number 003119. http://www.madameve.co.za/index.php
[346] Cartoon by Jonathan Shapiro, originally published in *Sunday Independent* 2006.

justify his behavior. Zuma "drew on patriarchal Zulu culture to suggest that his accuser had led him on" (*Newsweek* 2006). "'If she had said no, I would have stopped there and got up and left.' But, he claimed: 'I know as we grew up in the Zulu culture you don't leave a woman in that situation, because if you do then she will even have you arrested and say that you are a rapist'" (*Worldpress* 2006). On May 8, 2006, Zuma was acquitted of the rape charges.

There is perhaps no more perfect example of the way in which the struggle between 'modernity' and 'traditionalism' supports the myth of incommensurability than this court case and its media coverage. Throughout the entire ordeal, images of Zulu masculinity were paraded around, next to images of "women's rights activists" protesting the anti-feminist circus this court case had become.

Figure 5-3: A Zuma supporter holds up a picture of him outside the High Court [347]

[347] Photo taken by Themba Hadebe, Associated Press. Published in *Newsweek* 2006.

Figure 5-4: "Women's rights" activists vs. Zuma supporter at rape trial [348]

While Zuma is certainly the anti-thesis of the poor, Black man generally targeted by the 'crisis of masculinity' discourse, the court case did become an opportunity to celebrate 'traditional' sexuality.

> "'A young man stood up, (and) ... declared that Zuma was his leader and that from now on he would no longer be wearing a condom, to laughter and applause from many of the young men who filled the back benches and the upstairs gallery.' Zulu men who did speak out against the misogyny were portrayed as not being quite Zulu" (*Sunday Argus* 2006).

Zuma has gained popularity by constructing a self-image as a 'man of the people,' building support bases through his close alignment with COSATU and the SACP. In addition, his Zulu identity is seen as a welcome change to the hegemony of the Xhosa leadership of Mandela and Mbeki (*The Guardian* 2006). His idealized, media-spun caricature relies heavily on codes of Zulu masculinity.[349] But in reality, this presidential celebration of Zulu virility is an exercise in the 'banality of power' characteristic of the 'post-colony,' so perfectly described by Achille Mbembe where "the very act of

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[348] Photo taken by Alexander Joe. Published in *Worldpress* 2006.
[349] For an important and detailed critique of simplified versions of Zulu masculinity, see Waetjen 2004.

exercising command cannot be separated from the way licentiousness is produced" (Mbembe 1992).[350] Zuma is a far cry from the poor, contagious subject in the zone of abandonment. He may be an enemy of the stalwarts of modernity (and Mbeki), and so became a momentary target of media derision. But because he is a frighteningly powerful state bureaucrat, likely to become the next President,[351] he is not the target of the disciplinary power exercised through the 'crisis of masculinity' discourse. But it is potentially his willingness to publicly celebrate 'traditional' sexuality, and laugh in the face of 'modern' gender norms that explains his immense popularity amongst the poor. I will return to this point in the next section of this chapter on 'women's rights.'

The 'traditional' sexuality being constructed and subsequently pathologized through the circulation of the 'crisis of masculinity' discourse fetishizes a *particular* version of sexuality. And in so doing, erases the history, the social context and the complexity and fluidity of non-modern gender identities and sexualities. And in some sense, as the next section of the paper will illustrate, the very people who are targeted by the discourse cling to the fetish as well. They choose to embody their colonial interpellation. Everyone loses when debates about sexuality are reduced to a symbolic confrontation between the simplified, empty signifiers of 'modernity' and 'traditionalism.'

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[350] Terence Ranger also notes that codified, 'invented traditions' were often deployed by African men under colonialism in order to reify patriarchal culture in response to women's entry into the labor market (Ranger 1983/2003: 254).

[351] In December 2007, Zuma was elected head of the ANC, which means he will almost assuredly become the next President of South Africa (*Mail and Guardian* 2007f). Given the way in which his public image relies on this simplified trope of 'traditionalism,' it will be fascinating to observe how the politics of HIV/AIDS will play out under his Presidency.

The Politics of Blame

"[T]he myths and mystifications that surround AIDS and slow AIDS research often serve powerful interests. If, in Haiti and in parts of Africa, economic policies (for example, structural adjustment programs) and political upheaval are somehow related to HIV transmission, who benefits when attention is focused largely or solely on 'unruly' sexuality' or alleged 'promiscuity'? The lasting influence of myths and immodest claims has helped to mask the effects of social inequalities on the distribution of HIV and on AIDS outcomes" (Farmer 1999: 149).

While the 'crisis of masculinity' analyses indicate that economic factors, such as unemployment and poverty play a role in gender politics, these material causal explanations are supplanted by a fetishization of poor, Black sexuality. When economic dynamics *are* discussed in public sphere debates about sexuality, they are generally framed as residuals of apartheid or abstract "growing pains" of the post-apartheid period. There is rarely a detailed and careful analysis of the impact of neoliberal economic restructuring on gender relations and ideologies. Policies are aimed at modernizing gender, not addressing underlying economic factors.

This substitution serves to shift the blame for the spread of HIV from economic causal mechanisms to individual sexual practices. There are structural reasons why certain populations are more vulnerable to infection which have more to do with the relationship between health and deplorable living conditions, patterns of inequality, and exploitative inter-personal relations than with individual behavior. But the individualization of blame and an obsessive focus on "'unruly' sexuality or alleged 'promiscuity'" (Farmer 1999, quoted above) serves to mask the necessary critique which must be aimed at global economic policies. According to Alison Katz: "Blaming the victim is part of the neoliberal approach to health. It nicely avoids any discussion of

structural violence, which would be deeply threatening to the status quo of current international economic arrangements" (Stamoulis 2005: 55).

Blaming 'Women's Rights'

"When I...I lost my job, I had a lovely wife, you know. But since there was no income, she...she left. She took my two kids with her. And she went. I couldn't afford to keep her because I didn't have an income. For a while, she was working when I couldn't find work. She used to bring in food, you know, but ... it is not the custom. There is this mentality, the mentality that you have to pay in order to be a man. It is so fixed – that idea. So, if the man can't make money, then it ruins the relationship. But the issue is the norms. For this past year I was living single, you know. I was doing the cooking, the cleaning, and everything. For the first time in my life I was doing this, you know. And, um, I did manage, although it was hard ... But the problem is not within the house, but it's the people outside. How do they look upon it. People looked down on me in the community. They said, like "Wow, you're useless," and it was partially because I didn't have a woman. If you're a bachelor, you don't have a dignity."[352]

"Men struggle to find their dignity in Khayelitsha. We have high unemployment. So many men feel useless. They use alcohol and drugs to try to cure their frustrations. Then they vent their anger on women because they think women won't fight back. We need to give men their dignity back."[353]

Women's sexuality is valued materially, but men's is not. Due to the historic relationship between sexuality and a material economy of gift-exchange, women can 'transact' their sexuality.[354] Because sexuality is situated within an economy of exchange, in order to have sex, men must have purchasing power. Masculine esteem comes from the interrelation between economic and sexual prowess – the two are

[352] Thulani Skhosana. Interview held on June 11, 2006 in Sol Plaatje.
[353] This is an interview with Mandla Majola, who is the TAC provincial leader in Khayelitsha (an informal settlement on the outskirts of Cape Town). It appears on page 13 of *Equal Treatment* 2006. The interview was conducted by Vathiswa Kamkam and Nathan Geffen, and the article is called "Restoring Men's Dignity."
[354] This topic will be explored in detail later in this chapter. Briefly, sexual exchange is often accompanied by an exchange of gifts or money. Marriage is equally marked by a bridewealth payment. Due the constraints of neoliberalism, 'transactional sex' has largely replaced marriage in contemporary South Africa. This practice is not related to the institution of prostitution, but is rather, an exchange of sexual relations for material gifts or goods.

inextricably linked. Poor men, then, do not have the option of engaging in sexual relationships as a means of surviving increasing unemployment and poverty, and their dignity is lost when they are unemployed not only because they cannot fulfill their economic duties as breadwinners, but also because if they are earning no money, they are not worthy of sex. They are not only compelled to uphold a system in which children remain the (economic and social) responsibility of women, but their sense of 'manhood' is seriously undermined by impoverishment. According to my informants, then, many men *are* facing a 'crisis of masculinity':

> "To men, it's a shame, really. For them, its worse. They will not be able to make a transaction or to get any money in exchange. They can get money for lifting heavy things or gathering some firewood or something, or to go get water for people in the community – they will get paid with a plate of food. But then, no money, or clothes or soap or something. It's a shame."[355]

> "I think that's the reason why most men become criminals. If men don't have any money and they can't have sex for money, then maybe that's why they commit crimes. Because they need something. For women, there is a way out – to exchange money for sex."[356]

> "Women can have relationships with men in order to survive. With men, its different. There is this slang, *upanda*, which means: to try to make ends meet. Men resort to this kind of behavior. This includes criminal activities, and also taking other peoples' things and selling them, or stealing."[357]

Therefore, my research shows that men's sense of self is seriously undermined by their economic conditions.

However, in addition to unemployment and poverty, my informants blamed the introduction of 'women's rights' for destabilizing gender norms, thereby leading men to rape, exercise violence against women, and spread HIV/AIDS through multiple sex

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[355] "Sarah." Interview held on October 26th, 2005 in Lawley, Extension 2.
[356] "Mary." Interview held on October 26th, 2005 in Lawley, Extension 2.
[357] Pheello Limapo. Interview held on November 9, 2005 in Braamfontein, Johannesburg.

partners. Unlike Leclerc-Mdlala (2001a), who has argued that women in South Africa are more likely to celebrate and welcome changes in gender ideologies brought by feminism, whereas men are more likely to pine for the strictness imposed by an idealized notion of 'tradition,' I have found that *both* men and women blame liberal versions of femininity for destabilizing gender norms, which then lead to high rates of HIV infection.

> "I feel that women also abuse men – because of this thing of 50/50 and 'women's rights' … The women are losing sight of what their role is. Our president is giving more power to women, and this makes women disrespect men. The president should teach women about their rights *and* their responsibilities."[358]
>
> "Yes, men have lost their sense of manhood. Men are undermined now. Because of 'women's rights,' men is no longer the head of the family, and men can no longer do anything."[359]
>
> "If a woman says 'no, this is my right,' this encourages the husband or boyfriend to go out and seek other avenues for receiving pleasure or sex. As a result, this causes the spread of disease …"[360]

My empirical data reveal a widespread critique of liberal gender values and a subsequent pining for an idealized 'traditional' past in which gender norms were more clearly defined and practiced – the loss of which has resulted in a destabilization of masculinity which in turn provides a justification and even an apology for sexual double standards and violence against women.

Idealizing the Past

"Since the early 1990s, the interplay of economic, political and cultural shifts has changed the ways in which sex is negotiated, represented and displayed, so that sex is more overtly 'out there' - at the same time as its associations with bodily danger and death are starker and stronger than ever. As a result, the stigmatisation of AIDS is inseparable from popular renditions of the epidemic as the mark of all that has gone wrong with the 'new' South Africa" (Posel 2004: 16).

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[358] Female participant in FGD held on June 10, 2006 in Sol Plaatje.
[359] "Ntombi." Interview held on October 26, 2005 in Lawley 2.
[360] "Mary." Interview held on October 26, 2005 in Lawley 2.

"When we grew up, we were told by our forefathers about the previous generations – that, they used to follow their tradition, but now, we are not following our tradition. This might be a cause of HIV/AIDS – not following the traditions. At first, you find all those people exercising their traditions, they don't get ill so easily. Nowadays, people are running away from their origins, and customs – which might be a cause of HIV/AIDS."[361]

According to Deborah Posel's ethnographic research (2004), respondents felt that in the past, both sexual practices and ceremonies around death were respected, segregated from one another and disciplined by strict cultural codes; therefore, in these narratives, HIV/AIDS is explained as a direct result of transgressions against 'tradition.' 'Tradition,' in this sense, becomes a *constructed history* that carries tremendous symbolic weight in the context of apartheid. My research illustrates the way in which South Africans are struggling with shifts in gender norms, which affects their ability to understand the social world and their place within it. 'Tradition' is idealized and craved precisely because both men and women in contemporary South Africa are being forced to renegotiate their own identities. But this 'traditional' sexuality for which respondents pine is very different than the one constructed in public sphere discourses bemoaning the 'crisis of masculinity.'

> "I grew up during the era when women were not actually working in factories like we know they do today: working as clerks, as managers, and as vice presidents! And then, I mean women, they could...they were allowed to work as teachers and nurses. Those were their only professions. But during that era, women were actually actively involved in their housework and everything, doing their washing, making sure that their house is okay, watching after their babies and everything. But since, like, for instance, in this particular era, we find that women, they've got all those things, there are no families really like we used to know them before. *It's like if women can get all their rights, they will not know what is a man.*
>
> "During that era, women respected their in-laws, their marriage, but today, since there are rights, their rights, they don't want to respect their families anymore. Divorce never happened before. Even if people were oppressed, economically, then at least life was normal. You know, people would respect and

[361] Male participant in FGD held on October 14, 2005 in Sol Plaatje.

> relate to each other in a more respectful way. And they would respect their culture.
>
> "Women were treated like God, you know? Because women were pillars of the house or of the home. And they were respected, and they knew their place in the community and at home. And they were not even beaten. They were respected *so* much that, if the house had no woman, then that house was not very respectable. *But today, now that people have told them about their rights, it is only now that they are oppressed*. Because at that time, we didn't know what 'rights' were. It is only now that they say it was oppression. But women were living nicely then. These new rights for women … these new laws that they are bringing that they are trying to free them, in fact, it's not freeing them. It's actually oppressing them more, and confusing them."[362]

According to Dr. Tshabalala (and many others), 'traditional' gender norms and 'traditional' sexuality were well-bounded and respected. This is a far cry from the 'traditionalism' currently being constructed in the public sphere that insists that promiscuity is a defining feature of indigeneity. The 'crisis of masculinity' discourse assumes that 'traditionalism' is static and anachronistic, but according to my ethnographic research (supported by the various authors cited in this section), it is precisely the *shifting terrain of sexuality* that community members blame for the spread of AIDS.

According to Niehaus (2000), the transition to post-apartheid was marked, in part, by a kind of sexual revolution. In his research in rural villages in Limpopo, Stadler (2003) found that his informants blamed this new sexual freedom, coupled with an ability of *some* Black men to newly accrue wealth, for the spread of HIV/AIDS. "Villagers recognised the political nature of the AIDS crisis, and linked it to the new freedoms ushered in by the political transformations of the early 1990s … Thus conceptualised,

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[362] Robert Tshabalala. Interview held on September 3, 2005 in Orlando East, Soweto. Emphasis used to highlight particularly important aspects of the statement.

AIDS was not only a public health problem but posed an existential crisis that threatened the social fabric" (Stadler 2003: 124).

When I asked my informants why South Africa has the highest prevalence rates in the world, they very clearly pointed to changes initiated by the end of apartheid: the forces of 'modernity' have served to break down traditional values and beliefs, which also disrupted disciplinary norms of sexuality; the 'crisis of masculinity' which unleashed unbridled male sexuality, in which blame is often placed on the shoulders of *both* the apartheid and the post-apartheid government; the breakdown of sexual norms was also associated with the violation of powerful taboos, most of which are associated with women's bodies; and finally, witchcraft. While women's bodies and supposed powers (in terms of witchcraft) have always been sites of both suspicion and fear, blame and accusation aimed at women for their various transgressions tend to be heightened in times of social and economic insecurity (Niehaus 2001a and 2001b; Ashforth 2005).

The severity of poor communities' living conditions create feelings of distrust, competition over scarce resources, and a greater likelihood of stigmatization. According to Stadler (1996), Niehaus (2001a and 2001b), and Ashforth (2005), accusations of witchcraft are directly related to concerns about poverty, violence, political oppression and HIV/AIDS. "[F]or villagers, witchcraft has less to do with civilisation and African identity than with their experiences of misery, marginalisation, illness, poverty and insecurity …" (Niehaus 2001a: 193). For Ashforth, fears and suspicions of witchcraft arise when people feel out of control of their social environment. Their feelings of "spiritual insecurity," then, arise from a sense that they are "being exposed to invisible

evil forces" (Ashforth 2005: 1). And it is often older women who are then the target of malicious witch-hunting.

> "If you have AIDS, they'll say you've been bewitched."[363]
>
> "People didn't believe in HIV. They thought they were bewitched. So, this caused the stigmatization of women."[364]

However, according to Ashforth (2005), it is not older women's *dis*empowerment that makes them vulnerable to these accusations, it is actually the fact that men feel as though women have greater access to social and economic resources in post-apartheid South Africa. Men's social status is eroding, which contributes to feelings of both economic *and* spiritual insecurity (Ibid).

Therefore, the breakdown of tradition along with increasing economic insecurity has led community members to blame women for their (seemingly) greater success on the job market, for their new 'rights,' and for their 'supernatural' power. And both men and women take part in this gendered politics of blame:

> "Women also abuse other women. Women don't respect each other, and they don't hang around and discuss issues related to womanhood. And the level of competition amongst women is very high, so I think that this is one of the problems – it's not only men that abuse women. This issue of abuse is broader."[365]

However, I believe that women are simply easy targets for overwhelming feelings of disempowerment. Women can be blamed and controlled, but the broader social transformations that are the real root cause of peoples' oppression are evasive. Community discourses on 'women's rights' show, more than anything else, that township

[363] "Nhlanhla." [NGO staff.] Interview held on October 19, 2005 in Soweto.
[364] "Tebogho." [NGO staff.] Interview held on April 6, 2005 in Soweto.
[365] Female participant in FGD held on June 10, 2006 in Sol Plaatje.

and informal settlement residents feel they are the target of 'invisible forces' over which they have no control. But these malefic powers are not supernatural, they are *structural*.

Cultural Imperialism

My data provide evidence that the 'crisis of masculinity' explanation of contemporary gender politics is being deployed by Black communities themselves because community members feel that the imposition of 'women's rights' is meant to erase their sense of culture and identity. In the mouths of the media pundits, academics, and professionals, the 'crisis of masculinity' discourse targets 'tradition' as the cause of oppressive gender relations. But for the communities this discourse is interpellating, tradition is all they have left. Community members feel as though after fighting against the apartheid system, they live in worse material conditions than they did under apartheid and now face a devastating disease. How could those with money and power – those who still cling to their privileges despite 'liberation' – dare to now try to strip them of their cultural identity, in addition to everything else? This is the reason why any mention of 'women's rights' incenses and exasperates members of poor, Black communities.

> "This thing of 'rights' has changed our culture and our value systems, and how people should conduct themselves. The manner in which it happened – it just came and nullified who the men are. These things only promoted the rights of women.
>
> "Culture is culture … Claire, where you are from, you have your *own* culture, and we have our own culture. In fact, by assuming we will just adopt other peoples' culture and nullify our own culture, this is a problem. This is where we are going to lose ourselves … Now, we are taking other peoples' cultures more seriously than our own, and so we are going to lose our culture, and lose ourselves."[366]

[366] Pheello Limapo. Interview held on November 9, 2005 in Braamfontein, Johannesburg.

However, each time a Black South African claims that liberal gender ideologies are culturally imperialist, s/he falls prey to the indictment made by the media and politicians that communities are "defensively clinging" to "traditional" ideologies (Walker 2005). As such, these public discourses on gender are not only making intrinsic truth claims about the righteousness of Western definitions of gender and sexuality, they also serve a silencing and therefore disciplinary function.

The 'crisis of masculinity' argument assumes a fallacious dichotomy between modernity and traditionalism, and carries with it very dangerous assumptions about race and class. The poorer the person, the more likely s/he is to be a 'traditionalist.' Because rape, violence, stigmatization and promiscuity are blamed on 'traditionalist' ideologies, these kinds of behavior are directly linked to poverty. This backward-looking performance of 'traditionalism' (whose signified is firmly fixed) is juxtaposed with a celebration of 'modern' gender discourses which focus on 'rights' and 'equality.'

By defining progress and development as an abandonment of 'traditionalism' in the move towards liberal or constitutional definitions of gender and sexuality, an unquestioned cultural imperialism is at work in the popular, media discourses on masculinity. Many of my informants expressed their indignity at such an imperialist imposition:

> *So, given what you've told me, do you think 'women's rights' is a form of Western imperialism?* Yes, it comes with imperialism. It's clear that it was imposed on us, so that when we tried to consolidate the gains after the liberation struggle, instead of focusing on the redistribution of land, we focused on fighting amongst each other. While the imperialists were busy raping our soils, extracting our resources and taking our mines. So, we are fighting amongst ourselves instead of focusing on getting our lands and resources back.[367]

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[367] Pheello Limapo. Interview on November 9, 2005 in Braamfontein, Johannesburg.

Even if informants' demonization of 'modern' rights is homogenizing and misplaced, the underlying critique of the operations of power is significant. Their "[s]truggles are all directed against a technique of power, rather than against a specific institution or group – against the techniques of power that 'make individuals subjects'" (Foucault 2000a: 331).

Hybrid Gender Strategies

When I first began conducting interviews focusing on gender practices and ideologies, I would ask people the following question: "In your opinion, is there a connection between gender oppression and HIV/AIDS?" However, when my interpreter would repeat the question, a long discussion would almost inevitably ensue. He would provide a lengthy explanation of what the question meant, the informant would ask questions, and finally an answer would emerge. Almost every time, the answer would include the term 'women's rights,' which was likely to elicit both derision and anger from the informant. I soon learned that my questions and the language I used was interpreted as 'Western,' and why not, given the source?

I, on the other hand, would go home and wonder why *both* men and women in the communities in which I was working invoked such patriarchal notions of gender when asked to comment on them, when their actual practices told a very different story. Women who were outspoken leaders in their communities, who would 'put men in their place' in public meetings, and who would insist on their autonomy and strength at every occasion would not bat an eye when telling me that the reason for the high incidence of rape in their communities is because:

> "Rape is caused by the issue of behavior – how people behave themselves. And the dressing code as well. You find girls wearing mini skirts, you know,

> attracting those guys. And you find us maybe in some pubs, and find ladies drinking there. And sometimes ladies cannot control themselves. So, it's the behavior and the dressing code. *How some girls dress is an invitation to be raped*.[368]

In a series of focus group discussions I held in one of the communities in which I worked regularly (Lawley, Extension 2), one particular energetic female activist stood out. I will call her "Sarah." When asked to comment on the way the epidemic had impacted her community, Sarah was the first to blame the government's inaction, the greed of corporations, and the neoliberal restructuring taking place in her community.

> "But in fact, the disease will never go away as long as people are living in these conditions – a shortage of housing, no water, no electricity. We have to fight back. We have to combine our struggles – we have to fight against AIDS and this poverty we live in."[369]

> "Nothing has changed with this new government. It is the same horse. It is only the jockey who has changed. The jockey is now Black. Apartheid has never changed. This is why we are still discriminated against. Now, it's even worse. That horse is now racing at a high speed."[370]

I was very excited to get the chance to interview her one on one. But again, when I asked her about gender inequality, she responded:

> "Right now, because of these 'women's rights,' men have lost their dignity. They have nothing. Even when they are married, their wives refuse to sleep with them. They refuse to have sex because now they have rights. So, men end up going out somewhere and sometimes sleeping with the kids. Cause they don't have anything at home. In fact, do you think the diseases will end now? They can't."[371]

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[368] Female participant in FGD held on October 28, 2005 in Sol Plaatje (my emphasis).
[369] "Sarah." FGD held on October 6, 2005 in Lawley 2.
[370] "Sarah." FGD held on October 20, 2005 in Lawley 2.
[371] "Sarah." Interview held on October 26, 2005 in Lawley 2.

I walked away both disappointed and confused. Over the course of my field research, after I spent more time in these communities, I started to understand my initial misstep and appreciate the complexity of gender ideologies at play in communities ravaged by the epidemic. Terms like 'women's rights' and 'gender norms' are loaded with signification in post-apartheid South Africa. They are almost always seen as a 'Western' construction and imposition. By rejecting these concepts' importance or relevance, and instead invoking patriarchal ideologies, my informants were engaging in performative mockery. In the face of a colonial agent, people often perform their interpellated identity ineptly or in an exaggerated fashion in order to expose the failure of colonial inscription (Bhabha 1994).

The dichotomous construction of traditionalism and modernity disavows the fact that gender practices and norms in post-apartheid South Africa are more than anything else, hybrid. Clearly, not all poor South Africans are invested in preserving some idealized notion of 'tradition,' nor do they all blame 'women's rights' for the failures of liberation.

> "Old people have done wrong before. These traditions are rotten. They are not going with time – this is a new generation. This generation is not normal. Tradition needs to change."[372]

Many women recognize that they are disciplined with idealized notions of 'culture' *because* culture is viewed as static and safe:

> "It's just that I think that men still don't buy the idea of women having rights. Women own things … We believe in culture, we respect it also … but also with culture you cannot change. There are still women who have to bow. They know

[372] Male participant in FGD held on October 28, 2005 in Sol Plaatje.

> their man is infected with HIV, but if he refuses to sleep with them with a condom, there's nothing that I can do as a woman because of culture."[373]

Due in part to the shifts in gender identity in post-apartheid South Africa, poor women are also making new claims on the value of their contribution to the household and to the community.

> "I think that women should be paid for their work in the community. They should be paid for taking care of the sick. This is work. Real work – not child's pay. This should not be volunteer work. Women should be paid."[374]

> "I think that most of the people caring for the sick are women. So, they need to be paid up because they put so much time on this work of caring for the sick. It's overtime."[375]

The AIDS pandemic has, to a certain extent, provided women with new opportunities for employment. And women are also taking up leadership positions within the emerging social movements and within traditional healing organizations.

> "But traditional healing also has to change its view of women. There are more female traditional healers than men. Women should be in leadership positions in our organizations. This is something the men fight against. They have tried to undermine me in meetings, but this is going to change. Women build the organizations, and then once they are built, the men try to claim the victory … But we women do most of the work, so we should be in charge."[376]

In trying to understand why so many South African men and women demonize 'women's rights,' I am not attempting to celebrate 'traditionalist' ideologies or to excuse misogynist behavior of any kind. Rather, I am attempting to understand the statements within their social context. Contemporary articulations of traditional patriarchal gender

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[373] "Tebogho." [NGO staff.] Interview held on October 19, 2005 in Soweto.
[374] Female participant in FGD held on June 10, 2006 in Sol Plaatje.
[375] Female participant in FGD held on October 6, 2005 in Lawley, Extension 2.
[376] Dr. Martha Mongoya. Interview held on September 3, 2005 in Orlando East, Soweto. Dr. Mongoya is the Deputy Chairperson of the GTFMP.

ideologies reflect a profound sense of disempowerment. It is important to recognize the underlying structural critique that is being articulated. But it is equally important to delve beyond simplistic assumptions about gender and sexuality and how they are conceived and practiced in South Africa's poor communities. Only an ethnography situated within the communities hardest hit by the dual pandemics of poverty and AIDS can begin to make sense of the complexity and hybridity of gender roles and sexual practices indicative of the post-apartheid period.

Policies aimed at prevention must take these complexities into account in order to avoid supporting a fallacious dichotomy between 'modernity' and 'traditionalism,' but they also must recognize that African identity is tied to cultural norms of gender and sexuality. Community members must have a stake in creating prevention strategies or else they will continue to be viewed as imperialist impositions. Therefore, policies must be grounded in communities' lived experiences and incorporate peoples' ideologies about sexuality (Baylies and Bujra 2000), but they also must take economic factors seriously. Without economic empowerment, any policies attempting to stem gender violence and prevent transmission will fail (Booth 2004; Epstein 2007).

The Political Economy of Sexuality

So, given all of these gendered problems in your community (rape, abuse, misogyny, etc.), how do we begin to work towards a solution? … "The first thing is employment. We need to get everyone a job … For women, it would provide them with autonomy. Right now, women are completely dependent on men for their economic survival. If they had jobs, then they wouldn't have to depend on men for money, wouldn't have to exchange sex for money … For men, they don't have any jobs, and this starts to affect them – make them feel like they need some other way to prove their manhood. So, because they don't have jobs, they have sex with not one, but three women. This proves

to them (and the community) that even if they don't have a job, they are still manly. So, they substitute women for money."[377]

"The poor themselves seem to know that money is at the root of their AIDS problem. Perhaps this is why, when I came to talk to them about HIV, they told me about money instead" (Epstein 2002: 48).

Internationally, most of the academic work which explores the impact of neoliberalism on gender relations focuses on how the shift from industrial labor to immaterial labor (Hardt and Negri 2000) that is indicative of neoliberal capitalism has initiated a transformation of the gendered division of labor. It has become commonplace to argue that it is *because* women are therefore more employable, that crises of masculinity have become global phenomena (Silberschmidt 2004). However, in South Africa, the impact of neoliberalism on gender dynamics is far more complicated. There has been a certain feminization of the labor market. Women are employed at greater rates within NGOs (a source of ever-growing employment because of the AIDS pandemic), health care, domestic services, and a newly emerging service industry. However, this feminization process is tempered in three ways. First, in the late 1990s, the number of women seeking work in the labor market increased at twice the rate of the increase in the female population of working age (Casale and Posel 2002). Because of this considerable increase in the number of economically active women and because this feminization has not been accompanied by a shift in the gender division of labor, women are employed for far less income than men and have minimal access to assets (Makgetla 2004). "Those women who are employed find themselves in the worst paid sectors of the labour market, notably in domestic and retail work. In 2003, 96% of domestic workers

[377] Thulani Skhosana. Interview held on May 20, 2005 in Sol Plaatje.

were black (i.e. African, co-called 'Indian,' and so-called 'Coloured') women and 93% of these workers earned under R1000 (approximately USD180) per month" (Hassim 2005: 5). In addition to domestic work, women could only find employment in the poorly remunerated and unstable informal sector. Therefore, women's median income fell significantly in the post-apartheid period (Casale 2004). Second, because of migration, lack of employment opportunities for men, and shifting trends in gender relations, women are now increasingly heading households, taking on the full financial responsibility for their (often extended) families, and continuing to carry the burden of caring for the sick, the elderly and children. Forty-two percent of African households are female-headed, and of those households, thirty-six percent have either no income or live off of pensions or social welfare grants (Statistics South Africa 2004b). Finally, shifts in the labor market caused by the adoption of neoliberalism, accompanied by a historic political economy of sexuality, have given rise to 'transactional sex.'

The History of Isoka Masculinity

Mark Hunter (2004) provides the history of the rise of *isoka* masculinity, defined by engagement in "multiple concurrent sexual partners" (125). In rural areas, from the late 19th century through the middle of the 20th century, it was common and perceived as 'normal' that most men and unmarried women engaged in concurrent sexual relations. 'Thigh sex' was a means of ensuring that unwanted pregnancies with partners outside of marriage was avoided. However, in the 1950s, a new sexual double standard gained prominence. Masculinity was defined, and thus differentiated from femininity by concurrent sexual relations. To be a respectable woman, monogamy was essential. Stigmatizing labels were used to draw divisions between 'loose' women and

marriageable women. Despite the rise of *isoka* masculinity, marriage and becoming the head of a household were still the most important signifiers of manhood.[378]

In townships, marriage was a means of securing symbolic capital. "[T]ownship development … fostered a middle-class masculinity associated with marriage (increasingly Christian and monogamous) and the ownership of a four-room house" (Hunter 2004: 138). Ethnographies of the South African urban life from the 1930s through the 1970s support these findings (Hellmann 1948; Longmore 1959; Mayer 1971; Mager 1999; Delius and Glaser 2002).

The institution of marriage in South Africa is founded on the payment of bridewealth, or *ilobola*, a payment of approximately eleven cows, or the monetary equivalent thereof,[379] from the groom's family to the bride's family. As such, the children of the marriage will be affiliated with the paternal line. "*Lobola* is payment for the giving of the child. A family gives a girl-child, who is a valuable part of any home – women are the pillars of the home and only they have the capacity to reproduce that home through childbirth. So, the family loses a great deal in giving up their daughter. They have to be compensated for this loss."[380] There is a secondary exchange of gifts (smaller and less expensive) from the bride's side of the family to the groom's, as a sign of respect. If *lobola* is not paid, then the child belongs to the mother's family and may take the mother's surname.

Historically, then, sexuality could not be understood outside of a kind of exchange economy. However, because the payment of *lobola* is still expected in contemporary

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[378] This entire summary is gleaned from Hunter 2004.
[379] Today this amount ranges from R20,000-R30,000 (between $3,000 and $5,000) depending on the family and the circumstances.
[380] Dr. Robert Tshabalala. Interview held on September 3, 2005 in Orlando East, Soweto.

South African culture, marriage is becoming increasingly impossible due to high rates of unemployment and poverty (Hunter 2002: 107-108; 2005a; 2007).

> "The factors behind this decline are complex; they include (until recently) women's increased work prospects and thus their growing economic independence from men. But particularly from the mid-1970s, when unemployment rose sharply, men's inability to secure *ilobolo* … or act as dependable 'providers' became additional brakes on marriage … Marriage today is, in many respects, a middle-class institution" (Hunter 2007: 695).

In the place of marriage, sexual relations are now marked by the practice of 'transactional sex.' "With marriage unaffordable for many men and women, men's gifts to multiple-girlfriends have increasingly replaced *ilobolo* payment to parents … Indeed, today it is virtually taken for granted that sexual relationships will be cemented with gifts from men" (Hunter 2002: 108).

Therefore, with the rise of neoliberal economic policies and the subsequent shift in the economy, *isoka* masculinity is being newly redefined.

> "Today, men typically court for a short time before sexual relations begin; they aspire to have very many girlfriends and are rarely held to account for their intention to marry these women (men saying that they would like to have four or five girlfriends is not untypical); they are seldom able to make the step from being *isoka* to being an *umnumzana* [head of the household], even if most still hope to marry; and they typically see penetrative sex as the only proof of love" (Hunter 2004: 141).

> "We've been having multiple partners from the beginning, and people are used to it. It's in the blood. The more you do things, consciously, the more it becomes normal to you – it becomes a normal standard. It is something that is there. I am addicted to being with multiple partners."[381]

Therefore, sex – and the engagement in concurrent sexual relations in particular – has replaced both work and marriage as the defining signifiers of masculinity. "Because

[381] Male participants in FGD held on October 28, 2005 in Sol Plaatje.

there is no employment, you have men who are engaging in sex outside of marriage, in order to make themselves feel strong because they have no income. So, poverty is causing the HIV pandemic."[382] But strangely, along with this new definition of *isoka*, there is an *inability* to fulfill this identity, hence the 'crisis of masculinity.' "Because, um, men who have secure employment, and who have money, you know, they can chase ladies, they can, you know...they can have ... many ladies, you know. But if you don't, then ladies will run away … It's bad. Yeah. For poor men."[383]

Transactional Sex

Paul Farmer notes that risk of HIV must be understood within a political economy framework, in which it is essential to "investigat[e] the precise mechanisms by which such forces as racism, gender inequality, poverty, war, migration, colonial heritage, coups d'etat, and even structural-adjustment programs *become embodied as increased risk*" (Farmer 1999: 148; my emphasis).

Transactional sex is when women agree to relationships with men in exchange for material gifts or essential goods for themselves and their children. Transactional sex is now viewed as one of the primary reasons for the high rates of HIV prevalence throughout Africa.[384] This practice is in no way related to the institution or profession of prostitution (Hunter 2002 and 2005; Epstein 2007), nor is it necessarily related to promiscuity (Dunkle et al. 2004a; Epstein 2007). Most often, these kinds of relationships develop because 1) sexuality has been historically linked to an economy of gift-exchange (Caldwell et al. 1989; Kaufman and Stavrou 2004; Hunter 2002, 2004, 2005, and 2007);

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[382] Male participant in FGD held on October 14, 2005 in Sol Plaatje.
[383] Thulani Skhosana. Interview held on June 11, 2006 in Sol Plaatje.
[384] The literature on transactional sex and concurrency is vast. For general sources on Africa as a whole, see: Morris and Kretzschmar 1997; Luke and Kurz 2002; Luke 2003; Chatterji et al. 2004; Epstein 2002 and 2007; Halperin and Epstein 2004 and 2007; Barnett and Whiteside 2006; Epstein and Kim 2007. For sources on South Africa, in particular, see: Hunter 2002, 2004, 2005b, 2007; Selikow et al 2002; Wojcicki 2002; Leclerc-Madlala 2003; Dunkle et al. 2004.

2) poor women rely on transactional sex out of economic need (Hunter 2002 and 2005; Dunkle et al. 2004a); and 3) those who have income feel a sense of social responsibility toward those who don't (Swidler and Watkins 2007; Epstein 2007).

The rise of 'transactional sex' has become a common survival strategy for poor women in a neoliberal economy (Hunter 2002 and Stadler 2003). Poor women, who are often single-mothers to not only their own children but also those of deceased relatives, agree to relationships or partnerships with men in their communities (usually one at a time for a prolonged period of time) in exchange for essential goods. Here are some of the ways my research participants explained the need to engage in 'transactional sex' in the contemporary South African economy:

> "If you are hungry and having HIV/AIDS, then you don't have access to grant. So, you have to sell your body in order to make ends meet."[385]

> "My boyfriend helps me with money so that I can get to the clinic and get treatment at the hospital. If I leave this person, then I might not be able to get health care. My boyfriend assists me very well."[386]

> "There are a lot of women out there who are forced to, you know, to being bought, since they are totally relying on...on...on men, you know, to...to support their...their children. Yeah. It does happen. They still have to beg from the men, you see. For money, you see. And if a man gives a woman money or food, then he expects something in return."[387]

In a context in which wage labor has become precarious and casual, a woman often cannot count on any one partner to provide for her family, for any extended period of time. Therefore, it is much more common (and at least somewhat accepted) for

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[385] Female participant in a FGD held on October 14, 2005 in Sol Plaatje.
[386] Female participant in Iketsetseng Support Group FGD held on October 20, 2005 in Lawley 2.
[387] Thulani Skhosana. Interview held on May 20, 2006 in Sol Plaatje.

women to maintain multiple sexual relationships, often referred to as sexual 'concurrency.'

> "You need money, but there are no forms of employment. The only way to live is to have multiple partners in order to have money available. To have money, you have to lie down. That is how people get HIV/AIDS."[388]

Therefore, changes in the economy, due at least in part to neoliberal economics, have initiated shifts not only in definitions and expressions of manliness, but new forms of sexuality are now available to women. However, because men have been stripped of every means of performing their masculinity *other* than concurrent sexual relations, they attempt to hold copyright on this signification. In other words, a stringent and violently enforced double standard persists in contemporary gender norms: men earn pride and esteem through engaging in multiple sexual partnerships and women are still expected to remain monogamous. "If a woman sleeps with three men in one week, then we call her a 'tiger,' and we talk and whisper about her. She will be a target of the community. But if a man has sex with three women in one week, then that's just normal … it is because of our culture."[389]

In one of the focus group discussions I was holding in Sol Plaatje, with a mixed gender group of HIV-infected community members,[390] my interpreter turned to me to ask if I knew of a particular word that was being used by the FGD members in their discussion of sexual concurrency and its prevalence in their informal settlement. "Claire, do you know the word, *oyafayba*? It means being a prostitute – having multiple partners. *For a woman?* Yes, for a woman. *And for a man?*" At first there was surprise and

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[388] Female participant in FGD held on October 14, 2005 in Sol Plaatje.
[389] Martha Mongoya. Interview held on August 17, 2005 in Orlando East, Soweto.
[390] Held on October 28, 2005.

silence, and then a very heated discussion, interspersed with laughter, ensued. Several of the men offered different words (for which I did not get translation), but then one of the women said, *'inja.'* Now, if I had not known this word, I may have missed the significance of this conversation (since my interpreter was taking part in the debate). *'Inja'* means "dog." The men in the FGD immediately rejected this signifier, but since I had picked up on it, I laughed. The women joined in, but the men were indignant. They insisted, instead, that the equivalent term for a man who engaged in multiple sexual relations was 'stud.'

The persistence of this double standard has two very serious and dangerous consequences for women. First, given their economic dependence on their sexual partners, women are not necessarily able to negotiate condom use. Condom use is, therefore, directly associated with poverty. Because it is likely that at least the man (and perhaps also the woman) in any relationship, is engaged in more than one sexual relation at any one time, transactional sex becomes one of the primary mechanisms of HIV transmission (Morris and Kretzschmar 1997; Wojcicki and Malala 2001; MacPhail and Campbell 2001; Kaufman and Stavrou 2002; Dunkle et al. 2004a). In a demographic study on transactional sex in Soweto, the authors found that "transactional sex was associated with HIV seropositivity after controlling for lifetime number of male partners and length of time a woman had been sexually active"(Dunkle et al. 2004a: 1581).[391] According to one of my respondents:

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[391] According to this study, 21% of women attending antenatal clinics in Soweto engaged in sex "for material gain with a man other than a primary partner" (Dunkle et al. 2004a: 1588). There is no demographic information which compares the use of transactional sex in formal versus informal townships. However, Mark Hunter conducted a comparative ethnographic project (2002), where he found that transactional sex is used in both settings, but for different purposes. In formal townships, women engage in

> "Consider the fact that we are focusing on culture and we want to respect it. We are saying it's a democracy, but some women are still following their culture where the man is the head of the house, and they have to bow to whatever the man is saying. Think about it – if I've already disclosed to my partner about my HIV status, and he refuses to use a condom, then what option to I have? I'm not working – because that's another problem – unemployment. And I have children. What will happen if he kicks me out of the house? Because I ask him to use a condom. Because most women depend on their man for income, so I would agree with whatever the man says. Because he's the person who's maintaining me and looking after me. I have no choice but to accept his decision, even if I know it's putting my life in danger."[392]

The second side-effect of the double standard which marks post-apartheid gender identity is an increase in sexual violence.[393] Violence may be used to promote and enforce this new definition of *isoka* masculinity.

> "And the issue of guys who visit or go to the pubs without their partners. And they meet a lady there (whom they don't know) and spend so much money buying her drinks. At a later stage, I ended up using my money, so there is an expectation of sex. And that means, if she doesn't want it, then *ex kopi jo*, which means "I'm kicking your butt." Because I've already used my money."[394]

In addition, poor men, stuck in the catch-22 of the new definition of masculinity: the impossibility of feeling manly through marriage and household leadership, but also economically unable to engage in transactional sex, may resort to coercive means of performing *isoka* masculinity.

> [In] "nearly all of the cases, adult rapists fell well short of the adult masculine ideal. Owing to prolonged unemployment, many could not afford to pay bride wealth, marry, and to support dependents … [M]en … who could not control the

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transactional sex for cultural capital, where in informal settlements, women were much more likely to use it for economic survival. His research in informal settlements (2002 and 2007) has also suggested that the practice is *more* common in informal settlements. My research supports his findings.

[392] "Tebogho." [NGO staff member.] Interview held on April 6, 2005 in Soweto.

[393] On violence and its relationship to transactional sex, see: Karim et al. 1995; Zierler and Krieger 1997; Wood and Jewkes 2000; Jewkes et al. 2001; Jewkes et al 2002; MacPhail and Campbell 2001; Dunkle et al. 2004a)

[394] Male participant in FGD held on October 28, 2005 in Sol Plaatje.

> behaviour of their wives, were unable to represent themselves as active and aggressive in relation to femininity. Their victims were the only women whom they could control, and rape reconfirmed masculinity otherwise denied" (Niehaus 2003).

Finally, given the rise of female-headed households, the feminization of the labor market, and the ability of poor women to use their sexuality to at least secure their subsistence, poor men may act out their 'crisis of masculinity' on women's bodies.[395] However, Mark Hunter (2004) and Didier Fassin (2007) caution against the interpretation of violence as "somehow new or a simple reflection of recent socio-economic conditions" (Hunter 2004: 140). Fassin notes that it is not sexual violence that is new, only its public acknowledgement (2007).

Hybrid Sexuality

It is exceedingly important that women in post-apartheid South Africa, are not perceived as simply victims of the 'crisis of masculinity.' In fact, new gender ideologies and sexual practices, new claims for 'women's rights,' and new economic opportunities are also creating innovative outlets for women's sexual agency and reconfiguring the signification of femininity. The 'crisis of masculinity' discourse, especially as it circulates in the media, not only considers Black masculinity a phobogenic object, but also strips poor women of their agency. It serves to collapse the complexity of sexuality in post-apartheid South Africa into a simple narrative of aggressor and victim. Against

[395] New research has also shown that women who have already been abused are more likely to engage in transactional sex for the following reasons: 1) abusive relationships can leave women impoverished; 2) abuse might lead to depression, which in turn causes heightened drug and alcohol abuse, and the subsequent need for greater amounts of money to sustain these habits; and 3) abuse can reduce women's abilities to trust or become emotionally embedded in any relationship, causing women to view sex on purely economic terms (Dunkle et al. 2004a: 1589).

these impulses, I would like to highlight the ways in which poor, African women's sexuality is hybrid, complex, and often empowering.

First, transactional sex is used for different purposes. In addition to pure economic survival, many young women use transactional sex to achieve a higher status in particular youth cultures (Leclerc-Madlala 2001b; Nyanzi 2001; Hunter 2002; Kaufman and Stavrou 2002; Luke 2003). For these young women, transactional sex is a means of accruing cultural capital. More working-class and middle-class women also engage in transactional sex (Swidler and Watkins 2007; Hunter 2002). For these women, securing "sugar daddies" is a means of engaging in consumer society and allows them to link "sex to power in assertive new ways" (Hunter 2002: 115). Finally, just because sexual relationships are transactional in nature does not mean that they are not also monogamous or perceived as a relationship marked by 'love.'[396]

Second, transactional sex lends women a kind of autonomy from marriage constraints and a certain access to power and resources that they deploy strategically in order to survive the constraints posed by abject poverty and ever-increasing unemployment (Hunter 2002 and 2007). "Indeed, coming of age in an environment where the prospect of work and marriage is small and often aware of their own boyfriend's unfaithfulness, many women are quick themselves to see the benefits of securing multiple partners" (Hunter 2004: 143). In addition to lending economic agency to poor women, transactional sex can be tied to women's sense of self-respect (Caldwell et al. 1989; Wight et al. 2006; Johnson-Hanks 2006; Swidler and Watkins 2007). Some women with whom I spoke, found that they felt not only empowered by their ability to

[396] It is often in these long-term, affectionate relationships where condom use is *least* likely (Hunter 2007: FN 16, 697).

engage in transactional sex, but also found that they were better able to negotiate the *terms* of this sexual encounter:

> "Another thing is that I don't have a stable relationship, and I can only agree to have a relationship with someone who agrees to use a condom. The one who doesn't can't be with me – 'if its not on, its not in.' The men who say, no condom, then I say 'no.'"[397]

Finally, *isoka* masculinity is also *sometimes* challenged by both women and men in post-apartheid South Africa. "Bolstered by discourses of women's 'rights' in the post-apartheid period, some women now oppose with new energy *isoka's* right to secure more than one sexual partner" (Hunter 2004: 142).

> "Most of the problems that are caused by gender, when it comes to sex, is that women have not been told of their rights. Men will go around, sleeping around. And when he comes home, he wants to sleep with his wife. If she refuses, then she will be beaten. So, she doesn't understand this as rape. The men think: the woman is a woman and should abide by the decisions of the men. So, women need to learn they have rights too, and they don't need to be treated like this."[398]

Jonathan Stadler (2003) has also found that poor men blame wealthy men for the spread of HIV/AIDS, and so his evidence suggests that *isoka* masculinity is confined to a particular class. If this is true, then perhaps it becomes possible for poor men to find dignity in defining new forms of masculinity. I have found some evidence to suggest that this might be possible. Some men believed *isoka* sexuality to be a direct *defiance* of respectable masculinity:

> "The connection between manhood and the epidemic is that men have actually dented their reputations, or their charisma (aura) through rape, abuse of women, and to use power when it is not necessary in order to deal with women. This makes men lose – it challenges their masculinity. If there are men who believe they can cure AIDS from sleeping with an infant, then that reflects badly on men

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[397] "Mary." Interview held on October 26, 2005 in Lawley, Extension 2.
[398] Female participant in FGD held on June 10, 2006 in Sol Plaatje.

> in general. Who would respect a man like that? So now men lose who they are – because they started doing these kinds of things. If they had respected themselves from the beginning, then this wouldn't be a problem today. They have now lost this component of their charisma, or aura."[399]

And some men are seeking out new definitions of masculinity through the "Men as Partners" program which attempts to provide men with different gender scripts with which to challenge patriarchal norms, ideologies and practices (Walker 2004).

In conclusion, then, the 'crisis of masculinity' thesis, used as a *causal* argument highlights the economic basis of shifts in sexual practices in post-apartheid South Africa.

> "There is a serious problem that makes women vulnerable – poverty. Some women get casual work, for a few days. But then once that work is over, they look around and find they have no work. And they still have to feed their kids and make sure they have a roof over their head and food on the table. So, then, maybe she will exchange sex for money. Others, they don't do it because they like it, but because they have no choice. Maybe if the government could assist people to find work, then they wouldn't need to do this. Then the practice would diminish."[400]

Because sexuality is inextricably linked to a material economy of exchange, neoliberal economic policies have had a profound impact of peoples' capacity to engage in sexual behaviors which protect them from HIV transmission. It has also contributed to sexual violence. For men, new definitions of sexuality have undermined previous expressions of manhood that were based on work, marriage and the establishment of a home and community. "Today's tragedy of AIDS cannot be separated from the crisis of development in contemporary South Africa" (Hunter 2004: 145). Therefore, curbing the genocidal impact of HIV/AIDS in post-apartheid South Africa requires economic reform. But it is equally important to take into account the *complex* and *hybrid* nature of sexuality

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[399] Torong Ramela. Interview held on November 9, 2005 in Braamfontein, Johannesburg.
[400] "Sarah." Interview held on October 26th, 2005 in Lawley 2.

and gender identity. Because while it is essential to understand the economic foundation of sexuality, it is equally important to recognize that sexuality is never *simply* economic.

Sexuality as Symbolic Capital

> "… [*I*]*nstitutionally organized and guaranteed misrecognition* … is the basis of gift exchange and, perhaps, of all the symbolic labour aimed at transmuting the inevitable and inevitably interested relations imposed by kinship, neighbourhood or work, into elective relations of reciprocity, through the sincere fiction of disinterested exchange, and more profoundly, transform[s] … arbitrary relations of exploitation (of woman by man, younger brother by elder brother, the young by the elders) into durable relations, grounded in nature" (Bourdieu 1990: 112; emphasis in original).

Because of the way in which sexuality is linked to a material economy of gift/money exchange, it is easy to misrecognize transactional sex as purely economic and even utilitarian; however, transactional sex is an important form of symbolic capital – where economic investment is disavowed and only the honor and prestige accumulated in the exchange is recognized (Bourdieu 1977; 1980; 1990). Swidler and Watkins (2007) point out that transactional sex is embedded in a system of redistribution and reciprocity, where "ties of dependence" are linked to moral and social obligations of sharing, especially in desperate economic conditions (150-151). One could see this social redistribution as a form of *ubuntu*, a Southern African philosophy of communal responsibility.[401]

For Bourdieu, symbolic capital was a slippery and elusive concept. "The notion of symbolic capital is one of the more complex ones developed by Pierre Bourdieu, and his whole work may be read as a hunt for its varied forms and effects" (Bourdieu and

[401] It originates from a Zulu maxim *umuntu ngumuntu ngabantu*, "a person is a person through (other) persons."

Wacquant 1992: FN 73, 119). The inspiration for the concept of symbolic capital emerged out of Bourdieu's field work in Algeria, where he realized, in working with the Kabyle, that economists who had long declared pre-capitalist societies economically irrational, were in fact acting out their ethnocentrism in so doing (Bourdieu 1990:112 and Bourdieu 1977: 172). Bourdieu believed that gift-exchange was a misrecognized economic investment, whose profits were deferred over a period of time – which became his working definition of symbolic capital. "'Symbolic capital' is to be understood as economic or political capital that is disavowed, misrecognized and thereby recognized, hence legitimate, a 'credit' which, under certain conditions, and always in the long run, guarantees 'economic' profits" (Bourdieu 1980: 262).

Any species of capital (economic, social or cultural) can become symbolic if it is perceived through socially inculcated classificatory schemas, or when the arbitrariness of its accumulation is misrecognized. Symbolic capital is "the form that one or another of these species [of capital] takes when it is grasped through categories of perception that *recognize* its specific logic or, if you prefer, misrecognize the arbitrariness of its possession and accumulation" (Bourdieu and Wacquant 1992: 119). So, in addition to being a defining feature of Kabyle gift exchange, it is also the disinterestedness which marks "art for art's sake" (Bourdieu 1984; 1992). It is a (conscious or unconscious) strategy of making an *investment*, while not seeming to do so – while maintaining a disinterested disposition. In other words, it is capital that is misrecognized as capital (sometimes purposefully so). Symbolic capital "… prevents the economy from being grasped *as* an economy, i.e. as a system governed by the laws of interested calculation, competition, or exploitation" (Bourdieu 1977: 172).

> "Every kind of capital (economic, cultural, social) tends (to different degrees) to function as symbolic capital (so that it might be better to speak, in rigorous terms, of the *symbolic effects of capital*) when it obtains an explicit or practical recognition, that of a habitus structured according to the very structures of the space in which it has been engendered. In other words, symbolic capital … is not a particular kind of capital but what every kind of capital becomes when it is misrecognized as capital, that is, as force, a power or capacity for (actual or potential) exploitation, and therefore recognized as legitimate" (Bourdieu 2000: 242).

The term 'investment' has two meanings – it is a misrecognized economic investment (misrecognized because those who benefit accrue profit without consciously trying to – without consciously invest*ing*), but also an investment in the *illusion*. Symbolic capital *naturalizes* social hierarchies; "arbitrary relations of exploitation [are transformed] into durable relations, grounded in nature" (Bourdieu 1990: 112).

While Bourdieu criticized economists for their misrecognition of the economic nature of Kabyle gift-exchange, I would like to suggest that (most) of the researchers studying transactional sex make the opposite mistake. Sexuality is understood primarily as utilitarian exchange, but it is much more than this. Sex is transactionable in various forms of capital, but it is misrecognized as purely economic.

It may seem obvious that men are exchanging money for cultural and social capital. They accrue cultural capital in the sense of an affirmation of their masculinity, but they also accumulate social capital,[402] in the sense that prestige is gained through the accrual of people to whom they are both economically and sexually responsible. "[M]en seek to demonstrate their 'wealth in people' by becoming patrons to poorer women …" (Swidler and Watkins 2007: 152). Whereas for women, who engage in sex for economic

[402] Social capital is defined as "the aggregate of the actual and potential resources which are linked to membership in a group" (Bourdieu 1986: 250).

survival in a neoliberal economy, the exchange seems purely economic. But women are also involved in a whole complex system of capital exchange. As mentioned in the previous section, women also accrue cultural and social capital, as they accrue sexual partners.

One of the most understudied aspects of transactional sex is the way in which gift-exchange is accompanied by a whole host of exchanges of 'substance.' Because the act of sex also allows ancestral communication, sexual relations and their material base, are the nexus of spiritual, social *and* economic exchange.

> "This flow of goods replicates the flow of sexual substance in that it 'goes both ways' and represents a social and economic flow of good symbolising 'respect' and 'filiation' both of which create social identities and imbue them with *cultural capital*. The parallel flow of sexual substance similarly *constitutes the 'persons'* of those who share these substances, and thus generate the blood that flows into the next generation. Just as sex that involves flow of semen and vaginal fluid helps to constitute the body and person of both partners as well as their offspring, the flow of material goods constitutes the social context in which the relationship is validated and the child grows" (Thornton 2002a; my emphasis).

Linking indigenous notions of sexuality as a means through which the ancestors communicate *with* the sexual economy of gift exchange is crucial; however, with the exception of Robert Thornton (2002a), it is completely lacking from the vast literature on transactional sex.

In addition to important ancestral exchanges (and therefore, historical, social and communal affiliations), trust, prestige and respect are established through these various "flows of substances" (Thornton 2002a) that accompany sexual relations. Often, when men provide gifts or cash to a transactional partner, it is understood as a sign of respect. In addition, "transactional relationships are not always related to immediate material necessity and may in fact be a mark of a woman's self-respect" (Swidler and Watkins

2007: 154). Because sex is now affiliated with possible contagion (not only with HIV, but also with other forms of pollution), sex without a condom signifies trust and respect for the sexual partner (Thornton 2002a).

Therefore, sex constitutes complex social networks in which economic capital (money/gifts), spiritual capital (auras, blood), social capital ('wealth in people'), symbolic capital (trust, honour, prestige), and cultural capital (sexual and gender identity) are transacted, and thus legitimated and valued.

According to Bourdieu, symbolic capital is a form of capital characterized by a misrecognition of economic investment, and it is possible that in previous historic periods, the sexual economy of gift-exchange was precisely this. Below, I have provided a long quote from an interview with Dr. Tshabalala where he actually pines for an idealized past when sex was simply symbolic.

> "This notion of girls expecting gifts from their boyfriends, it comes with these new laws ... the *new rights of women and everything*. And now it has become a notion or trend where a lot of girls are expecting something from men before maybe they have sex. They don't actually respect their bodies … A woman is someone who is very respected and these bodies that they have, they are not even theirs. They should respect their flesh. If nothing is exchanged, they will ... they will think that 'this man doesn't love me, because he isn't actually buy me x, y and z.' And then that thing, it's a problem. There was no such thing before.
>
> "Now they want to make it like sex is a money-making scheme or the employment bureau. I used to come from town and look in the taxi, and there were so many girls, little girls, counting their money and asking each other, 'how much did you make?' And then I'm wondering where do these kids come from? You know, and that thing *is busy killing the nation*."
>
> *What did you mean when you said that women's bodies are not their own?*
> "They are pillars of the house … of the family. The woman's vagina is not hers. It's the gift for her to build her family or home. Supposing a woman disrespects her vagina, then there is no way that she can build a house and a home. And no way she can satisfy anyone … And everyone will just isolate her. Because this vagina, it produces here at home. *And then actually bears the nation*, you know.

> And then the family and the nation, or the community. It produces...it's a production. [laughs] It's a company."[403]

I have quoted this long explanation because it illustrates a number of the complicated aspects of contemporary sexuality in South Africa. First, Dr. Tshabalala holds that traditionally, women's role in the economy was limited to domestic production and reproduction. With the rise of transactional sex, women are using their bodies to enter the labor market. According to Dr. Tshabalala, this is antithetical to the very definition and purpose of female sexuality. The economy is not the space for sex. Sex is not a commodity to be exchanged for material wealth or even survival. Its value is *symbolic*.

He blames 'women's rights' for this shift, and at another point in this interview (quoted earlier), he equated transactional sex and the other ways in which women are currently entering the labor market. In becoming bread-winners (and often household heads) in their own right, women are transgressing social hierarchies, but also traditional identities. And in so doing, they are not respecting the *symbolic* quality of sexuality. Therefore, Dr. Tshabalala's analysis supports Bourdieu's theory of gift-exchange and symbolic capital. But in post-apartheid South Africa, previous social hierarchies, well bounded identities, gendered spaces of production, divisions between the private and the public, are being reconfigured and reinvented. Therefore, today, sexuality itself is hybrid – it has becomes a point of convergence for all of the various forms of capital, which had previously been conceptualized as distinct or at least, circumscribed – each with its own particular logic of exchange and conversion. After years of being trapped between two

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[403] Robert Tshabalala. Interview held on September 3, 2005 in Orlando East, Soweto; italics are used to highlight important components of his analysis (and to indicate a question I posed for further clarification).

economies, two cultural systems, two racial hierarchies – condemned to a habitus in hysteresis, in post-apartheid South Africa, Black men and women are exploding binaries and embodying multiplicitous hybridity. And in so doing, they are inventing new modes of exchange and new forms of capital, even within the stringent confines erected by neoliberal economics and a thanatopolitics of exclusion and devastation.

But according to Tshabalala, "this thing is busy killing the nation." For him, the transgression of both gender roles and sexual practices is dangerous, not simply to the people involved, but for the nation as a whole. This belief reflects a widespread national anxiety about the state of the post-apartheid nation.

The Crisis of Liberation

In an analysis of the way in which public awareness and outcry over sexual violence developed, Deborah Posel argues that the young nation's sudden concern with the crisis of manhood that sexual violence exposes has less to do with the rise of feminist analyses and activism, and more to do with "political and ideological anxieties" about the state of the nation (Posel 2005: 241). Therefore, for Posel, male sexual violence becomes the signifier of deep-seated concerns about the moral economy of the new democracy.

The 'crisis of masculinity' thesis is used to support very different subject positions and their accompanying ideologies … When analyzed through both a discourse analysis *and* ethnographic data, this 'crisis' thesis and its prevalent reiteration (in both the media and in township ideologies) show us that the concern it masks is a deep-rooted anxiety about the identity of the post-apartheid nation and its relationship to Western culture and ideologies. This concerns key questions about race, class and nationalism.

The imperialism is perceived as coming both from within the nation, as well as from external imperialist forces. Those in power wield this thesis to protect their economic interests, and those being targeted by the thesis resort to traditionalism in order to defend themselves against a perceived imperialist threat. Therefore, again, this becomes a battle between 'modernity and traditionalism' – each blaming the other for the moral bankruptcy of the nation.

And the 'crisis of masculinity' has become a facile panacea for the national identity crisis plaguing the post-apartheid state. Although a 'crisis of masculinity' is indeed a reality in post-apartheid South Africa, the media has transformed it into a transcendental signifier. Julia Kristeva notes that phobia *displaces* fear through the inversion of signs, through *metaphorization* (1982: 39-40). Phobia can only be controlled, therefore, through representation. The poor, Black, male body has been fetishized and forced to embody (and thereby neutralize) all of the volatility and crises plaguing the nation. It is not masculinity that is in crisis, but rather, the promises and ideals of liberation itself.

The fear embodied in the figure of the poor, Black man is not only one of sexual potency or revolutionary defiance of race and class oppression, it is also a fear of contamination because this figure is assumed to be HIV-positive. The corporeal contagion this body represents is not only physical but symbolic. The eruption of discursive flurry about the politics of contemporary masculinity reflects a deeply rooted anxiety plaguing post-apartheid South Africa: the AIDS body undermines the post-apartheid imaginary by exposing the failure of the state to actualize the promises of

liberation. As such, the AIDS body has been foreclosed from the body of the post-apartheid nation. It has been relegated to the margins of sovereign responsibility.

> "… the realm of bare life – which is originally situated at the margins of the political order – gradually begins to coincide with the political realm, and exclusion and inclusion, outside and inside … enter into a zone of irreducible indistinction … When its borders begin to be blurred, the bare life that dwelt there frees itself in the city and becomes both subject and object of the conflicts of political order, the one place for both the organization of State power and emancipation from it." (Agamben 1998: 9)

The symbolic fury over sexuality disguises a disavowal and a lack: an unwillingness and impossibility to incorporate the AIDS body into the body of the nation and to therefore take sovereign responsibility for its well-being and healthiness. So instead, that body is transformed into a phobogenic object, such that the focused attention of the public and the state is concentrated on disciplining it.

The discourse targets, blames and disciplines the group of surplus citizens who have been relegated to the margins of neoliberal sovereignty, abandoned by post-apartheid politics and who therefore present a very real threat to not only the stability and development of the state, but also to the constructed imaginary of the nation as victors over racism and colonialism. Foucault labels biological crises like famines and epidemics "thresholds of modernity," the sites where the body escapes our attempts to discipline and control it. "It is not that life has been totally integrated into techniques that govern and administer it; it constantly escapes them" (Foucault 1978/1990: 143). But under a bio-political regime, the body is part of the power-knowledge nexus and the political machinery of the state. Even when the body is 'out of control,' it is still the *target* of power and knowledge. Political technologies are wholly invested in containing and policing the boundaries of the biological and social body.

Chapter 6

At the Threshold of the Biological and the Social Body

Due to the overwhelming toll AIDS had had on poor, Black communities in South Africa, Avalon, the cemetery on the outskirts of Soweto, has become a primary focal point of community activity. On any given Saturday,[404] the entire geography of Soweto is reconfigured to accommodate the 'production' of funerals. My research assistant and I drove to Soweto on August 13, 2005, where we waited at a corner and joined a convoy of 20 cars, buses, and bakkies[405] heading toward Avalon. On our way, our convoy was mixed up with several others. There seemed to be no other traffic on the roads. Police officers were directing traffic. I was struck by the efficiency of the operation – both on the streets of Soweto and at the gates of the cemetery – a rare occurrence in post-apartheid South Africa with its byzantine bureaucratic regulations. The 'production' of

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[404] Most burials happen on Saturday – this is now the 'fashion,' but it also allows family members traveling from afar to attend the ceremony. During the week, the family will gather to figure out the logistics of the burial (scheme coverage, insurance, burial plots, ceremony planning, invitations, furnishing rental, the purchasing of food, etc.). The family will visit the corpse at the mortuary and will bring the clothing the deceased will wear for the burial (as well as any keepsakes that should be placed in the casket). On Friday, before 3:00, the hearse will deliver the casket (with the corpse in it) to the family house – before sunset. The casket will be placed inside the home, and the women will remain around the casket, while the men hold vigil outside. The vigil lasts all night. In the morning, people will all attend the funeral at the gravesite, followed by two full days of mourning at the homestead, lasting from after the funeral until sunset on Sunday night. (Torong Ramela. Interview held on August 13, 2005 at Avalon Cemetary, Soweto.)

[405] Trucks.

funerals has in fact become a kind of industry of death due to the AIDS pandemic. And Avalon, generally a horrific, austere, and sinister site of mass-scale death –

Figure 6-1: Avalon Cemetery [406]

with its tombstones that stretch silently and disquietingly for miles on end – was transformed into a bustling site of community participation. But with all of this obvious attention paid to the genocidal level of deaths the epidemic has produced, the words HIV or AIDS are never mentioned at funerals. The bodies are piling up, but their significance is cloaked in silence.

Accompanying the pervasive proliferation of discourses *about* AIDS and sexuality and the various cacophonous symbolic struggles in which the post-apartheid state is embroiled is an eerie silence that circulates with deadly force within communities stricken by the dual pandemics of poverty and AIDS. The lack of words is a response to the answerlessness of thanatopolitics – the incomprehensibility of being abandoned by the state, civil society, and the community – left with a terrifying and flesh-eating disease as one's only company.

[406] Photo taken by the author.

> "But the unaudibility of talk about AIDS is often less a matter of brute repression or secrecy than of complicated 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; my emphasis).

The "epidemic of signification" (Treichler 1999a) which marks the social landscape of AIDS in South Africa does not succeed in abating the lingering sense of unease and anxiety about a disease that has such an incomprehensible capacity to kill and destroy. As discourses abound, communities' own sense of meaning is destabilized. They are unable to make symbolic sense of the genocidal destruction they are suffering. As a result, communities have begun to impose strict disciplinary measures on each other – delimiting the boundaries of the speak-able.

In this chapter, I will explore the significance of silence and the corporeality of AIDS. Silence circulates around taboos associated with death, transgression and bodily disintegration. Women's bodies often mark the threshold of the social body, and the social exclusionary tactics of thanatopolitics parallel the bodily destruction wrought by AIDS. Therefore, this chapter will examine the concomitant processes of state abandonment, community isolation and corporeal decay.

The Significance of Silence

> "[S]ome people explicitly linked the extraordinary power and menace of AIDS to its mysteriousness, as a disease which has eluded both western medicine and indigenous healers: 'it seems this AIDS is like magic. Nobody can stop it'" (Posel 2004: 14).

When a community member is dying of this disease, everyone *knows* it, and yet they do not speak of it. They do not utter its name. "We call it Z3, so that we don't have

to say its name out loud."[407] This silence illustrates one situation in which ideologies of HIV/AIDS are contradicted by the materiality of the body. When HIV/AIDS remains in the realm of the discursive, there is a very important ambiguity between those *affected* by the virus, and those *infected* by it. However, the body itself refutes the ambiguity that discourse allows by betraying the infected person through the very obvious physical manifestations of the symptoms of HIV/AIDS. Once the virus has become literally inscribed on the body, the indexical sign gains dominance, unveiling a new register of signification. As such, a different relationship between sign and object emerges, as silence then replaces the cacophony of proffered discourses.

There is, therefore, a very complex relationship between disclosure, silence, and the way in which HIV/AIDS is mapped very literally onto the bodies of those infected. In fact, in addition to a refusal to name the disease, many South Africans refuse to believe the disease even exists unless it has manifested itself materially. One support group member explained, "I tell people I'm HIV+ because I'm open about my status. But when I tell people, they don't believe me. They refuse to believe! And they won't believe me until I start to lose weight."[408] An NGO staff member, whom I have called "Thandi," chuckled as she told me, "when I disclose, people say, 'no man, but you're fat!' Nowadays people are even afraid to diet!"[409] "Tebogho" explained the reason for this disbelief in the following way: "People are more aware of AIDS, than HIV. Because when the person is HIV, the person looks normal. But when a person gets sick or starts

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[407] "Tebogho." [NGO staff.] Interview held on October 19, 2005 in Soweto.
[408] Female participant in FGD held during a support group meeting of the anonymous NGO where I conducted participant observation. The FGD was held on April 13, 2005 in Zola, Soweto.
[409] "Thandi." [NGO staff.] Interview held on April 15, 2005 in Soweto.

to go to the clinic all the time, then they will get stigmatized, even if they haven't disclosed."[410] Therefore, only the body itself can prove the reality of AIDS.

Disclosure is then offered as the panacea. According to many respondents, failing to disclose portends a quick and rapid decline. "If you are quiet and are HIV+, it hurts you. A lot of people who die of AIDS it's because they don't disclose."[411] But there is something almost predatory about a disease unnamed and unspoken – it is almost as if HIV/AIDS feeds off of silence. "I think it's good to speak because it's not going to haunt you. If you are quiet about your status and don't say it, it will eat you slowly – psychologically. Those who disclose live longer."[412] In addition to combating the unspeakableness of the disease, disclosure magically disallows the emergence of physical symptoms. It's as if the virus has a certain need to *be* signified. It achieves symbolic power through its very materiality. Left unnamed, it has learned to speak.

> "If you hide your status, the status will try to show itself – the virus will make itself visible. So, even if you don't disclose, we'll still see that something is there."[413]

> "If you don't disclose, people in the community will eventually know anyway. By the time they know … even if you don't disclose, eventually the disease will come out and show itself to the people, you know."[414]

Fear and silence police the zones of bodily liminality and transgression, and in so doing, they map the limits of *both* the biological and the social body. Therefore, silences circulate in various ways around corporeal boundaries: sexuality, pollution, and death.

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[410] "Tebogho." [NGO staff.] Interview held on April 6, 2005 in Soweto.
[411] "Nhlanhla." [NGO staff.] Interview held on April 15, 2005 in Soweto.
[412] Female Traditional Healer. Participant in FGD held on June 6, 2005 in Ipelegeng Community Center, White City, Soweto.
[413] Female Traditional Healer. Participant in FGD held on May 9, 2005 in Diepkloof Community Center, Diepkloof, Soweto.
[414] Pheello Limapo. Interview held on August 18, 2005 in Lawley, Extension 2.

Corporeal Thresholds

"There [in abjection], I am at the border of my condition as a living being … If dung signifies the other side of the border, the place *where I am not* and *which permits me to be*, the corpse, the most sickening of wastes, is a border that has encroached upon everything" (Kristeva 1982: 3).

Mary Douglas's anthropological work (1966/2000) reveals the way in which the boundaries of the physical body become the limits of the social body. All social structures are vulnerable at their margins, making thresholds dangerous places (Ibid); therefore pollution and contagion, which permeate and therefore threaten the wholeness and normality of the body, must be well disciplined and controlled. For Julia Kristeva (1982), who was influenced by Douglas's work and theory, the identity of the social being is constructed through the act of expulsing that which society deems polluted, that which jeopardizes the purity and sanctity of its whole and contained integrity. However, these threatening elements (blood, semen, vomit, feces, as well as social acts, such as: masturbation, incest, homosexuality, prostitution, etc.) can never be fully annihilated; they continually and constantly threaten to disorder and dissolve the wholesome social form.

The abject is "what of the body falls away from it while remaining irreducible to the subject/object and inside /outside oppositions" (Grosz 1994:192). Abjection demarcates the borders between self and other, and it is always a self that is imminently in danger of extinction, in a state of perpetual danger. "[T]he expelled abject haunts the subject as its inner constitutive boundary; that which is repudiated forms the self's internal limit. The abject is 'something rejected from which one does not part'" (Kristeva 1982: 4). Therefore, the abject constitutes a threshold between the internal and external, but because its indeterminacy is threatening, a solid and coherent boundary must be

established and constantly policed. Abjection is a border, a liminality, an ambiguity, according to Kristeva, precisely because it perpetually threatens the subject with disintegration. Exclusionary rituals, therefore, are necessary to confirm and solidify both the body politic and the physical body.

> "[A]bjection is a process through which we create individual, social, and political order. It is a process by which we demarcate self from others on a personal and collective level . . . It is in and through … exclusionary rituals… which jettison that which 'disturbs identity, system, order' . . . that both social order and individual identity - the 'clean and proper body' - are produced" (Zivi 1998: 35).

Both the political and social order *and* the stability of the ego are at stake if the abject is not expulsed, but this process is ceaseless because the abject is in-eliminable. Expulsion is a perpetual process. However, in an effort to secure a sense of stability, a source of contagion must be located and then repudiated in order for identity and social order to be constituted and maintained. "The boundary of the body as well as the distinction between internal and external is established through the ejection and transvaluation of something originally part of identity into a defiling otherness" (Butler 1990: 133). This abject other is what is thrust aside in order to construct and sustain the boundaries of the self. The "jettisoned object" (Kristeva 1982), the abject, threatens the subject with fragmentation and dissolution. But also with meaninglessness, incomprehensibility, an excess of signification. Therefore, the construction of an other, against whom rituals of expulsion can be practiced, creates the conditions for fantasies of coherence, integration, and intelligibility.

The process of securing limits, of abject*ing*, is enacted through processes of othering, but also through the policing of permeability.

> "Abject. It is something rejected from which one does not part, from which one does not protect oneself as from an object … It is thus not lack of cleanliness or health that causes abjection but what disturbs identity, system, order. What does not respect borders, positions, rules. The in-between, the ambiguous, the composite" (Kristeva 1982: 4).

For Kristeva, fluids like blood, pus, faeces, semen reveal the body's permeability. Douglas (1966/2000) relegates bodily fluids to a borderline status. Corporeal substances "mark the routes of interchange or traffic with the world" (Henderson 2004: 17); they trace the intersection between the self and other. "What is disturbing about the fluid is its refusal to conform to the laws governing the clean and proper, the solid and the self-identical, its otherness to the notion of an entity" (Grosz 1994:195).

AIDS and those who embody its threat to the social order serve as South Africa's abject. "AIDS creates disorder in the bodies of the afflicted as well as in social worlds due to large-scale deaths" (Henderson 2004: 16). This is why, for Foucault, bio-power and the production and governmentality of technologies of the self are inextricable operations of state power (2000a). It is at the level of the body that disciplinary measures must be both enforced and performed (Foucault 1977/1995; 1978/1990). Because disease is particularly menacing to our sense of coherence, discourses on health and healing construct and delimit the contours of the stable social body. But so, too, do thanatopolitics. The abject lives in the zone of abandonment – a liminal space without meaning or order.

> "It is the irruption of the abject, and the experience of the afflicted as being relegated to a place of abjection, that in some respects marks the ways in which hegemonic society skirts around the suffering of individuals" (Henderson 2004: 16).

The threshold of the body parallels the threshold of the body politic. With AIDS, both are threatened with contagion and disintegration.

Sex and death are thresholds of the biological and bio-political. AIDS is magical and horrifying at least partially because it begins and ends at these limits – where the self and the social merge. Just as those who threaten the illusion of freedom upon which the post-apartheid imaginary depends and the integrity of 'clean and proper' body politic are jettisoned into zones of indistinction, so too must infected body fluids be contained. Expulsionary corporeal actions like sex (when various substances are exchanged), illness (when fluids cannot be controlled) and healing (when invasive pollutants are purged through rituals of cleansing) are, therefore, policed by silence, taboo and stigma.

The Silence of Sexual Transmission

There are several forms of silence circulating around sex. First, community members say that their culture prohibits the transmission of sexual knowledge from parent to child, due to strictly enforced norms of respect. "Respect and the expectations associated with it generally require the suppression of speech of any kind that refers to sex or any direct, frank talk about it. This creates barriers between age classes and between generations" (Thornton 2002a). There is an expectation that children will learn about it on their own, from experience.

> "We never talk to our kids about sex and sexuality, but they are there. They are sexually active, and I think since they are already sexually active, so we need to talk to them about the consequences of their actions."[415]

> "Most of the kids know about sexual intercourse, know about sexual activities, but they don't learn about them in their homes. They learn about it from outside. And then it's difficult for them to come back in their homes and ask what they

[415] "Sarah." Interview held on October 26, 2005 in Lawley, Extension 2.

> heard outside. I remember in some other instance where a child said, 'Yes, I did hear about it, but I went back to my mom to ask and my mom beat me up.'"[416]
>
> "There is no discussion of sex in the family, even between couples."[417]
>
> "Even in schools, we educate children about HIV, but we don't talk to them about sexuality. And they don't get this information from home either. We need to tell children what is going on with their bodies, and teach them how to respect themselves. This is really lacking from our sex education programs."[418]

Traditionally, sex is bound in silence due to barriers of respect. However, another form of silence circulates around sexually transmitted diseases. This is the silence of shame.

> "Perhaps, therefore the internal stigma is connected with the merely sexual – not homo- or hetero-sexual. Perhaps in our deepest selves we feel that a sexually transmitted infection shows others that we have been 'caught out.' The infection leaves a mark, a stain, a print, linking us back to an act so private, so intimate, so sacrosanct, so emotionally and spiritually unguarded – the moment of sexual coupling – that its external manifestation in an illness, its exposure to the world, is deeply embarrassing and therefore shameful" (Cameron 2005: 71).

When I asked community members why stigma is so prevalent in their communities, they responded: "because the disease is transmitted sexually." Cameron notes that this is because AIDS exposes the most sacrosanct, private and intimate actions to the world. When AIDS outs, it inscribes your sexuality on the surface of your body. And in a culture where sexuality is already perceived as sacred and secret, this public exposure is deeply disgraceful.

TAC activists have claimed that when Mbeki criticizes the racist colonial assumptions associating Blackness and promiscuity, he contributes to the silence and shame surrounding sexuality. Jonathan Berger, advocate for the AIDS Law Project,

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[416] Thulani Skhosana. Interview held on September 2, 2005 in Sol Plaatje.
[417] Male participant in a FGD held on October 28, 2005 in Sol Plaatje.
[418] "Tebogho." [NGO staff.] Interview held on April 6, 2005 in Soweto.

explained this point in an interview: "I see these inherent contradictions in the President's … views on sex and sexuality, and how if you say we have lots of sex, it's a bad thing. Who said sex is a bad thing? Queen Victoria might have, but maybe it's not part of African culture that looks at sex and sexuality and the body as inherently evil and disgusting!"[419] According to several TAC analysts and activists, instead of engaging the critique about racism implicit in historically colonialist views on African sexuality, the TAC has attempted to reclaim and celebrate sexuality (Lewis 2001; Berger 2004; Robins 2004; Cameron 2005). Steve Robins explains: "TAC has adopted a very different approach to these representational questions. Instead of resorting to a defensive, and potentially lethal, response of AIDS denial, TAC AIDS activists have sought to destigmatize and depathologise African sexualities" (Robins 2004: FN 17, 660).

While this is certainly a laudatory goal, it may not be very practical. When I asked Justice Edwin Cameron[420] about this tactic in an interview, he replied:

> "I think it is a conscious tactic on the part of HIV activists. And ... the underlying issue really is the problem of...of the stigmatization of the sexually transmitted disease. And the fact is ... that even 20 years after acquiring the virus, and 19 years this month after my diagnosis, I think I still feel at some level that my illness is different because I acquired it sexually. And what the TAC activists have tried to do is to ... render that more indifferent. And it's been very difficult because I think at some profound level … people do think it's different to get a disease sexually ... One cannot really say that the ways in which people have sex, transact with sex, negotiate with sex, and, in fact engage in sex, is ... is a matter of indifference. One can't say that."[421]

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[419] Jonathan Berger. Head of the Law and Treatment Access Unit, AIDS Law Project. Interview held on November 24, 2005 in the ALP offices in Johannesburg, University of Witwatersrand.
[420] Edwin Cameron is a Supreme Court of Appeal Justice, who was one of the first and still remains one of the only high ranking governmental officials to publicly disclose his HIV status. He is also author of a best-selling book, *Witness to AIDS* (2005), which is also quoted above.
[421] Edwin Cameron. Interview held on December 9, 2005 in Brixton, Johannesburg.

In other words, there is so much invested in sexuality, it is difficult to change its signification and materiality. In addition, because the TAC has eschewed indigenous healing, and with it, ontologies of the body essential to the identity and ideologies of African communities, TAC activists' efforts to 'depathologize African sexuality' is a bit ironic, not to mention unfeasible. Because indigenous sexuality is inextricable from communal and ancestral exchange, and because subjectivity is ontologically permeable, many of the forms of silence that circulate within communities are associated with taboos inscribed on certain kinds of bodies. Without knowledge of these cultural beliefs, sexual silence will remain inscrutable.

Taboo and Pollution

Dr. Tshabalala: "If you sleep with a widow or with someone who has had an abortion, you know, it's very dangerous, because that person is still very sick, I mean spiritually, and then now that person is going to contract that disease, *makhome*, because the blood of the woman is dirty …"

Dr. Mongoya: "Yes, it is dirty because the *isithunzi* (aura) of the dead husband or child is still a part of the woman … until she is cleansed. So, if she has not gone through the cleansing ritual, then it is dangerous for anyone to have sex with her. She can pollute a man, and he will contract *makhome*."

Dr. Tshabalala: "If the woman hasn't been cleansed and has sex with someone else, she will pass on bad blood. It is polluted with the *isithunzi* of someone else …"[422]

Henri Junod defines taboos as "any act, object, or person that implies a danger for the individual or for the community, and that must consequently be avoided; this object, act, or person being a kind of ban" (1913/1962: 573). Taboos serve to protect individuals from pollution and communities from contagion. As evidenced by the conversation included above between Drs. Mongoya and Tshabalala, some of the most

[422] This exchange took place during an interview held with Robert Tshabalala and Martha Mongoya on August 17, 2005 in Orlando East, Soweto.

important taboos associated with indigenous ontologies of the body attempt to prevent "inauspicious sex" (Neihaus 2002: 198). People who are grieving (but particularly widowed women), those who have come into contact with a corpse (especially the corpse of a relative or loved one), women who have aborted (and the men who have sex with them), pregnant women (and a man who has sex with a woman who is pregnant with someone else's baby) are all sexually banned because their blood is considered polluted, dirty or 'bad' due to the fact that it is contaminated with the *isithunzi*, or aura, of a being in liminal state – a state of passage between life and death. Because blood is believed to be exchanged during sexual intercourse, having sex with a person who is inhabited by the aura of a recently deceased person or an unborn child can be put into a "dangerous state of heat" (Niehaus 2002: 193), which can lead to the indigenous illness known as *makhome*.[423]

According to Niehaus (2002), this form of pollution is generally analyzed as a taboo associated with marginality and liminality (Hammond-Tooke 1981). However, Niehaus insists, instead, that it is a sign of *multiplicity*. "Whereas liminality and anomalies are structurally underdetermined, multiplicity is structurally overdetermined" (Niehaus 2002: 197). Sex is powerful and dangerous because substances that are usually kept distinct are mingled. And one's blood is 'polluted' *by* another person's aura. Niehaus comes to this conclusion, at least based in part on the anomaly presented by

[423] This information is gleaned from multiple sources. I yield priority and expertise to my respondents, and in particular Drs. Martha Mongoya and Robert Tshabalala. But their explanations are generally confirmed by ethnographic research conducted with other traditional healers by Junod (1913/1962), Krige (1936/1950), Schapera (1940), Hammond-Tooke (1974 and 1981), Green (1999), Niehaus (2002) and Thornton (2002b).

taboos associated with menstruation. Some traditional healers claim that men should not have sex with a woman who is menstruating because:

> "Women's bodies naturally cleanse themselves. During the course of the month, a woman's blood collects heat. So, then every month, it is a normal process of cooling and rebalancing itself."[424]

> "The problem is when hot and cold blood mix. When men want to have sex, their blood becomes hot, and it is only by having intercourse that he can become rebalanced. But, sometimes a woman's blood is cold – like during her time of the month – because the blood in her womb is cold. So, if the hot and cold blood mix, this can be dangerous to the man."[425]

Niehaus never explains how his theory of multiplicity applies to the taboo associated with menstruation, and I actually found that this sexual taboo was a point of contention amongst traditional healers. Dr. Mongoya claimed there was no risk of pollution associated with having sex with a woman who is menstruating.[426]

Despite this particular ambiguity, I believe that these taboos associated with "inauspicious sex" are *both* multiple and liminal. Meaning, the person's blood is 'polluted' with the aura of another person, but not just any other person, a person who is journeying between the social and ancestral worlds. In terms of menstruation, it seems that the woman is herself in a liminal zone – her body is in the process of cleansing, which must not be disrupted.[427] This conclusion is supported by the fact that sex is also prohibited during the period of time when an *umthwasa*, an initiate or trainee, is going through the rigorous apprenticeship to become a *sangoma*.[428] And sometimes, depending

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[424] Dr. Robert Tshabalala. Interview held on August 17, 2005 in Orlando East, Soweto.
[425] Dr. Mputhi. Interview held on July 18, 2005 in Evaton West.
[426] Interview held on August 17, 2005 in Orlando East, Soweto.
[427] Dr. Moki. Interview held on November 1, 2005 in Evaton West.
[428] Dr. Tshabalala and Dr. Mongoya. Interview held on August 3, 2005 in Orlando East, Soweto.

on the illness, one is asked to abstain during the course of a treatment.[429] This abstinence is often justified because the patient or trainee is asked to concentrate all of their energies on the ancestral world. If the subject is too tied to the material, social world around them, then the healing or apprenticeship can fail.[430] But at the same time, these trainees generally also serve as domestic servants to their *gobela*, trainer (Thornton 2002b),[431] and people who are ill are undergoing rigorous ancestral *and* bodily treatments. Therefore, in both of these cases as well, the patient is in-between or double – straddling, as it were, the material and the ancestral worlds.

Therefore, people who are in liminal *and/or* multiple states of being are the sites of sexual bans. Their blood and aura is replete with multiple subjectivities, or they are in the process of movement between two states (cleansed or uncleansed),[432] or they are in the potentially dangerous position of bestriding the material and ancestral realms. One of the primary questions I then posed to the traditional healers with whom I worked closely was: "why are these taboos so often associated with *women's* bodies?" The answer to this question concerns the differential ontologies of female and male bodies. And it also begins to explain some of the gendered stereotypes associated with HIV/AIDS.

Mary Douglas notes that women's bodies often mark the boundaries of the social order in particular ways (1966/2000). Leclerc-Madlala has argued that in local discourses, women are often blamed for the spread of the HIV/AIDS, while men are

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[429] Ibid.
[430] Drs. Tshabalala and Mongoya. Interview held on April 8, 2005 in Orlando East, Soweto.
[431] The series of interviews I conducted with Drs. Martha Mongoya and Robert Tshabalala took place in Martha's home in Orlando East, Soweto, where she also practices as a *sangoma*. But she also serves as a *gobela*, a trainer for people apprenticing to become a *sangoma*. In addition to learning the intricacies and skills of divining, they act as servants to the *gobela*, to learn humility and to pay homage to the authority of the *sangoma*. Thornton (2002b) describes this process. During the many hours we spent in Martha's home, the various *umthwasa* served us tea and snacks, and ran errands for Martha.
[432] This is suggested by Douglas 1966/2000, Hammond-Tooke 1981, and Pauw 1990.

signified as the passive recipients of infection (2002: 32-33). I have found the exact opposite to be the case.[433] In my research, I found that men's *actions* were blamed (their rampant sexuality), but the virus was perceived to reside in women's bodies – to be stored there. Women are the passive containers.

> "Women are dishes in which men pour. Women get sick because a man takes a number of partners outside and the men will go and get that pollution from maybe...maybe a woman, and come back at home and pour into the dish – his wife. But at the same time, if this wife finds out that she's very sick and something is wrong with her. The very same man will say, 'No, it's you,' you see? 'This disease is from you.'"[434]

Men are the source and origin, whereas women almost transmogrify *into* the virus. Interestingly, in different research she conducted, Leclerc-Madlala makes this same distinction. Women and AIDS are not only "linked constructions, they are really one construction. Woman *is* AIDS" (Leclerc-Madlala 2001c: 43; emphasis in original).

> "In terms of sex, men have all the powers. They don't *have* the virus. HIV is only for women, not for men. It is for women, because they are on the receiving side."[435]

Therefore, the women who act as the "dishes into which men pour" are not blamed for the spread of the disease, they just *signify* the disease. However, again the double standard persists. There are the 'innocent' women who simply passively receive the virus, and then there are the original women with whom the promiscuous man has sex out of wedlock. Strangely, these women are not necessarily blamed either. Their status is just accepted as ontologically infectious. And this same ontological distinction applies

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[433] This finding is supported by research conducted by Stadler 2003, which found that wealthy men were the population most often blamed for spreading the virus through their vigorous assumption of *isoka* sexuality.
[434] Dr. Tshabalala. Interview held on August 17, 2005 in Orlando East, Soweto.
[435] "Nhlanhla." [NGO staff.] Interview held on April 15, 2005 in Soweto.

to the diseases associated with transgressing sexual bans on liminality. I asked several healers why taboos were all associated with women's bodies, and while many of the women discussed how this feeds into the double standard against women, they never questioned the cultural presumptions upon which these beliefs are based. They never questioned the fact that women's bodies have the power to produce pollutants.

> "Even with *makhome*, it is the man's fault. He will sleep with women outside of the marriage, not caring if they are widows, and then bring this illness back to their wives. This all started with migrant labor."[436]

Women's bodies are often perceived as multiplicitous and liminal. As such, they are the source of various taboos. If the thresholds of the slippages between zones are not respected, if the social bans are not heeded, then contagion is inevitable. In addition, due to a sexual double standard, women's roles in infectious epidemiology are bifurcated. Women either act as sources or depositories of transmission. Either way, their bodies are passive containers: dishes into which men dip or pour. This gendered nature of the ontology of blame is a source of bitter indignation.

> "The taboos are all associated with women because women are oppressed. Even though sex brings together two people, in partnership, there is no equality. Women are blamed, but men are the ones who say that it is in their culture to sleep around. Sex is supposed to be for them only, and the woman isn't supposed to enjoy sex, or else she is stigmatized. These parts of our culture need to change."[437]

And yet, the underlying beliefs about the causal agents of pollution go unchallenged. Taboos are meant to act as prophylactics. But because subjectivity is necessarily porous and multiple, the possible sources of contagion are incalculable. And

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[436] Dr. Martha Mongoya. Interview held on August 17, 2005 in Orlando East, Soweto.
[437] Ibid.

then, the culpable agent becomes obvious. Communities are vulnerable at their margins because 'modernity' has destroyed peoples' respect for these time-honored taboos. It has destroyed communities' only barriers of protection – their physical and social bodies are left open and exposed to the ravages of 'modern' rule.

Indigenous beliefs in taboos that ward off pollution are, in part, relics of the past. Delius and Glaser (2005) argue that these historical beliefs have been simply transposed into contemporary situations: stigma from the past explains the stigma associated with HIV/AIDS. Such an analysis ignores the ways in which these ideologies of contagion have been newly reinscribed (Niehaus 2002: 205). Indigenous beliefs cannot be reduced to (or essentialized as) timeless and rigid (See: Fabian 2002). In fact, I have tried to show, throughout my dissertation, that traditional beliefs reflect the spiritual, political, and economic insecurities of the post-apartheid era.

Disintegration

"The visible paring away of the body - its substance and efficacy in the world - is often mirrored by a paring away of benign social relations in relation to the person afflicted … The vertiginous disintegration of the body as manifested in a successive series of afflictions without a cure draws fear. The failure of bodies to hold, to maintain a modicum of coherence is externalised and mirrors an experience of collapsing sociality" (Henderson 2004: 5).

Mary Douglas (1966/2000) and Julia Kristeva (1982) have argued that abject fluids are sources of fear and respect because they threaten the body's coherence. The body's permeability is the site for "the articulation of power, desire and disgust, of the individual, the social and the spatial" (Pile 1996: 184). Drawing on these authors, Patricia Henderson notes that the particular fears associated with HIV, and the hysterical degree of stigmatization these phobia produce are due to the "slippage of boundaries"

with which AIDS assaults the body (2004: 4). AIDS is the source of nightmarish, irrational fears because it literally dis-figures the body, and this fleshy disintegration is contagious and incurable.

The body of the AIDS sufferer gushes contaminated fluid. People are abandoned to isolation and silence, in part, because of a fear of touch. Caretakers are forced to don gloves in order to avoid infection. Even in the hospitals, patients complain that the nurses will leave people lying in their bodily waste because of heightened fears of permeability and contagion. And so the sense of communal responsibility and care is also broken down. The body of the AIDS sufferer has literally forsaken its own margins. But then stringent social boundaries, encircling the sick, are erected and policed. The community is atomized. As such, the disintegration of the body becomes a sad metaphor for the break-down of social relations.

Many of the fears and pain surrounding HIV have to do with its paranormal and horrific assault on the body. The signifiers respondents chose to describe its power were monstrous. They told me that AIDS was 'flesh-eating,' that it 'consumed,' or that it magically infantilized their bodies.

> "I'm fighting my body because this is not the structure of my body. I weighed 39 kilos [85.8 pounds] the last time I went to the clinic. [438] This is not my body. It's not mine. It used to not look like this. I used to be very strong and I used to have like a well-built structure of the body, and then I used to be big. Yes, I'm fighting that I go back to my normality and then I get my body not to look like I'm wasting away … I really fear my body because right now what is happening is that it's like I'm like a baby, it's like I'm a...because this is not the structure of my body … Because even when I bathe, I look at myself, I feel like I have gone down again like a baby."[439]

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[438] Pheello is approximately 5'5" tall.
[439] Pheello Limapo. Interview held on November 9, 2005 in Braamfontein, Johannesburg.

The idea of a flesh-eating virus renders peoples speechless, terrified, and alone:

> "The pain is so difficult to describe. But there's something else. Sometimes there is no pain, but this thing is still inside you, in your blood. If we could talk about, if there were words to talk about, how HIV consumes your body … But having something that you have never had, that is very, very much strange, and even difficult to tell the doctor. You know, and you may think the doctors obviously, they know. But it's something that is not talked about. Like the flu. I know the symptoms of flu, you know, and the feeling if you have flu. But the feeling around HIV/AIDS, it's something...if...if one could say it, needs to be emotional, needs to include sorrow [laughs sadly] … it's something difficult to describe."[440]

AIDS is a viscous disease – not only is it transmitted sexually, but it literally causes the body to run. Dying from AIDS entails diarrhea, night-sweats, oozing bed sores, an inability to control the bladder, blood-stained urine, and an emaciation of the body that transmogrifies human beings into ghastly visions of the living dead. The first time I ever visited an AIDS ward at the Chris Hani Baragwanath Hospital, I felt like I was walking into Auschwitz. AIDS has turned entire communities in South Africa into death camps, peopled by nightmarish walking corpses, whose bodies bear the mark of the most horrific forms of thanatopolitics.

> *What is your biggest fear associated with the virus?*
> "My biggest fear is that I don't know how I'm going to get sick, when I get sick. I don't know if it's going to be bad for 2 or 3 years before I die – like it does with other people who go from one hospital to another. Some people with HIV/AIDS, we see them get very sick until they get very small – like babies. With that tiny body, they just sit on the bed, not saying anything … This scares me. Because I know what kind of suffering those people have … I fear people who are very sick … Sometimes I think they don't have a soul – that's what they look like. Sometimes if I can see a person like that, that vision will not go away from me. I will keep on thinking about it for days wondering how a person can live in this condition."[441]

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[440] Thulani Skhosana. Interview held on September 30, 2005 in Sol Plaatje.
[441] "Mary." Interview held on October 26, 2005 in Lawley, Extension 2.

Securing the Signifier

"But there remains something even harder to grapple with. The most inaccessible, the most intractable element of stigma is the *disfiguring* sense of shame that emanates from the internal world of some with HIV or AIDS. This sense colludes with external stigma, overcoming efforts to deal with the disease rationally, keeping those with AIDS or HIV in involuntary self-imposed isolation, casting a pall of contamination and silence over the disease" (Cameron 2005: 70).

Disclosure is the most common solution proffered by health care professionals, activists, NGO workers and government officials for stemming the confusion, silence and stigmatization surrounding HIV/AIDS. If the disease has incurable and perilous paranormal powers, then providing it with a fixed signifier, bringing it securely into the realm of the symbolic, may rob it of its magic. "[W]hatever the metaphoric density of the disease, the capacity for treatment, together with popularly accepted and 'ordinary' medical versions of the disease, will play a critical role in the de-stigmatisation of AIDS" (Posel 2004: 15). In this way, disclosure and biomedical hegemony become facile panacea, the magic potion, the 'cure' for the post-modern plague.

> "[W]hen I realize that the disease wasn't going to consume my body, and I realized it so early, it was such a dramatic moment. It was such a revelatory moment, it was a physiological realization, which gave me a spiritual release and a moral release, that this really was just a virus. It wasn't a punishment. And the public disclosure just took that process forward enormously."[442]

Pheello told me that disclosing allowed him to gain new knowledge about the disease. Once he was able to understand what was going on in his body, what symptoms he could expect and how to treat them, then the virus became less frightening and more manageable. He pointed out that disclosing allows people to ask for the kind of help and support they need to survive.

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[442] Justice Edwin Cameron. Interview held on December 9, 2005 in Brixton, Johannesburg.

> "If you take the pain out and show it to people, people in your life, even if they can't give you something tangible, they can give you advice and assist you to maneuver, you know, in your life. Also if the pain is in here and then it's not out, then it becomes a problem. If it's out, people come and give you hand-outs and assist you, because now the pain is outside. You have to take the disease out, and let people hear about it. That is why it's important to have a support group, because that's where we share, even amongst ourselves information and everything … by disclosing it opens many doors for assistance, you know, as compared to closing the doors. Because if you're closing, you're closing for the help that should have come your way. You know, then by disclosing you're opening many doors for assistance."[443]

In South African culture, disclosure is often associated with adopting a biomedical paradigm of healing. It is tied into the governmentality associated with the ideology of 'positive living.' TAC strongly encourages its members and associated groups to openly disclose. This practice can have extremely positive effects: it attempts to combat the silence and stigma which has an overwhelmingly negative impact on communities; it encourages communities to talk to one another, to share information and to provide support to fellow community members who are also affected by the disease. In other words, it helps to build and sustain communities. On the other hand, it can actually serve to silence people who may not fully subscribe to a biomedical paradigm. These people are further ostracized by an approach which inadvertently states that the biomedical approach to HIV is the *only* answer. Further, HIV is a retrovirus, and the scientific explanations of how it subsists in the body and how anti-retovirals treat it are complicated. And in the extremely under-resourced and under-staffed public health institutions, nurses and doctors do not take the time to explain the illnesses diagnosed or the treatments prescribed. In this way, people are kept in the dark. Expert knowledge can also produce silence.

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[443] Pheello Limapo. Interview held on August 18, 2005 in Lawley, Extension 2.

In fact, South Africans are quite well-educated on the basics of HIV/AIDS transmission, progression and treatment. In my experience of as an HIV/AIDS educator in the United States, I believe South Africans to be better knowledgeable on HIV/AIDS than the majority of Americans. NGO workers often note that the scope of HIV education campaigns in South Africa is so extensive that community members are getting bored with the routine. "A lot of people have been educated – the education on HIV has worked and done a lot in this country … They know so much … people are tired of hearing about HIV. Children are tired because they've had so many people come who are HIV+ and tell their story. They are bored. It shows a lot has been done …."[444]

When I asked them why they thought stigma was still so pervasive if people are well educated on HIV/AIDS, the issue was complexified. One NGO staff member responded: "People are well educated on HIV/AIDS, but they are ignorant. People in South Africa are really ignorant – that's the problem."[445] In other words, education on HIV/AIDS does not necessarily address underlying sources of discrimination – it fails to make sense of the inequalities people face based on their race, gender, class, sexuality, etc. Biomedical education does not address the incomprehensibility of oppression. And the populations who are targeted by thanatopolitics are facing two inextricable pandemics: poverty *and* HIV/AIDS.

> *Why don't people talk about HIV/AIDS in your community if so many people are dying?*
> "Because talking isn't going to change the situation. It is not going to change their living conditions. And so, it's not going to change the fact that people are spreading this disease and dying from it … You know, I thought if there could be access to health, access to jobs, access to, you know, basic services, that would enable communities to decide to live. But no one could take a different path, no

[444] "Nhlanhla." [NGO staff member.] Interview held on April 15, 2005 in Soweto.
[445] "Thandi." [NGO staff member.] Interview held on April 15, 2005 in Soweto.

> one could choose from various types of lives that you are having here, you know. We don't have an option but to live in the dark … we have to live there."[446]
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> "How can I change my lifestyle if I don't eat good food, you know? That's it, you know. HIV/AIDS … strikes in the informal settlements, in the underprivileged communities, because they...even though they want to change their life, they're not able to. Then if you were HIV-positive, then your days are numbered ... you can't do otherwise, you know … Education won't work unless people have the capacity to change. Having a healthy lifestyle means eating nutritious food, drinking good water, going to see the doctor if you have an illness. What is the point of this information if people cannot follow it? For information to matter to people to … to really matter and make a difference for them … it has to apply to them … If people have no way to change their lives, because of poverty, then what good is the information?"[447]
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> "People have reached a stage where they don't care. Like I said before, they know that even if they live positively, they will die. So, they have reached a point where they aren't afraid to die, and they don't care what kills them anymore … People are not afraid to die. And they're tired. They've reached a point, where they just don't care."[448]

The effort to symbolize and thus neutralize the dis-ordering threat of HIV/AIDS is also an effort to discipline – to lock in place the uncontrollable chain of signifiers (Derrida 1978) and to secure the boundaries of the body politic. The abject embodies ambiguity and transgression. The ritualization of abjection therefore is an obligatory practice in society; it represents an attempt to deflect the threat the abject poses to the sanctity of the social body through its symbolization (Kristeva 1982: Chapter 3).

Thus the solution proffered by healers, government officials and civil servants alike, amounts to the imposition of a 'transcendental signifier' over and above a complex and multi-vocal discursive field (Derrida 1978). "[A] despotic Signifier destroys all the [signifying] chains, linearizes them, biunivocalizes them …" (Deleuze and Guattari

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[446] Thulani Skhosana. Interview held on May 20, 2006 in Sol Plaatje.
[447] Thulani Skhosana. Interview held on September 2, 2005 in Sol Plaatje.
[448] "Nhlanhla." Interview held on April 15, 2005 in Soweto.

1972/1983: 40). However, AIDS itself resists this symbolic circumscription. Once it has been elucidated, once biomedical science thinks it has it in its grasp, the virus mutates. It is constantly undermining treatment and definition. The disease is porous, it slips in and around barriers, it cannot be contained. At the threshold of the body politic, people are left with no discourse to ultimately make sense of their isolation and disease …

'The Body in Pieces'

"The function of ideology is not to offer us a point of escape from our reality but to offer us the social reality itself as an escape from some traumatic, real kernel" (Žižek 1994: 45).

According to Lacanian psychoanalysis, every individual is subjected to the alienating power of language, and is therefore always fragmented. "By submitting to the Other (here: language), the child nevertheless gains something: he or she becomes … one of language's subjects … the child, submitting to the Other, allows the signifier to stand in for her or him" (Fink 1995: 49). Through this process of alienation, the subject gains solely a *potential* of being – it gains an empty space, a place-holder of subjectivity. However, this alienation and fragmentation is threatening and estranging. Therefore, the subject *identifies* with imaginary fantasies of wholeness and integration. During the mirror stage (Lacan 1949/2002), a child views its own image in the mirror. In contrast to its own feelings of awkwardness and lack, the specular image is *gestalt*. This vision of completion and coordination "threatens the body with disintegration and fragmentation" (Evans 1996: 6). In order to resolve this aggressive anxiety, the subject *identifies* with the image. This secondary identification with the counterpart in the mirror results in the

formation of the ego.[449] In true Lacanian fashion, the language deployed to describe this process is significant. *Méconnaissance* is 'misrecognition,' but *me connaissance* refers to self-knowledge (Lacan 1949/2002). The subject is aware, in some sense, that this secondary identification is *imaginary*. S/he will be haunted, throughout his/her life by fantasies of the 'body in pieces.'[450]

This is at least partially because this process of misrecognition and identification is necessarily incomplete, and *un reste*, or leftover always remains to taunt the subject. This rem(a)inder of one's fragmentation and subjection is Lacan's *objet petit 'a'* which will consistently threaten the subject with disintegration. The Real is a very ambiguous concept in Lacan's work. Sometimes it is an extra-discursive referent, but more often it *is* the *objet petit 'a,'* which emerges in the interstices of the Symbolic order. The *objet 'a'* should be conceptualized *as* lack, or a hole in the Symbolic order which is filled by a specter that *signifies* the Real (Žižek 1994). Although subjects have no access to this 'kernel of the Real' (Žižek 1989; 1994), they have a perpetual, paradoxical relationship to it in two ways. First, it is that which allows for desire, and second, it propels the 'ideological work' in which subjects must constantly engage in order to function in the realm of the everyday. These two relationships to the Real are intertwined – though subjects are able to live their lives, as Althusser notes (1970/ 1994), because they 'act' within the imaginary, this constructed illusion and their consistent misrecognition is persistently in jeopardy. In a metaphorical sense, subjects often 'bump into' this specter

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[449] The *ideal ego* is the name Lacan gives to this fantasy of *gestalt*, this illusion of unity on which the ego is built.

[450] In fact, this whole process is a repetition of primary alienation from the archaic dyadic unity the child believes it achieved with its mOther. But because the mirror stage is essential to the formation of the *bodily* ego, it is more relevant here (See Lacan 1969/1991).

of the Real (Žižek 1994), and they ward off the menace of *recognition* it poses by constructing new illusions and thus retreating into the comforting arms of ideology.

Although Lacan locates the initiation of the imaginary order in the mirror stage, it is actually a realm that coexists alongside the symbolic order. "[T]he imaginary offers forms of identification that deny difference, estrangement, and the loss of symbiotic plenitude; they disavow their debt to the Other. The imaginary is thus a sort of estrangement from the 'inevitable estrangement' of the Symbolic" (Steinmetz 2006: 458). Therefore, it is not the Real that truly frightens the subject, but the *symbolic*.[451] The 'specter of the Real' simply unveils the Symbolic order in all its alienating and fragmentary glory and therefore, makes imaginary identification difficult to sustain.

George Steinmetz (2006) suggests that Lacan's theory of imaginary identification helps us to make sense of Bourdieu's somewhat conflictual theory of habitus. In his re-working, Steinmetz suggests that Lacan's *ideal ego*, the fantasy of wholeness, explains Bourdieu's own privileging of the *integrating* function of habitus. "[N]o matter how often Bourdieu restated his definition of habitus he never seemed to come any closer to explaining how and why this integration occurs, and why it sometimes fails" (Steinmetz 2006: 457). But Bourdieu did often *recognize* the fact that habituses were often internally contradictory (1999a), split fundamentally because the subject was coercively forced to straddle two different social systems (1958/1962; 1963/1979; 1964/2004), and he even refers to his own habitus as *clivé* – cloven or cleaved (Bourdieu 2004; quoted in

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[451] This is most obvious in Lacan's re-analysis of the story Freud tells about a father who falls asleep while watching over his son's dead body and dreams of his son reprimanding him: "Father, can't you see that I'm burning?" The father wakes to find that he son's arm has caught fire from one of the candles lit for the vigil. Freud's original analysis is located in the *Interpretation of Dreams* (1955), and Lacan's reinterpretation is found in Lacan 1973/1998. Lacan's analysis is also the one of the primary inspirations for Žižek's work on ideology (1989).

Steinmetz 2006: 457). Steinmetz suggests that the only way to make sense of the tension between integration and fragmentation the concept of habitus seems to embody is to reanalyze the concept within a Lacanian framework. The integrating drive of *bodily hexis* is an imaginary identification, which is always under threat from the Real and the Symbolic. As such, re-analyzing the concept within this analytic paradigm "explains why a 'cloven' habitus is just as likely as a unified one … The Imaginary is forever overcoded by the Symbolic, which pushes against integration and toward fragmentation and difference. All of this is haunted by the repressed memory of the 'body in pieces'" (Steinmetz 2006: 458-459).

I would like to suggest that when South Africans identify with either 'tradition' or 'science,' and in so doing, attempt to fix the signification of HIV/AIDS, they are engaging in an imaginary identification. The ideal 'traditional' or 'biomedical' body is simply a fantasy of integration and completion. In fact, people also identify with a whole social body – they disavow the failure of liberation, and choose instead to believe in the post-apartheid imaginary, in the democratic illusion of equality. But AIDS, and its wild chain of signifiers and unruly materiality, disrupts and disallows facile imaginary identifications.

> "[T]he danger of filth represents for the subject the risk to which the very symbolic order is permanently exposed, to the extent that it is a device of discriminations, of differences … But from where and from what does the threat issue? From nothing else but … the frailty of the symbolic order itself" (Kristeva 1982: 69).

The Symbolic is fragmentary, alienating and repressive. And AIDS acts as a 'specter of the Real,' constantly forcing people to *recognize*. In response, subjects search in vain for

despotic signifiers that can halt the ever-erupting chain of signification, and yet, AIDS remains elusive. It disallows symbolic fixity.

Given the fact that people living on the threshold of the body politic are in constant touch with the realities of AIDS and poverty, their imaginary identifications are less convincing. Many retreat into the refuge of silence. Perhaps, because their fragmentation cannot be foreclosed, they are consistently forced by their very bodies and material social conditions into a constant state of recognition. Their bodies are always 'in pieces,' and it is perhaps for this reason that a hybrid habitus is inevitable.

Chapter 7

Conclusion

HIV/AIDS unveils, with horrifying vividness, the often obscured fault lines of economic and cultural disparity. In South Africa, the spatial, cultural and economic schisms of inequality inherited from apartheid and maintained under post-apartheid are clearly inscribed on those infected with HIV/AIDS. The bodies of those infected with the disease bear the marks of history, but also of new, post-modern regimes of (national and global) injustice. The AIDS body is not only emblazoned with inequity, it also signifies a threshold of exclusion. The sufferers' corporeal margins and the borders of the spatial zones in which the infected bodies are circumscribed reveal the limits of the post-apartheid body politic.

By exposing South Africa's schisms of contemporary inequality, AIDS undermines the state's claims to a successful liberation, a narrative upon which its national identity depends. But in addition to a symbolic and ideological menace, AIDS jeopardizes South Africa's economic and social security. The threat that AIDS poses to the body politic of South Africa is particularly acute because of the tenuous nature of the post-apartheid state. HIV/AIDS engulfed the nation in its most vulnerable moment – during the period of transition from apartheid to a capitalist democracy. This conjuncture of transformations served to destabilize the boundaries of the nascent post-apartheid body politic. No one institutional or dominant discourse on HIV/AIDS has been capable of

constructing or maintaining the authority necessary to assume hegemony and therefore impose its paradigm of the body over the entirety of the public sphere.

The source of this discursive multiplicity is complicated, but there are several historical causal factors. First, through indirect rule and a bifurcated governmental apparatus, the apartheid regime institutionalized the polarization and concretization of segregated cultural ideologies and identities, drawing a line between two constructs: traditionalism and modernity. Despite this invented incommensurability, colonized populations developed hybrid habituses in order to circumnavigate the structural obstacles imposed by a system of dichotomous segregation. Second, although the profession of divination was outlawed under apartheid, the institutionalization of segregation and the system of indirect rule not only preserved non bio-medical forms of healing, but nurtured them as a form of resistance to racist colonial oppression. Third, while processes of hybridization are common to all post-colonial societies, South Africa is situated at a uniquely ambivalent historical-social position within the global capitalist world system where it straddles both first- and third-worldness.

The final and most important factor for understanding the multi-vocality of corporeal logics vying for hegemony concerns the confluence of doxic crises in South Africa's recent history. The AIDS pandemic struck the nation at precisely the moment of transition from apartheid to a capitalist democracy, a transition that was facilitated by the ANC's adoption of a neoliberal macro-economic strategy. The political transition itself is marked by an ambiguous volleying, on the part of the state elite, between contradictory ideological positions. On the one hand, the ANC embraces a pan-Africanist renaissance which incorporates a biting critique of Western cultural imperialism. On the other, the

adoption of economic liberalism has wrenched open South Africa's national borders to the onslaught of international capital and its accompanying ideologies.

The dilemma that all post-colonial states face of attempting to sustain a national identity in the face of the deterritorializing forces of globalization is heightened in South Africa for several reasons: its late transition from colonialism, its efforts to maintain its position as an economic leader on the African sub-continent, and its need to deal successfully with the mutual pandemics of AIDS and poverty. AIDS and debates over healing, then, become overdetermined sites for working through this contradiction. And as such, hegemony becomes the primary stake in a vociferous symbolic struggle over the signification of AIDS, taking place in South Africa between developmental state actors, biomedical proponents and indigenous healers.

All of these factors combine to produce a uniquely polyvocal field of healing in which myriad discourses compete for ultimate legitimacy and claims on the 'solution' for AIDS. Because discourses on HIV/AIDS and healing more generally are rooted in structuring corporeal ontologies and because they implicate classificatory systems of exclusion/inclusion (the "vision and division" of the social), wielding power in the field of healing has wide-reaching repercussions in the field of power.

Despite the multi-vocality that distinguishes the 'unsettled' field of health and healing in South Africa, the field, like the state, is still ravaged by colonial and post-colonial bifurcations. As such, the idealized constructs of 'modernity' and 'traditionalism' still matter and still wield causal power in contemporary power relations. Therefore, the contemporary 'myth of incommensurability' which is established and reinforced in the battle between denialists in the government, the proponents of

biomedical science, and traditional healers is in some ways simply a rearticulation of colonial inventions. Equally, however, new post-colonial and neoliberal rationalities also structure the field. Biomedical science draws strength (and capital) from global sources, but the state and traditional healers also utilize post-colonial logics and ideologies to reap symbolic rewards. Securing a hegemonic ontology of the body is a primary stake in the symbolic struggle raging in the field of health and healing, so operations of bio-power are of utmost concern. Because HIV/AIDS infects those who are already marginalized on the basis of class, race and gender and because AIDS undermines the sanctity and security of the body politic, the dividing line between bio-power and thanatopolitics is often drawn on the basis of infection.

Therefore, the field of health and healing is bifurcated on a number of axes: ontologically, economically, culturally, and structurally. And yet, the subjects' of post-apartheid exhibit a profoundly hybrid habitus. In other words, the bifurcations that plague the field of health and healing are incorporated and circumnavigated in subjects' *experiences* of HIV/AIDS. This is the primary puzzle with which this dissertation is concerned. In attempting to understand why and how this disjuncture is incorporated and lived, the project suggests that contemporary theories of practice require some revision. While Pierre Bourdieu's conceptualization of habitus is by far the most complicated, nuanced and intriguing theory of practice, which is all the more compelling for its applicability to the colonial and post-colonial context, this project seeks to challenge Bourdieu's own disavowal of hybridity. For Bourdieu, the purpose of the habitus is to synthesize contradiction, but the data explored throughout the dissertation suggests, rather, that the "inclusive disjunctions" that Deleuze and Guattari posit in their

schizoanalysis (1972/1983) form an important intervention in theories of subjectivity in late capitalism.

> "He ['the schizo'] does not reduce two contraries to an identity of the same; he affirms their distance as that which relates the two as different. He does not confine himself inside contradictions; on the contrary, he opens out and, like a spore case inflated with spores, releases them as so many singularities that he had improperly shut off, some of which he intended to exclude, while retaining others, but which now become point-signs" (Deleuze and Guattari 1972/1983: 77).

In making sense of the disjuncture between the structure and layout of the field of health and healing and the experiences, practices and beliefs of communities deeply affected by the disease, this dissertation makes several significant sociological interventions. First, there is very little research being conducted on the role of traditional healing (or traditional beliefs) in contemporary South Africa. This is particularly surprising in a country ravaged by a health crisis. Much of the qualitative research on traditional healing *still* assumes the practice is well bounded, static, and homogenous; however, my research shows that traditional beliefs cannot be reduced to (or essentialized as) timeless and rigid (See: Fabian 2002). In fact, I would argue that traditional beliefs reflect the "spiritual," political, and economic insecurities of the era (Ashforth 2005). Therefore, my dissertation contributes to our understanding of the impact of HIV/AIDS on the profession and ontology of African healing, as well as the relationship between traditional healing, biomedical health care, and the neoliberal state.

Second, this project situates peoples' understandings of and experiences with the disease within an analysis of developmental state policy, neo-liberal economics, and international policy interventions. In this way, the project links large-scale structures with communities' lived experiences. Analyzing the AIDS pandemic with this particular

mixture of macro-sociology and ethnography is essential given the way in which patterns of HIV infection lay bare long histories of structural inequality and oppression.

In addition, exploring the intersection between the economy of representation of disease and peoples' grounded experiences and lived realities allows for a bi-directional causal analysis. Discourses are incorporated into peoples' private ideologies and practices through various processes of inscription, but participants in this study are also internally stratified along a variety of different axes (class, 'ethnicity,' gender, religion, etc.) that affect their receptivity to available discourses. Some are able to exercise agency in selecting discursive resources to inform their personal ideologies and practices. In this way, the causal direction shifts, as people actively and creatively deploy certain discourses toward their own ends.

Discourses and bodies inter-relate, intersect and mutually inform one another. By including an analysis of the various innovative ways in which people creatively transform and (sometimes) subvert discourses by exploiting them for their own purposes and by exploring the processes of inscription and incorporation of contradictory corporeal ideologies, I have attempted to avoid positing a simplistic causal link between discourse and practice. In fact, this project informs the theoretical debate *about* the relationship between discourse and materiality – a debate which has privileged discourse to such an extent that the body becomes a simple vessel to be filled. My research challenges this theoretical disembodiment. Given the plurality of discourses competing in the symbolic struggle over the power to define HIV/AIDS, analyzing the ways in which people construct their own corporeal ideologies by translating their bodily experiences, their material conditions, *and* the public discourses into narratives about health and HIV/AIDS

is essential in contributing to our understanding of the complex relationship between discourse and the body.

Therefore, the project is theoretically significant in a number of ways. Today, in the wake of globalization, new theories examining the links between structural forces and subjects' practices are emerging; however, much of this literature uncritically celebrates a post-modern grand narrative of ubiquitous fluidity and heterogeneity, which fails to attend to the very rigid structural obstacles neoliberal economics and exploitative state policies impose on subjects, whose movement and sovereignty are still circumscribed by the most stringent classifications of class, race, gender, nationality, etc. Because Bourdieu's theories allow for an understanding of the dual logics of structure and agency – as well as the necessity of consistently and vigilantly paying heed to the tension and negotiation between these two scales of power – this project utilizes the concepts of field, capital and habitus. Given the fact that Bourdieu had not yet developed his theory of the field while conducting research in Algeria, his field theory has only rarely been applied to the colonial, let alone the post-colonial context. In so stretching its empirical application, I hope to enhance and supplement this theory. In addition, however, the project seeks to revitalize Bourdieu's *original* conception of habitus and, as discussed previously, push it in new directions. This project ends, then, precisely where Bourdieu's career as a social theorist began. Just as Bourdieu himself utilized his ethnographic research in colonial Algeria to construct a more generalizable theory of practice, this project's theoretical contribution extends beyond the case of South Africa. Although the hysteresis effect was developed out of research conducted during the transition to post-colonialism in Algeria, my research is exploring a different systemic transformation. This project will, then,

provide an analysis of the embodied contradictions characteristic of not only post-colonialism, but a neoliberal world order.

Finally, this project has profound significance for the development of more effective health care policy. In fact, it argues that until we understand the hybrid nature of South Africans' identities and take their material social conditions into account, prevention and treatment campaigns will continue to fail in implementation. By analyzing the specific impact the AIDS pandemic has had on poor communities in South Africa, more general conclusions can be drawn about the limitations of international models of care and prevention, the impact of neoliberal economic restructuring on the ability of communities in the global south to access health care and sustain a healthy lifestyle, and the importance of collaboration between indigenous and biomedical forms of healing. In conclusion, then, this project has political, analytic, methodological, theoretical, and policy significance.

In focusing on the *bio-politics* of HIV/AIDS in South Africa, this project enriches our understanding of the complex processes of hybridization that occur in post-colonial societies. Because of its theoretical focus on the body, this study also contributes to our understanding of the way in which discourses/ideologies and material conditions are incorporated into peoples' identities and conceptualizations of their bodies. Through an exploration of the multiple, divergent and often contradictory discourses on AIDS in South Africa and the bodies that have emerged from this contested terrain in the past 20 years of the 'AIDS crisis,' this project will serve to multiply and expand our conceptualizations of race, ethnicity, gender, and sexuality.

Appendices

Appendix 1: Participant Observation

Population Group	Organization	Location	Dates
People Living with HIV/AIDS	**Iketsetseng Support Group**	Lawley 2	April 1 – December 28, 2005 May and June 2006
People Living with HIV/AIDS	**Mandelaville Support Group**	Sol Plaatje	July 27 – December 28, 2005 May and June 2006
People Living with HIV/AIDS	**National HIV/AIDS NGO Support Groups**	Soweto: Zola, Orlando, Dobsonville	December 1, 2004 – September 30, 2005
Traditional Healers	**Gauteng Traditional Healer's Task Team (GTHTT)**	Johannesburg	July 1 – Decemeber 20, 2005
Traditional Healers	**Gauteng Traditional and Faith Medical Practitioners (GTFMP)**	Soweto and Johannesburg	February 7 – December 20, 2005
Traditional Healers	**Soweto Traditional Healer's Forum**	Soweto: Orlando & Diepkloof	January 24 – December 20, 2005
Traditional Healers	**Consultations with Traditional Healers**	Orlando & Diepkloof	December 1, 2005
Social Movements	**Anti-Privatisation Forum (APF)**	Soweto & Sol Plaatje	January 11 – December 28, 2005 May and June 2006
Social Movements	**Landless Peoples' Forum (LPM)**	Lawley	April 4 – December 28, 2005
NGO/Activist	**Treatment Action Campaign (TAC)**	Johannesburg, Soweto, Khayelitsha	October 1 – December 20, 2005 May and June 2006
NGO	**National HIV/AIDS NGO**	Soweto: Zola, Orlando, Phiri, Dobsonville	December 1, 2004 – September 30, 2005
Clinics	**Soweto Clinics (through above NGO)**	Zola, Orlando East, Dobsonville	January 15 – August 31, 2005
Hospital Visitations	**Individuals living with HIV/AIDS**	Bara Hospital (Soweto)	August 1 – September 22, 2005
Hospital Visitations	**Individuals living with HIV/AIDS**	Hamburg, Roodepoort	September 16, 2005

Appendix 2: Focus Group Discussions

Population Group	Organization	Location	Dates	Participants
Traditional Healers	**Soweto Traditional Healers Forum**	Diepkloof, Soweto	May 2, 2005 May 9, 2005	16 (11♀) 18 (11♀)
Traditional Healers	**Gauteng Traditional and Faith Medical Practitioners (GTFMP)**	White City & Pimville, Soweto	June 6, 2005 June 13, 2005	17 (15♀) 7 (7 ♀)
Traditional Healers	**Alexandra Traditional Healing Association**	Alexandra, Joburg	June 20, 2005	23 (14 ♀)
Traditional Healers	**Soweto Traditional Healers Forum**	Pimville, Soweto	Sept 6, 2005 Sept 13, 2005	17 (10♀) 33 (24♀)
People living with HIV/AIDS	**Iketsetseng Support Group**	Lawley 2	Oct 6, 2005 Oct 20, 2005	10 (9♀) 10 (9♀)
People living with HIV/AIDS	**Mandelaville Support Group**	Sol Plaatje	Oct 14, 2005 Oct 28, 2005 June 10, 2006	6 (3♀) 8 (2♀) 35 (27 ♀)
People living with HIV/AIDS	**Phiri Community Members**	Phiri, Soweto	June 8, 2006	18 (7♀)
People living with HIV/AIDS	**Zola Support Group**	Zola, Soweto	April 13, 2005	10 (6♀)
Home-Based Care	**Soweto Home-Based Care Givers**	White City, Soweto	Aug 10, 2005 Sept 14, 2005 Oct 4, 2005	14 (13♀) (each time)
TOTAL				**270 (194♀)**

Appendix 3a: Interviews

Population Group	Organization	Location	# of Interviews
Traditional Healers	**GTFMP**	Soweto & Johannesburg	16 (10 ♀)
Traditional Healers	**Soweto Traditional Healers Forum**	Soweto	8 (2 ♀)
Traditional Healers	**Traditional Healer's Organization (THO)**	Johannesburg & Cape Town	5 (4 ♀)
Traditional Healers	**Alexandra Traditional Healing Organization**	Alexandra	6 (4♀)
Traditional Healers	**Not associated with organization**	Johannesburg, Sol Plaatje, Soweto	9 (3♀)
			Total TH = 44 (23 ♀)
People living with HIV/AIDS	**Iketsetseng Support Group**	Lawley 2	8 (3 ♀)
People living with HIV/AIDS	**Mandelaville Support Group**	Sol Plaatje	6 (all ♂)
People living with HIV/AIDS	**Phiri Residents, NGO Support Group & TAC Activists**	Soweto	9 (6 ♀)
			Total PWAs = 23 (9 ♀)
NGOs	**National HIV/AIDS**	Soweto & Alexandra	14 (10♀)
NGOs	**National Association of People with AIDS (NAPWA)**	Johannesburg	5 (4 ♀)
NGOs	**Township AIDS Project**	Soweto	1 (♀)
NGOs	**AIDS Consortium**	Johannesburg	1 (♀)
NGOs	**AIDS Law Project (ALP)**	Johannesburg & Cape Town	3 (2♀)
NGOs	**Treatment Action Campaign (TAC)**	Johannesburg & Cape Town	10 (2♀)
			Total NGOs = 34 (20 ♀)
Home-Based Care	**Soweto Home-Based Care Givers**	Soweto	2 (1♀)
Home-Based Care	**Thari ya Sechaba**	East Rand	2 (♀)
			Total HBC = 4 (3♀)

Appendix 3b: Interviews, continued

Population Group	Organization	Location	# of Interviews
Nurses/Matrons	**Chris Hani Barawanath Hospital**	Soweto	4 (♀)
Nurses/Matrons	**Soweto Clinics**	Zola, Phiri, Dobsonville	4 (♀)
Doctors	**Soweto Clinics**	Zola, Dobsonville, Lilian Ngoyi	3 (all ♂)
			Total Nurse/Doctor = 11 (8♀)
Governmental	**Johannesburg Department of Health**	Johannesburg	2 (♀)
Governmental	**Gauteng Department of Health**	Johannesburg	1 (♀)
			Total Government = 3 (all ♀)
Community Stakeholders	**Local Counselors, community leaders, social workers, etc.**	Lawley 2 & Sol Plaatje	4 each = 8 (4 ♀)
			Total Stakeholders = 8 (4 ♀)
Other	**Dr. Rath Foundation**	Cape Town	5 (all ♂)
Other	**Funeral Associations**	Soweto	1 (♂)
Total # of Interviews			**133 (70 ♀)**

Bibliography

Bibliography

Abdool- Karim, S.S., T.T. Ziqubu-Page, and R. Arendse. 1994. "Bridging the Gap: Potential for Health Care Partnership between African Traditional Healers and Biomedical Personnel in South Africa." Report of the South African Medical Research Council. *South African Medical Journal* 84 (December Insert): s1-s16.

Abu-Lughod, Lila. 1991. "Writing against Culture." Pp. 137-62 in *Recapturing Anthropology: Working in the Present*, edited by Richard Fox. Sante Fe: School of American Research.

Achmat, Zackie. 2004. "The Treatment Action Campaign, HIV/AIDS and the Government." *Transformations* 54: 76-84.

Agamben, Giorgio. 1998. *Homo Sacer: Sovereign Power and Bare Life.* Translated by Daniel Heller-Roazen. Stanford, CA: Stanford University Press.

-------. 2005. *State of Exception*. Translated by Kevin Attell. Chicago: University of Chicago Press.

Alexander, Neville. 2002. *An Ordinary Country: Issues in the Transition from Apartheid to Democracy in South Africa*. Pietermaritzburg: University of Natal Press.

Althusser, Louis. 1969. *For Marx*. Translated by Ben Brewster. New York: Verso.

-------. [1970] 1994. "Ideology and Ideological State Apparatuses." Pp. 100-140 in *Mapping Ideology*, edited by Slavoj Žižek. New York: Verso.

-------. 1971. *Lenin and Philosophy*. Translated by Ben Brewster. New York: Monthly Review Press.

Appadurai, Arjun. 1996. *Modernity at Large: Cultural Dimensions of Globalization*. Minneapolis, MN: University of Minnesota Press.

Apter, Andrew. 1999. "The Subvention of Tradition: A Genealogy of the Nigerian Durbar." Pp. 213-252 in *State/Culture: State-Formation after the Cultural Turn*, edited by George Steinmetz. Ithaca: Cornell University Press.

Ashforth, Adam. 1990. *The Politics of Official Discourse*. Oxford: Oxford University Press.

-------. 2002. "An Epidemic of Witchcraft? The Implications of AIDS for the Post-Apartheid State." *African Studies* 61, 1 (July): 121-43.

-------. 2005. *Witchcraft, Violence and Democracy in South Africa*. Chicago: University of Chicago Press.

Ashforth, Adam and Nicoli Nattrass. 2005. "Ambiguities of 'Culture' and the Antiretroviral Rollout in South Africa." *Social Dynamics* 31, 2: 285-303.

Asuni, T. 1979. "The Dilemma of Traditional Healing with Special Reference to Nigeria." *Social Science and Medicine* 13: 33-39.

Auyero, Javier and Débora Swistun. 2007. "Confused because Exposed: Towards an Ethnography of Environmental Suffering." *Ethnography* 8, 2 (June): 123-144.

-------. *Forthcoming*. "The Social Production of Toxic Uncertainty." *American Sociological Review*.

Barchiesi, Franco. 2005. *Social Citizenship and the Transformation of Wage Labour in the Making of Post-Apartheid South Africa, 1994-2001*. Dissertation: University of the Witwatersrand, Johannesburg, South Africa.

Barnett, Tony and Alan Whiteside. 2002. *AIDS in the Twenty-First Century: Disease and Globalization*. New York: Palgrave Macmillan.

Baylies, Carolyn and Janet Bujra. 2000. *AIDS, Sexuality and Gender in Africa: Collective Strategies and Struggles in Tanzania and Zambia*. New York: Routledge.

Beall, Jo, Owen Crankshaw, Susan Parnell. 2002. *Uniting a Divided City: Governance and Social Exclusion in Johannesburg*. Sterling, VA: Earthscan Publications.

Beinart, William and Saul Dubow, eds. 1995. *Segregation and Apartheid in Twentieth-Century South Africa*. London: Routledge.

Berger, Jonathan. 2004. "Re-Sexualising the Epidemic: Desire, Risk and HIV Prevention." *Development Update* 5, 3: 45-67.

Bhabha, Homi K. 1994. *the location of culture*. New York: Routledge.

Biehl, João. 2001. "Vita: Life in a Zone of Social Abandonment." *Social Text* 68, Vol. 19, No. 3 (Fall): 131-149.

-------. 2004. "The Activist State: Global Pharmaceuticals, AIDS and Citizenship in Brazil." *Social Text* 80, Vol 22, No 3 (Fall): 105-132.

-------. 2005. *Vita: Life in a Zone of Social Abandonment*. Berkeley: University of California Press.

-------. 2006. "Will to Live: AIDS Drugs and Local Economies of Salvation." *Public Culture* 18, 3: 457-472.

Bond, Patrick. 2000a. *Elite Transition: From Apartheid to Neoliberalism in South Africa*. Pietermaritzburg: University of Natal Press.

-------. 2000b. *Cities of Gold, Townships of Coal: Essays on South Africa's New Urban Crisis*. Trenton, NJ: Africa World Press.

-------. 2002a. *Against Global Apartheid: South Africa Meets the World Bank, IMF and International Finance*. Cape Town: University of Cape Town Press.

-------. 2002b. *Unsustainable South Africa: Environment, Development and Social Protest*. Pietermaritzburg: University of Natal Press.

-------. 2004a. *Talk Left, Walk Right: South Africa's Frustrated Global Reforms*. Durban: University of Kwa-Zulu Natal Press.

-------. 2004b. "Can Five Million People with AIDS Celebrate South African Freedom?" *Against the Current* (July/August).

Bonner, Philip and Lauren Segal. 1998. *Soweto: A History*. Cape Town: Maskew, Miller and Longman Ltd.

Booker, Salih and William Minter. 2001. "Global Apartheid." *The Nation*, July 9. http://www.thenation.com/doc/20010709/booker

Booth, Karen M. 2004. *Local Women, Global Science: Fighting AIDS in Kenya*. Bloomington, IN: Indiana University Press.

Bourdieu, Pierre. [1958] 1962. *The Algerians*. Translated by Alan C. M. Ross. Boston: Beacon Press.

-------. [1962] 2004. "The Peasant and his Body." *Ethnography* 5, 4 (December): 579-599.

-------. 1971. "Champ du pouvoir, champ intellectuel et habitus de classe." *Scolies* 1: 7-26.

-------. 1977. *Outline of a Theory of Practice*. Translated by Richard Nice. Cambridge: Oxford University Press.

-------. 1979a. *Algeria 1960*: *The Disenchantment of the World; The Sense of Honour; The Kabyle House or the World Reversed*. Translated by Richard Nice. Cambridge, UK: Cambridge University Press.

-------. 1979b. "Symbolic Power." *Critique of Anthropology* 4 (Summer): 77-85.

-------. 1980. "The Production of Belief: Contribution to an Economy of Symbolic Goods." Translated by and Richard Nice. *Media, Culture and Society* 2, 3 (July): 261-293.

-------. 1984. *Distinction: A Social Critique of the Judgment of Taste*. Translated by Richard Nice. Cambridge, MA: Harvard University Press.

-------. 1985. “The Genesis of the Concepts of *Habitus* and *Field*.” *Sociocriticism* 2 (2): 11–24.

-------. 1986. “The Forms of Capital.” Pp. 241-58 in *Handbook of Theory and Research for the Sociology of Education*, edited by J.G. Richardson. New York: Greenwood Press.

-------. 1988. *Homo Academicus*. Translated by Peter Collier. Stanford: Stanford University Press.

-------. 1989. “Social Space and Symbolic Power.” *Sociological Theory* 7: 14-25.

-------. 1990. *The Logic of Practice*. Translated by Richard Nice. Stanford: Stanford University Press.

-------. 1991. *Language and Symbolic Power*. Translated by Gino Raymond and Matthew Adamson. Cambridge, MA: Harvard University Press.

-------. 1993a. *The Field of Cultural Production*. New York: Columbia University Press.

-------. 1993b. *Sociology in Question*. Translated by Richard Nice. *Theory, Culture and Society Series*, Volume 18. London: Sage Publications.

-------. 1996a *The Rules of Art: Genesis and Structure of the Literary Field*. Translated by Susan Emanuel. Stanford: Stanford University Press.

-------. 1996b *The State Nobility: Elite Schools in the Field of Power*. Translated by Lauretta C. Clough. Cambridge, UK: Polity Press.

-------. 1998. *Acts of Resistance: Against the Tyranny of the Market*. New York: The New York Press.

-------. 1999a. *The Weight of the World: Social Suffering in Contemporary Society*. Cambridge: Polity Press.

-------. 1999b. “Rethinking the State: Genesis and Structure of the Bureaucratic Field.” Pp. 53-75 in *State/Culture: State Formation after the Cultural Turn*, edited by George Steinmetz. Ithaca, NY: Cornell University Press.

-------. 2000. *Pascalian Meditations*. Translated by Richard Nice. Stanford, CA: Stanford University Press.

-------. 2001. *Masculine Domination*. Translated by Richard Nice. Cambridge, UK: Polity Press.

-------. 2004. *Esquisse pour une auto-analyse*. Paris: Raisons d’Agir.

Bourdieu, Pierre and Abdelmalek Sayad. [1964] 2004. "Colonial Rule and Cultural Sabir." *Ethnography* 5, 4 (December): 544-86.

Bourdieu, Pierre and Loïc J.D. Wacquant. 1992. *An Invitation to Reflexive Sociology*. Chicago: Chicago University Press.

Bourdieu, Pierre and Terry Eagleton. 1994. "Doxa and Common Life: An Interview." Pp.265-277 in *Mapping Ideology*, edited by Slavoj Žižek. New York: Verso.

Bozzoli, Belinda. 2000. "Why were the 1980s 'Millenarian'? Style, Repertoire, Space and Authority in South Africa's Black Cities." *Journal of Historical Sociology* 13, 1 (March): 78-110.

-------. 2004. *Theatres of Struggle and the End of Apartheid*. Johannesburg: Wits University Press.

Bull, Malcolm. 2004. "States don't really mind their citizens dying (provided they don't all do it at once): They just don't like anyone else to kill them." *London Review of Books* 26: 3-6.

Burawoy, Michael, Joseph A. Blum, Sheba George, Zsuzsa Gille, Teresa Gowan, Lynne Haney, Maren Klawiter, Steven H. Lopez, Seán Ó. Riain, and Millie Thayer. 2000. *Global Ethnography: Forces, Connections, and Imaginations in A Postmodern World*. Berkeley: University of California Press.

Butler, Judith. 1990. *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge.

-------. 1997a. *Excitable Speech: A Politics of the Performative*. New York: Routledge.

-------. 1997b. *The Psychic Life of Power: Theories in Subjection*. Sanford, CA: Stanford University Press.

Caldwell, John C., Pat Caldwell, and Pat Quiggin. 1989. "The social context of AIDS in sub-Saharan Africa." *Population and Development Review* 15(2): 185–234.

Calhoun, Craig. 1993. "Habitus, Field and Capital: The Question of Historical Specificity." Pp. 61-88 in *Bourdieu: Critical Perspectives*, edited by Craig Calhoun, Edward LiPuma, and Moishe Postone. Cambridge: Polity Press.

Cameron, Edwin. 2005. *Witness to AIDS*. Cape Town: Tafelberg.

Campbell, Catherine, Gerhard Mare, and Cherryl Walker. 1995. "Evidence for an Ethnic Identity in the Life Histories of Zulu-Speaking Durban Township Residents." *Journal of Southern African Studies* 21, 2 (June): 287-301.

Campbell, Susan Schuster. 1998. *Called to Heal: Traditional Healing Meets Modern Medicine in Southern Africa Today*. London: Zebra Press.

Casale, D. 2004. "What has the Feminisation of the Labour Market Bought Women in South Africa? Trends in Labour Force Participation, Employment and Earnings, 1995-2001." Cape Town: Development Policy Research Unit, Working Paper 4, 84.

Casale, D. and D. Posel. 2002. "The Continued Feminisation of the Labour Force in South Africa: An Analysis of Recent Data and Trends." *The South African Journal of Economics* 70, 1: 168-195.

Chatterji, Minki, Nancy Murray, David London, and Philip Anglewicz. 2004. "The Factors Influencing Transactional Sex among Young Men and Women in 12 Sub-Saharan African Countries." USAID Policy Project (October).

Chavunduka, G.L. 1994. *Traditional Medicine and Modern Zimbabwe*. Harare: University of Zimbabwe Press.

Clarno, Andy. *Forthcoming*. "The Empire's New Walls: Sovereignty, Neoliberalization and the Constitution of Urban Space in Post-Apartheid South Africa and Post-Oslo Palestine/Israel." Dissertation in Sociology, University of Michigan, Ann Arbor.

-------. 2009. "A Tale of Two Walled Cities: Neoliberalization and Enclosure in Johannesburg and Jerusalem." *Political Power and Social Theory* 19.

Clifford, James and George Marcus, eds. 1986. *Writing Culture: The Poetics and Politics of Ethnography*. Berkeley: University of California Press.

Collins, T. & Stadler, J. (2001) *Love, Passion and Play: Sexual Meaning among Youth in the Northern Province of South Africa*. Paper presented at International Conference, *AIDS in Context*, April 4-7, University of the Witwatersrand, Johannesburg, South Africa.

Comaroff, Jean. 1985. *Body of Power, Spirit of Resistance: The Culture and History of a South African People*. Chicago: University of Chicago Press.

-------. 2007. "Beyond Bare Life: AIDS, (Bio)Politics, and the Neoliberal Order." *Public Culture* 19, 1: 197-219.

Comaroff, John L. and Jean Comaroff. 1997. *Of Revelation and Revolution: The Dialectics of Modernity on a South African Frontier*, Volume Two. Chicago: University of Chicago Press.

Connell, R.W. 2005. *Masculinities*. Cambridge: Polity Press.

Cooper, Frederick. 1983. *Struggle for the City: Migrant Labor, Capital and the State in Urban Africa*. London: Sage Publications.

-------. 1997a. "The Dialectic of Decolonization: Nationalism and Labor Movements in Postwar French Africa." Pp. 406-435 in *Tensions of Empire: Colonial Cultures in a Bourgeois World*, edited by Frederick Cooper and Ann Laura Stoler. Berkeley: University of California Press.

-------. 1997b. *Decolonization and African Society: The Labor Question in French and British Africa*. Cambridge: Cambridge University Press.

Coronil, Fernando. 1992. "Can Postcoloniality Be Decolonized? Imperial Banality and Postcolonial Power." *Public Culture* 5 (Fall): 99-100.

Crankshaw, Owen. 1993. "Squatting, Apartheid, and Urbanisation on the Southern Witwatersrand." *African Affairs* 92, 366: 31–51.

Crimp, Douglas. 1988. *AIDS: Cultural Analysis, Cultural Activism*. Cambridge, MA: MIT Press.

Davis, Mike. 2005. *The Monster at Our Door: The Global Threat of Avian Flu*. New York: Henry Holt and Company.

-------. 2006. *Planet of Slums*. New York: Verso.

de Certeau, Michel. 1984. *The Practice of Everyday Life*. Berkeley: University of California Press.

De Waal, Alex. 2006. *AIDS and Power: Why There is No Political Crisis – Yet*. New York: Zed Books.

Deacon, Harriet, Inez Stephney and Sandra Prosalendis. 2005. *Understanding HIV/AIDS Stigma: A Theoretical and Methodological Analysis*. Human Science Research Council Social Cohesion and Integration Unit (HSRC SCI), in collaboration with the HSRC's Social Aspects of HIV/AIDS Unit (SAHA). Cape Town: HSRC Press.

Deedat, Hameda. 2002. "Viva Prepaids, Viva! Assessing New Technology for Cost Recovery in the Rural Northern Cape." Pp. 143-156 in *Cost Recovery and the Crisis of Service Delivery in South Africa,* edited by David McDonald and John Pape. Cape Town: HSRC Press.

Deleuze, Gilles and Félix Guattari. [1972] 1983. *Anti-Oedipus: Capitalism and Schizophrenia*. Translated by Robert Hurley, Mark Seem and Helen R. Lane. Minneapolis: University of Minnesota Press.

Delius, Peter and Clive Glaser. 2005. "Sex, Disease and Stigma in South Africa: Historical Perspectives." *African Journal of AIDS Research* 4, 1: 29-36.

Derrida, Jacques. 1978. *Writing and Difference*. Translated by Alan Bass. Chicago: University of Chicago Press.

-------. [1994] 2006. *Specters of Marx: The State of the Debt, the Work of Mourning, and the New International*, translated by Peggy Kamuf. New York: Routledge Classics.

Devenish, Annie. 2005. "Negotiating Healing: Understanding the Dynamics amongst Traditional Healers in Kwazulu-Natal as they Engage with Professionalisation." *Social Dynamics* 31, 2: 243-284.

Dirks, N., Eley, G, Ortner, S., eds. 1993. *Culture/Power/History: A Read in Contemporary Social Theory*. Princeton: Princeton University Press.

Dirlik, Arif. 1996. "The Postcolonial Aura: Third World Criticism in the Age of Global Capitalism." Pp 294-320 in *Contemporary Postcolonial Theory: A Reader*, edited by Padmini Mongia. New York: Arnold.

Douglas, Mary. [1966] 2000. *Purity and Danger: An Analysis of Concepts of Pollution and Taboo*. New York: Routledge.

Dubow, Saul. 1995. *Scientific Racism in Modern South Africa*. Cambridge: Cambridge University Press.

Dunkle, Kristin L., Rachel K. Jewkes, Heather C. Brown, Glenda E. Gray, James A. McIntryre, Siobán D. Harlow. 2004a. "Transactional Sex among Women in Soweto, South Africa: Prevalence, Risk Factors and Association with HIV Infection." *Social Science & Medicine* 59, 8: 1581–1592.

-------. 2004b. "Gender-Based Violence, Relationship Power, and Risk of HIV Infection in Women attending Antenatal Clinics in South Africa." *Lancet* 363, 9419: 1415–1421.

Eagleton, Terry. 1991. *Ideology: An Introduction*. New York: Verso.

Ellwood, Wayne. 2001. *The No-Nonsence Guide to Globalization*. Oxford: New Internationalist Publications.

Emirbayer, Mustafa and Ann Mische. 1998. "What is Agency?" *American Journal of Sociology* 103, 4 (January): 962-1023.

Epstein, Helen. 2002. "The Hidden Cause of AIDS." *New York Review of Books* 49, 8: 43-49.

-------. 2007. *The Invisible Cure: Africa, the West, and the Fight against AIDS*. New York: Farrar, Straus, and Giroux.

Epstein, Helen and Julia Kim. 2007. "AIDS and the power of women." *New York Review of Books* 54(2): 39–41.

Evans, Dylan. 1996. *An Introductory Dictionary of Lacanian Psychoanalysis*. New York: Routledge.

Evans-Pritchard, E. E. [1937] 1976. *Witchcraft, Oracles, and Magic among the Azande*. Oxford: Clarendon Press.

Fabian, Johannes. 2002. *Time and the Other: How Anthropology Makes Its Object*. New York: Columbia University Press.

Fallers, Lloyd. 1965. *Bantu Bureaucracy*. Chicago: University of Chicago Press.

Fanon, Frantz. [1952] 1967. *Black Skin, White Masks*. Translated by Charles Lam Markmann. New York: Grove Press.

-------. 1963. *The Wretched of the Earth*. Translated by Constance Farrington. New York: Grove Press.

Farmer, Paul. 1992. *AIDS and Accusation: Haiti and the Geography of Blame*. Berkeley: University of California Press.

----------. 1998. "Bad Blood, Spoiled Milk: Bodily Fluids as Moral Barometers in Rural Haiti." *American Ethnologist* 15, 1: 62-83.

-------. 1999. *Infections and Inequalities: The Modern Plagues.* Berkeley: University of California Press.

-------. 2005. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley: University of California Press.

Fassin, Didier. 2007. *When Bodies Remember: Experiences and Politics of AIDS in South Africa.* Berkeley: University of California Press.

Feierman, Steven and John Janzen, eds. 1992. *The Social Basis of Health and Healing in Africa.* Berkeley: University of California Press.

Fink, Bruce. 1995. *The Lacanian Subject: Between Language and Jouissance*. Princeton: Princeton University Press.

Flint, Karen. 2001. "Competition, Race, and Professionalization: African Healers and White Medical Practitioners in Natal, South Africa in the Early Twentieth Century." *Social History of Medicine* 14, 2: 199-221.

Fort, Meredith, Mary Anne Mercer, and Oscar Gish, eds. 2004. *Sickness and Wealth: The Corporate Assault on Global Health*. Cambridge, MA: South End Press.

Foster, G. 1983. "Introduction to Ethnomedicine." Pp. 17-24 in *Traditional Medicine and Health Care Coverage*, edited by R. Bannerman, J. Burton, and Ch'en Wen-Chieh. Geneva: WHO.

Foucault, Michel. [1965] 1988. *Madness and Civilization*. New York: Vintage Books.

-------. 1972. *The Archaeology of Knowledge and the Discourse on Language*. New York: Pantheon Books.

-------. [1973] 1994. *The Birth of the Clinic: An Archaeology of Medical Perception*. New York: Vintage Books.

-------. [1977] 1995. *Discipline and Punish*. New York: Vintage Books.

-------. [1978] 1990. *History of Sexuality*. New York: Vintage Books.

-------. 1991a. "Politics and the Study of Discourse." Pp. 52-72 in *The Foucault Effect: Studies in Governmentality*, edited by Graham Burchell, Colin Gordon, and Peter Miller. Chicago: University of Chicago Press.

-------. 1991b [1978]. "Governmentality." Pp. 87-104 in *The Foucault Effect: Studies in Governmentality*, edited by Graham Burchell, Colin Gordon, and Peter Miller. Chicago: University of Chicago Press.

-------. 1997. *"Society Must be Defended": Lectures at the Collège de France, 1975-1976*. New York: Picador.

-------. 2000a [1982]. "The Subject and Power." Pp. 326-339 in *Power: Essential Works of Foucault, 1954-1984*, Volume 3, edited by Paul Rabinow. New York: New Press.

-------. 2000b [1982]. "The Political Technology of Individuals." Pp. 403-417 in *Power: Essential Works of Foucault, 1954-1984*, Volume 3, edited by Paul Rabinow. New York: New Press.

Fox, Richard G. 1991. *Recapturing Anthropology: Working in the Present.* Santa Fe, NM: School of American Research.

Freeman, M. and M. Motsei. 1992. "Planning Health Care in South Africa – Is There a Role for Traditional Healers?" *Social Science and Medicine* 34: 1183-1190.

Freud, Sigmund. 1955. *The Interpretation of Dreams*. Translated by James Strachey. New York: Basic Books.

Friedman, Jonathan. 1994. *Cultural Identity and Global Process*. London: Sage.

Friedman, Steven and Shauna Mottiar. 2004. "Rewarding Engagement?: The Treatment Action Campaign and the Politics of HIV/AIDS." Case study for: Globalisation, Marginalisation and New Social Movements in post-Apartheid South Africa. http://www.ukzn.ac.za/ccs/

Frosh, Stephen, Ann Phoenix, and Rob Pattman. 2002. *Young Masculinities*. Basingtoke: Palgrave.

Garnham, N. and Williams, R. 1980. "Pierre Bourdieu and the Sociology of Culture." *Media, Culture and Society* 2-3: 297-312.

Gartman, David. 1991. "Culture as Class Symbolization or Mass Reification: A Critique of Bourdieu's *Distinction*." *American Journal of Sociology* 97, 2 (September): 421-47.

Gevisser, Mark and Edwin Cameron. Eds. *Defiant desire: Gay and Lesbian Lives in South America.* NY: Routledge, 1995.

Gevisser, Mark. 2007. *Thabo Mbeki: The Dream Deferred.* Johannesburg: Jonathan Ball Publishers.

Giddens, Anthony. 1984. *The Constitution of Society: Outline of theTheory of Structuration*. Berkeley: University of California Press.

Gilroy, Paul. 1993. *The Black Atlantic: Modernity and Double-Consciousness*. Cambridge: Harvard University Press.

Giroux, Henri. 1983. *Theory and Resistance in Education: A Pedagogy for the Opposition*. New York: Bergin and Garvey.

Gordon, Colin, 1991. "Governmental Rationality: An Introduction" Pp. 1-51 in *The Foucault Effect: Studies in Governmentality*, edited by Graham Burchell, Colin Gordon and Peter Miller. Chicago: University of Chicago Press.

Gorski, Philip. 2006. "Bourdieusian Theory and Historical Analysis: Maps and Methods." Paper presented at *Practicing Pierre Bourdieu: In the Field and Across the Disciplines*, September 28-30, 2006. University of Michigan, Ann Arbor.

Gramsci, Antonio. [1971] 1999. *Selections from the Prison Notebooks*. Edited and translated by Quintin Hoare and Geoffrey Nowell Smith. New York: International.

Green, Edward. 1994. *AIDS and STDs in Africa: Bridging the Gap between Traditional Healing and Modern Medicine*. Boulder, CO: Westview Press.

-------. 1996. *Indigenous Healers and the African State: Policy Issues Concerning African Indigenous Healers in Mozambique and Southern Africa*. New York: PACT Publications.

-------. 1999. *Indigenous Theories of Contagious Disease*. London: AltaMira.

Greenberg, Stephen. 2004. "Post-Apartheid Development, Landlessness, and the Reproduction of Exclusion in South Africa." Centre for Civil Society Research Report, 17 (May). http://www.ukzn.ac.za/CCS/files/RR17.pdf

Greenwood, Davydd and Morten Levin. 2006. *Introduction to Action Research: Social Research for Social Change*, Second Edition. Thousand Oaks, CA: Sage Publications.

Grosz, Elizabeth. 1994. *Volatile Bodies: Towards a Corporeal Feminism*. Bloomington, IN: Indiana University Press.

Gumede, M.V. 1990. *Traditional Healers: A Medical Practitioner's Perspective*. Cape Town: Blackshaws.

Gumede, William Mervin. 2005. *Thabo Mbeki and the Battle for the Soul of the ANC*. Cape Town: Zebra Press.

Halperin, Daniel T. and Helen Epstein. 2004. "Concurrent sexual partnerships help to explain Africa's high HIV prevalence: Implications for prevention." *Lancet* 364(9,428): 4–6.

-------. 2007. "Why is HIV prevalence so severe in Southern Africa?" *The Southern African Journal of HIV Medicine* 26 (March): 19–25.

Hammond-Tooke, W. D., ed. 1974. *The Bantu-Speaking Peoples of Southern Africa.* Boston: Routledge & K. Paul.

Hammond-Tooke, W.D. 1981. *Boundaries and Belief: The Structure of a Sotho Worldview*. Johannesburg: University of Witwatersrand Press.

Haraway, Donna J. 1989a. "The Biopolitics of Postmodern Bodies: Determinations of Self in Immune System Discourse." *Differences* 1, 1: 3-43.

-------. 1989b. *Primate Visions: Gender, Race and Nature in the World of Modern Science*. New York: Routledge.

-------. 1991. *Simians, Cyborgs, and Women*. London: Free Association.

Hardt, Michael and Antonio Negri. 2000. *Empire*. Cambridge: Harvard University Press.

Harrison, P. 1992. "The Policies and Politics of Informal Settlement in South Africa: A Historical Perspective." *Africa Insight* 22, 1: 14–22.

Hassim, Shireen. 2005. "Gender, Welfare and the Developmental State in South Africa." United Nations Research Institute for Social Development (UNRISD). http://www.sarpn.org.za/documents/d0001335/index.php

Hellmann, E. 1948. *Rooiyard: A Sociological Survey of an Urban Slum Yard.* Manchester: Manchester University Press.

Henderson, Patricia. 2004. "The Vertiginous Body and Social Metamorphosis in a Context of HIV/AIDS." HIVAN Centre for HIV/AIDS Networking. Presented at *Life and Death in a Time of AIDS: The Southern African Experience* Symposium, 14-16 October 2004. Wits Institute for Social and Economic Research. Johannesburg: University of Witwatersrand.

-------. 2005. "A Gift without Shortcomings: Healers Negotiating the Intersection of the Local and Global in the Context of HIV/AIDS." *Social Text* 31, 2: 24-54.

Herwitz, Daniel. 2006. "Understanding AIDS in South Africa." *The Journal of the International Institute* 13, 2 (Winter): pages 2 and 4.

Hobsbawm, Eric. [1983] 2003. "Inventing Traditions." Pp. 1-14 in *The Invention of Tradition*, edited by Eric Hobsbawm and Terence Ranger. Cambridge, UK: Cambridge University Press.

Holleman, J.F. 1969. *Chief, Council and Commissioner*. London: Oxford University Press.

Huchzermeyer, Marie. 2001. "Housing for the Poor? Negotiated Housing Policy in South Africa." *Habitat International* 25: 303-331.

-------. 2004. *Unlawful Occupation: Informal Settlements and Urban Policy in South Africa and Brazil*. Trenton, NJ: Africa World Press.

Hunter, Mark. 2002. "The Materiality of Everyday Sex: Thinking beyond 'Prostitution.'" *African Studies* 61 (1): 99-120.

-------. 2004. "Masculinties, Multiple-Sexual-Partners, and AIDS: The Making and UnMaking of *Isoka* in Kwa-Zulu Natal." *Transformation* 54: 123-153.

-------. 2005a. "Building a Home: Unemployment, Intimacy, and AIDS in South Africa. PhD thesis, Department of Geography, University of California at Berkeley.

-------. 2005b. "Cultural Politics and Masculinities: Multiple Partners in Historical Perspective in Kwa-Zulu Natal." Pp. 139-160 in *Men Behaving Differently: South African Men Since 1994*, edited by Graeme Reid and Liz Walker. Cape Town: Double Storey.

-------. 2006. "Informal Settlements as Spaces of Health Inequality: The Changing Economic and Spatial Roots of The Aids Pandemic, From Apartheid to Neoliberalism." *Centre For Civil Society Research Report,* Volume 1, No. 44: 143-166.

-------. 2007. "The Changing Political Economy of Sex in South Africa: The Significance of Unemployment and Inequalities to the Scale of the AIDS Pandemic." *Social Science and Medicine* 64, 3: 689-700.

Inda, Jonathan Xavier, ed. 2005. *Anthropologies of Modernity: Foucault, Governmentality, and Life Politics*. Malden, MA: Blackwell.

Ingstad, B. 1990. "The Cultural Construction of AIDS and Its Consequences for Prevention in Botswana." *Medical Anthropology Quarterly* 4, 1: 28-40.

Jacobs, Sean and Richard Calland, eds. 2002. *Thabo Mbeki's World: The Politics and Ideology of the South African President*. Durban: University of Natal Press.

Jacobs, Sean and Krista Johnson. 2007. "Media, Social Movements and the State: Competing Images of HIV/AIDS in South Africa." *African Studies Quarterly* 9, 4 (Fall). http://www.africa.ufl.edu/asq/v9/v9i4a8.htm

Jameson, Frederic. 1981. *The Political Unconscious: Narrative as a Socially Symbolic Act*. Ithaca: Cornell University Press.

Janzen, John M. 1981. "The Need for a Taxonomy of Health in the Study of African Therapeutics." *Social Science and Medicine* 15B, 3: 185-194.

-------. 1992. *Ngoma: Discourses of Healing in Central and Southern Africa*. Berkeley: University of California Press.

Jewkes, R. K, Vundule, C., Maforah, F., & Jordaan, E. 2001. "Relationship Dynamics and Teenage Pregnancy in South Africa." *Social Science & Medicine* 52, 5: 733–744.

Jewkes, R. K., Levin, J. B., & Penn-Kekana, L. A. 2002. "Risk Factors for Domestic Violence: Findings from a South African Cross-Sectional Study." *Social Science & Medicine* 55, 9: 1603–1617.

Jochelson, Karen. 2001. *The Colour of Disease: Syphilis and Racism in South Africa, 1880-1950*. New York: Palgrave.

Johnson, Krista. 2004. "The Politics of AIDS Policy Development and Implementation in Postapartheid South Africa." *Africa Today* 51, 2 (Winter): 107-128.

Johnson-Hanks, Jennifer. 2006. *Uncertain Honor: Modern Motherhood in an African Crisis*. Chicago: University of Chicago Press.

Junod, Henri. [1913] 1962. *The Life of a South African Tribe*. New Hyde Park, NY: University Books.

Kalichman, S. C. and L.C. Simbayi. 2004. "Sexual assault history and risks for sexually transmitted infections among women in an African township in Cape Town, South Africa." *AIDS Care* 16, 6: 681-689.

Karim, Q. A., Karim, S. S., Soldan, K., & Zondi, M. 1995. "Reducing the Risk of HIV Infection among South African Sex Workers: Socioeconomic and Gender Barriers." *American Journal of Public Health* 85, 11: 1521–1525.

Kaufman, Carol E. and Stavros E. Stavrou. 2004. "'Bus fare please': The economics of sex and gifts among young people in urban South Africa." *Culture, Health & Sexuality* 6(5): 377–391.

Kistner, Ulrike. 2003. *Commissioning and Contesting Post-Apartheid's Human Rights: HIV/AIDS, Racism, Truth and Reconciliation*. Munster, Germany: Lit Verlag.

Kleinman, Arthur. 1988. *The Illness Narratives*: *Suffering, Healing, and the Human Condition*. New York: Basic Books.

Kleinman, Arthur, Veena Das, and Margaret Lock, eds. 1997. *Social Suffering*. Berkeley: University of California Press.

Knorr-Cetina, Karin D. 1981. *The Manufacture of Knowledge: An Essay on the Constructivist and Contextual Nature of Science*. Oxford: Pergamon.

Knorr-Cetina, Karin D. and Michael Mulkay, eds. 1983. *Science Observed: Perspectives on the Social Study of Science*. London: Sage.

Krige, Eileen Jenson. [1936] 1950. *The Social System of the Zulus*. Pietermaritzburg: Shuter and Shuter.

Kristeva, Julia. 1982. *Powers of Horror: An Essay on Abjection*. Trans. Leon S. Roudiez. New York: Columbia University Press.

Kuhn, Thomas. [1962] 1996. *The Structure of Scientific Revolutions*. Chicago: University of Chicago Press.

Lacan, Jacques. [1949] 2002. "The Mirror Stage as Formative of the *I* Function." Pp. 3-9 in *Écrits*. Translated by Bruce Fink. New York: W.W. Norton and Company.

-------. [1969] 1991. *Le Séminaire, livre XVII: L'envers de la psychanalyse*. Texte établi par Jacques-Alain Miller. Paris: Éditions du Seuil.

-------. [1973] 1998. *The Four Fundamental Concepts of Psychoanalysis: The Seminar of Jacques Lacan, Book XI*. Edited by Jacques-Alain Miller, and translated by Alan Sheridan. New York: W.W. Norton and Company.

Laclau, Ernesto and Chantal Mouffe. 1985. *Hegemony and Socialist Strategy: Towards a Radical Democratic Politics*. New York: Verso.

Lambeck, Michael and Andrew Strathern. 1998. *Bodies and Persons: Comparative Perspectives from Africa and Melanasia*. Cambridge: Cambridge University Press.

Lambo, Thomas Adeoye. 1963. *African Traditional Beliefs: Concepts of Health and Medical Practice*. Ibadan: Ibadan University Press.

Last, Murray and G.L. Chavunduka, eds. 1986. *The Professionalisation of African Medicine*. Dover, NH: Manchester University Press.

Latour, Bruno. 1987. *Science in Action: How to Follow Scientists and Engineers through Society*. Cambridge, MA: Harvard University Press.

Latour, Bruno and Steve Woolgar. 1986. *Laboratory Life: The Construction of Scientific Facts*. Princeton, NJ: Princeton University Press.

Le Marcis, Frédéric. 2004. "The Suffering Body of the City." Translated by Judith Inggs. *Public Culture* 16, 3: 453-477.

Leclerc-Madlala, Suzanne. 1997. "'Infect One Infect All': Zulu Youth Responses to the AIDS Epidemic in South Africa." *Medical Anthropology* 17: 363-380.

-------. 2001a. "Virginity Testing: Managing Sexuality in a Maturing HIV/AIDS Epidemic." *Medical Anthropology Quarterly* 15, 4: 533-552.

-------. 2001b. "Chasing King Cash could Prove to be our Undoing." *Mail and Guardian*, June 15, 2005.

-------. 2001c. "Demonising Women in the Era of AIDS: On the Relationship between Cultural Constructions of both HIV/AIDS and Femininity." *Society in Transition* 32, 1: 38–46.

-------. 2002. "Youth, HIV/AIDS and the Importance of Sexual Culture and Context. *Social Dynamics* 28, 1: 20–41.

-------. 2003. "Transactional sex and the pursuit of modernity." *Social Dynamics* 29, 2: 213–233.

Levinsohn, James. 2007. "Estimating Correct HIV Prevalence Rates: The Case of Botswana." Presentation for the "Appraisal and Action: HIV/AIDS in southern Africa" conference held at the University of Michigan, Ann Arbor, on 29-30 November 2007.

Lewis, Jack. 2001. *A Luta Continua* (The Struggle Continues). Documentary Film. Volume 14 of "Steps for the Future." Series Producer: Don Edkins, Day Zero Film and Video.

Liddell, C., L. Barrett, and M. Bydawell. 2005. "Indigenous Representations of Illness and AIDS in Sub-Saharan Africa." *Social Science and Medicine* 60: 691-700.

Lodge, Tom. 1983. *Black Politics in South Africa since 1945*. Johannesburg: Raven Press.

Longmore, L. 1959. *The Dispossessed: A Study of the Sex-Life of Bantu Women in Urban Areas in and around Johannesburg.* London: J Cape.

Luke, Nancy and Kathleen Kurz. 2002. "Cross Generational and Transactional Sexual Relations in Sub-Saharan Africa: Prevalence of Behavior and Implications for Negotiating Safer Sexual Practices. USAID, Africa Bureau: AIDSMark project (September).

Luke, Nancy. 2003. "Age and Economic Asymmetries in the Sexual Relationships of Adolescent Girls in Sub-Saharan Africa." *Studies in Family Planning* 34, 2: 67–86.

MacPhail, C., and C. Campbell. 2001. "'I think condoms are good but, aai, I hate those things': Condom Use among Adolescents and Young People in a Southern African Township." *Social Science & Medicine* 52, 11: 1613–1627.

Mager, A. 1999. *Gender and the Making of a South African Bantustan: A Social History of the Ciskei, 1945-1959*. Portsmouth: Heinemann.

Makinde, M. Akin. 1988. *African Philosophy, Culture, and Traditional Medicine*. Athens, Ohio: Ohio University Center for International Studies.

Mamdani, Mahmood. 1996. *Citizen and Subject: Contemporary Africa and the Legacy of Late Colonialism*. Princeton: Princeton University Press.

Mandela, Nelson. 1990. *The Struggle is My Life*. New York: Pathfinder.

Mantel, Hillary. 2007. "Saartjie Baartman's Ghost." *London Review of Books* 29, 18 (September 20).

Marais, Hein. 1998. *South Africa, Limits to Change: The Political Economy of Transition*. New York: Zed Books.

-------. 2005. *Buckling: The Impact of AIDS in South Africa.* Pretoria: University of Pretoria Press.

Mare, Gerhard and Georgina Hamilton. 1987. *An Appetite for Power: Buthelezi's Inkatha and the Politics of Loyal Resistance*. Johannesburg: Raven Press.

Marks, Shula. 1986. *The Ambiguities of Dependence in South Africa*. Johannesburg: Raven Press.

Marks, Shula and Richard Rathbone, eds. 1982. *Industrialisation and Social Change in South Africa: African Class Formation, Culture and Consciousness, 1870-1930*. New York: Longman.

Mathebe, Lucky. 2001. *Bound by Tradition: The World of Thabo Mbeki*. Pretoria: University of South Africa Press.

Mayer, P. 1971. *Townsmen or Tribesmen*. Oxford: Oxford University Press.

Mbali, Mandisa. 2002. "Mbeki's Denialism and the Ghosts of Apartheid and Colonialism for Post-Apartheid AIDS Policy-Making." Paper presented at the Public Health Journal Club Seminar on May 3, 2002. Durban: University of Natal.

-------. 2003. "HIV/AIDS Policy-Making in Post-Apartheid South Africa" Pp. 312-329 in *State of the Nation*, *2003-2004*, edited by John Daniel, Adam Habib, and Roger Southall. Johannesburg, SA: Human Sciences Research Council.

-------. 2004. "AIDS Discourses and the South African State: Government Denialism and Post-Apartheid AIDS Policy-Making." *Transformation* 54: 104-122.

-------. 2005. "The Treatment Action Campaign and the History of Rights-Based, Patient-Driven HIV/AIDS Activism in South Africa." Research Report #9. Centre for Civil Society, University of KwaZulu-Natal, South Africa. www.nu.ac.za/ccs/files/RReport_29.pdf

Mbembe, Achille. 1992. "Provisional Notes on the Post-Colony." *Africa* 62, 1: 3-37.

-------. 2003. "Necropolitics." *Public Culture* 15, 1: 11-40.

Mbembe, Achille, and Sarah Nuttall. 2004. "Writing the World from an African Metropolis." *Public Culture* 16: 347-372.

McClintock, Anne. 1992. "The Angel of Progress: Pitfalls of the Term 'post-Colonialism.'" *Social Text* 10, 31/32 (Spring): 84-98.

-------. 1995. *Imperial Leather: Race, Gender, Sexuality and the Colonial Contest*. New York: Routledge.

McGregor, Liz. 2005. *Khabzela: The Life and Times of a South African*. Johannesburg: Jacana Media.

McKinley, Dale T. 2006. "The Making of a Myth: South Africa's Neo-Liberal Journey." *Centre for Civil Society*. http://www.nu.ac.za/ccs/default.asp?3,28,11,2476

Morrell, Robert, ed. 2001. *Changing Men in Southern Africa*. New York: Zed Books.

Mzala. 1988. *Gatsha Buthelezi: Chief with a Double Agenda*. London: Zed Books.

Mills, Elizabeth. 2005. "HIV Illness Meanings and Collaborative Healing Strategies in South Africa." *Social Text* 31, 2: 126-160.

Minkler, Meredith and Nina Wallerstein. 2003. *Community Based Participatory Research for Health*. San Francisco, CA: Jossey-Bass.

Morris, M., & Kretzschmar, M. 1997. "Concurrent Partnerships and the Spread of HIV." *AIDS* 11, 5: 641–648.

Murdock, G.P. 1980. *Theories of Illness*. Pittsburgh: University of Pittsburgh Press.

Myers, Jason. Forthcoming. *The Costumed State: Counterfeiting Legitimacy in Segregationist South Africa*. Rochester, NY: Rochester Press.

Naidoo, Prishani. *Forthcoming*. "The Making of The Poor In Post-Apartheid South Africa: A Case Study of Orange Farm and the City of Johannesburg." PhD Dissertation. University of Kwa-Zulu Natal, Policy and Development Studies.

Naidu, Veni and Geoff Harris. 2006. "The Cost of HIV/AIDS Related Morbidity and Mortality to Households: Preliminary Estimates for Soweto." *South African Journal of Economic and Management Sciences* 9, 3: 384-391.

Naidu, V., G. Martin, H. Struthers, R. van Niekerk, A. Violari, J. McIntyre, G. Gray. 2004. "The Impact of Morbidity and Mortality on the Vulnerable Children in Soweto." Perinatal HIV Research Unit: Johannesburg.

Nattrass, Nicoli. 2003. *The Moral Economy of AIDS in South Africa*. Cambridge:Cambridge University Press.

Navarro, Vincente, ed. 2007. *Neoliberalism, Globalization, and Inequalities: Consequences for Health and Quality of Life*. Amityville, NY: Baywood Publishing Company, Inc.

Negri, Antonio. 1999. *Insurgencies: Constituent Power and the Modern State*. Minneapolis: University of Minnesota Press.

Niehaus, Isak. 2000. "Towards a Dubious Liberation: Masculinity, Sexuality and Power in South African Lowveld Schools, 1953-1999." *Journal of Southern African Studies* 26, 3: 387-407.

-------. 2001a. *Witchcraft, Power, and Politics: An Ethnographic Study of the South African Lowveld*. Johannesburg: University of Witwatersrand Press.

-------. 2001b. "Coins for Blood and Blood for Coins: From Sacrifice to Ritual Murder in the South African Lowveld." *Ethnofoor* 1, 2: 31-54.

-------. 2002. "Bodies, Heat, and Taboos: Conceptualizing Modern Personhood in the South African Lowveld." *Ethnology* 43, 3 (Summer): 189-208.

------- 2003. "'Now Everyone is Doing It': Towards a Social History of Rape in the South African Lowveld." Sex and Secrecy: The 4th Conference of the International Association for the Study of Sexuality, Culture, and Society: Johannesburg, South Africa, June 22–25, 2003.

Nyanzi, S., Pool, R., & Kinsman, J. 2001. "The Negotiation of Sexual Relationships among School Pupils in South-Western Uganda." *AIDS Care* 13, 1: 83–98.

O'Manique, Colleen. 2004. *Neoliberalism and Aids Crisis in Sub-Saharan Africa*. New York: Palgrave Macmillan.

Ong, Aihwa. 1999. *Flexible Citizenship: The Cultural Logics of Transnationality*. Durham, NC: Duke University Press.

Ortner, Sherry. 1994. "Theory in Anthropology since the Sixties." Pp. 399-401 in *Culture/Power/History*, edited by Nicholas Dirks, Geoff Eley, and Sherry Ortner. Princeton NJ: Princeton University Press.

Ouzgane, Lahouchine and Robert Morrell, eds. 2005. *African Masculinities: Men in Africa from the Late 19th Century to the Present*. Durban: University of KwaZulu-Natal Press.

Packard, Randall. 1989. *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa*. Berkeley: University of California Press.

Patton, Cindy. 2002. *Globalizing AIDS*. Theory Out of Bounds, Volume 2. Minneapolis: Minnesota Press.

Pauw, B. 1990. "Widows and Ritual Dangers in Sotho and Tswana Communities." *African Studies* 49, 2: 76-95.

Pellegrino, E. 1999. "The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic." *Journal of Medicine and Philosophy* 24, 3: 243-266.

Petryna, Adriana, Andrew Lakoff, and Arthur Kleinman, eds. 2006. *Global Pharmaceuticals: Ethics, Markets, Practices*. Durham, NC: Duke University Press.

Pile, Steve. 1996. *The Body and the City: Psychoanalysis, Space and Subjectivity*. London. Routledge.

Pool, Robert. 1994. "On the Creation and Dissolution of Ethnomedical Systems in the Medical Ethnography of Africa." *Africa* 61, 1: 1-20.

Posel, Deborah. 2004. "Sex, Death and Embodiment: Reflections on the Stigma of AIDS in Agincourt, South Africa." Seminar Paper: *Life and Death in a Time of AIDS: The Southern African Experience* Symposium, 14-16 October. Wits Institute for Social and Economic Research, University of the Witwatersrand, Johannesburg.

-------. 2005. "The Scandal of Manhood: 'Baby Rape' and the Politicization of Sexual Violence in Post-Apartheid South Africa." *Culture, Health and Sexuality* 7 (3): 239-252. This paper was also reproduced in Reid and Walker 2005.

Quinn, Thomas C. and Overbaugh, Julie. 2005. "HIV/AIDS in Women: An Expanding Epidemic." *Science.* Vol. 308, No. 5728 (June 10): 1582 – 1583.

Ranger, Terence. [1983] 2003. "The Invention of Tradition in Colonial Africa." Pp. 211-262 in *The Invention of Tradition*, edited by Eric Hobsbawm and Terence Ranger. Cambridge: Cambridge University Press.

Reid, Graeme and Liz Walker. 2005. *Men Behaving Differently: South African Men Since 1994*. Cape Town: Double Storey.

Rigby, Peter. 1996. *African Images: Racism and the End of Anthropology*. Washington, DC: Berg.

Roberts, Ronald Suresh. 2007. *Fit to Govern: The Native Intelligence of Thabo Mbeki*. Johannesburg: STE Publishers.

Robins, Steven. 2004. "'Long Live Zackie, Long Live': AIDS Activism, Science and Citizenship after Apartheid." Journal of Southern African Studies 30(3): 651-672.

-------. 2006. "From 'Rights' to 'Rituals': AIDS Activism in South Africa." *American Anthropologist* 108, 2: 312-323.

Rödlach, Alexander. 2006. *Witches, Westerners, and HIV: AIDS and Cultures of Blame in Africa*. Walnut Creek, CA: Left Coast Press.

Rosaldo, Renato. 1989. *Culture and Truth: The Remaking of Social Analysis*. Boston: Beacon.

Roth, Nancy and Katie Hogan, eds. 1998. *Gendered Epidemic*. New York: Routledge.

Sarakinsky, M. 1984. "From 'Freehold Township' to 'Model Township:' A Political History of Alexandra, 1905-1983. Dissertation in Development Studies. University of Witwatersrand, Johannesburg.

Schapera, I. 1940. *Married Life in an African Tribe*. London: Farber and Farber.

Scheper-Hughes, Nancy and Philippe Bourgois, eds. 2004. *Violence in War and Peace: An Anthology*. Malden, MA: Blackwell.

Schmitt, Carl. [1922] 1985. *Political Theologies: Four Chapters on the Concept of Sovereignty*. Translated by George Schwab. Cambridge, MA: MIT Press.

Schneider, Helen. 2002. "On the Fault-Line: The Politics of AIDS Policy in Contemporary South Africa." *African Studies* 61, 1: 145-68.

Schneider, Helen and Joanne Stein. 2001. "Implementing AIDS Policy in Post-Apartheid South Africa." *Social Science and Medicine* 52, 5 (March): 723-731.

Schoepf, B., Schoepf, C., & Millen, J. 2000. "Theoretical Therapies, Remote Remedies: SAPs and the Political Ecology of Poverty and Health in Africa." Pp. 91-126 in *Dying for Growth: Global Inequality and the Health of the Poor*. Monroe, Maine: Common Courage Press.

Schüklenk, U. 2004. "Professional Responsibilities of Biomedical Scientists in Public Discourse." *Journal of Medical Ethics* 30, 1 (February 1): 53-60.

Scott, James C. 1985. *Weapons of the Weak: Everyday Forms of Peasant Resistance*. New Haven: Yale University Press.

Selikow, T., Zulu, B., & Cedras, E. 2002. "The Ingagara, the Regte and the Cherry: HIV/AIDS and Youth Culture in Contemporary Urban Townships." *Agenda* 53: 22–32.

Setel, Philip, Milton Lewis, and Maryinez Lyons, eds. 1999. *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa*. Westport, CN: Greenwood Press.

Sewell, William H., Jr. 1992. "A Theory of Structure: Duality, Agency, and Transformation." *The American Journal of Sociology* 98, 1 (July): 1-29.

Shohat, Ella. 1992. "Notes on the 'Post-Colonial.'" *Social Text* 10, 31/32 (Spring): 99-113.

Silberschmidt, Margrethe. 2001. "Disempowerment of Men in Rural and Urban East Africa: Implications for Male Identity and Sexual Behaviour." *World Development* 29, 4 (April): 657-671.

-------. 2004. "Poverty, Male Disempowerment and Male Sexuality: Rethinking Men and Masculinities in Rural and Urban East Africa." In Ouzgane and Morrell 2004.

Somers, Margaret. 2005. "Beware Trojan Horses Bearing Social Capital: How Privatization Turned *Solidarity* into a Bowling Team." Pp 233-274 in *The Politics of Method in the Human Sciences: Positivism and Its Epistemological Others*, edited by George Steinmetz. Durham: Duke University Press.

Sontag, Susan. 1988. *AIDS and Its Metaphors*. New York: Picador.

Southall, Roger. 1981. "Buthelezi, Inkatha, and the Politics of Compromise." *African Affairs* 80, 321 (October): 453-481.

Snow, Rachel. 2007. "Who is Testing for HIV?: A Look at Demographic and Health Surveys from Africa." Presentation for the "Appraisal and Action: HIV/AIDS in southern Africa" conference held at the University of Michigan, Ann Arbor, on 29-30 November 2007.

Stacey, Judith. 1999. "Ethnography Confronts the Global Village: A New Home for a New Century?" *Journal of Contemporary Ethnography* 28, 6 (December): 687-697.

Stadler, Jonathan. 1996. "Witches and Witch-Hunters: Witchcraft, Generational Relations and the Life-Cycle in a Lowveld Village." *African Studies* 55, 1: 87-110.

-------. 2003. "The Young, the Rich, and the Beautiful: Secrecy, Suspicion and Discourses of AIDS in the South African Lowveld." *African Journal of Aids Research* 2, 2: 123-135.

Stamoulis, Arthur. 2005. "Infected by Inequality: AIDS Rates are Closely Tied to Socio-Economic Boundaries." Interview with Alison Katz. *Clamor: The Revolution of Everyday Life*, 30 (January/February): 54-55.

Staugard, F. 1985. *Traditional Healers: Traditional Medicine in Botswana*. Gaborone: Ipelegeng.

Steinberg, Malcolm, Saul Johnson, Gill Schierhout, David Ndegwa, Katherine Hall, Bev Russell, and Jonathan Morgan. 2002. "Hitting Home: How Households Cope with the Impact of the HIV/AIDS Epidemic." Washington DC: Henry J. Kaiser Family Foundation. http://www.kff.org/southafrica/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14028

Steinglass, Matthew. 2001. "It takes a village healer – Anthropologists believe traditional medicines can remedy Africa's AIDS crisis. Are they right?" *Lingua Franca* 11, 3 (April). Cover Story.

Steinmetz, George. 1993. *Regulating the Social: The Welfare State and Local Politics in Imperial Germany*. Princeton, NJ: Princeton University Press.

-------. 2002. "Precoloniality and Colonial Subjectivity: Ethnographic Discourse and Native Policy in German Overseas Imperialism, 1780s–1914." *Political Power and Social Theory* 15:135–228.

-------. 2003. "'The Devil's Handwriting': Precolonial Discourse, Ethnographic Acuity and Cross-Identification in German Colonialism." *Comparative Studies in Society and History* 45 (1): 41–95.

-------. 2005a. "The Epistemological Unconscious of U.S. Sociology and the Transition to Post-Fordism: The Case of Historical Sociology." Pp. 109-160 in *Remaking Modernity: Politics, History and Sociology*, edited by Julia Adams, Elisabeth S. Clemens, and Ann Shola Orloff. Durham: Duke University Press.

-------. 2005b. "The Genealogy of a Positivist Haunting: Comparing Prewar and Postwar U.S. Sociology." *Boundary 2* 32, 2 (Summer): 109-135.

-------. 2005c. "Positivism and Its Others in the Social Sciences." Pp 1-56 in *The Politics of Method in the Human Sciences: Positivism and Its Epistemological Others*, edited by George Steinmetz. Durham: Duke University Press.

-------. 2005d. "Scientific Authority and the Transition to Post-Fordism: The Plausability of Positivism in U.S. Sociology since 1945." Pp. 275-323 in *The Politics of Method in the Human Sciences: Positivism and Its Epistemological Others*, edited by George Steinmetz. Durham: Duke University Press.

-------. 2006. "Bourdieu's Disavowal of Lacan: Psychoanalytic Theory and the Concepts of 'Habitus' and 'Symbolic Capital.'" *Constellations* 13, 4: 445-464.

-------. 2007a. *The Devil's Handwriting: Precoloniality and the German Colonial State in Qingdao, Samoa, and Southwest Africa*. Chicago: University of Chicago Press.

-------. 2007b. "American Sociology before and after World War II: The (Temporary) Settling of a Disciplinary Field." Pp. 314-366 in *Sociology in America: A History*, edited by Craig Calhoun. Chicago: University of Chicago Press.

-------. 2008. "La sociologie historique en Allemagne et aux Etats-Unis: Un transfert manqué (1930-1970)." *Genèses*, 71 (June): 123-147.

Stewart, Charles and Rosalind Shaw, eds. 1994. *Syncretism/Anti-Syncretism: The Politics of Religious Synthesis*. London: Routledge.

Stillwaggon, Eileen. 1998. *Stunted Lives, Stagnant Economies: Poverty, Disease and Underdevelopment*. New Jersey: Rutgers University Press.

Stoler, Ann Laura. 1995. *Race and the Education of Desire: Foucault's* History of Sexuality *and the Colonial Order of Things*. Durham, NC: Duke University Press.

-------. 2002. "State Racism and the Education of Desires: A Colonial Reading of Foucault." Pp. 3-26 in *Deep Histories: Gender and Colonialism in Southern Africa*, edited by Wendy Woodward, Patricia Hayes, and Gary Minkley. New York: Rodopi.

Swidler, Ann. 1986. "Culture in Action." *American Sociological Review* 51: 273-86.

-------. 2006. "Syncretism and Subversion in AIDS Governance: How Locals Cope with Global Demands." *International Affairs* 82, 2: 269-284.

Swidler, Ann and Susan Cotts Watkins. 2007. "Ties of Dependence: AIDS and Transactional Sex in Rural Malawi." *Studies in Family Planning* 38, 3 (September): 147-162.

Taussig, Michael. 1980. *The Devil and Commodity Fetishism in South America*. Chapel Hill, NC: University of North Carolina Press.

Taylor, C. 1990. "Condoms and Cosmology: The 'Fractual' Person and Sexual Risk in Rwanda." *Social Science and Medicine* 31, 9: 1023-1038.

Terrblanche, S. 2002. *A History of Inequality in South Africa, 1652-2002*. Pietermaritzburg: University of Natal Press.

Thomas, Kylie. 2001. "HIV and AIDS and the sick body politic or 19 ways to make a body disappear." *Medical Research Council of South Africa*. Tygerberg, South Africa. http://www.mrc.ac.za/aids/dec2001/sickbody.htm

Thornton, Robert. 2002a. "Flows of 'Sexual Substance' and Representation of the Body in South Africa." Paper presented at the Association of Social Anthropologists of the United Kingdom and Commonwealth, in Arusha, Tanzania, 8-12 April 2002. 'Draft' form: Cited with permission from the author.

Thornton, Robert. 2002b. "Traditional Healers, Medical Doctors and HIV/AIDS in Gauteng and Mpumalanga Provinces, South Africa." Final Report to the Margaret Sanger Institute. Johannesburg: University of the Witswatersrand. 'Draft' form: Cited with permission from the author.

Treichler, Paula A. 1999a. "AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification." Pp. 11-41 in *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS*. Durham, NC: Duke University Press. (Originally published in *AIDS: Cultural Analysis/Cultural Activism*, edited by Douglas Crimp, pages 31-70. Cambridge: MIT Press, 1988.)

-------. 1999b. "AIDS, HIV, and the Cultural Construction of Reality." Pp. 149-175 in *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS*. Durham, NC: Duke University Press.

-------. 1999c. "AIDS, Africa, and Cultural Theory." Pp. 205-234 in *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS*. Durham, NC: Duke University Press.

van der Linde, I. 1997. "Western and African Medicines Meet." *South African Medical Journal* 87: 268-270.

Viljoen, M., A. Panzer, K.L. Roos, and W. Bodemer. 2003. "Psychoneuroimmunology: From Philosophy, Intuition, and Folklore to a Recognized Science." *South African Journal of Science* 99: 332-336.

von Schnitzler, Anna Christina. 2006. "Citizenship Prepaid: Non-Payment, 'Smart Meters' and Neoliberal Governmentality in Soweto." Paper presented at the African Studies Association conference held on November 16-19, 2006 in San Francisco, CA.

Wacquant, Loïc J.D. 1989. "Toward a reflexive sociology: a workshop with Pierre Bourdieu." *Sociological Theory* 7: 26-63.

-------. 1996. "Foreword." Pp. ix-xxii in *The State Nobility: Elite Schools in the Field of Power*, by Pierre Bourdieu. Cambridge, UK: Polity Press.

-------. 2004. "Following Pierre Bourdieu into the Field." *Ethnography* 5, 4 (December): 387-414.

Waetjen, Thembisa. 2004. *Workers and Warriors: Masculinity and the Struggle for Nation in South Africa*. Champaign-Urbana: University of Illinois Press.

Wagner, Roy. 1986. *Symbols that Stand for Themselves*. Chicago: University of Chicago Press.

Walker, Liz. 2005. "Men Behaving Differently: South African Men Since 1994." *Culture, Health and Sexuality* 7 (3): 225-238.

Watney, Simon. 1987. *Policing Desire: Pornography, AIDS, and the Media*. Minneapolis: University of Minnesota Press.

Webb, D. 1992. *HIV and AIDS in Africa*. London, Pluto Press.

Weinrich, A.K.H. 1971. *Chiefs and Councils in Rhodesia.* London: Heinemann.

Whitehead, Stephen. 2002. *Men and Masculinities: Key Themes and New Directions*. Cambridge: Polity Press.

Wight, Daniel, Mary L. Plummer, Gerry Mshana, Joyce Wamoyi, Zachayo S. Shigongo, and David A. Ross. 2006. "Contradictory sexual norms and expectations for young people in rural northern Tanzania." *Social Science & Medicine* 62(4): 987–997.

Wood, K., Maforah, F., & Jewkes, R. 1998. "He Forced Me to Love Him: Putting Violence on Adolescent Sexual Health Agendas." *Social Science & Medicine* 47, 2: 233–242.

Wood, K., & Jewkes, R. 2001. ‘‘Dangerous’’ Love: Reflections on Violence among Xhosa Township Youth.” Pp. 317-336 in *Changing Men in Southern Africa*, edited by Robert Morell. Pietermaritzburg: University of Natal Press.

Wojcicki, Janet Maia. 2002a. “Commercial sex work or *Ukuphanda*? Sexfor- money exchange in Soweto and Hammanskraal Area, South Africa.” *Culture, Medicine, and Psychiatry* 26: 339–370.

Wojcicki, Janet Maia and J. Malala. 2001. “Condom Use, Power and HIV/AIDS Risk: Sex-Workers Bargain for survival in Hillbrow/Joubert Park/Berea, Johannesburg.” *Social Science & Medicine* 53, 1: 99–121.

Xaba, Thokozani. 2002. “The Transformation of Indigenous Medical Practice in South Africa (1985 to 2000).” In *Bodies and Politics: Healing Rituals in the Democratic South Africa*, edited by Véronique Faure, pages 23-39. Johannesburg: *Les Cahiers de l’IFAS*, Number 2 (February).

-------. 2005. “Witchcraft, Sorcery or Medical Practice? The Demand, Supply, and Regulation of Indigeneous Medicines in Durban, South Africa.” Ph.D. dissertation, University of California, Berkeley.

Yamba, C.B. 1997. “Cosmologies in Turmoil: Witch-Finding and AIDS in Chiawa, Zambia.” *Africa* 67, 2: 200-223.

Zierler, S., & Krieger, N. 1997. “Reframing Women’s Risk: Social Inequalities and HIV Infection.” *Annual Review of Public Health* 18: 401–436.

Zivi, Karen. 1998. “Constituting the ‘Clean and Proper’ Body.” Pp. 33-62 in *Gendered Epidemic: Representations of Women in the Age of AIDS*, edited by Nancy Roth and Katie Hogan. New York: Routledge.

Žižek, Slavoj. 1989. *The Sublime Object of Ideology*. New York: Verso.

-------. 1994. “The Spectre of Ideology.” Pp. 1-33 in *Mapping Ideology*. New York: Verso.

Zuma, Khangelani. 2007. “What Do the Numbers Reveal? Obstacles to Effective Monitoring and Appraisal.” Presentation for the “Appraisal and Action: HIV/AIDS in southern Africa” conference held at the University of Michigan, Ann Arbor, on 29-30 November 2007.

Archives

Advertising Standards Authority of South Africa (ASASA). 2005. http://www.asasa.org.za/.

African National Congress (ANC). 1975. "Forward to Freedom."

-------. 1994. *A National Health Plan for South Africa*. Johannesburg: African National Congress.

-------. 2001. *A National Guideline on Home-Based Care and Community-Based Care*. Pretoria: African National Congress.

AIDS Law Project (ALP). 2008. www.alp.org.za I accessed this website consistently from 2002 through 2008. Its archives and research reports are all available on the website.

Akintola, O. 2005. "Impact of Home Based Care on Women and Girls in Southern Africa: Implications for Policies and Programmes." ActionAid International, Southern African Partnership, Johannesburg.

Anti-Privatisation Forum (APF). 2004. "Nothing for Mahala: The Forced Installation of Pre-paid Water Meters in Stretford, Extension 4, Orange Farm, Johannesburg." A joint report by the APF, Public Citizen, and the Coalition against Water Privatisation. Contributing authors: Maj Fiil-Flynn and Prishani Naidoo. www.wateractivist.org

-------. 2006a. "Lessons From The War Against Prepaid Water Meters." Report of Community Participatory Action Research, conducted in Phiri, Soweto.

-------. 2006b. "HIV/AIDS and the Struggle for Life." Report of Community Participatory Action Research, conducted in Sol Plaatje and Phiri, Soweto.

Anyamele, Chukwuemeka, Ronald Lwabaayi, Tuu-Van Nguyen and Hans Binswanger. 2005. "Sexual Minorities, Violence and AIDS in Africa." World Bank, African Region. Working Paper Series, 84.

Avert. 2005. "HIV and AIDS in South Africa." http://www.avert.org/aidssouthafrica.htm

Berman, Kim. 2008. "Art Saves Lives: The Creative Arts, Community Engagement, & HIV/AIDS in South Africa." Creative Community Partnerships for Creative Community Development: University of Johannesburg-University of Michigan Collaborations. University of Michigan, March 3-7, 2008.

Cabinet, South African Government. 2007 (May 2). Statement on Cabinet Meeting. http://www.info.gov.za/speeches/2007/07050311151002.htm

Campbell, Carol. 2007. "Traditional Medicine for HIV to go on Trial." September 4. http://www.scidev.net/en/news/traditional-medicine-for-hiv-to-go-on-trial.html

"Castro Hlongwane, Caravans, Cats, Geese, Foot & Mouth And Statistics: HIV/AIDS And The Struggle For The Humanisation Of The African." 2002. Unknown Author. First posted to the ANC website by Peter Mokaba on March 2002. Reprinted on www.tac.org.za.

Centre for Applied Legal Studies, CALS. 2003 (June). "Out of Site, Out of Mind: Relocation and Access to Schools in Sol Plaatje." Research Report, conducted by Stuart Wilson.

Centre for Applied Legal Studies, CALS. 2008 (April 30). "Prepayment Water Meter System Unconstitutional, Free Basic Water To Be Increased." Statement on court case, Mazibuku vs. the City of Johannesburg. http://www.law.wits.ac.za/cals/

Chris Hani Baragwanath Hospital. 2008. "General Information." http://www.chrishanibaragwanathhospital.co.za/bara/article.jsp?id=161. Website accessed on May 15, 2008.

Colvin, M., L. Gumede, K. Grimwade, and D. Wilkinson. 2001. "Integrating Traditional Healers into a Tuberculosis Control Programme in Hlabisa, South Africa." *Medicine Control Council Brief, No. 5* (December). www.mrc.ac.za

Crime Information Analysis Centre. 2005. "Rape in the RSA for the period April to March 2001/2002 to 2004/2005." http://www.saps.gov.za/statistics/reports/crimestats/2005/_pdf/crimes/rape.pdf

Cullinan, Kerry. 2000. "Editorial" in *Community Based Care: Update for Health Workers, Planners and Managers*. Health Systems Trust, Issue 58. http://www.hst.org.za/publications/403)

Department of Health, South Africa. 1996 (January). National Drug Policy. http://www.doh.gov.za/docs/policy/drugsjan1996.pdf

Department of Health, South Africa. 2003. Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa. November 19. http://www.info.gov.za/otherdocs/2003/aidsplan.pdf

Department of Health, South Africa. 2005. "National HIV and Syphilis Sero-prevalence Survey in South Africa 2004." http://www.avert.org/safricastats.htm

Department of Health, South Africa. 2006. "A National Human Resources Plan for Health." http://www.doh.gov.za/docs/factsheets/guidelines/hrplan/index.html

Department of Health and Human Services, United States (DHHS). 2008 (January 9). "Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents." January 9. Developed by the Panel on Antiretroviral Guidelines

for Adults and Adolescents – A Working Group of the Office of AIDS Research Advisory Council (OARAC).

Department of Housing, South Africa. 2005. www.**housing**.gov.za

Department of Social Development, South Africa. http://www.socdev.gov.za/

Dr. Rath Foundation. 2005a. http://www.dr-rath-foundation.org.za/ and http://www4.dr-rath-foundation.org/.

Dr. Rath Foundation. 2005b. "No Censorship of Life-Saving Natural Health Information!" *The Sowetan*. January 25, 2005. http://www.dr-rath-foundation.org.za/

EngenderHealth. 2008. "Men as Partners." Website accessed in June 2008. http://www.engenderhealth.org/our-work/gender/men-as-partners.php

Equal Treatment Newsletter (of the Treatment Action Campaign). 2004. "Electronic Newsletter concerning the THO." November 24, 2004. http://www.tac.org.za/newsletter/2004/ns23_11_2004.htm

Equal Treatment Newsletter. 2005a. "Statistics South Africa mortality report confirms massive increase in deaths due to AIDS." February 21, 2005. Issue 14. (not available online).

Equal Treatment Newsletter. 2005b. "Traditional Healers and Public Health." Issue 15 (May). www.**tac**.org.za/ET/**EqualTreatment**May2005**Issue15**.pdf

Equal Treatment Newsletter. 2005c. "Health Workers Speak Out." Issue 18 (December). http://www.tac.org.za/documents/et18.pdf

Equal Treatment Newsletter. 2006. "Women and HIV." June 20, 2006. Issue 20. http://www.tac.org.za/documents/et20.pdf

Equal Treatment Electronic Newsletter. 2007 (June 3). "Public Service Strikes." http://www.tac.org.za/community/node/2154

Equal Treatment Electronic Newsletter. 2008 (June 13). "Cape High Court interdicts Matthias Rath and orders Government to investigate and stop breaches of the Medicines Act."

Freedom of Expression Institute (FXI). 2006. Annual Report 2005/2006. http://www.fxi.org.za/PDFs/Governance/FXIAnnualReport2006.pdf

GRAIN. 2001. "'TRIPS-Plus' through the Back Door: How bilateral treaties impose much stronger rules for IPRs on life than the WTO." http://www.grain.org/briefings/?id=6#_edn1

Heywood, Mark. 2004a. "Condemn the Threats by NAPWA against AIDS Activists." *TAC Newsletter* 30 (March 30). http://www.tac.org.za/newsletter/2004/ns30_03_2004.htm

-------. 2004b. "Price of Denial," *Development Update* 5:3. Online at http://www.tac.org.za/documents/priceofdenial.doc

-------. 2008. "Politics of Health." Online book about the TAC. http://www.tac.org.za/community/heywood

Human Rights Committee of South Africa. 2002 (January 15). Press Release: "Forced Removals in Mandelaville: Chilling Echoes of Apartheid." Braamfontein: Johannesburg.

Human Sciences Research Council. 2004. "Fact Sheet: Poverty in South Africa." 26 July 2004. South African Regional Poverty Network: http://www.sarpn.org.za/documents/d0000990/index.php

Human Sciences Research Council (HSRC). 2005. "Fact Sheet: National HIV prevalence in South Africa - the graphics." http://www.hsrc.ac.za/Factsheet-40.phtml

Long, Scott. 2003. "More than a Name: State-Sponsored Homophobia and Its Consequences in Southern Africa." Report by Human Rights Watch and the International Gay and Lesbian Human Rights Commission. http://www.hrw.org/reports/pdfs/g/general/safriglhrc0303.pdf

Love, James. 2005. "Closing the Access Gap: The Equitable Access License." Consumer Project on Technology. www.essentialmedicine.org/EALPrimer.pdf

Madame and Eve cartoons. April 8, 2006. "Great South African Lies and Myths." Cartoon number 003119. http://www.madameve.co.za/index.php

Makgetla, Neva Seidman. 2004. "Women and the Economy in South Africa." www.genderstats.org.za/economy.shtml

Mandelaville Crisis Committee. 2005. "Community Resource Information Centre." Funding Application.

Mbeki, Thabo. 2006. "Understanding South Africa's Approach to AIDS." *ANC Today: Online Voice of the African National Congress*, Vol 6, No 34. 7 September, 2006. http://www.anc.org.za/ancdocs/anctoday/2006/at34.htm

Medicines Control Council (MCC), South Africa. 2005. http://www.mccza.com/

Medical Research Council (MRC), South Africa. 2003. National Reference Centre for African Traditional Medicines: A South African Model. http://www.mrc.ac.za/traditionalmedicines/national.htm

Medical Research Council (MRC), South Africa. Annual Report 2005. http://www.mrc.ac.za/annualreport/annual.html

Myburgh, James. 2007 (September). "The Virodene Affair, Parts I and II." *Politicsweb*. http://www.politicsweb.co.za/politicsweb/view/politicsweb/en/page71619?oid=83156&sn=Detail

Oxfam Briefing. 2001 (October). "Priced Out of Reach: How WTO patent policies will reduce access to medicines in the developing world." http://www.oxfam.org.uk/resources/policy/health/index.html

Pefile, Sibongile. 2005. "South African Legislation on Traditional Medicine." Policy Brief, March 1. http://www.scidev.net/en/policy-briefs/south-african-legislation-on-traditional-medicine.html

Reconstruction and Development Programme (RDP). 1995. *Key Indicators of Poverty in South Africa*. RDP is under the Ministry in the Office of the President.

Schwabe, Craig. 2004. "Fact Sheet: Poverty in South Africa." Human Sciences Research Council (HSRC). http://www.sarpn.org.za/documents/d0000990/index.php

Smetherham, Jo-Anne. 2003 (July 4). "MRC Research on Muthi: Could Traditional Medicine Fight Off AIDS?" www.learnscapes.co.za/news%20-%202003-07-08.htm

Statistics South Africa. 2004a (March). "Labour Force Survey." http://www.statssa.gov.za/PublicationsHTML/P0210March2004/html/P0210March2004.html

Statistics South Africa. 2004b (July). "General Household Survey." http://www.statssa.gov.za/publications/P0318/P0318July2004.pdf

Statistics South Africa. 2006a (July). "General Household Survey." http://www.statssa.gov.za/PublicationsHTML/P0318July2006/html/P0318July2006.html

Statistics South Africa. 2006b (June). "Non-financial census of municipalities for the year ended." http://www.statssa.gov.za/PublicationsHTML/P9115June2006/html/P9115June2006_16.html

Statistics South Africa. 2006c (March). "Labour Force Survey." http://www.statssa.gov.za/publications/statsdownload.asp?PPN=p0210&SCH=3748

THO Siyavuma News. 2004 (Spring). The Journal of the Traditional Healers Organisation. Volume 5, Edition 1.

Treatment Action Campaign (TAC). 2000. "Defiance Campaign: Questions and Answers." http://www.tac.org.za/Documents/DefianceCampaign/Q_A_ImportBrazil.htm

Treatment Action Campaign (TAC). 2005a. "TAC Briefing: The harmful activities of Matthias Rath," April 18, 2005. http://www.tac.org.za/newsletter/2005/ns19_04_2005.htm

Treatment Action Campaign (TAC). 2005b. "The Wrongs of Matthias Rath." Website with all of the TAC documents on the Dr. Rath Foundation. http://www.tac.org.za/community/rath

Treatment Action Campaign (TAC). 2006. "Judgment on TAC vs. Rath" on defamation charges. March 3, 3006. http://www.tac.org.za/Documents/Court_Cases/Rath/JudgmentTACvRath-20060303.pdf

Treatment Action Campaign (TAC). 2008. www.tac.org.za. I accessed this website consistently from 2002 through 2008. The history of the organization and all of its archives are available online.

UNAIDS. 1999 (March). "Gender and HIV/AIDS: Taking stock of research and programmes." By D. Whelan. http://data.unaids.org/Publications/IRC-pub05/JC419-Gender-TakingStock_en.pdf

UNAIDS. 2000 (May). "Caring for Carers: Managing Stress in Those Who Care for People with HIV and AIDS." Case Study, Best Practice Collection. http://data.unaids.org/Publications/IRC-pub02/JC717-CaringCarers_en.pdf

UNAIDS. 2004a. "AIDS Epidemic in sub-Saharan Africa: Factsheet." http://www.unaids.org/bangkok2004/factsheets/FS_SSAfrica_en.pdf

UNAIDS. 2004b. "Report of the United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa." http://womenandaids.unaids.org/regional/docs/Report%20of%20SG's%20Task%20Force.pdf

UNAIDS/WHO. 2004c. *2004 Report on the Global AIDS Epidemic*. Geneva. www.unaids.org.

UNAIDS. 2006. *2006 Report on the Global AIDS Epidemic*. Geneva. www.unaids.org.

UNDP (United Nations Development Programme). 2003. *South Africa Human Development Report, 2003*. Oxford: Oxford University Press.

United Nations Human Settlements Program. 2003. *The Challenge of Slums: Global Report on Human Settlements*. London: Earthscan Publications, Ltd.

UN Integrated Regional Information Networks (UN IRIN). 2005. "South Africa: Men Falling through the Cracks." (July 25, 2005). http://www.aegis.com/news/irin/2005/IR050766.html

United Nations Population Fund (UNFPA). 2007. "The Gender Dimensions of the HIV/AIDS Epidemic." http://www.unfpa.org/gender/aids.htm

van den Heever, Christo Dr. 2008. "History of Chris Hani Baragwanath Hospital." http://www.chrishanibaragwanathhospital.co.za/bara/article.jsp?id=157. Website accessed on May 15, 2008.

Voluntary Service Overseas. 2006. "Reducing the Burden of HIV and AIDS Care on Women and Girls." http://www.icw.org/files/AIDS%20Agenda%20-%20Burden%20of%20Care%20Policy%20Brief%20-%20August%202006.pdf

World Bank. 2008. "What is Social Capital." http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALDEVELOPMENT/EXTTSOCIALCAPITAL/0,,contentMDK:20185164~menuPK:418217~pagePK:148956~piPK:216618~theSitePK:401015,00.html

World Health Organization (WHO). 2002. "World Report on Violence and Health." Geneva. http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf

World Trade Organization. 1994. *Trade Related Intellectual Property Rights Agreement*. Annex 1C of the Marrakesh Agreement Establishing the World Trade Organization, signed in Marrakesh, Morocco on 15 April 1994. http://www.wto.org/english/tratop_e/trips_e/t_agm0_e.htm

Zapiro. (Jonathan Shapiro). 2000. *The Devil Made Me Do It!* Cape Town: David Philip Publishers.

Zapiro. 2007. *Take Two Veg and Call Me in the Morning*. Johannesburg: Jacana Media.

Archival Collections:

South African History Archive. 2002-2003. "Mandelaville Forced Removals." Collection: AL2878, "Freedom of Information Programme (FOIP)." Special Projects: A6: South African Migration. Johannesburg: William Cullen Library, University of Witwatersrand.

Wits Historical Papers. 1940-1970. Press Clippings on African Healing. Collection: AD1912, "South African Institute of Race Relations Press clippings." Boxes 112-113: Health. Johannesburg: William Cullen Library, University of Witwatersrand.

-------. 1986-88. "Lawley Squatters Court Case." Collection: A2346, "Community Research and Information Network." Box D14: Informal Settlements. Johannesburg: William Cullen Library, University of Witwatersrand.

Speeches:

Mbeki, Thabo. 1999 (October). Speech given in Parliament. "Debates of the National Assembly." *Hansard,* 16 November, 1999.

-------. 2000. Speech of the President of South Africa at the Opening Session of the 13th International AIDSA Conference, Durban, South Africa.

-------. 2001. Address of the President of South Africa, Thabo Mbeki, at the Third African Renaissance Festival, Durban, March 31.

-------. 2002. "Speech at the Funeral of Sarah Baartmann." *Hankey* 9 August 2002. http://www.dfa.gov.za/docs/speeches/2002/mbek0809.htm

-------. 2004. Speech given to a group of faith leaders at the AGS Tabernacle in Kimberly, Northern Cape. "Mbeki meets up with faith leaders." *SABC News*. March 30, 2004. http://www.sabcnews.com/politics/elections/0,2172,76916,00.html

Tshabalala-Msimang, Manto. 2003. "Speech by the Minister of Health." 21 August 2003. http://www.info.gov.za/speeches/2003/1008.htm

Zuma, Jacob. 2001. Address given to the Moral Regeneration Movement National Consultative Meeting. 23 November 2001. http://www.anc.org.za/ancdocs/history/zuma/2001

Legislation:

Republic of South Africa. 1957. *Witchcraft Suppression Act*, No. 3. Assented to on the 19th of February, 1957.

Republic of South Africa. 1974. *Health Professsions Act*, No. 56. Assented to on 9th of October, 1974.

Republic of South Africa. 1996. *Constitution of the Republic of South Africa*, approved by the Constitutional Court (CC) on 4 December 1996 and took effect on 4 February 1997. http://www.info.gov.za/documents/constitution/index.htm

Republic of South Africa. 1997. *Medicines and Related Substances Control Amendment Act*, No. 90. Government Gazette. Volume 390, Number 18505. 12 December 1997. http://www.info.gov.za/gazette/acts/1997/a90-97.pdf

Republic of South Africa. 1998. *South African Medicines and Medical Devices Regulatory Authority Act*, No. 132. http://www.info.gov.za/view/DownloadFileAction?id=71294

Republic of South Africa. 2005. *The Traditional Health Practitioners Act, 2004*. Cape Town: Government Gazette. Volume 476, Number 27275. 11 February 2005. http://www.doh.gov.za/docs/bills/thb.html.

Newspapers:

BBC News Online. 2005. (December 1). "South Africa to have gay weddings." http://news.bbc.co.uk/2/hi/africa/4487756.stm

City Press. 1993. "AIDS: The Great Muti Debate." By Bereng Mtimkulu. Page 29.

Fortune. 2004. "Fortune 500: How the industries stack up." Volume 149, Number 7.

The Friend. 1964 (April 16). "Africans wait in vain for the Tokoloshe."

The Guardian. 2005 (May 14). "Discredited doctor's 'cure' for Aids ignites life-and-death struggle in South Africa." By Sarah Boseley. http://www.guardian.co.uk/world/2005/may/14/southafrica.internationalaidanddevelopment

The Guardian. 2006 (May 9). "Acquitted Zuma ready to fight for presidency." By Andrew Meldrum. http://www.guardian.co.uk/southafrica/story/0,,1770514,00.html

The Guardian. 2007 (November 6). "Mbeki admits he is still Aids dissident six years on." By Chris McGreal.

Health-E News. 2004 (November 28). "Responses to HIV/AIDS." By Anso Thom and Kerry Cullinan. http://www.health-e.org.za/news/article.php?uid=20031154

Health-E News. 2005 (May 12). "Another Bizarre Year for AIDS Policy" by Kerry Cullinan. http://www.health-e.org.za/news/article.php?uid=20031345

Health-E News. 2007 (June 18). "New Strategic Plan: Is AIDS denialism dead?" by Kerry Cullinan. http://www.health-e.org.za/news/article.php?uid=20031694

Independent Online. 2000 (July 15). "Parks in trouble for 'Aids orphan dilemma.'" By Mariette le Roux. http://www.int.iol.co.za/index.php?set_id=l&click_id=13&art_id=qw963660420888O615

Independent Online. 2001 (October 7). "AIDS is South Africa's New Apartheid, says Tutu."

http://www.iol.co.za/index.php?sf=2813&set_id=&sf=2813&click_id=13&art_id=qw1002460681991B232&set_id=1

Mail and Guardian. 1999 (May 7). "Africa still stigmatises HIV-positive people." By A. Nicodemus.

Mail and Guardian. 2000a (March 16). Zapiro cartoon: "Pres Mbeki's Select Advisory Panel."

Mail and Guardian. 2000b (July 13). Zapiro cartoon: "World AIDS Conference."

Mail and Guardian. 2001 (October 26-November 1). "Mbeki in Bizarre AIDS Outburst." By Drew Forrest and Barry Streek. Page 5.

Mail and Guardian. 2002a (April 5-11). "Down in the Dumps." By Thabo Mohlala.

Mail and Guardian. 2002b (November 15). "The Vilest of Crimes."

Mail and Guardian. 2003 (August 14). Zapiro Cartoon: "The Devil is in the Details."

Mail and Guardian. 2004 (30 Novemer). Dr. Rath Advertisement. "Why should South Africans continue to be poisoned with AZT?"

Mail and Guardian. 2005 (October 28 – November 3). "Official nod for voodoo trials?" by Cullinan, Kerry and Anso Thom.

Mail and Guardian. 2006a (January 6). "The rise and rise of SA's shacks." By Donwald Pressly. http://www.mg.co.za/articlePage.aspx?articleid=260652&area=/breaking_news/breaking_news__national/

Mail and Guardian. 2006b (September 7). Zapiro Cartoon: "Manto against the World."

Mail and Guardian. 2006c (October 28). "South African Government Ends Aids Denialism." http://www.mg.co.za/articlePage.aspx?articleid=288029&area=/breaking_news/breaking_news_nation/

Mail and Guardian. 2006d (November 22). Zapiro cartoon. "Manto's Sick Leave."

Mail and Guardian. 2007a (June 15). "In the Firing Line." www.mg.co.za/articlePage.aspx?articleid=311384&are...

Mail and Guardian. 2007b (June 15). "Wages: State may go it alone." www.mg.co.za/articlePage.aspx?articleid=311342&are...

Mail and Guardian. 2007c (June 28). "The Strike is Over." http://www.mg.co.za/articlePage.aspx?articleid=312556&area=/breaking_news/breaking_news__business/#

Mail and Guardian. 2007d (August 8). Zapiro Cartoon: "Madlala-Routledge's 'unauthorized leave.'"

Mail and Guardian. 2007e (August 17-23). "Address the Land Question." By L. Ntsebeza.

Mail and Guardian. 2007f (December 18). "Zuma is New ANC President." By Riaan Wolmarans and Matthew Burbidge. http://www.mg.co.za/articledirect.aspx?articleid=328048&area=ancconference_news

Mail and Guardian. 2007g (December 20). "Decision to charge Zuma 'imminent.'" http://www.mg.co.za/articlePage.aspx?articleid=328151&area=/breaking_news/breaking_news__national/

Natal Mercury. 1965 (March 23). "Health teachers to fight witchcraft."

The New Review. 2006. "Khabzela: The Life and Times of a South African by Liz McGregor." Review by Michelle McGrane. http://www.laurahird.com/newreview/khabzela.html

The New York Times. 1996 (May 3). "South Africa Losing Battle to House Homeless." By Suzanne Daley.

The New York Times. 1998 (December 28). "Neighbors Kill an H.I.V.-Positive AIDS Activist in South Africa." By Donald McNeil Jr. http://query.nytimes.com/gst/fullpage.html?sec=health&res=9A02E1DA173FF93BA15751C1A96E958260

The New York Times. 2004 (May). Dr. Rath Advertisement. "Stop AIDS Genocide by the Drug Cartel."

The New Yorker. 2007 (March 12). "The Denialists: The Dangerous Attacks on the Consensus about HIV and AIDS." By Michael Specter.

Newsweek. 2006 (May 8). "Showers, Sex and AIDS: How a rape trial involving a leading South African politician has hurt the battle to stop the spread of HIV." By Karen MacGregor. http://www.msnbc.com/id/12647411/site/newsweek/

The Observer. 2004 (February 29). "AIDS Death of DJ Highlights Anguish of South Africa." Review of Liz McGregor's *Khabzela*. http://observer.guardian.co.uk/international/story/0,6903,1158701,00.html

The Observer. 2007 (September 2). "Is Mandela's heir one of the world's worst presidents?" By John Carlin.

Rand Daily Mail. 1955 (September 25). "Tokoloshe did the killings says man on murder charge."

Rand Daily Mail. 1956 (February 14). "Laying the Tokoloshe."

Rand Daily Mail. 1964 (July 23). "There is work for the witchdoctors." By Carnegie Buyana.

Rand Daily Mail. 1969 (October 16). "School Tokoloshe conquered."

South African Press Association (SAPA). 2002 (December 17). "Mbeki says AIDS issue to be 'adequately dealt with' in ANC resolution."

South African Press Association (SAPA). 2006 (August 26). "Government 'Balanced' on HIV/AIDS." http://www.news24.com/News24/South_Africa/Aids_Focus/0,,2-7-659_1988716,00.html

The Sowetan. 2000 (August 16). Zapiro cartoon. "Mbeki plays the race card with Tony Leon."

The Sowetan. 2004 (February 11). Zapiro Cartoon: "What AIDS Crisis?"

The Star. 1964 (March 21). "Witchdoctors still popular."

The Star. 1965a (January 27). "Nganga, your day is done." By Alan Campling.

The Star. 1965b (May 7). "Witchcraft has firm hold on African life."

The Star. 1967 (April 19). "Magic Ritual in Townships."

The Star. 2002 (November 26). "It's a new model of masculinity." By Nomboniso Gasa.

The Star. 2003 (July 17). "The Art of Talking about Rape." By Tanya Farber.

The Star. 2005a (January 14). "Crisis as SA Steadily Loses Qualified Nursing." By Bruce Venter. http://www.thestar.co.za/index.php?fSectionId=129&fArticleId=2373406

The Star. 2005b (May 6). "Health minister defiant on ARV side-effects." By Sheena Adams. Page 6.

The Star. 2008 (March 22). "Johannesburg closes tap of poor's free water." Page 2.

Sunday Argus. 2006 (April 13). "Women the losers in Zuma rape case." By Christelle Terreblanche.

The Sunday Independent. 2004 (November 7). "Deputy minister sees traditional healers helping to find a cure for Aids."

The Sunday Independent. 2005 (March 6). "Voices being raised against baby rape." By Charlene Smith.

The Sunday Independent. 2006 (July 6). Zapiro cartoon. "Zuma sues Shapiro for damage to his reputation."

The Sunday Independent. 2008a (March 13). Zapiro cartoon: "TAC vs. Matthias Rath."

The Sunday Independent. 2008b (May 4). "Development Bank releases shocking statistics on Aids in SA." By Eleanor Momberg.

Sunday Times. 1998 (December 27). "Mob kills woman for telling truth: Health worker stoned and beaten for confession about HIV." By K. Bareng-Batho and M. S'Thembiso.

Sunday Times. 1999 (April 4). "Child Rape: A Taboo within the AIDS Taboo."

Sunday Times. 2001 (October 24). Zapiro cartoon: "Playing the Dissident Fiddle."

Sunday Times. 2002 (February 15). Zapiro cartoon: "Lemon is not a vegetable."

Sunday Times. 2005 (May 8). Zapiro Cartoon: "Rath and Manto's Veg and Vitamin Remedy."

Sunday Times. 2006 (November 5). "Manto Muscled Out in Palace Coup" by Kerry Cullinan.

Time magazine. 2000 (September 11). "You cannot attribute immune deficiency exclusively to a virus." By T. Karon.

Washington Post. 2001 (June 15). "Dead Wrong on AIDS" by Amir Attaran.*Washington Post*. 2005 (December 2). "S. Africa's Top Court Blesses Gay Marriage." By Craig Timberg. Page A16. http://www.washingtonpost.com/wp-dyn/content/article/2005/12/01/AR2005120100583.html

Washington Post. 2006 (December 1). "Same-Sex Marriage Law Takes Effect in S. Africa." By Clare Nullis. Page A20. http://www.washingtonpost.com/wp-dyn/content/article/2006/11/30/AR2006113001370.html

Worldpress. 2006 (April 29). "Zuma Trial Heightens Rape Awareness." By Eugene Soros. http://www.worldpress.org/print_article.cfm?article_id=2449&dont=yes

Ethnography

Anti-Privatisation Forum (APF). January 11 – June 15, 2006. Active member of the Research Subcommittee and participant observation of general meetings and affiliate meetings.

Gauteng Traditional Healing Task Team (GTHTT). Participant observation of meetings held in Johannesburg from July 1 – December 20, 2005.

Iketsetseng Support Group. April 1 – December 28, 2005. Participant observation of support group meetings held in Lawley 2.

Landless People's Movement (LPM). April 4 – December 28, 2005. Participant observation of HIV/AIDS programming and activities in the greater Johannesburg area, and more specifically in the Lawley 2 branch.

Mandelaville Support Group. July 27 – December 28, 2005. Participant observation of support group meetings held in Sol Plaatje, an informal settlement on the outskirts of Johannesburg.

Orange Farm Water Crisis Committee. July 2005. Participant observation of community health initiatives and interviews with Bricks Mkolo, the organization's chairperson.

Prominent National HIV/AIDS NGO. [452] December 1, 2004 – September 30, 2005. Participant observation of the Care and Support program, which entailed visiting the 19 support groups it operates in Soweto and participating in three of them, held in Orlando, Zola, and Dobsonville.

[452] In order to preserve the anonymity of those involved in this study, it is important not to disclose the name of this NGO.

Focus Group Discussions

Traditional Healers:

Gauteng Traditional and Faith Medical Practitioners, GTFMP. FGD held on May 2, 2005 in Diepkloof Community Center, Diepkloof, Soweto.

-------. FGD held on May 9, 2005 in Diepkloof Community Center, Diepkloof, Soweto.

-------. FGD held on June 6, 2005 in Ipelegeng Community Center, White City, Soweto.

-------. FGD held on June 13, 2005 in the Career Center Community Hall, Pimville, Soweto.

-------. FGD held on June 20, 2005 in Alexandra, Johannesburg.

Soweto Traditional Healers Forum. FGD held on September 6, 2005 in the Career Center Community Hall, Pimville, Soweto.

-------. FGD held on September 13, 2005 in the Career Center Community Hall, Pimville, Soweto.

HIV-positive Community Members:

Iketsetseng Support Group. FGD held on October 6, 2005 in Lawley.

-------. FGD held on October 20, 2005 in Lawley.

Mandelaville Support Group. FGD held on October 14, 2005 in Sol Plaatje.

-------. FGD held on October 28, 2005 in Sol Plaatje.

Phiri community members. FGD held on June 8, 2006 in Phiri, Soweto.

Prominent National HIV/AIDS NGO Support Group. FGD held on April 13, 2005 in Zola, Soweto. [453]

Sol Plaatje community members. FGD held on June 10, 2006 in Sol Plaatje.

[453] In order to preserve the anonymity of those involved in this study, it is important not to disclose the name of this NGO.

Home-Based Care:

Soweto Home-Based Care Givers. FGD held on August 10, 2005 in White City, Soweto.

-------. FGD held on September 14, 2005 in White City, Soweto.

-------. FGD held on October 4, 2005 in White City, Soweto.

Interviews

Biomedical Practitioners:

Dr. Liz Floyd, Director of the Intersectoral HIV/AIDS Unit, Gauteng Department of Health. Interview held on November 1, 2005 at the Gauteng Department of Health offices, Johannesburg.

Matron Koka (Retired). Interview held on September 7, 2005 in Noord Wyk, Johannesburg.

Female Nurse, Reproductive Health. Interview held in January 2003 at the Chris Hani Baragwanath Hospital in Soweto.

Female Nurse, HIV Clinic. Interview held on May 25, 2006 at the Chris Hani Baragwanath Hospital in Soweto.

Female Nurse, Critical Care Ward. Interview held on May 25, 2006 at the Chris Hani Baragwanath Hospital in Soweto.

Female Head Nurse and Unit Manager in Critical Care. Interview held on May 25, 2006 at the Chris Hani Baragwanath Hospital in Soweto.

Female Nurse, Maternity Ward. Interview held on May 25, 2006 at the Chris Hani Baragwanath Hospital in Soweto.

Female Matron, Dobsonville Clinic. Interview held on June 7, 2006 in Dobsonville, Soweto.

Female Matron, Project Manager of HIV/AIDS Services, Zola Clinic. Interview held on June 7, 2006 in Zola, Soweto.

Traditional Healers:

Anonymous Male Inyanga. Interview held on April 22, 2005 in Alexnadra, Johannesburg.

Anonymous Male Sangoma. Interview held on April 13, 2005 in Diepkloof Extension, Soweto.

Anonymous Female Sangoma. Interview held on April 20, 2005 in Mapetla Extension, Soweto.

Anonymous Female Sangoma. Interview held on August 29, 2005 in Orlando East, Soweto.

Anonymous THO leader. Interview held on August 1, 2005 in Johannesburg.

Dr. Koka. Interview held on September 7, 2005 in Noord Wyk, Johannesburg.

Phephsile Maseko. National Coordinator of the THO. Interview held on April 11, 2005 in the THO offices in downtown Johannesburg.

-------. Interview held on May 15, 2005 in the THO offices in downtown Johannesburg.

Dr. Mndaweni. GTFMP Chairperson. Interview held on April 6, 2005 in the GTFMP offices in downtown Johannesburg.

-------. Interview held on April 25, 2005 in the GTFMP offices in downtown Johannesburg.

Dr. Martha Mongoya. Interview held on April 8, 2005 in Orlando East, Soweto.

-------. Interview held on July 22, 2005 in Orlando East, Soweto.

-------. Interview held on August 3, 2005 in Orlando East, Soweto.

-------. Interview held on August 17, 2005 in Orlando East, Soweto.

-------. Interview held on September 3, 2005 in Orlando East, Soweto.

-------. Consultation held on December 1, 2005 in Orlando East, Soweto.

Dr. Moki. Interview held on November 1, 2005 in Evaton West.

Dr. Mputhi. Interview held on July 18, 2005 in Evaton West.

Dr. Rebecca Rogerson. Interview held on August 19, 2005 in Melville, Johannesburg.

Dr. Robert Tshabalala. Interview held on April 8, 2005 in Orlando East, Soweto.

-------. Interview held on July 22, 2005 in Orlando East, Soweto.

-------. Interview held on August 3, 2005 in Orlando East, Soweto.

-------. Interview held on August 17, 2005 in Orlando East, Soweto.

-------. Interview held on September 3, 2005 in Orlando East, Soweto.

-------. Consultation held on December 2, 2005 in Diepkloof, Soweto.

NGOs:

"Lily." NGO Staff. Interview held on October 19, 2005 in Soweto.

"Nhlanhla." NGO Staff. Participant observation from December 1, 2004 – September 30, 2005.

-------. Interview held on April 15, 2005 in Soweto.

-------. Interview held on October 19, 2005 in Soweto.

"Tebogho." NGO Staff. Participant observation from December 1, 2004 – September 30, 2005.

-------. Interview held on April 6, 2005 in Soweto.

-------. Interview held on October 19, 2005 in Soweto.

"Thandi." NGO Staff. Participant observation from December 1, 2004 – September 30, 2005.

-------. Interview held on April 15, 2005 in Soweto.

Treatment Action Campaign and AIDS Law Project:

Anonymous AIDS Law Project lawyer and activist. Interview held on November 22, 2005 in Johannesburg ALP offices at the University of Witwatersrand.

Anonymous TAC National Leader. Interview held on November 21, 2005 in Braamfontein, Johannesburg.

Jonathan Berger. Head of the Law and Treatment Access Unit, AIDS Law Project. Interview held on November 24, 2005 in the Johannesburg ALP Offices.

Edwin Cameron. Supreme Court of Appeal Justice and long-term TAC supporter and activist. Interview held on December 9, 2005 in Brixton, Johannesburg.

Fatima Hassan. Advocate for the AIDS Law Project. Interview held on November 14, 2005 in ALP offices in Cape Town.

Mark Heywood. Head of AIDS Law Project, and National Treasurer of Treatment Action Campaign. Interview held on November 24, 2005, in Johannesburg ALP Offices.

Xolani Kunene. Gauteng Provincial Organizer. Interview held on December 12, 2005 in Johannesburg.

Isaac Skhosana. Gauteng Provincial Executive Chairperson. Interview held on November 9, 2005 in TAC Johannesburg offices.

-------. Interview held on May 18, 2006 in TAC Johannesburg offices.

Dr. Rath Foundation:

Anthony Brink. Interview held on May 20, 2005 in the Rath Foundation Offices in Cape Town.

-------. Interview held on November 16, 2005 in the Rath Foundation Offices in Cape Town.

Rath Foundation Spokesperson. Interview held on May 20, 2005 in the Rath Foundation Offices in Cape Town.

-------. Interview held on November 16, 2005 in the Rath Foundation Offices in Cape Town.

HIV-positive community members:

Alexandra:

"Ellen." Female Traditional Healer. Interview held on April 22, 2005 in Alexandra, Johannesburg.

-------. Interview held on August 8, 2005 in Alexandra, Johannesburg.

-------. Interview held on September 29, 2005 in Alexandra, Johannesburg.

Lawley:

Pheello Limapo. Interview held on August 18, 2005 in Lawley 2, Johannesburg.

-------. Interview held on September 22, 2005 in Lawley 2, Johannesburg.

-------. Interview held on October 5, 2005 in Lawley 2, Johannesburg.

-------. Interview held on November 9, 2005 in Braamfontein, Johannesburg.

-------. Interview held on November 23, 2005 in Lawley 2, Johannesburg.

-------. Interview held on June 17, 2006 in Lawley 2, Johannesburg.

-------. Hospital visit on August 1, 2005 at the Chris Hani Baragwanath Hospital in Soweto.

-------. Hospital visit on August 3, 2005 at the Chris Hani Baragwanath Hospital in Soweto.

-------. Hospital visit on August 6, 2005 at the Chris Hani Baragwanath Hospital in Soweto.

-------. Hospital visit on August 11, 2005 at the Chris Hani Baragwanath Hospital in Soweto.

-------. Hospital visit on August 12, 2005 at the Chris Hani Baragwanath Hospital in Soweto.

-------. Hospital visit on August 25, 2005 at the Chris Hani Baragwanath Hospital in Soweto.

-------. Hospital visit on September 8, 2005 at the Chris Hani Baragwanath Hospital in Soweto.

-------. Hospital visit on September 19, 2005 at the Chris Hani Baragwanath Hospital in Soweto.

-------. Hospital visit on September 22, 2005 at the Chris Hani Baragwanath Hospital in Soweto.

-------. Hospital visit on June 9, 2006 at the Helen Joseph Hospital in Westdene, Johannesburg.

"Mary." Interview held on October 26, 2005 in Lawley 2, Johannesburg.

"Ntombi." Interview held on October 26, 2005 in Lawley 2, Johannesburg.

"Sarah." Interview held on October 26, 2005 in Lawley 2, Johannesburg.

Sol Plaatje:

Anonymous HIV-positive community member. Interview held on September 30, 2005 in Sol Plaatje.

Anonymous HIV-positive community member. Interview held on October 14, 2005 in Sol Plaatje.

Thulani Skhosana. Interview held on September 2, 2005 in Sol Plaatje, Johannesburg.

-------. Interview held on September 30, 2005 in Sol Plaatje, Johannesburg.

-------. Interview held on May 20, 2006 in Orlando East, Soweto.

-------. Interview held on June 5, 2006 in downtown Johannesburg.

-------. Interview held on June 11, 2006 in Sol Plaatje, Johannesburg.

-------. Hospital visit on September 16, 2005 at the Roodepoort Clinic, Johannesburg.

Thulani Skhosana. Speech given at a community meeting in Sol Plaatje/DRD on June 10, 2006.

Soweto:

Anonymous HIV-positive community member, Zola. Interview held on September 12, 2005 in Zola, Soweto.

Anonymous HIV-positive community member, Phiri. Interview held on May 26, 2006 in Phiri, Soweto.

US:

Interview with HIV-positive US activist. February 2001. This interview was part of a research project conducted in 2001-2002 in the MidWest. (University of Michigan Institutional Review Board #6099 and #6584).

Other:

Female Community activist. Interview held in February 2003 in White City, Soweto.

Male Community activist. Interview held on April 6, 2005 in Newtown, Johannesburg.

Khayelitsha residents. Interview held on Saturday, November 12, 2005 in Mandela Park, Cape Town.

-------. Interview held on Friday, November 18, 2005 in Mandela Park, Cape Town.

Torong Ramela. Interview held on April 6, 2005 in Newtown, Johannesburg.

-------. Interview held on June 10, 2005 in Parktown, Johannesburg.

-------. Interview held on August 13, 2005 at Avalon Cemetery, Soweto.

-------. Interview held on November 9, 2005 in Braamfontein, Johannesburg.