



## Chapter 2

# **Spiritual Insecurity and AIDS in South Africa**

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### **Introduction**

The biological assault upon African populations afflicted by the HIV epidemic, coupled with the attendant medical and educational responses, marks a moment of dramatic social and cultural change in South Africa. The demographic impact of the current levels of infection will be profound. One-fifth of the South African adult population will soon be dead. Even with treatment, AIDS patients on antiretrovirals are only expected to live an additional four years. Life expectancy at birth is plummeting; infant mortality is rising. The epidemic is fracturing households and communities, placing ever-increasing strain on support networks.

The ways in which people make sense of this suffering and find meaning in the misfortunes afflicting them will not only affect the ways in which people cope, or fail to cope, with illness and death, but will also impact upon the rates at which future generations become infected. Any effort to alter the course of the epidemic that fails to understand its cultural dynamics, particularly at this moment in the history of the epidemic when treatment is emerging as a possibility for those afflicted in poor countries, will either fail or have unintended consequences that may make matters even worse.

In my book *Witchcraft, Violence, and Democracy in South Africa* (Chicago 2005), I anatomise the sources of spiritual insecurity in everyday life – the sense of danger, doubt and fear arising from an awareness of exposure to invisible forces acting to cause misfortune – originating in four sets of power relations: amongst persons in social



contexts conditioned by a presumption of others' access to invisible forces; between persons and substances, images, and objects deemed to possess powers to heal and/or harm; between persons and invisible beings such as deities, spirits, and ancestors; and within the realms of personhood such as those described as 'body,' 'mind,' 'spirit,' and 'soul'. In that work, drawing from fieldwork in Soweto, I seek to identify the questions emerging in everyday life pertaining to spiritual insecurity, the resources people draw on in seeking answers and the uncertainties that arise in the process. Here I want to identify some patterns of emergent questions pertaining to the epidemic in its current phase.

These questions can be categorised as questions of agency, danger and vulnerability. Questions of agency include the problem of interpreting the nature of the agency of the HIV virus, along with the various other agencies involved in accounts of immunity and therapy, and assessing how those agencies relate to the myriad other invisible agencies responsible for well-being and misfortune in life (such as God, the ancestors, spirits and witchcraft). Questions of danger include reckonings of the power of the new invisible agencies in relation to other forces as well as the new dangers posed by the disease and the death it is bringing which cannot be accounted for by discourses of tradition or modernity. Emergent questions of vulnerability are those reflecting upon the sense of exposure to harm being produced in the new circumstances and how persons can secure themselves against it.

### **'Body Soldiers', Snakes and the Concept of the 'Antiretroviral'**

A central issue in the roll-out of anti-retroviral therapy (ART) involves how to translate the concepts of the virus, the immune system, and antiretroviral drugs to people with only limited education and limited exposure to biomedical theories of disease. Central to this problem is the question of agency: How does the agency inherent in this thing we are calling a 'virus' relate to other forms of agency long known to cause harm and misfortune? Furthermore, how do the powers and agencies called upon in the quest for security in everyday life relate to the agency of the virus and the powers of the substances and procedures designed to resist it?

In discussions with voluntary counselling and testing (VCT) counsellors employed in the Africa Centre's HIV surveillance project (which has established 18 counselling centres throughout the republic of South Africa where persons who have been tested during the HIV surveillance can obtain confidential results using private-public key encryption on hand-held computers), two everyday metaphors have been found to dominate understandings of the disease. The first invokes the metaphor of dirt and describes the infection as a form of pollution: 'dirty blood'. Many illnesses and everyday maladies in this part of the world are understood as the results of pollution, and the procedures of cleansing – particularly using purgatives and emetics – are staples of non-medical healers of all varieties. Some of these forms of pollution derive from breach of moral codes of 'taboos'; others are the result of more mundane encounters with filth (Ashforth 2005). HIV, then, can be presented as another form of dirt in the blood, and antiretrovirals serve as a cleaning agent.

The second metaphor frames the infection in terms of warfare. In this account, the body is being attacked by destructive forces which kill its 'soldiers' – *amasojha omzimba* in Zulu. VCT counsellors in the Hlabisa District with whom I have discussed this issue are adamant that the concept of 'body soldiers' is an ancient Zulu notion. It cannot be found, however, in the work of ethnographers of Zulu medicine such as Arthur Bryant (Bryant 1970; Conco 1972; Ngunbane 1977). It is, most likely, a Zulu translation of the concept of immunity. '*Amasojha*' is, after all, a phonetic rendition in Zulu of the English word 'soldiers'.

In the ART clinic at Hlabisa Hospital where the roll-out of drugs is beginning, VCT counsellors use a video entitled 'Adherence to Anti-Retroviral (ARV) Therapy: A Life Choice' in preparing patients for admission to their ART program. The video was written and produced by a Yale medical school student, Ilene Yi-Zhen Wong, for a doctoral dissertation project and is now being distributed by the Department of Health, dubbed into local languages from its original English version, as a standard teaching aid for ARV clinics around the country. The script explains immunity, HIV and ARVs:

As you may know, your body's immune system – or *amaso tsha amzimba* [sic] is an army of soldier cells that guard your body from sicknesses like HIV. But HIV is a particularly bad sickness because it not only fights your body, it fights CD4 soldier cells. HIV is like a poisonous snake, sneaking



up to the CD4 soldiers while they are sleeping and killing them. These snakes are small and wily, hiding, so the soldiers cannot find them to fight them. The snakes also breed very quickly, multiplying and multiplying until they overwhelm the CD4 soldiers and the body becomes very sick.

This is where ARVs come in. ARVs can prevent the multiplication of the HIV virus. It is as if the body's soldiers could find the HIV snake nests, and pour poison on the snake eggs to keep the eggs from hatching.

However, ARVs are a kind poison that only works for a limited amount of time. They must be taken every day, in the morning and evening, or else the HIV virus can start reproducing. (Wong 2004: 59)

In her thesis describing the video project, Wong hypothesised that a 'culturally-sensitive audio-visual patient education program may be of significant use in increasing patient understanding of concepts of resistance and medication-taking skills, particularly in areas of low literacy' (2004: 2). Her project demonstrated that ART patients were better able to answer questions about adherence to therapy after viewing the video, though she was unable to address its impact on adherence over the long term. Use of the video in the rural KwaZulu context of Hlabisa Hospital has also shown it to be useful in communicating notions of infection and adherence. It is too early to know whether it is effective in fostering long-term adherence to therapy.

Wong reports that patients watching the video were particularly responsive to the dramatisation, using tame snakes rented from a Johannesburg company called ReptiPet (2004: 19), of attacks by snakes on body soldiers:

The wisdom of using a snake-soldier metaphor to describe the replication of the HIV virus was illuminated when one of the pharmacist viewers noted, 'It was very smart of you to use the snakes; Africans do not like snakes'. Indeed, the cultural significance of snakes clearly made a visceral impact on many of the patient viewers, grabbing their interest and giving the abstract concept of an unseen virus a concrete manifestation that could be 'fought against' by the 'soldiers of the body' (immune system). (Wong 2004: 40)

Hlabisa patients were also moved by these images. Wong does not discuss the origin of the snake-egg metaphor other than to report that her script 'was produced by the study author in conjunction with an experienced scriptwriter' and submitted for review to a focus group consisting of VCT counsellors who 'were specifically asked to

comment on the appropriateness of the snake-egg metaphor' (2004: 18). These same counsellors were also asked 'what kind of animals were considered to be particularly frightening in their culture' and 'mentioned snakes as a potentially strong metaphor for Africans' (2004: 26). The counsellors also told her that 'they frequently depict the HIV virus as a kind of monster' in their counselling work.

The use of snakes in a therapy adherence education video may well prove effective. The snake most certainly is a significant symbol in this part of the world. But there is more to its cultural significance than Wong seems to have been aware of, for there are different types of snakes and different cultural traditions pertaining to them in this part of the world. For example, according to Axel-Ivar Berglund in his account of Zulu 'thought patterns and symbolism', pythons 'symbolize togetherness, undivided oneness' and their skins are used in creating the *inkhatha yesizwe*, the central symbol of Zulu national unity (Berglund 1976: 61). Berglund, following the work of A. T. Bryant, spent a great deal of time discussing the symbolism of snakes with Zulu informants in the 1960s who insisted that a wide variety of snakes could be the manifestation of ancestral spirits, or 'shades,' charged with protecting the welfare of their descendants. These shade snakes are also associated symbolically with childbirth and the transfer of the spirit or shades to newborns. In the words of one informant, a diviner:

The child grows for nine months (lit. moons). It is born in the tenth. The shades drive it out from the womb. It glides out, leaving behind its skin (placenta). All this is like the snake that leaves its skin. It (the snake) is like the child when it comes out of the womb. The snake discards the skin as the child discards the placenta. (Berglund 1976: 96)

This same diviner also explained how he used the skin of a snake in treating difficulties relating to childbirth (1976: 97). Snakes are also, according to Edward Green, taken by many in southern Africa to symbolise the source of bodily power and purity (Green 1996). Snakes, particularly pythons, are often associated with the experience of the call to become a diviner, and many healers report spending time beneath water in a river or a lake communing with a snake. Zulu diviners use the vertebrae of dangerous snakes caught during their initiation to demonstrate their courage and the power of the ancestral spirits to protect them (Berglund 1976: 156).

Different peoples have different traditions relating to snakes. Nowhere is this better described than in A. C. Jordan's classic Xhosa-language novel, *The Wrath of the Ancestors*, where a young Mpondomise royal marries a girl from another nation whom he meets at Fort Hare University. When the young bride notices a snake near her newborn baby, she panics and kills it, much to the horror of her husband's people who attribute the snake to a manifestation of the ancestors and subsequently lay the blame for great misfortunes befalling the nation upon the heedless bride (Jordan 1980). In addition to real snakes being interpreted as representations of ancestral spirits, a variety of what might be called mythical snakes populate the south of Africa. Amongst these the best known are the snakes Mamlambo – a voracious creature with whom a person enters a sort of devil's compact by sacrificing blood kin in return for power and wealth (see Hunter 1961: 287); and iNkosi ya Manzi, a giant snake that lives in water and wreaks destruction in the form of tornadoes (see Ashforth 1998).

Perhaps the strongest image associated with snakes in southern Africa, however, is that of witchcraft. In witchcraft, the snake serves in two distinct guises: as an emissary of 'familiar', dispatched by a witch in order to cause harm and misfortune, and as a creature manufactured by a witch and dispatched in *muthi* which, when eaten with food (either in a real meal or food taken in a dream), consumes the victim from within. This form of witchcraft is known, in Zulu, as *idliso*. *Idliso* and the ailments associated with it are usually translated into English as 'poison' and 'poisoning', but the understandings of the power of substances to cause harm that are typically engaged in notions of *idliso/sejeso* and the substances that serve as the medium of engagement between the witch and his or her victim (called *muthi*) are much broader than the concepts of 'poison' that inform biomedical notions of infection or basic principles of toxicology. The witch deploying *muthi* in the manner of *idliso* manufactures a creature that manifests itself in the body of the victim in a form resembling a snake, lizard or crab which devours the victim from within, causing all manner of misfortune to befall the person in the process.<sup>1</sup> When referring to poison in English, however, Africans with a vivid sense of the powers of *muthi* invoke a much wider field of action and intention in relation to the agency of substances than that typically imagined by toxicology (Ashforth 2005). A video embracing both the

image of the snake and the idiom of poisoning is entering a cultural zone where interpretations of meaning cannot easily be predicted.

Since the beginning of 2000, whenever the bi-annual census of the Africa Centre for Health and Population Studies in Somkhele (near Hlabisa) KwaZulu-Natal (ACDIS) identifies a death in the study population, a nurse practitioner trained in conducting verbal autopsies interviews a household member knowledgeable about the circumstances of the death, preferably a caregiver. The interview is in the form of an algorithm of symptoms designed to facilitate a biomedical diagnosis of the causes of death in an area where death certificates are either non-existent or unreliable. Completed interviews are independently examined by two physicians who arrive at a diagnosis of probable causes of death. Verbal autopsy records, protected by anonymity, are entered into the ACDIS database and linked to demographic, health and socioeconomic records. In the course of the interview, the informants are also asked for their opinions regarding the cause of death and these 'layman's diagnoses' are recorded by the nurses, usually in a mixture of English and the Zulu vernacular, mixing indigenous and biomedical terms. These narrative accounts are then entered into the database. They suggest important avenues of research into local understandings of illness and death, particularly in the discrepancies between biomedical categories of explanation and local discourses stressing supernatural factors.

My examination of verbal autopsy records of 2,744 deaths during 2000 and 2001 in the ACDIS found that while more than half of all deaths were AIDS-related, only one in every fifty informants interviewed in the case of an AIDS death mentioned either HIV or AIDS in relation to the illness and death. One in four of the deaths identified by physicians as AIDS-related are identified by informants as being caused by *ubuthakathi*, or 'witchcraft', a concept incorporating both the inherent capacities of human persons to cause supernatural harm and their use of substances in sorcery to do so). This is a surprising result, not so much for the extent of the belief in witchcraft – a wealth of anthropological literature over the past two decades (Moore and Sanders 2001), suggests this is an under-representation of the actual prevalence of witchcraft beliefs – but rather for the fact that people are prepared to speak openly to a stranger about matters that are highly sensitive in family and community relations (Ashforth 2005). For when an illness or death is said to be caused by witch-

craft, it is interpreted by kin and others connected with the deceased as having been deliberately inflicted by others within the victim's community. That is to say, such a death is akin to murder – only the forms of violence are believed to be occult (Ashforth 2001). Perhaps the advantage for families in speaking thus is to deflect blame for the death away from the victim. The most common form of witchcraft cited in the verbal autopsy reports is *idliso*.

Symptoms of illness associated with the onset of AIDS, such as persistent coughing, diarrhoea, abdominal pains and atrophy have long been associated in this part of the world with the malicious assaults of witches known in Zulu as *idliso* and in Sotho as *sejeso*, both deriving from the root verb 'to eat' (*ukudlisa*, Zulu; *ho ja*, Sotho). Other ways of using *muthi* are also said to kill in a manner similar to AIDS. AIDS awareness accounts of HIV as an invisible agency inhering in the already potentially dangerous mess of bodily fluids that is the medium of exchange of sex resonates powerfully with local understandings of invisible agents involved in witchcraft that contaminate a victim and then begin to attack the victim by destroying the person's defences, precipitating illness, misfortune and death. The language of 'attack' and 'defence' common in virology and AIDS awareness discourses is precisely the same language used in describing the actions of poison and poisoners spoken of as witchcraft.

The soldier-snake metaphors and the idiom of medicine as poison in the ARV therapy adherence video, then, while striking the medical student Ilene Wong as 'culturally appropriate,' gloss over a host of questions of agency emerging from the context of the epidemic, questions such as: What kind of snakes are these? Who sent them? Are they merely 'natural' or do they embody some sort of supernatural power or respond to some other person or being? How do procedures devised to protect against other sorts of dangers posed by snakes relate to ARVs and their mode of poisoning snake eggs? How do the powers embodied in ARVs relate to and compare with those inherent in the *muthi* used by traditional healers or the healing substances used by faith healers?

Even for those who have not been exposed to the soldier-snake video, questions of agency remain pressing. While the metaphor of 'dirty blood' posits a passive form of agency in the polluting substance, the metaphor of warfare, with 'body soldiers' and invisible assailants of one kind or another, posits an active agency. My point



is not that the video is misguided, but rather that a widespread process of cultural change is underway in this part of the world driven by the biological forces of the epidemic, the medical imperatives of securing treatment, the particularities of local schemes of interpretation, and struggles amongst local, national and global authorities to produce definitive interpretations. The forms of a person's relations with the invisible forces he or she experiences as acting upon the course of life are not always easy to discern.

### **Stigma, Pollution and the Anomalous Category of Terminal Disease**

The advent of antiretroviral drugs has resulted in a medical redefinition of HIV infection from a terminal disease (AIDS) to a manageable chronic condition. The Treatment Action Campaign, a social movement devoted to advancing an agenda of treatment in the face of the national government's reluctance to address the epidemic, has made the slogan 'AIDS is not a death sentence' the centrepiece of its campaigns. This is quite a turnaround, for the message of AIDS awareness campaigns for more than a decade in this part of the world had been insisting on the incurability of AIDS. The notion of AIDS as terminal illness, moreover, has been propagated in an African context where the idea of an illness identified by particular symptoms being incurable was not part of the historical repertoire of healing practices. The question I want to address here is, What sort of impact might the availability of treatment and the reconfiguration of the nature of the disease have upon the stigma associated with AIDS?

The subject of stigma associated with HIV infection and AIDS has become in recent years a central focus of the World AIDS Campaign. Most of the writing and research on the subject of stigma has drawn inspiration from the now classic work of Irving Goffman (Goffman 1963). Goffman outlined a framework for studying what he termed 'spoiled identity,' the ways bearers of certain distinctive traits were assigned to discredited social categories and were then mistreated accordingly. Since the HIV/AIDS epidemic was first identified in populations of male homosexuals, an already somewhat discredited group in many societies, Goffman's concept of stigma served well in identifying key patterns in the social dynamics surrounding responses to the epidemic. The connection between the evident mis-

treatment of persons ill with AIDS and the presumption they were suffering from ‘stigma’ caused by the popular association of their suffering with membership in a social category practicing illicit sexuality became entrenched not only in the academic literature but in public health campaigns and popular consciousness. This conception of stigma also connects with well-established politics of antidiscrimination such as those pioneered by social movements for civil rights and social equality.

In June of 2001, the United Nations General Assembly in a special session on HIV/AIDS adopted a Declaration of Commitment aimed at tackling the problems of stigma and discrimination. In a document prepared as a ‘conceptual framework’ for the World AIDS Campaign’s focus year on stigma and discrimination, UNAIDS argued that ‘All over the world, the shame and stigma associated with the epidemic have silenced open discussion, both of its causes and of appropriate responses,’ causing guilt and shame amongst those infected and leading ‘politicians and policy-makers in numerous countries to deny that there is a problem, and that urgent action needs to be taken’ (Aggleton and Parker 2002: 5). Yet as the authors of this document and others have pointed out, the conventional notion of stigma deployed in much public health research fails to account adequately for the complexity of responses to illnesses associated with HIV infection and AIDS.<sup>2</sup> The UNAIDS ‘conceptual framework’ document argues that

HIV/AIDS related stigma does not arise out of the blue, nor is it something dreamed up in the minds of individuals. Instead, like the responses to diseases such as leprosy, cholera and polio in the past, it plays to deep-rooted social fears and anxieties. Understanding more about these issues, and the social norms they reinforce, is essential to adequately responding to HIV/AIDS related stigma and discrimination. Otherwise, we run the risk of developing programmes and interventions that are not comprehensive, thus achieving little impact. (Aggleton and Parker 2002: 7)

Amongst other effects of stigma, the UNAIDS report argues, are

powerful psychological consequences for how people with HIV/AIDS come to see themselves, leading, in some cases, to depression, lack of self-worth and despair. [Stigma and discrimination] also undermine prevention by making people afraid to find out whether or not they are infected, and seek treatment, for fear of the reactions of others. They cause

those at risk of infection and some of those affected to continue practising unsafe sex in the belief that behaving differently would raise suspicion about their HIV positive status. And they cause people with HIV/AIDS erroneously to be seen as some kind of 'problem', rather than part of the solution to containing and managing the epidemic. (Aggleton and Parker 2002: 5).

In my discussions of stigma with groups of VCT counsellors in South Africa, as well as in everyday conversations and media representations, the conviction has been expressed that the mistreatment of persons suffering from AIDS stems from the association between AIDS and illicit sex. This association has two puzzling aspects. The first, as I usually point out in these discussions, is that other instances of illicit sex do not evoke the same response. Virtually every family in this country, for example, has had to deal with infractions of sexual mores such as the problem of pregnant unmarried teenaged daughters, or wayward sons being confronted by the relatives of pregnant girlfriends, or a father's secret progeny appearing suddenly on the scene to demand recognition, or learning that a mother's children have several different fathers. These events are rarely welcomed, occasionally causing feelings of shame for parents and children, and are always treated with discretion. They are almost never, however, a matter of eternal and sometimes fatal stigma in the manner of AIDS. Why, I ask my interlocutors, should the stigma attaching to AIDS be any different? Why should the fear of contact with HIV/AIDS victims be so intense? After raising such questions, I inevitably elicit discussions of the fact that AIDS is not just associated with sex, but with death. Illicit sex manifested in pregnancy, we all agree, can also be – once the shame and anger passes – an occasion for rejoicing over the birth of new life. Symptoms of AIDS presage suffering, pain and death. To the question of why these symptoms, even if taken as a sign of divine punishment, should be the occasion for further mistreatment of the afflicted, however, there is no answer.

The second puzzle arising from the widespread mistreatment of persons with AIDS stems from the near universality of knowledge regarding HIV and its modes of transmission. Virtually everyone in South Africa old enough to know about sex is able to answer correctly questions about HIV transmission. Moreover, most will answer questionnaires about attitudes to AIDS with responses indicating they do not believe persons with AIDS should be discriminated against.

Yet persons with symptoms of AIDS are still shunned and avoided. Even people in contact with AIDS sufferers are sometimes avoided. Even Nelson Mandela, after spending time with a family of AIDS orphans, was subject to such treatment (Ashforth 2005: 154–56). Veena Das has suggested that in the everyday life of communities, stigma and contagion are frequently elided (Das 2005). Something similar to this phenomenon seems to be happening in South Africa. AIDS stigma seems connected with concerns and uncertainties about the dangers of pollution from contact with the dead as well as shame about sex. Similar anxieties accompany other terminal diseases, most notably cancer.

Long before AIDS became a major concern in South Africa, doctors noticed a tendency of patients to abscond from hospital when given a diagnosis of cancer (Wright 1997). African cancer patients also report anxieties about stigma similar to HIV/AIDS sufferers (Mtalane et al. 1993). Feelings of discomfort in the presence of the terminally ill are by no means restricted to Africans and AIDS. Yet the widespread and widely noted phenomenon of social avoidance of persons with AIDS and the tragic accounts of ostracism and abandonment that occur all too frequently are confounded by a multitude of cases of selfless devotion to the care and treatment of patients, particularly by family members. The ACDIS interviews revealed that in most instances the mother, grandmother, or other relative struggled to ease the pain and suffering of the dying person, often in the most dire circumstances without running water, electricity or money for food, let alone medical care.

While disapproval of illicit sexuality no doubt plays a part in the mistreatment of persons with AIDS as do psychological elements of discomfort pertaining to the unafflicted, something else seems also to be at work in the South African context. This dimension of mistreatment having to do with social avoidance of the afflicted, I would argue, is not properly described as ‘stigma’ in the conventional sense. Social avoidance, I have argued, is connected not with fears of contagion in the biomedical sense but rather with issues of pollution (Ashforth 2005). These issues, however, are not of the sort that can be adequately addressed within existing frames of interpretive authority normally available in African everyday life.

To oversimplify somewhat, though without presuming that culture is some sort of homogeneous body of shared representations and be-

liefs, let me suggest three fundamental predicates of local notions of illness and death. The first is that illness is a struggle between forces responsible for health and well-being (including those possessed by spiritual agencies and substances and those inherent in persons) and evil forces bent on causing suffering, misfortune and death. This struggle is inherently moral, a clash between good and evil forces external to the person and a struggle for righteousness in the person and his or her relevant healing community. A huge variety of particular interpretations can be brought to bear upon this struggle, and people struggling with illness are constantly forced to choose between various means of making sense of and coping with their troubles. In the forms of both 'traditional' and Christian 'faith' healing popular in southern Africa, healing is quintessentially a power struggle involving the client, his or her family, the healer, forces inherent in material substances known to the healer, ancestors, sundry other spirits, and, of course, God. All of these powers are involved in a contest against the forces – human, material and spiritual – bent on causing harm. Typically, when a person dies he or she will be spoken of as having been called to join their ancestors and God – though in moments of grief their loved ones may wonder whether they have not rather been abandoned by those powers. Within such political and moralised conceptions of illness and healing, the notion of an incurable or terminal disease presents categorical difficulties. For to name an illness as 'incurable' in advance of the struggle to restore health and wholeness is to implicitly deny the power of healers, medicines, ancestors, spirits and, ultimately, God to preserve life. No one I have ever met in Africa will readily deny these powers – particularly not in relation to someone loved and cared about.

The second predicate of most discourse pertaining to illness and death in this part of Africa is that death is a process, indeed a social process engaging the forces of persons in the community of the living as well as the dead, rather than a merely discrete event. It is akin to that of birth, in which a person rather than passing into nothingness becomes another kind of being. Again, a wide range of interpretations are available to people grappling with questions about the nature and status of those who have 'passed away' – to say someone is 'dead' is almost taboo – provided by huge numbers of religious entrepreneurs as well as established churches. Ancestors, for example, are revered by some as protectors of a family's welfare while being



denounced by others, often in the same family, as manifestations of evil spirits.

To name a disease as incurable is tantamount to saying a person is already dead and thus to raise questions about the dangers of pollution that person may present to others with whom they come into contact – questions which neither ‘tradition’ nor ‘science’ is currently able to answer. A person accustomed to local rituals and practices relating to death coming into contact with an AIDS victim may understand well that they have a minimal risk of catching HIV from that person, since they know HIV is a virus transmitted through sex, yet still fear the presence of this person for the same reasons they might fear the presence of the already dead. Since they know that people named as carrying AIDS will soon be dead, they might worry about whether contact with them risks exposure to those unknown and indefinable forms of pollution that may, perhaps, bring misfortune in a manner similar to that of the well-known pollution emanating from the already dead.

The point here is not that there are ‘African traditions’ that teach the culture of AIDS. On the contrary. In the absence of authoritative traditions and respected authorities prepared to address the sources of their fears, people are forced to figure out the new dangers for themselves. Clearly one of the things they have figured out is that being in contact with people dying of AIDS is a dangerous matter, despite the repeated insistence of medical authorities, AIDS activists and the occasional political leader (such as Nelson Mandela) to the contrary.

The third predicate is that death is a moment of great danger – both to the person undergoing the transition from the living body to the spiritual entity and those in contact with the body of the deceased. Dead bodies have customarily been treated with great care, respect and reverence in Africa. This regard for the dead body is not only due to respect for the memory of the departed or the desire to pay tribute to human dignity. Nor is it simply a necessary precaution to ensure the departed’s transition from the bodily presence of a living person to the spectral presence of an ancestor, a process which exposes the person departing to vulnerabilities not unlike those facing a new baby in the process of being born. It emerges also from a sense that the presence of death can be dangerous and polluting, bringing upon the unwary all manner of misfortunes.

When people attend burials, for example, they are careful to undergo a brief cleansing procedure, washing their hands in a basin of water with a couple of aloe leaves in it when returning from the cemetery. Tradition also demands that families of the deceased undergo cleansing rituals at intervals after the interment. These days, most people – especially younger people – have difficulty articulating quite what these procedures are meant to achieve other than a general necessity of cleansing in order to avoid ‘bad luck’ or ‘bad things’ such as illness or misfortune. Nonetheless, few would willingly ignore them. Nor do they treat these procedures as merely symbolic in the sense of being without material effect. Dead bodies are widely considered dangerous entities, and the cemeteries where they congregate are dangerous places from which emanate mysterious forces that can result in real physical misfortunes. Failure to cleanse oneself of invisible pollutants after attending a funeral or visiting the home of a recently deceased person opens one to the risk of illness and misfortune. One young man I know in KwaZulu insists that the government should be distributing latex gloves as well as condoms to protect people from the epidemic. Were a family not to provide a basin of water and aloe after a funeral in Soweto, their lapse would not only be considered a scandalous breach of ritual procedure, but also a criminal assault on public safety.

A central contention in discussions of the imperative of providing drug treatments to AIDS patients in poor countries is that treatment will result in a reduction of levels of stigma (see Arachu and Farmer 2005). What is not clear in the literature, however, is how and why treatment might have this effect. In relation to what might be termed the sociological dimensions of stigma, the dynamics of discrimination and mistreatment of individuals and groups because of their spoiled identity, it is hard to see how treatment availability would alter the equation. Indeed, contrary to the assertions of activists like Paul Farmer, those who argue that stigma in this sense of the term is itself an obstacle to effective treatment may turn out to be correct (Valdiserri 2002). In relation to the cultural dimensions of stigma I have described above pertaining to fears of pollution emanating from the person of the ‘already dead,’ however, the availability – perhaps even the mere perception of availability – of treatments may have a dramatic effect by redefining the nature of AIDS as a death sentence and, hence, a potential source of pollution. Whether

it further invigorates the domain of struggle between evil forces and those promoting the good remains to be seen.

## **Conclusion: Spiritual Insecurity and HIV/AIDS**

The cases discussed above illustrate the complexities of the cultural dynamics emerging in the wake of the HIV/AIDS epidemic. That these matters are in constant flux is important to remember. A wide variety of authorities are preaching, many of them quite literally, to people about the correct way of interpreting the nature of the forces evidently acting upon their lives and resulting in so much death. The AIDS awareness industry is a massive multi-million Rand operation. The national roll-out of antiretrovirals, though not as successful yet as many would like, has created the largest public-health AIDS treatment program in the world. Yet, in 2005 an estimated 571,000 persons were newly infected with the virus (Rehle et al. 2007: 197).

I have tried to show in the above examples how questions about the dangers posed by invisible forces are emerging in the context of this epidemic for which answers are provided by a multitude of conflicting authorities. These questions impinge upon the central enigmas of the social response to the epidemic: the problem of 'denial,' the resistance to behaviour change, the problem of 'stigma,' and the challenges of treatment arising from the transformation of a 'death sentence' to a 'manageable chronic condition.' Yet, just as few people subject to the epidemic can find reliable answers to these emergent questions that can withstand assault from all contradictory authorities, so social scientists should be wary of simple descriptions that purport to account for local responses to the epidemic.

The cultural context within which the biological assault upon South African populations is taking place is one marked by generations of change consequent to large-scale processes such as labour migration, urbanization, industrialization, Christianization and western education that have disrupted and transformed local social structures and knowledge systems (Ashforth 2005). Associated ritual practices have also been transformed, often in ways that exacerbate a general sense of exposure to evil and invisible forces. Everyday life is lived amidst multiple clashes of worldviews taking place within families, communities and the country as a whole. Varieties of non-



medical healing, premised upon access to invisible spiritual powers, abound.

By showing how the apparently simple matter of explaining the action of antiretroviral drugs can open a snake's nest of tricky questions, or how the apparently obvious issue of stigma can become a philosophical puzzle beyond the purview of either 'traditional' or 'modern' authorities, I hope to encourage more sustained inquiry by anthropologists and public health experts alike into the emergent questions surrounding HIV/AIDS in Africa. For only by investigating these in particular local contexts, and over time, can the unintended consequences of well-intentioned efforts at treatment and prevention be mitigated.

## Notes

1. For a description of *idliso* in relation to biomedical interpretations of symptoms, see Conco (1972); for a psychological study of suffering from what was considered to be *idliso*, see Farrand (1988); and for accounts of traditional healers and AIC prophets comparing *idliso* with tuberculosis, see Wilkinson et al. (1999) and Oosthuizen (1992: 100), respectively.
2. For a critique of the theoretical underpinnings of public health discourse on stigma, see Arachu and Farmer (2005).

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