'I Don't Want to Hear':
HIV, AIDS and the Power of Words in Bushbuckridge, South Africa [1]

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Since the 1990s, the globalisation paradigm, advocated by scholars such as Hannerz (1996) and Appadurai (1996) has had deep impact on anthropological theory and practice. This paradigm has been shown to be particularly appropriate to the study of AIDS, a global pandemic, characterised by various transnational flows and assembleges (Nguyen 2005). The rapid diffusion of HIV was accompanied by the distribution of resources and techniques to fight AIDS. These include finance, technologies, drugs, and medical personnel, but also more immaterial goods such as moral agendas, geographies of blame, and blueprints for prevention and intervention. Moreover, HIV/AIDS has brought about new transnational identities and forms of therapeutic citizenship, based on common plight and mutal obligations (Nguyen 2005).

Among these flows, Nguyen (2009, 2010) highlights the transplantation of 'confessional technologies' as one means of confronting the pandemic. These technologies have an exceedingly long history in Europe. Born in Catholic ritual, they were redeployed with the rise of psychotherapy in the early twentieth century (Foucault 1972). The notion of the 'talking cure' is also expressed in 'coming out' narratives that emerged among the gay communities within the United States since the 1960s. Liberation and acceptance was to be found in bringing to words one's innermost, authentic, self (Weston 1997). With the emergence of AIDS, ideologies of religious salvation, psychoanalysis, and sexual liberation merged in new confessional technologies. These include undergoing voluntary counselling and testing, 'coming out' with HIV positivity, and providing public testimony about the sickness and transformative effects of antiretroviral medication (Nguyen 2009, 2010).

In South Africa, the country with the highest rates of HIV infection worldwide [2], 'confessional technologies' are most widely deployed by the urban-based TAC (Treatment Action Campaign). Headed by the well-known activist for gay and civil rights, Zachie Achmat, the Campaign fought for the provision of affordable antireroviral drugs, confronting pharmaceutical companies and an obstinate South African government in the process (LeClerc-Madlala 2005, Robins 2004). Robins (2006) shows how TAC activisits, drawn from among those attending *Medicines Sans Frontieres* (MSF) treatment programmes, conceptualise their journey from 'near death' to 'new life'. They drew on religious, social and medical meanings to forge new identites. The activists transformed the stigma of HIV/AIDS into a 'badge of pride' that they displayed on T-shirts during township funerals, demonstrations and workshops (Robins 2006:314). Trough speech and story-telling, they strove to overcome pathos and subordination (Fassin, Le Marcis and Lethaba 2008).

This article acknowledges the value of perspectives that focus on the transnational diffusion of medical meanings, and recognises the potential liberatory effect of 'confessional technologies'. But, at the same time, the article warns against the assumption that global connections assume a linear character that progressively eradicates plurality and difference (Sahlins 1999). Globalisation not only implies

disconnections (Ferguson 1999), but also generates 'frictions' and 'zones of awkward engagement' where competing perspectives and interests combine in unpredicable, often messy, misunderstandings (Tsing 2004). With reference to ongoing, intermittent fieldwork in Impalahoek, a large village of the South African lowveld [3], I point to various forms of hidden resistance (Scott 1990) against the imported cosmopolitan practice of confessing, and I analyse silence as an alternative response to the pandemic.

Until the end of apartheid in 1994, Impalahoek formed part of the Lebowa Bantustan. But since then it has been administered by the newly constituted Bushbuckridge Municipality and Mpumalanga Province. Impalahoek currently has a population of about 24,000 Northern Sotho and Tsonga (Shangaan) speakers, whom rely largely upon the remittances of migrant labourers, employed in Gauteng and upon social welfare payment such as pensions and child maintenance grants (Niehaus 2006). The HIV/AIDS pandemic reached Bushbuckridge fairly late, but then spread very rapidly. A verbal autopsy survey on common symptoms of death shows that until 1995 the predominant causes of death in Bushbuckridge were infectious diseases and malnutrition in children, accidents and violence in adolescents and young adults, and cardiovascular disease in adults and the middle aged. But between 1995 and 2002 AIDS was the predominant cause of death in all age groups (Tollman et al 2002). Between 1995 and 2005, life expectancy in Bushbuckridge fell by 12 years for women and 14 years for men (Kahn et al. 2007). In 2008 sero-prevalence among pregnant women receiving antenatal care at Tintswalo Hospital in Bushbuckridge stood at 32% (MacPherson et al 2008:2).

Despite the severity of the pandemic, many residents of Impalahoek have refrained from undergoing voluntary counselling and testing. Those who do test for HIV antibodies tend to do so in the latter stages of infection, and even then, try their best to avoid speaking about their condition, especially in public domains. My observations confirm the findings of previous studies that show silence to be the predominant response to the AIDS pandemic in rural South Africa (Stadler 2003, McNeill 2011). But I do not merely view silence as a means of avoiding the imposition of a stigmatised identity (Campbell et al 2005, Niehaus 2007). Instead, I focus on beliefs about the intrinsic and transformative capacity of words, instead. I suggest that contrary to activists of the TAC who embrace the liberatory potential of speech, residents of Impalahoek fear the potentially dangerous impact of words, such as ponouncements that one is HIV positive. In local knowledge, such words can be deadly. They crystalise sickness, invoke negative emotions associated with pending death, and hereby worsen suffering. Therapeutic interventions imposed from cosmopolitan centres frequenty ignore these local concerns.

'If I test HIV positive I will die'

Voluntary counselling and testing – sometimes known by the abbreviation VCT – forms the basis of medical interventions in the case of AIDS. Medical propaganda assumes obvious advantages of knowing one's HIV status. Those who test 'negative' can rest assured. Those who test 'positive' can protect their sexual partners and breast-fed babies from being infected with a potentially deadly virus and can also protect themselves from re-infection. Since 2005, they can also access HAART

(Highly Active Antiretroviral Therapy), which effectively suppresses viral replication, from public health care facilities. Moreover, an HIV positive diagnosis is often a prerequisite to securing highly valued social grants [4].

And yet, many residents of Impalahoek have actively shunned away from counselling and testing. During 2004 and 2005 I asked twenty-five informants, with whom I was acquainted, whether they might undergo a test for HIV antibodies. My informants included men and women, and were mainly in their twenties and thirties. Many had lost family members during the pandemic, and some had personally cared for kin suffering from AIDS. Only two of my informants said they had tested and both claimed that the results were negative. All others were of the opinion that it was better not to know one's status. A woman teacher, who had attended several workshops on AIDS, aptly summarised their feelings:

> 'People say they will die if they know [their status]. They say prevention is better than cure and for them prevention is not knowing.'

Such resistance is by no means exceptional. Other studies confirm that many South Africans refrain from undertaking tests for HIV antibodies. In 2000 public health researchers offered 2,500 residents in the mining town of Carltonville free and anonymous tests. Not a single person accepted (Ashforth 2002:1). After a slow start, the South African Health Ministry launched successive campaigns to increase the numbers of people accessing testing (IRIN 2010), and have achieved some success. Official figures for 2009 show that 32% of men and 71% of women had tested (Government of South Africa 2010) [5]. But many barriers persist. People at higher risk of HIV infection, such as victims of gender based violence, were not more likely to get tested (Steven at al 2010, Adams et al 2011). Moreover, testing by itself does not guarantee the anticipated benefits. Vociferous AIDS awareness campaigns at the University of Limpopo led 17% of first year students to test for HIV antibodies. But only 20% actually came for their results (Oxlund 2009:225).

The statements of my informants give insight into the reasons why they were apprehensive of testing. Ace Ubisi, who had been unemployed for nearly a decade, and occasionally worked as my research assistant, claimed that knowledge of a positive status would only hasten one's death:

> '98% of people from here won't go there [to test for HIV antibodies]. Only 2% might go – maybe the educated ones and the Reborn Christians [*bazalwane*]… They trust themselves. The rest of us don't. If I test HIV positive I will die within three days. I might run away into the forest with a firearm [to commit suicide]…If I test positive I will think all the time, thinking about dying or surviving.'

Justice Kgwedi, a young man, who had recently left school, Joseph Nyathi, a motor mechanic, and Peter Manzini, who operated a small tuckshop - known as *spaza* store in this part of the world – expressed roughly similar views:

> 'I hate to be tested. I hate to know that I'm going to die. I hate people telling me that I'm HIV positive. It will be a problem because I would worry too much.

> When the disease and the worries get together, I will be mourning too much. I will be fighting two battles'
>
> 'If someone says you are HIV positive you won't enjoy your wife or your girlfriend. I will only check my body for TB [tuberculosis] and for other diseases – not for HIV. If you know you have HIV you will never feel alright. You will think.'
>
> 'I am too scared to be tested. I don't want to hear. It is alright if I die tomorrow, but it is not alright to hear I'm going to die. It will make you worry. If you are aware that you are infected you will think too much. You will become mad'

These responses are not indicative of ignorance of biomedical practice. George Bila had once worked as an AIDS educationist at the local LoveLife Youth Centre, where he taught teenagers to live a positive lifestyle in the context of the pandemic. George echoed the views of others:

> 'I have never heard of a single person going for an HIV test. We blacks, we are taught to believe that death is a terrible tragedy. If they tell you that you are positive you will think of dying. When they tell you, you automatically become a living dead. If you talk about it, it becomes worse. In this way they [possibly nurses and neighbours] put a negative stigma on you. If you know [your status] you will survive one year, if you don't know it may even be five or ten years. You worry and you worry that you worry. You worry twice. You will think and you will dream of a grave all the time. In your mind you will see death and what happens to your body.'

Many informants not only feared hearing medical personnel pronounce that they had been infected. They were petrified that a positive result might lead to neighbours and friends gossiping about their condition. George Bila said that he would be furious if anyone said his brother had AIDS. 'Even if he is correct, I will beat him.' Lissie Mohlala, a woman in her early thirties who works as a secretary at the local municipality, responded as follows, when I asked her whether she had tested:

> 'I might go [for testing], but I will definitely not go around here. There are many people here and they gossip, especially the nurses and your friends. They are the ones who gossip the most. The nurses will tell you that you have AIDS and they will tell you what your CD4 count is. But they will also tell your friends, show them the pills and gossip about you. If you know you are HIV positive you will have stress. You will ignore to eat and you will be unable to sleep. You will die. You will always think about death.'

Such statements were made in a context of a super-abundance of information about HIV and AIDS. Throughout Bushbuckridge, the public health care fraternity and several Non Governmental Organisations (including the Health Systems Development Unit, Reproductive Health Groups Project, Bushbuckridge Social Service Consortium and LoveLife Youth Project) conducted vigorous campaigns to promote AIDS-awaress. Health activists regularly addressed different public forums on the on sexual hygiene. The activists also trained teachers as sex educators. By focusing on

prevention rather than cure, these interventions portrayed AIDS as an invariably fatal condition, and created the impression that nothing could be done to assist those infected with HIV.

Christian discourses were also prominent in framing people's understandings of sickness and death. Throughout Bushbuckridge, church leaders associated the skin lesions of persons living with AIDS, and sometimes AIDS, itself, with Biblical leprosy. Like Biblical leprosy, they portrayed AIDS as a sign of God's wrath and as divine retribution for sin. Like Biblical lepers, they located those suffering from AIDS-related diseases in a liminal domain, betwixt-and-between life and death (Niehaus 2009).

These public health and religious discourses emphasised culpability and also contributed to victim-blaming and stigmatisation. In everyday contexts, residents of Impalahoek blamed persons with AIDS for their own sickness; and condemned them for infecting past and present sexual partners with a deadly virus (McNeill and Niehaus 2010:33-39). They widely referred to persons living with AIDS as 'living corpses' (*setopo sa gopela*) whose bodies were literally decomposing whilst they were still alive. This alludes to the overpowering symbolic load of labelling: it immediately tainted the newly infected person with death, denying the very gradual progression from infection to illness and death (Niehaus 2007).

Woefully inadequate treatment options reinforced the association between AIDS and death. A network of three hospitals and twelve medical clinics screened pregnant women for sero-prevalence, provided voluntary counselling and testing on request, and treated the symptoms of AIDS-related diseases. Hospital amenities, particularly in the tuberculosis ward, were spartan. Only in 2003 did Masana Hospital, located 30 kilometres from Impalahoek, begin to supply the antiretroviral drug, Nevirapine (McNeill and Niehaus 2010:23-25).

> But social prejudice and poor treatment options do not fully explain people's reluctance to test. We are still left with many unanswered questions. Why should people who go through great lengths to act morally under normal circumstances, risk infecting their sexual partners and breast-fed babies, and re-infecting themselves, with HIV? The relationship between testing and stigma is perhaps less direct than one would suppose. People can simply undertake an HIV test elsewhere, as my informant Lissie Mohlala suggests, and conceal their status from kin and neighbours. Refusing to undertake a test is also no guarantee to avoiding discrimination and social ostracism. It is extremely hard to conceal the symptoms of AIDS, which are well known throughout Bushbuckridge. Constant coughing, drastic weight loss, ugly skin lesions and fluffy hair are sufficient, in themselves, to provoke prejudice, and generate the most malicious forms of gossip (Stadler 2003).

Moreover, treatment options have improved drastically, enhancing the chances of HIV positive persons to live full and productive lives. In 2005, Rixile ('rising sun' in Tsonga) Clinic, located within walking distance, began to supply HAART to patients who had registered a CD4 count of below 200. Within three years, the clinic had enrolled 6,638 patients. Clinical evidence shows reasonable rates of retention, with a mortality rate only slightly higher than reported in urban settings (MacPherson et al

2008). But people's willingness to learn about their HIV status has not matched these changes. Sick persons generally saw testing as a 'last resort' (Mfecane 2010:33).

Speaking in Euphemisms

Something is clearly amiss. A careful re-examination of the statements by interviewees suggests that they do not simply fear knowing that they suffer from an incurable, potentially fatal, condition. My research participants were petrified of hearing medical personnel and others pronounce that they are 'HIV positive'. This is apparent in the statements by my research participants, 'I hate people *telling* me that I am HIV positive'; 'if someone *says* you are HIV positive'; 'I don't want to *hear*'; and 'when they *tell* you'. My informants were less concerned that neighbours might see their sickness, than they were about neighbours speaking and gossiping about their condition. Their statements seem to express a belief that speech about HIV itself could be deadly, and that certain words possess intrinsic agency and transformative power (Basso 1969). Words such as 'HIV' and 'AIDS' have the capacity to materialise, bring into consciousness and thought, and ultimately change the status of persons, from merely being to being afflicted with death.

The fear of hearing others pronounce unpleasant words about one's destiny is evident in the tendency to avoid speaking about HIV/AIDS in public domains. In Impalahoek, as indeed elsewhere in South Africa, talk about AIDS was confined to backstage regions of social interaction (Stadler 2003, McNeill and Niehaus 2010: 60-65). But even in these domains people tend to avoid mentioning the words 'HIV' and 'AIDS' directly. As an alternative, villagers deployed a broad, varied and creative range of euphemisms. They would say that an infected person suffered from the 'three letters' (*maina a mararo*), 'germs' (*twatši*), 'the painful sickness' (*kukuana hloko*), or from 'the disease of right now' (*bolwetši gona bjalo*); had purchased 'a single ticket' (in English); was on 'diet' (*dayeta*); or had 'eaten herbs that make one disappear' (*enga moragela kgole*). Other euphemisms for AIDS include *twalaza* (a dance in which dancers look upwards to the sky). I, myself, soon learnt to refer to HIV/AIDS as 'the dreaded disease' during interviews and fieldwork [6].

The Agency of Words: Ethnographic Observations

The assumption that words possess intrinsic agency was seldom explicitly formulated, but could be inferred from a number of observations during fieldwork, in contexts that initially seemed to me to have little to do with sickness and healing.

On a Saturday in 2005 I took a break from fieldwork and visited the Mount Sheba nature reserve with fieldwork participants from Impalahoek. My friends were struck by the beauty of nature. Ace Ubisi, who was once an active churchgoer, said that he found it incomprehensible that God could have created the mountains, valleys and forests in only six days. 'It took two hundred men two years to build the new police station and jail in Impalahoek, so how could God make all of this in only six days.' Ace's maternal uncle, who was a preacher of the Zion Christian Church (ZCC), tried to eliminate Ace's confusion. God, he said, brought nature into being through the act of divine speech. 'In the Bible we read that God would say 'Let there be light!' and

the light appeared. He would also say 'Let there be mountains and waters!' and the mountains and waters appeared.' Christian cosmology equates the very act of creation with divine speech.

A belief in the power of words was also apparent in secular contexts. During 1996 the South African football team, Bafana Bafana, participated in the World Cup in France. I watched the opening game between South Africa and the host nation, with friends in Impalahoek. I did not entertain high hopes. Bafana Bafana fielded an inexperienced team, which had never come close to beating top opposition. But to my surprise everyone else said they expected Bafana Bafana to win - not merely the game, but also the tournament. Some predicted that the final would be against Nigeria, another popular African team. I was astonished. My friends included football coaches, an accomplished referee, and a former player in South Africa's Premier League – who knew far more about the game than I did. Bafana Bafana lost the opening game 0-3, and was eliminated after the first round of the tournament in a most humiliating manner. Only much later did some of my friends admit that they too expected South Africa to lose, but could not bring themselves to say so. As an avid football fan explained to me; 'If you say South Africa will lose, we will lose. When we played Switzerland all South Africans said we would win and we won.'

Words seem to possess a certain materiality, and were on occasions treated as if they were things. My research assistants and I were eager to learn about a certain episode of witchcraft accusation. We heard that after several instances of misfortune occurred at a local bakery, all employees hired a bus to consult a witch-diviner close to the Swaziland border. The diviner apparently revealed three witches among the bakery employees. We approached a number of potential informants, but they all referred us to the shop-steward, Freddy Malene. Freddy had organised a witch-hunt and, for this reason, his employers suspended him from work. Freddy warmly welcomed us and offered a splendidly detailed account of events at the bakery. We briefly gave Freddy some advice, saying that his employer could not dismiss him without proper warning, and urging him to consult the legal advisors of his trade union. Freddy's mother overheard our conversation and, as we were about to leave, thanked us 'for the words we gave her son'. To express her gratitude, she offered me a beautiful reed mat, which must have taken her a week to manufacture. I left thinking, were words so concrete that they could be reciprocated with gifts?

In Impalahoek one could clearly observe the constructive power of speech during invocations to the ancestors, Christian hymns, prayers and confessions. Whenever a man set off to seek work in Johannesburg, he would call his paternal aunt (*rakgadi*), and kneel with her at an isolated spot in the yard. She would then sip a maize drink and spit the liquid in all four directions, proclaiming, 'Fathers. Here is Fundani! He is going to work in Johannesburg! Give him luck! Let him get work!' Migrants invoked the ancestors in a similar manner upon returning from work, and would then thank them for their protection and support [7].

In the numerous Zionist, Apostlic, and Pentecostal churches of Impalahoek, prayers were seldom silent. [8] During sermons and funerals, congregants were expected to kneel on the ground and to pray out loudly to God, as if screaming out the words. Their individual voices mingled in a cacophony of sound (Comaroff 1985:245-247). People widely acknowledged the miraculous power of prayer. Father Silinda, who

was a wealthy storeowner and founder of the Nazarene Revival Crusade, reportedly prayed earnestly after thieves stole money and groceries from his store. Within days the thieves came to him to ask forgiveness, and returned all the cash and belongings that they had taken. These churches occasionally deployed confession (*ipolela*) and means of managing the social and sexual lives of congregants. I never confessed myself. But I did observe Zionist church members meeting with ministers out of earshot of the congregation. One confessant told me that he had engaged in an extra-marital affair and afterwards suffered remorse (*pona molato*, literally, 'seeing crime in oneself'). After verbalising what he had done, the minister simply replied, 'This is sin! May God forgive you!' 'Hereafter I immediately felt relief', he told me. Unlike prayer, confessions were strictly private.

Deadly Words, Unfortunate Names and Curses

As shown, residents of Imaplahoek acknowledged the agency of words, and in certain contexts, ranging from sport and religion, deployed the power of speech in a constructive manner. These meanings might well support 'confessional technologies' as employed by activists of the TAC, as a means of confronting HIV and AIDS (Nguyen 2009, Robins 2006). But there is one crucial difference: fear about the dangerous and destructive potential of words regularly outweighed faith in their therapeutic potential. This too is apparent in numerous everyday contexts.

Gossip and swearing provoked great unease among my informants. Jonsson (2004:23) writes that young women in Bushbuckridge very seldom discussed sex or private affairs with each other, and when they did talk about these topics, they generally spoke in the third person. Young women distrusted each other, and feared that gossip might spoil their reputations. They told Jonsson that one good thing about having boyfriends, was that they could talk with them about intimate matters without provoking envy. People took even greater offence at swearwords, particularly when others insulted their mothers. Men who swore frequently used the Afrikaans words *bliksem* ('lightning') and *moerskont* (literally 'mother's vagina'), asif they were acting outside of themselves, and dissociating themselves from swearing. Others swore by calling persons animal names. I heard a mother shout 'donkey' (*bongolo*) and 'witch-familiar' (*thuri*) at her disobedient daughter, when she was in a state of rage.

Certain words, that were not necessarily swearwords, seem to have the power to disrupt social hierarchy; create envy and conflict; provoke disgust, and unleash powerful emotions. Rules of respect (*hlonipa*) dictated that it was morally inappropriate to pronounce them in certain social contexts. For example, younger persons were not allowed to call elders by name. They had to address related elders by kinship terms such as 'maternal uncle' (*malome*), and unrelated adults by their relation to their peers, such as, 'mother of Fundani' (*MmaFundani*). Neither were they allowed to ask an elder where he or she had been, since the answer might prove embarrassing. They were not allowed to say directly that he or she is drunk, but had to use the euphemisms, 'he chases goats' (*o kgapa diputi*) or he 'has eaten maize' (*a jele mabele*), instead. Villagers also had to deploy euphemisms when referring to urination of excretion. Instead of saying 'urinate' (*rota*) villagers had to use phrases 'blindfold rats' (*fahla magotla*) or 'spill water' (*ntšha meetse*). Instead of 'excrete' (*nya*), they

had to say I'm 'going outside' (*go ya ntla*), or 'I'm going to send myself' (*ke nyaka go te thoma*).

Talk about sex and death was strictly proscribed. Elders, particularly parents, were prohibited from speaking directly to younger people about sex, and *vice versa*. Notable exceptions were the mother's brother and father's younger siblings, who could speak to youngsters about sex in a pedagogical manner. A male teacher told me that he found it exceptionally difficult to teach sex education as part of the curriculum for life orientation. In local practice, he said, it was taboo to refer to sexual organs when addressing children. He thus decided to use the English alternatives instead. 'Had I used the Northern Sotho terms, their parents might even have demanded my resignation'. Only grandparents could joke with grandchildren about sex. But such joking was not reciprocal. One could only speak directly about sex with spouses, lovers, coevals, friends, and also to outsiders such as anthropologists. Moreover, cousins shared a reciprocal joking relationship, in which they frequently shared lewd sexual jokes. In these forms of talk, sex was referred to indirectly, by euphemisms such as 'to share a blanket' (*ke lepai re ya apolelana*), 'penetrate' (*tobetsa*), 'taste' (*kwa*), 'perform' (*maka*) or 'sleep' (*robala*).

It is perhaps for a similar reason that no person could refer directly to death. In many contexts, adults signified death by non-verbal means. For example, an initiation master indicated that a young man had died at a circumcision lodge by breaking a clay pot in front of his mother. [9] Symbolic inversions, such as turning around logs in a fire and placing their thick ends in the centre, also signified death (Berglund 1979: 230-8). Common euphemisms for death were that the deceased had been 'taken by a hyena' (*tšerwe ke phiri*) or 'gone to the place of the ancestors' (*o ile badimong*); or that the 'house has fallen' (*o wetše ke ntlo*), the 'water had dried up' (*meetse a pshele*), or 'sun had set' (*dikeletswe ke letšatsi*).

My informants were also sensitive to dissonance between words and their referents. I often cross-checked the information supplied by research participants and I was surprised how seldom the lied. My research participants sometimes shied away from unpleasant facts through omission, and by distorting minor details in the storyline. But they were usually honest, sometimes brutally so. A former prisoner told me that he was incarcerated for the illegal possession of a firearm. But, he said, the police should actually have arrested him for attempted murder: the firearm belonged to a man whom had hired him to kill his wife's lover, and friends of his intended victim overpowered him before he could shoot.

Residents of Impalahoek were anxious about the predictive power of words. There is hardly any local tradition of prophecy. People seem to fear that, as in the case of witchcraft, unpleasant words could bring about unpleasant consequences. Mabetha Monareng recalled that in 1986 lightning struck next to a Zionist church, killing two boys and two cows. Neighbours incorrectly informed Mabetha's mother that he was one of the deceased. When Mabetha arrived at home, she was delighted to see that he was still alive. But she immediately placed ash on Mabetha's forehead to protect him against the destructive power of the pronouncement. Having withstood the flames of fire, ash was a prominent cooling substance, and was frequently used in healing rites (Hammond-Tooke 1981:154).

The agency of words was apparent in personal names. Individuals had up to six different names. Whereas mothers gave birth to babies, fathers named them and bestowed them with social identity. A baby's first name usually pertained to an incident that occurred at the time of his or her birth. For example, a man named his son, Soweto, because he was visiting this city at the time of the baby's birth. Children soon earned additional names. Nurses and teachers conferred to them English or Afrikaans names, used when interacting with white employers and government bureaucracies. Such names were often taken from the Bible. The third name was usually that of an ancestor. Elders sometimes perceived a baby's incessant crying as a sign that a forgotten ancestor was plaguing him or her. The crying would stop only once a diviner had identified the responsible ancestor and parents appeased the ancestor by naming the baby after him or her (Mönnig 1988:102-7). Children also earned nicknames (*dikwero*) from their playmates and peers. These could include Lepara ('walking stick'), Badzy (a 'cousin' to everyone), Duma (a talkative person), or Dubuka (someone who assists people). Finally, upon returning home from the circumcision lodge, a boy was entitled to give himself his own name. Kelebotse ('I am handsome') is an obvious example.

Names were never simply rhetorical, but closely described a person's dispositions. It was never quite clear whether the dispositions led to the name or *vice versa*. Naming a person after an ancestor created a special bond between living and deceased persons. One man was named after his maternal great-grandmother, called Ramadimabe ('father of misfortune'). He explained that she was prone to misfortune, but also extremely resilient and able to contain the misfortune she experienced. 'Like her' he said, 'my life has also been a life of long suffering, but I am also resilient and tough.' Other informants told me that they appropriated the dispositions of the ancestors after whom they were named. Mbhekeni said that like his great-grandfather, he was prone to be short-tempered. Kotšo (a mispronunciation of the Northern Sotho word for 'peace', *kgotšo*) said that like his great-grandfather, he was rude and fortunate in money matters. During rituals a person named after the most senior ancestor was treated as the most senior sibling, even although he or she might not actually be the first-born.

Names which referred to specific events at the time of a person's birth could also shape his or her destiny. A woman named, Bareforiye ('we have been calmed') claimed that she was good at resolving disputes. Mohlopeng ('someone who is troubled') told me that as a child he was always restless and cried throughout the night. As he grew older, he was prone to experience bouts of aggression. Lekhudani ('one who is ill'), said, 'Even as an adult I have never been well.' Tshikiwane ('to be abandoned') was forsaken by her own parents, and later deserted by her husband. 'I believe you follow your name', she told me. 'What I have lived throughout my life was the same as my name'. In these instances it was deemed impossible to avoid one's destiny. This is captured by the saying, 'tolerate a good name tolerate a bad name' (*Lebitso lelebotse seroma, Lebitso lebe seroma*).

The agency of words is also apparent in witchcraft. Observers have noted that whereas Mediterranean people tend to fear the malevolent power of sight, as in the evil eye (Galt 1982), in much of southern Africa people fear the malevolent power of sound. West (2007) argues that Muedans in Mozambique construct sorcery through speech and experience it through threats and accusations. 'People do not speak of

sorcery', he writes, 'they actually speak sorcery' (p.21) [10]. My fieldwork in Bushbuckridge, on the other side of the Mozambique/South African border, supports some of these observations. It would be unwise to reduce witchcraft to words, only because these words often have very real material referents, such as concrete episodes of misfortune. But the power of cursing was, nonetheless, obvious. The most well-known curse in Bushbuckridge was the simple expression 'I'll see you!' (*Ke tlo go bona*). These words were purported to have deadly consequences, particularly if the speaker possessed innate malevolent power.

Two examples attest to the potentially destructive power of cursing. Rexon Khoza once suspected another man of having an extra-marital affair with his wife. Rexon confronted him in public and in a state of severe anger threatened: 'I'll see you'. Only two days later an unknown assailant shot dead this man, in what appeared to be an incident of robbery. Onlookers did not regard the murder as co-incidental, and henceforth suspected Rexon of harbouring the power of witchcraft.

My second example is of Khazamula Nyathi, a man in his seventies who was the leader of the local *muchongolo* dance team. At one event his twenty-eight year old grandson, Maguduza Nyathi, a lawyer, said that he would never dance for the team. A fierce argument erupted. Khazamula apparently shouted at Maguduza, 'You are a Shangaan! *Muchongolo* is our tradition!' and beat him with a stick. Maguduza retaliated with his firsts. Khazamula then reportedly cursed him, saying 'For beating me, you'll die! You think I'm nothing and that you're a lawyer. I'm your grandfather. You can be a lawyer in heaven or in hell.' Only one month later, Maguduza tried to separate two fighting men at a drinking tavern, and was fatally wounded. Onlookers believed that Khazamula's curse brough about his death.

Another practice bordering on witchcraft, which also shows the destructive power of words, is the 'bottling' of football players. Ace Ubisi, a former player of Impalahoek Fast Eleven, recalled that their team manager sometimes brought a bottle containing strong, dark-coloured, potions that smelt like rum, to their camp. Three hours before the game, he would call Ace and ask him to speak into the bottle. Ace recalled that he usually said words such as: 'Givens [the name of his opponent]! I'm Ace! I'm going to play against you. Today I bottle you! You have nowhere to go!' Ace then breathed into the bottle, the manager closed the lid, and buried the bottle in a termite heap, behind the goal box. Bottling, Ace believed, made his opponents useless.

Powerful words were also deployed as vengeance magic (*letšwa),* and were used to make witchcraft rebound. Loicy Shai suspected that she had been bewitched. She was unable to find work, her finace left her for another woman, and she was plagued by the most horrible nightmares. She would, for example, dream that her younger sister, who was still alive, was deceased. A Zionist healer revealed to Loicy that her boyfriend's mother has spoken a curse against her. The healer instructed Loicy to do the following. She had to take a Coca Cola bottle, speak into the bottle, verbalise her distress and anger, and immediately close the lid. She then had to take the bottle to a crossroads, smash it on a stone, and walk away without looking back. 'This', the healer said, 'would remove your misfortune (*bati*). It will make those who want you to suffer, suffer.' Within a year after she had performed the ritual, Loicy secured a secretarial position and found a new boyfriend.

HIV/ AIDS: Concealment, Silence and Discreet Speech

Anxiety about the potentially destructive effects of words underlies people's fear of hearing medical personnel pronounce that they had tested HIV positive. It also illuminates the tendency to avoid speaking about HIV and AIDS in public domains. Unlike activists of the urban-based TAC, residents of Impalahoek resisted the practice of confession (Nguyen 2009), and responded to HIV and AIDS deploying alternative tactics - concealment, silence, and on occasions, also discreet speech.

Klaits (2010) analysis of speech in an Apostolic Church of Botswana illuminates some of the reasons for the prominence of silence in Impalahoek. He observes that church members perceive of faith (*tumelo*) as vital to healing. In cases of sickness, they communicated faith and love from their own bodies to those of persons who are unwell. Church members believed that Hymns, prayers and words of compassion mitgated harm and assisted healing. By the same token, they perceived expressions of scorn and of jeasousy as morally inappropriate forms of speech that worsened suffering. The church members avoided certain topics. To protect themselves from the power of witchcraft, they refrained from speaking about it, and refused to share in the sentiments of those they suspected of practicing it. Apostolic Christians also avoided speaking about AIDS, and never pronounce AIDS as the cause of death at funerals. To call an illness AIDS would amount to a curse that prophesises immanent death. Moreover, announcing AIDS as a cause of death at funerals would cast aspersions on individual character (also see, Durham and Klaits 2002). Hence, in matters of witchcraft and of AIDS, silence avoided anger, victim-blaming, and strife.

Silence and concealment were most prominent during the early stages of the pandemic, before the availability of effective anti-retroviral medication. As soon as the first symptoms of AIDS became apparent, fellow household members secluded the afflicted person. This was done not only to avoid others polluting him or her, or *vice versa*, but also to preclude speech about his or her condition. Only a select few people – usually a mother, sibling or a younger relative – nursed, washed and fed the sick person. The carers were expected to comfort and strengthen (*phorola*) him or her verbally. Even if the situation was gravely serious, it was deemed inappropriate to name the person's disease, speak about any topics that might upset him or her, or worse still, to say that he or she was about to die. Carers hardly ever announced the nature of sickness to neighbours. Instead, a constantly burning fire indicated sickness in a household. Visists to hospital were hedged in secrecy. Joseph Mnisi, the only person to own a van in his village section, told me that his neighbours once came to his home late one evening and begged him to take her critically ill daughter to hospital. He suspected that she might suffer from AIDS-related diseases because they draped a blanket over her head.

Some carers, themselves, were unsure whether their patients suffered from AIDS-related diseases. Jonas Mohlala, who was a medical doctor, asked his nephew, Thabo, and his nephew's wife to take care of his critically ill son. But Jonas did not tell them anything about the nature of his sickness. The couple, nonetheless, assumed these duties with great moral compassion. They gave Thabo's sick cousin medicine, fed him, washed him, and did his laundry, each day. They also invited their church choir to stand outside his room and sing for him. On a few occassions they took Thabo's cousin to hospital, in the hope that doctors might alleviate his suffering. But these visits always happened at night.

My informants condemned those who failed to provide proper care for close kin suffering from AIDS-related sicknesses. They also criticised open speech about AIDS. After Roniah Mashile's daughter became critically ill, she confided in neighbours that her daughter's condition was terminal, because she had contracted AIDS. This statement provoked suspicions that Roniah might actually have bewitched her own daughter, and merely invoked AIDS as a means of hiding her own culpability.

In 2005, there was great improvement in the prospects of persons living with AIDS. For many the availability of effective antiretroviral medication brought new hope. Once a terminal illness, AIDS had now become a potentially chronic, manageable condition. Medical researchers monitored 1,353 patients who were initiated onto HAART at Rixile Clinic between October 2005 and September 2007. After 24 months, 84% (1,131) of the patients were retained on treatment: 9% (124) had died, 5% (63) had been transferred, and 3% (35) could not be traced (MacPherson et al. 2008:2). Several patients experienced drastic improvement. Within four months the weight of one patient receiving HAART increased from 20 kg to 70kg.

But HAART has not suddenly generated a spate of confessions. My research participants still perceived of AIDS as a potentially life-threatening and stigmatising condition. Fears of hearing medical personnel ponounce that one is HIV positive have persisted, and residents of Impalahoek delayed testing for HIV antibodies until they were severely ill (Mfecane 2010). Medical personnel at the Rixile Clinic experience late presentation and advanced levels of immuno-suppression as formidable barriers to effective treatment (MacPherson et al. 2008:4).

Those who did present for treatment expected health workers to treat their health status with the utmost of confidentiality. Tintswalo Hospital sometimes dispatched volunteers to provide home- based care for sick persons residing in their neighbourhoods. The volunteers washed disabled persons, cooked for them, did their laundry, and cleaned their yards. Nurses issued all volunteer carers with hospital cards, providing a profile of the patient's medical history. But the cards, never explicitly indicated whether the patient was HIV positive. As one volunteer observed:

> 'Sometimes, on the corner of the card, there would be a picture of a book. This tells us that the person has AIDS. You must never say it out loudly. The patients usually conceal this. Even the family members may not know.'

People using medication perceived speech acts as a crucial dimension of therapeutic encounters. Whereas the indiscreet pronouncement of dangerous words might impede healing, in certain contexts, appropriate words instilled faith in the therapeutic potential of antiretroviral drugs. This is very evident in the case of Reggie Ngobeni, a man in his mid forties. By August 2005, Reggie was in a desperate situation. He had previously resided in Johannesburg, but returned to his mother's home in Impalahoek after he was retrenched and from work and started suffering from excruciating stomach cramps. He spent a month in the tuberculosis ward, and started undergoing an apprenticeship to qualify as a diviner. But Reggie's condition grew worse. He had diarrhoea, his nose bled, and he vomited and coughed throughout most nights. Reggie eventually blamed the woman who had trained him in the art of divination for his deteriorating health. She had reportedly warned him that if he did not pay his training fees of R3,000 (£250) AIDS would strike him down. Reggie told me, 'I cried when I heard those painful words.

When someone promises you AIDS you will remember it.' This statement suggests that Reggie saw his AIDS-like symptoms as the product of a curse. It is out of desperation that Reggie's brother took him to the Rixile clinic. Here Reggie tested positive for HIV antibodies and registered a CD4 count of only 94. After being administered HAART, Reggie's health improved, and his opportunistic infections disappeared. Reggie also became a baptised member of the Zion Christian Church. Reggie told me that the doctor at Rixile warned him that unless he took his medication as instructed, he would die. This statement prompted him to comply with treatment. If I don't take these tablets people would say that AIDS killed me.'

The uncoupling of HIV and death has, in certain contexts, paved the way for supportive and discreet speech. Custom Chiloane relayed to me that his friend, Lucas Malebe, who was seriously ill, had lost all hope of recovery, and refused to go to hospital. Custom was shocked because he had anticipated a more positive response from his friend.

> 'Lucas told me, "There is no need for me to go to hospital. I will go there, I will return, and I'll still be sick. No doctor or nurse can help me. The best thing is simply to stay here and die. I was involved with three girls. They all died. People gossiped that it was HIV."
>
> Lucas lay in bed waiting for death. I think his problem was hope. I went home and came up with a strategy. I decided to lie to Lucas. I told him: 'Lucas the dreaded disease affects everyone. I too am HIV positive. I only look healthy because I am on [antiretroviral] treatment.'

One week later Lucas phoned Custom and told him that he had tested and was now 'taking tablets'. However, Lucas was furious when he discovered that Custom had lied to him, and yelled at Custom on the phone. But Lucas later sent a text message on the mobile phone, expressing the wish to continue their friendship. Custom told me, 'HIV needs positive thinking. If you do not think positively it will destroy you.'

Conclusions

This essay has warned against the assumption that confessional technologies – such as coming out with HIV positivity – provide a universally appropriate means of confronting the AIDS pandemic. Confessional technologies are premised upon the assumption that speech has the capacity to transform persons, combat stigma, and bring new hope in the context of suffering and pain. These assumptions accord with classical anthropological observations that the potency of ritual lies as much in the uttering of words as in the manipulation of objects (Malinowski 1965, Tambiah 1968). For example, Levi-Strauss (1968) argues that South American shamans utilise speech to heal cases of problematic childbirth. By naming the mother's pains and chaotic sensations, and by placing them in a meaningful symbolic framework, the shamans make them bearable. But, as we have seen, words can also be deadly. They also have the capacity to invoke negative emotions such as jealousy and scorn, and bring about harmful effects.

But words operate in material contexts. Urban-based activists of the TAC have used these technologies as a means of forging social support, accessing medication and of

attaining the benefits of therapeutic citizenship (Nguyen 2010, Fassin, Le Marcis and Lethaba 2008). But in insecure rural areas such as Bushbuckridge and Venda concealment and silence has continued to be the predominant response to HIV and AIDS (McNeill and Niehaus 2010). Here anxiety about the destructive capacity of words – as in cursing, swearing, and direct speech about sex and death – were overpowering. The words 'HIV' and 'AIDS' bore a negative symbolic load and prophesized death and enhanced sickness. Being pronounced as - and pronouncing oneself to be - 'HIV positive' was more likely to provoke stigma than compassion. Prior to 2005, effective medication was out of reach to everyone suffering from AIDS-related sicknesses. After this date they were generally available to all. With the availability of medication discreet speech has gradually replaced complete silence. People generally delay testing, and they expect medical personnel to speak in a supportive manner and to maintain confidentiality.

It makes greater sense to treat speech and silence as alternative, perhaps equally appropriate, modes of dealing with disease. It is imperative that health workers learn to deal with silence, maintain confidentiality and to speak with descretion.

Notes

1.I thank my research assistants, Eliazaar Mohlala and Eric Thobela, for their help during fieldwork. Many of my ideas were shaped in ongoing conversation with Nicole Angotti, Florence Bernault, Fraser McNeil, and Jonathan Stadler. Hansjorg Dilger provided extremely helpful comment on an earlier draft of this paper.

2. By 2007 2.1 million South Africans had died of AIDS-related diseases, and another 5.5 million were HIV positive (Plusnews 2007).

3. I use pseudonymns to describe the village of fieldwork and all personal names. This is done to protect the identity of my informants.

4. South Africans who test HIV positive and register a CD4 count of 200 or less are judged incapable of working and are entitled to receive monthly disability grants valued at R780 ($90) in 2005. These grants frequently constituted a significant source of income to poor households (Leclerc-Madlala 2006),

5. By the 2000s testing levels have improved significantly in South Africa. A National Communications Survey found that in 2006, only 17% of men and 38% of women in South Africa had tested for HIV antibodies (Government of South Africa 2010). A similar trend is apparent in neighbouring Botswana. During 2001, the government of Botswana launched an extremely comprehensive programme of free testing and treatment. But after two years, only 15,000 people had come forward to utilise these facilities (Steinberg 2009:1). However, by 2005, about 158,000 tests were administered (Klaits 2010:39).

6. See McAllister's (2006) discussion of the importance of oratory in beer drinks, held to welcome home migrants, by Xhosa-speaking households in the Eastern Cape.

7. Danger is generally more apparent when words are spoken in the mother tongue. However, the words 'HIV' and 'AIDS' seemed to have special power because they had

recently become venacularised. People were being forced to bring words into their language they saw as bringing misfortune into society.

8. At the time of fieldwork there were 27 churches in Impalahoek with a combined total of nearly 6,000 adult baptised members. 75% of the Christians in the village belonged to 'Zionist-type' churches, 16% to Pentecostal-type churches, and only 9% to mission churches (Niehaus with Mohlala and Shokane 2001:31-36).

9. See De Heusch's (1980) analysis of the analogy between birth and the baking and firing of clay pots among Tsonga-speaking people.

10. A belief in the malevolent power of words is evident in the case of the sahir in Northern Sudan. Here the casting of evil is attributed to utterances in the form of metaphors, rather than to the gaze of one's eye (Ibrahim 1994).

References

Adams, J. N. Hansen, A. Fox. B. Taylor, M Jansen van Rensburg, R. Mohlahlane, K. Sikhema. 2011. Correlates of HIV testing among abused women in South Africa. *Violence against Women*, 4 July.

Appadurai, A. 1996. *Modernity at Large: Cultural Dimensions of Globalisation*. University of Minnesota Press.

Ashforth, A. 2002. An Epidemic of Witchcraft? Implications of AIDS for the Post-Apartheid State. *African Studies* 61 (1), 121-144.

Basso, K. 1969. *Western Apache Witchcraft*. Tucson: University of Arizona Press.

Berglund. A-I. 1976. *Zulu thought-patterns and symbolism*. Uppsala: Swedish Institute of Mission Research.

Campbell, C. Y. Nair, and S. Maimane. 2005. *Understanding and Challenging HIV/AIDS Stigma.* Durban: University of KwaZulu/Natal.

Comaroff, J. 1985. *Body of Power, Spirit of Resistance: The Culture and History of a South African People.* Chicago: The University of Chicago Press.

De Heusch, L. 1980. 'Heat, Physiology, and Cosmogony: Rites de Passage among the Thonga'. In I. Karp and C. S. Bird (eds.) *Explorations in African Systems of Thought*. Bloomington: Indiana University Press, 53-76.

Durham, D. and F. Klaits. 2002. Funerals and the Public Space of Sentiment in Botswana. *Journal of Southern African Studies* 28 (4), 777-795.

Fassin, D, F. le Marcis and T. Lethata. 2008. Life & Times of Magda A: Telling a story of Violence in South Africa. *Current Anthropology* 49 (2), 225-347.

Ferguson, J. 1999. *Expectations of Modernity: Myths and Meanings of Urban Life on the Zambian Copperbelt*. Berkeley: University of California Press.

Foucault, M. 1972. *The History of Sexuality*. Volume One: An Introduction. New York: Vintage

Galt, A. 1982. The Evil Eye as Synthetic Image and its Meanings on the Island of Pantelleria, Italy. *American Ethnologist* 9 (4), 664-681.

Government of South Africa. 2010. *The National Communications Survey of HIV/AIDS, 2009.* www. info.gov.za./issues/hiv/survey – 2009. htm#implications (accessed on15 September 2011).

Hannerz, U, 1996. *Transnational Connections: Culture, People, Places.* London and New York : Routledge.

Ibrahim, A. 1994. *Assaulting With Words: Popular Discourses and the Bridle of Shar'ia*. Evanston Ill: Northwestern University Press.

IRIN. 2010. South Africa: National HIV testing Campaign Disappoints. *World Countries News.*. http://world-countries.net/archives/74328 (accessed on15 September 2011).

Jonsson, G. 2004. *The Construction of Young Women's Sexuality in a Limpopo Village, South Africa.* BA Honours Dissertation, Pretoria: Department of Anthropology and Archaeology, University of Pretoria.

Hammond-Tooke, W.D. 1981. *Boundaries and Belief: The Structure of a Sotho Worldview*. Johannesburg: Wits University Press.

Kahn, K, M. Garenne, M. Collinson and S. Tollman. 2007. Mortality Rates in the New South Africa: Hard to Make a Fresh Start. *Scandinavian Journal of Public Health* 35 (69), 29-34.

Klaits, F. 2010. *Death in a Church of Life: Moral Passion During Botswana's Time of AIDS.* Berkeley: University of California Press.

LeClerc-Madlala, S. 2005. Popular Responses to HIV/AIDS and Policy. *Journal of Southern African Studies* 31 (4), 845-856

Leclerc-Madlala, S. 2006. 'We will eat when I get the grant': Negotiating AIDS, poverty and antiretroviral treatment in South Africa. *African Journal of AIDS Research* 5 (3), 249-256.

Levi-Strauss, C. 1963. 'The Effectiveness of Symbols' In *Structural Anthropology: Volume 1*: New York: Basic Books,186-205

MacPherson, P, M. Moshabela, N. Martinson and P. Pronyk. 2008. 'Mortality and loss to follow-up among HAART initiators in rural South Africa'. *Transactions of the Royal Society for Tropical Medicine and Hygiene* 1: 1-6.

Malinowski, B. 1965. *Coral Gardens and their Magic* (Two Volumes). Bloomington: Indiana University Press.

McAllister, P. A. 2006. *Xhosa Beer Drinking Rituals: Power, Practice and Performance in the South African Rural Periphery*. Durham NC: Carolina

McNeill, F. 2011. *AIDS, Politics and Music in South Africa.* New York: Cambridge University Press.

McNeill, F. and I. Niehaus. 2010. *Magic: AIDS Review 2009*. Pretoria: Centre for the Study of AIDS.

Mfecane, S. 2010. *Exploring Masculinities in the Context of ARV Use: A Study of Men Living with HIV in a South African Village*. Unpublished PhD thesis: Johannesburg: WISER, University of the Witwatersrand.

Mőnnig, H.O. 1983. *The Pedi*. Pretoria: LJ Van Schaik.

Nguyen, V-K. 2005. Antiretroviral globalism: biopolitics, and therapeutic citizenship. In A. Ong, and S Collier (eds.), *Global assemblages: technology, politics, and ethics as anthropological problems*. Oxford: Blackwell.

____ 2009. 'Therapeutic Evengelism- Confessional Technologies, Antiretrovirals and Biospiritual Transformation in the Fight against AIDS in West Africa'. In F. Becker and P.W. Geissler (eds.) *AIDS and Religious Prectice in Africa*. Leiden: Brill, 359-378.

____ 2010. *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS*. Durham NC: Duke University Press.

Niehaus, I. 2006. 'Doing Politics in Bushbuckridge: Work, Welfare and the South African Elections of 2004', *Africa* 76 (4), 521-548.

Niehaus, I. 2007. Death before Dying: Understanding of AIDS Stigma in the South , African Lowveld. *Journal of Southern African Studies* 33 (4), 845-860.

Niehaus, I. 2009.'Leprosy of a Deadlier Kind: Christian Conceptions of AIDS in the South African Lowveld.' In Felicitas Becker and Wentzel Geissler (eds.) *AIDS and Religious Practice in Africa*. Leiden: C.J. Brill, 309-332

Niehaus, Isak with Eiazaar Mohlala and Kally Shokane. 2001.Witchcraft, Power and Politics: Exploring the Occult in the South African Lowveld. London: Pluto.

Oxlund, B. 2009. *Love in Limpopo: Becoming a Man in a South African University campus.* PhD-series no. 54. Copenhagen: Department of Anthropology: University of Copenhagen.

Plusnews. 2007. HIV/AIDS Barometer-May 2007, *Mail and Guardian Online* http://www.mg.co.za/articlePage. aspx?articleid=306829&area+ /insight/hiv-aids-barometer (retrieved on 20 July 2007).

Robins. S. 2004. Long Live Zackie, long live': AIDS activism, science and citizenship after apartheid. *Journal of Southern African Studies* 30 (3), 651-672.

Robins, S. 2006. From 'Rights' to 'Ritual': AIDS Activism in South Africa. *American Anthropologist* 108 (2), 312-323.

Sahlins, M. 1999. What is anthropological enlightenment? Some lessons of the Twentieth century. *Annual Review of Anthropology* 28, 1-23.

Scott, J. C. 1990. *Domination and the Arts of Resistance: Hidden Transcripts*. New Haven CONN: Yale University Press.

Stadler, J. 2003. Rumour, Gossip and Blame: Implications of HIV/AIDS prevention in the South African Lowveld. *AIDS Education and Prevention* 15 (4), 357-369.

Steinberg, J. 2008. *Three Letter Plague: A Young Man's Journey through a Great Epidemic.* Johannesburg and Cape Town: Jonathan Ball.

Steven, M., A. Cockroft, G. Lamothe and N. Andersson. 2010. Equity in HIV Testing: Evidence from a cross-sectional study in ten South African countries. *International Health and Human Rights* 10 (23), 67-89.

Tambiah, S. 1968. The Magical Power of Words. *Man* 3 (2), 175-208.

Tollman, S., K. Kahn, K. Herbst, M. Garenne and J. Gear. 1999. Reversal in mortality trends: Evidence from the Agincourt field site, South Africa, 1992 to 1999. *AIDS* 13, 1091-1097.

Tsing, A. 2004 *Friction: An Ethnography of Global Connection*. Princeton NJ: Princeton University Press.

West, H. 2007. *Ethnographic Sorcery*. Chicago: University of Chicago Press. \

Weston, K. 1997. *Families We Choose: Lesbians, Gays, Kinship*. New York: Columbia University Press.