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WILL ANTIRETROVIRALS CURE AIDS STIGMA IN SOUTH AFRICA?

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The biological assault upon southern African populations unleashed by the HIV epidemic, coupled with the attendant medical and educational responses mobilized by individuals, institutions and organizations – at all levels, from local to global – marks a moment of social and cultural change in this part of the world that is unprecedented in scale, speed, and intensity. The current phase of the HIV/AIDS epidemic in South Africa is marked by a high HIV prevalence rate that appears to be stabilizing with no sign of decline, [1] a steady increase in the burden of illness and death, [2] an almost universal spread of knowledge, [3] albeit superficial, about HIV and AIDS, and a growing awareness, coupled with limited availability, of anti-retroviral drug therapies (Department of Health 2004). It is also marked by continued high levels of what are commonly described as 'denial' and 'stigma' with little evidence of widespread change in sexual behavior in line with the ABC doctrines of the AIDS-awareness industry. [4] This paper is a preliminary exploration of some cultural aspects of the epidemic relating to issues of 'stigma' drawn from fieldwork in Soweto and northern KwaZulu-Natal, South Africa where, in collaboration with researchers from the University of KwaZulu-Natal, I am developing an ethnographic research project at the Africa Centre for Health and Population Studies. [5]

The demographic impact of the current levels of infection will be profound. In the Africa Centre's surveillance area, HIV prevalence is approximately 40% of adults. Life expectancy at birth is currently 47.4 years for women and 42.0 years for men, reduced by 14 years because

of AIDS (AC Policy Briefing 2). Under-5 mortality, at 106 per thousand live births, is 62% higher than it would have been without AIDS (AC Policy Briefing 5). The epidemic is fracturing households and communities, steadily increasing strain on support networks – particularly on the elderly whose pensions currently account for half of all household expenditure (AC Policy Briefing 7). Half of all deaths are AIDS related. One quarter of the population in this region will soon die. The severity of the epidemic varies across the country, but nowhere is the impact of HIV and AIDS anything less than dire.

The ways in which people make sense of this suffering, find meaning in the misfortunes afflicting them, and fashion their own strategies for securing themselves against dangers will not only affect the ways in which the society copes, or fails to cope, with the misery, illness, and death wrought by this virus, but will also impact upon the rates at which future generations become infected and die. Efforts by outsiders to alter the course of the epidemic that fail to understand these cultural dynamics, no matter how well-intentioned they may be in the face of this obvious calamity, will either fail or have unintended consequences that may make matters even worse.

Two ideas, radically new to this part of the world, have been propagated by the AIDS-awareness industry. The first is that bodily afflictions, long known in these parts, taking the form of diarrhoea, persistent coughing, wasting, swollen ankles, rashes, and sores – to name only the most common symptoms of what the doctors call 'AIDS' – are actually symptoms of a sexually transmitted disease. Nothing in the experience of these ailments, or in existing local practices of treating them, suggested sex as a cause – at least in its ordinary everyday physicality, which has long been known to result in a variety of rashes, inflammations, sores, and discharges of the genitals. The second is that a person experiencing a combination of the above symptoms is the bearer of a single incurable, terminal, disease – nevermind that it is defined biomedically as a 'syndrome' – with a name: AIDS. This notion of AIDS as terminal illness has been propagated in a context where the idea that an illness, identified by a particular set of symptoms, could be described as 'incurable' prior to the start of healing was not part of the historical repertoire of healing practices. As the death toll rises in the face of the best efforts of all healers, however, this anomalous category of 'terminal illness' has become undeniably plausible despite the offence that it causes to some of the most cherished notions people have about the powers of the invisible beings they deem ultimately responsible for their health and wellbeing.

In 2004, after sustained national and international campaigns highlighting the immorality of inequities in access to treatment, an extraordinary global consensus emerged regarding the imperative of providing antiretroviral therapy to AIDS patients in poor countries. The

World Health Organization and UNAIDS launched the '3by5' campaign, promising to provide drug treatment for three million persons in developing countries by the end of 2005 (Anti-discrimination Task Team 2005). The United States *President's Emergency Plan for AIDS Relief* proposed funding for treatment of 2 million persons by 2008 (United States Global AIDS Coordinator 2004). The Global Fund to fight AIDS, TB, and Malaria proposed plans for placing 700,000 patients on ART within five years (The Global Fund 2004). Even in South Africa, where the government led by President Thabo Mbeki had been reluctant to countenance the provision of antiretrovirals, an *Operational Plan for Comprehensive HIV and AIDS Care, Management, and Treatment* was published by the Department of Health announcing the ambition of providing drug treatments for 1,470,510 AIDS patients by 2008 (Tshabalala-Msimang 2003).

Rollout of antiretroviral therapy to date has been slow. It is, however, happening. 'By the end of September, 2004,' the Department of Health reported in its first monitoring review of the rollout, 'over 11,253 patients including children were put on treatment' (Department of Health 2004 2). In the coming years, tens of thousands of patients will be on antiretroviral therapy in South Africa. The *perception* that medical treatment is available, however, will reach many more people. This cultural effect will be as important as the purely medical in determining the impact of ART on the epidemic in this part of the world. The advent of antiretroviral drugs has resulted in a medical redefinition of HIV infection from a 'terminal disease' to a 'manageable chronic condition.' The Treatment Action Campaign in South Africa, 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 centerpiece of their campaigns. This is quite a turnaround, for the message of AIDS-awareness campaigns over more than a decade in this part of the world has been that AIDS equals death.

The rollout of antiretroviral drug therapies to treat the HIV epidemic is one of the biggest medical experiments in history. I call it an experiment because no-one knows how to provide these treatments in poor countries on large scales, and no-one can predict the outcome. Advocates of expanding antiretroviral therapies in poor countries – when they are not simply pointing out the immorality of the fact that persons infected in rich countries can continue to live relatively healthy lives while those in poor countries are condemned to a slow painful death or insisting on the medical moral imperative of saving lives – typically assert that provision of antiretrovirals will have a positive effect in preventing infections and will reduce the stigma and discrimination that so often accompanies the onset of AIDS (Stein 2003a). The question I want to address here is: What sort of impact might the availability of treatment and the consequent reconfiguration of the nature of the disease have upon the stigma associated with AIDS? Or, to put it another way: Will antiretrovirals cure AIDS stigma in South Africa?

In order to begin to answer this question, and we can only think about beginnings since treatment efforts are in their infancy, we need to do two things: First, we need to do some conceptual work on the notion of stigma, disaggregating the phenomena generally covered by the term and opening the way for closer analysis of the mechanisms by which treatment might potentially impact upon the phenomena in question. Second, since there can be no purely theoretical answer to such questions, we need to figure out how to investigate these potential effects in particular contexts.

Most of the writing and research on the subject of stigma has drawn inspiration from the now classic work of Irving Goffman, *Stigma: Notes on the Management of Spoiled Identity* (Goffman 1963). Goffman outlined a framework for studying what he termed 'spoiled identity,' the ways bearers of certain distinctive traits were identified as belonging to discredited social categories and mistreated accordingly. 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 in the early years of the epidemic served well in identifying key patterns in the social dynamics surrounding responses to the epidemic. The connection between the evident mistreatment of persons ill with AIDS and the presumption they were suffering from a 'stigma' caused by the popular association of their suffering with membership of a social category practicing illicit sexuality became entrenched not only in the academic literature but in public health campaigns and popular consciousness (Herek and Capitanio 1999). And there was no shortage of public figures willing to castigate AIDS patients as victims of their own immorality. This conception of stigma also connects with well-established politics of anti-discrimination such as those pioneered by social movements for civil rights and social equality (UNAIDS 2003).

In recent years, the stigma and discrimination suffered by persons afflicted with AIDS has become a central focus of the World AIDS Campaign. 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 adequately account for the complexity of responses to illnesses associated with HIV

infection and AIDS. [6]

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).

These psychological dimensions of stigma, then, consist both of attitudes in the minds of the HIV-infected as well as 'deep-rooted social fears and anxieties.' What a 'social fear' might be, however, is by no means clear.

When talking of stigma, we should always remember that the widespread and widely noted phenomenon of social avoidance of persons with AIDS as well as the tragic accounts of ostracism and abandonment that are all too frequent, are confounded by a multitude of cases of selfless devotion to the care and treatment of patients, particularly by family members. Tens of thousands of caregivers around the country are looking after AIDS patients in hospitals, clinics, and homes, often in circumstances of the direst poverty, with selfless devotion and love. In the verbal autopsy reports of the ACDIS, which are based on interviews, where possible, with the primary 'caregiver' of the person who died, in most instances the mother, grandmother, or other female relative struggles 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. Chimwaza and

Watkins have described similar concern in Malawi (Chimwaza and Watkins 2004).

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. There are two puzzling aspects of this association. 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 norms of sexual virtue propounded by the ubiquitous representatives of Christianity in these parts such as the problem of pregnant unmarried teenaged daughters, or wayward sons being confronted by the relatives of pregnant girlfriends, or father's secret progeny appearing suddenly on the scene to demand recognition, or learning that mother's children have several different fathers. These events are rarely welcomed, often occasion feelings of shame for parents and children, are always treated with discretion, but are rarely a matter of eternal and sometimes fatal mistreatment in the manner often suffered by persons with AIDS. [7] Why, I ask my interlocutors, should the 'stigma' attaching to AIDS be any different? Why should the fear of contact with persons infected with HIV or suffering from AIDS 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. However, to the question of why these symptoms, even if taken as a sign of divine punishment, as they sometimes are, should be the occasion for further mistreatment of the afflicted, there is no answer.

The second puzzle arising from the widespread mistreatment of persons with AIDS in South Africa, and it is by no means restricted only to that country, 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 correctly answer questions about HIV transmission (Pettifor, Rees, Steffenson, Hlongwa-Madikizela, McPhail, and Kleinschmidt 2004). Moreover, most will answer questionnaires about attitudes to AIDS with responses indicating they do not believe persons with AIDS should be discriminated against. [8] Yet it remains an undeniable fact that persons with symptoms of AIDS are still shunned and avoided (Stein 2003b). Persons known to be in contact with AIDS patients or others suspected of being infected with HIV are also at times avoided. Even Nelson Mandela, after spending time with a family of AIDS orphans, was subject to such treatment (Ashforth 2005 154–6).

Veena Das, in a briefing paper prepared for an NIH conference to establish a research agenda on stigma and health, suggests that in the everyday life of communities, stigma and contagion are frequently

elided (Das 2005). Something similar to this 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 accompanies other terminal diseases, most notably cancer (Fife and Wright 2000). 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, Uys, and Preston-Whyte 1993). Feelings of discomfort in the presence of the terminally ill are by no means restricted to Africans and AIDS.

While disapproval of illicit sexuality no doubt plays a part in the mistreatment of persons with AIDS, along with 'psychological' elements of discomfort arising from anxieties of the unafflicted, something else seems also to be at work in the South African context. This dimension of mistreatment is not properly described as 'stigma' in the conventional sense. Since that term is so entrenched, however, we may as well stick with it. Social avoidance, I have argued elsewhere, is connected less with fears of contagion in the bio-medical sense but rather with issues of pollution (Ashforth 2005 Ch.6). 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 beliefs belonging to clearly defined social collectivities, let me suggest three fundamental predicates of local notions of illness and death that might help illuminate some of the puzzles of stigma in this part of the world. [9] The first is that illness is a struggle between forces responsible for health and well-being (including those possessed by spiritual agencies, substances, and 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 are. Persons battling illness are constantly being forced to choose between competing ways 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 persons of 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 they 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 politicized and moralized 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. This no-one I have ever met in Africa will readily do – particularly not in relation to someone they love and care about.

The second predicate of discourse pertaining to illness and death in these parts 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 single 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 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 which that person may present to others with whom they come into contact – questions which neither 'tradition' nor 'science' is currently able to answer.

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 as elsewhere. 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 their 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 funerary procedures are meant to achieve other than a general necessity of cleansing in order to avoid 'bad luck' or 'bad things,' to wit: 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, even in these days when death is usually presided over by medical authorities and burial handled by the mortuary industry, are widely considered dangerous entities and the cemeteries in which they repose are dangerous spaces 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 for this very reason. Were a family not to provide the customary basin of water laced with slices of aloe for mourners to wash hands 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 person accustomed to local rituals and practices relating to death coming into contact with a someone evidently suffering from AIDS, then, 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' teaching 'culture' about these things. 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. [10] 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.

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.

If stigma is considered primarily as the mistreatment of individuals and groups on account of their deviant identities, what might be termed the Goffmanesque sociological dimensions of stigma, it is hard to see how the availability of antiretroviral therapies would alter the extent of the social mistreatment of AIDS patients. For if AIDS, in the eyes of those who see need to shun its victims, is the sign that identifies – literally,

stigmatizes – those who are morally unworthy because of illicit sex, successful medication will not make them any less immoral. Of course, those who are successfully treated may avoid stigmatization, but only because they no longer bear the mark of the stigmatized group. But if this were all there is to the phenomenon known as stigma, when symptoms of the disease disappear the mistreatment would cease only if underlying attitudes to the putative reason for stigmatization change. In the absence of a general reevaluation of moral norms, what would be required, in a word, would be tolerance. Though it has long been embraced as a pleasurable pastime, and tolerated by those who know it is futile to hope for chastity, there are few signs that promiscuous sex is becoming a more valued norm in southern African moral schemes. Antiretroviral therapy for HIV infection is unlikely to change this. Men who have sex with men in the United States, similarly, do not seem to be more respected these days as a result of the arrival of highly active antiretroviral therapy.

If the concept of stigma is disaggregated in the ways I have suggested above into what we might, roughly, call sociological, psychological, and cultural dimensions, it is possible to see how treatments that transform AIDS from a 'death sentence' to a 'manageable chronic condition' might in fact alter the stigma equation. In relation to psychological dimensions, we might expect to see something equivalent to the changes witnessed by cancer patients in recent decades as treatments for many kinds of cancer have become more effective and the fear and anxiety aroused in both patients and their communities of support has diminished. This could be particularly important in relation to the sort of inadvertent mistreatment of patients that results from well-intentioned people being unable to meet their own fears and uncertainties in the face of impending death.

On 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. Drug therapies, by redefining the nature of AIDS as a death sentence might reduce the fear of the 'walking dead' as a potential source of pollution. As the 'Lazarus effect' of severely ill patients being restored to active living spreads, the dread associated with the symptoms of AIDS may perhaps decline. On the other hand, when symptoms do appear – whether in those who remain untreated (who will most likely remain in the majority of patients in poor countries for many years to come) or in those for whom treatment has failed (which is currently expected to occur in most South African patients after four years of therapy when the two currently approved drugs regimes lose efficacy) – the fear of dangers posed by the 'walking dead' may reappear.

We cannot conclude *a priori*, then, that the introduction of antiretroviral treatment for HIV patients will necessarily have a positive impact upon the stigmatization, or, more generally, the mistreatment, of persons living with AIDS in southern Africa. Nor can we generalize from the

positive experiences being currently reported in pilot projects such as those operated by Médecins Sans Frontières to other places or longer terms. [11]

How, then, might we reliably investigate the impact of antiretroviral therapies on stigma and mistreatment? Using survey questionnaires to measure levels of stigma will hardly help in a context where people already know the 'right' answers to questions about how to treat HIV infected people. Asking questions about fears of pollution might produce some interesting results, but even in semi-structured interviews it would be difficult to know whether the interviewer's interests were structuring the respondents' response. In the discussions I report above about the pollution/stigma connection, I usually witness a sort of 'penny drop' moment where the plausibility of my suggestion that mistreatment of persons with AIDS might be informed by fears of pollution becomes apparent to my interlocutor. I choose to interpret this as the revelation of a structure of emergent plausibility produced within the everyday context. I am aware, however, that this is pure surmise on my part. To test this surmise, I would need to participate in the everyday life of communities afflicted by HIV and AIDS over the long term, at least long enough for the rollout of antiretrovirals to run its course and, perhaps, for widespread treatment failure to begin.

By means of participant observation ethnography over the long term researchers may be able to uncover the dynamics of relations in families and communities affected by AIDS and the impact of antiretroviral therapies upon them. Even if we could assure ourselves that in the conduct of this research we had overcome the problems of bias and undue influence by the observer, we would still only have limited information about the particular people and places I had observed and could not be sure we had really uncovered the dynamics driving change in attitudes and practices.

One way around some of these problems would be to deploy teams of ethnographers throughout a population, particularly locals fluent in local languages and conversant with customs, to make observations in different places over time. Another would be to establish a process where the ethnographic insights derived from participant observation could be subjected to scrutiny, analysis, debate and review by others in the study community, perhaps by making video reports on the ethnographic research for local screening and discussion. Documenting the changes being wrought on these populations is imperative.

So, will antiretrovirals cure AIDS stigma? Maybe. Antiretroviral rollout will surely have an impact upon the ways people understand their suffering in the face of HIV and AIDS and shape their strategies for protecting against infection and affliction. Without serious and large scale ethnographic research, however, these effects will remain obscure.

And one of the largest medical experiments in world history will pass without adequate scrutiny of its impact.

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NOTES

1. 27.9% of women attending ante–natal care clinics in 2003 were estimated to be HIV infected (Makubalo et al. 2003).
2. In February of 2005, Statistics South Africa published a long–awaited and contentious report on mortality statistics which indicated that the total number of deaths between 1997 and 2003 had increased by 57% while the population growth was approximately 10%(Statistics South Africa 2005 3.1). Most of the people infected with HIV and dying of AIDS are young adults in what should be their most fertile and productive years. Adult deaths increased in the same period by 62% (Statistics South Africa 2005 3.1).
3. A national survey of young South Africans found that 94% could correctly answer questions about how to protect themselves from HIV infection (Pettifor et al. 2004).
4. An examination by the author of verbal autopsy records of 2744 deaths during 2000 and 2001 in the Africa Centre Demographic Information System (ACDIS), for example, 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. The 1st National Survey of Youth Risk Behaviours conducted by South Africa's Department of Health found that only 28.8% of sexually active 'learners' (i.e. schoolchildren) reported consistent condom usage (Department of Health 2002 55).
5. The Africa Centre for Health and Population Studies is a demographic surveillance system (DSS) covering a demographic surveillance area (DSA) of 435 square kilometers with a population in 2001 of 89,132 people. The DSA is centered on Somkhele in northern KwaZulu–Natal, near the town of Mtubatuba in the municipality of uMkhanyakude and the health sub–District of Hlabisa. Since 1999, the Africa Centre has been conducting a census of the 11,314 households in the DSA every

six months collecting a wide range of demographic, health, and socio-economic data. Beginning in 2003, the demographic surveillance has been augmented with HIV sero-prevalence surveillance involving blood testing of adults in a project planned to continue over five years. Results are available on a confidential basis through a network of 18 voluntary counselling and testing (VCT) centres located throughout the DSA and staffed by trained counsellors. The data base of the ACDIS serves demographic and socio-economic researchers as well as providing a platform for clinical studies and intervention research. These studies are supported by Wellcome Trust Grants 065377 and 067181 to the Africa Centre for Health and Population Studies.

6. For a recent critique of the theoretical underpinnings of public health discourse on stigma, see (Arachu and Farmer 2005).

7. For an historical account of attitudes to illicit sex in this part of the world, see (Delius and Glaser 2002) (Delius and Glaser 2004).

8. In the national survey of young South Africans regarding HIV and sexual behavior, 'Youth were asked whether they would remain friends with a friend they discovered was HIV positive and 86% of youth said, yes, they would. An even higher percentage of youth (96%) reported being willing to care for their family members if they became sick with HIV/AIDS' (Pettifor, Rees, Steffenson, Hlongwa-Madikizela, McPhail, and Kleinschmidt 2004 60). For a critique of efforts to measure stigma, see (Stein 2003b).

9. For a more extended discussion of these issues, with references, see my recent book *Witchcraft, Violence, and Democracy in South Africa* (Chicago, 2005), Part Two.

10. For an example of how those who claim to speak in the name of 'African tradition' are frustrated by the epidemic, see the outburst by Credo Mutwa, South Africa's premier celebrity traditional healer, bewailing the conspiracy of the West to perpetrate genocide on Africans by means of AIDS while four of his children are dying despite his ministrations reported in (Martin 2001), available on the web at <http://www.davidicke.com/icke/articles3/stopkillingus.html> .

11. For a glowing report on the consequences of the introduction of antiretrovirals in Pondoland, a rural region in the Eastern Cape Province, see <http://www.accessmed-msf.org/prod/publications.asp?sctid=2232004949435&contenttype=PARA&> .

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