The young, the rich, and the beautiful: Secrecy, suspicion and discourses of AIDS in the South African Lowveld

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This article investigates emic accounts of the AIDS deaths that have occurred in a village in the Bushbuckridge district of the South African Lowveld. I argue that whilst AIDS was publicly hidden and shrouded in secrecy, private gossip created moral scripts about those suspected of having died of AIDS. Details of 47 AIDS deaths revealed that young women and relatively wealthy, sometimes powerful men were vulnerable to AIDS. I suggest that AIDS constitutes a moral crisis; peoples’ sexual secrets and desires for commodities and sex featured prominently in local AIDS discourses. The article explores the similarity between AIDS and witchcraft as a metaphorical analogy. Both were highly secretive, and subjective, and circumstantial evidence identified witches and AIDS victims. AIDS and witchcraft were also concerned with the problem of unnatural and uncontrolled desire. The article explores these themes with regard to men and women’s experiences respectively. Young ‘beautiful women’ who used sex to acquire wealth were said to ‘buy their own coffins’ (die of AIDS), yet relationships with wealthy men ensured household survival. Relatively affluent men were labelled incorrigible ‘womanisers’ who spread AIDS. Discourses of masculine sexuality focussed on men’s lack of agency in sexual decision making. The article points to the tendency to ignore men’s vulnerability and its implications for AIDS prevention.

Keywords: Bushbuckridge, gender, South Africa, witchcraft

Introduction

At a funeral in Bushbuckridge a young schoolgirl was being buried. The cause of her death was announced in vague terms. Those who were called to witness her death pronounced that she ‘had been sick for a long time’. Not much more was said, but the look on the faces of many of the mourners suggested that there was more to it than that. Later, small groups of mourners drifted away from the funeral, talking as they made their way home. I asked what had caused the death of such a young woman. One of the young men held up four fingers, silently spelling out the phrase ‘three numbers plus bonus’ — a direct reference to the national lottery that pays out dividends for matching three or more numbers. Here however, this signalled a coded reference to the initials A-I-D-S.

Typical of local humour, the juxtaposition of the ‘lotto’ with AIDS indicated an enduring irony: easy money, it warned, has hidden costs. While the lottery slogan declares ‘tata ma chance; tata ma million’ (take a chance, take a million), my young friends from the funeral seemed to suggest that ‘going for the jackpot’ was a gamble between life and death. Later, in the privacy of an interview, a young man who knew the deceased stated that her death was caused by her love of money and commodities such as cell phones and that she had relationships with wealthy men who drove cars. In the eyes of many villagers, this apparently lethal combination of her desire for money, her beauty and her youth had made AIDS a very plausible cause of her death.

This article draws on ethnographic research undertaken since 2002 in KwaBomba, a village in the Bushbuckridge district.1 In 1973 KwaBomba was incorporated into the Gazankulu Bantustan, a former native reserve that supplied labour to South African industry and a site for resettled populations. In 1994 the village formed part of the Northern (now Limpopo) Province. Most residents of KwaBomba spoke Xitsonga although I was able to communicate with younger men and women in English.

KwaBomba was divided into six neighbourhoods or sections, demarcated by footpaths and dirt roads. Village sections also formed distinct neighbourhoods relating to villagers’ varied historical experiences and socio-economic circumstances. I concentrated my research in three sections, Hlengweni — the neighbourhood where I did most of my fieldwork — was dominated by older families who had been relocated from nearby settlements in 1962.2 These families were regarded as being slightly better off; some younger men and women were teachers at the local primary and secondary schools. Many houses were made of bricks, had tiled roofs and electricity. However, limited and irregular access to potable water was a constant problem. I also conducted interviews in Brenda section. Residents of Brenda left their homes in Burlington (about 30 kilometres to the south east) in the early 1980s following a dispute with the Mnisi tribal authority and were allocated new stands in KwaBomba. Almost everyone in Brenda was unemployed and households often depended for their survival on government child welfare grants and food parcels from the Department of
Social Welfare. In contrast to Hlengweni, Brenda’s residents had organised a child protection unit, AIDS awareness group and a community policing forum. From 1985 a size-able population of Mozambiquan refugees were allocated land in Tsembenenge (‘trust your feet’). The name alludes to the long walk refugees made from Mozambique. Tsembenenge was also known as ‘Springs’ (a town in Gauteng Province) because of its reputation for crime. Many Mozambiquans were employed on commercial farms as labourers, but were rumoured to be involved in the theft and sale of guns and cars.

In contrast to large-scale social and epidemiological surveys on AIDS, this article highlights the subtleties and nuances of local meanings and experiences. The information I present is based on personal participation at village events, recordings of gossip and local rumours about AIDS, as well as formal interviews on sexuality and AIDS. Gossip and rumour, as I have suggested elsewhere, evokes moral scripts that provide insights into the meanings of AIDS (Stadler, 2003).

AIDS research in South Africa has highlighted the crucial influence of gender and poverty on HIV risk. Disproportionate numbers of young women are HIV positive in contrast to men of the same age. Rates of infection tend only to level out in the older age groups. These patterns are attributed to socio-economic factors that reinforce the power of older men over younger women. Young women are thought to be particularly vulnerable to infection from HIV due to their inability to negotiate the terms of sexual encounters (Varga & Makubalo, 1996; Varga, 1997; Harrison, Xaba, Kunene & Ntuli, 2001; Jewkes, Vundule, Maforah & Jordaan, 2001). The spread of AIDS is thus attributed to poverty. Ironically, as Leclerc-Madlala (2002) argues, local discourses blame women for the spread of AIDS, while men are represented as passive recipients of HIV infection (pp. 32–33).

My research findings seemed to confirm the link between gender, poverty and AIDS. However, I argue that the focus on poverty and women’s vulnerability ignores the vulnerability of men, particularly of relatively wealthy and elite classes of men.

Young women frequently entered into sexual relationships with older men in exchange for cash and favours. Men promised women jobs, offered school girls better grades at school, and provided regular financial support and groceries in return for sexual favours. Men who provided food in exchange for sex were known as ‘lunch boys’; those who paid rent were awarded the title ‘minister of housing’; the ‘minister of education’ paid school or university fees; and the ‘minister of communication’ provided mobile phones and air time.

Poverty and relative affluence shaped the expectations and the structure of sexual relationships. The local employment market was sharply segregated between well remu-nerated civil service positions such as teaching and nursing, and poorly remunerated unskilled work on local farms. Although younger men occasionally found contract work, full time salaried jobs were extremely scarce. However, even men with the lowliest jobs were regarded as extremely fortunate and were described as the ‘wealthy of the poor’.

Younger, unemployed men complained that they were unable to attract women because of their poverty. Similarly, Hunter (2002) observes that in KwaZulu-Natal men occupy a ‘privileged position (that is) rooted in their access to the most lucrative segments of the formal and informal economy as well as to resources such as housing’, and that this underlies the material basis of sexual relations (p. 101). Women, Hunter continues, have come to rely heavily on the sexual economy to survive (2002, p. 105).

Although, villagers criticised women’s sexual behaviours, blame for the spread of AIDS was not directed at women but at men. Relatively affluent and powerful men were often labelled as ‘womanisers’ who infected their wives. Local teachers were accused of infecting school girls with HIV. Unskilled road and construction workers moved from village to village, spreading HIV. Economic migrants contracted AIDS in the urban centres and transported the virus to the lowveld. Accounts in the popular media of men who raped infants and children further fuelled local discourses of blame against men.

Villagers recognised the political nature of the AIDS crisis, and linked it to the new freedoms ushered in by the political transformations of the early 1990s. The 1994 elections created huge expectations of wealth, jobs, housing and a ‘new life for all’. As Niehaus (2000) argues, this was also perceived as a ‘sexual revolution’, making possible new forms of sexuality and relationships. This created new, untramelled desires for men and women. The objects of male and female desires were, however, distinct.

In local accounts of AIDS, young ‘beautiful women’ were said to ‘buy their own coffins’, not only because of economic desperation but also for wealth, status and entertainment. Relatively wealthy men were pursued by young women who entertained fantasies of power and affluence. These men were described as womanisers who spread AIDS because of their untramelled sexual desires. The uncontrollable and all consuming nature of desire was regarded as particularly problematic. Thus conceptualised, AIDS was not only a public health problem but posed an existential crisis that threatened the social fabric.

My article begins by showing how public secrecy about AIDS gave rise to private suspicions and rumours about the disease. I then highlight how the witchcraft idiom gave shape to local issues about AIDS. Witchcraft provides an informative analogy for local understandings of AIDS. Witchcraft is highly secretive; witches cannot be easily identified by their appearances and they behave in a surreptitious and clandestine manner. In a similar, analogous mode, HIV infection cannot be easily detected. In KwaBomba the public secrecy of AIDS was fertile ground for suspicion and speculation. Discourses of witchcraft and AIDS were also preoccupied with women and men’s excessive and untramelled desires for wealth and sex. The article then deals with accounts about men and women separately. In the discussion I try to represent the voices of both men and women in narratives of AIDS. I show how women’s accounts of AIDS drew attention to their impoverished and desperate economic circumstances. Men highlighted their perceived lack of agency in sexual decision making. My conclusions draw out the implications of these findings.
AIDS, secrets and suspicions

From a biological perspective, HIV is able to survive secretly, evading public scrutiny for years. It is possible for someone to unknowingly or even surreptitiously to spread HIV/AIDS. As Whiteside, Mattes, Willan and Manning (2002, p. 1) point out, ‘the epidemic silently creeps through the population’, only manifesting as illness and death years later.6

The social behaviour around AIDS is similarly secretive and surreptitious. Despite the large numbers of South Africans currently infected, few are aware of their status and even fewer disclose their status to family and community members. Individuals remain extremely fearful of disclosing their HIV status even privately. Public disclosure can have disastrous consequences for both the afflicted and their family members. Gugu Dlamini — a young woman from KwaZulu-Natal — was brutally murdered after she had disclosed her HIV positive status (Nicedemus, 1999). Her case became a symbol of discrimination against people who are infected by HIV.

In a survey of Sowetan’s attitudes towards people living with HIV/AIDS 38% of adults believed that people living with HIV should be separated from society, 6% believed that they should be killed and only 34% said that they should be cared for by their families (cited in Webb, 1992). Similar reports from elsewhere in Africa describe the rejection of families whose members have died of AIDS (Topouzis & Hemrich, 1995). Understandably, care providers tread precariously between maintaining silence and assisting people living with HIV/AIDS.7

South Africa does not have a national register of AIDS deaths, nor is AIDS a notifiable disease. Government intentions to make AIDS notifiable were successfully resisted by NGOs and community groups in the late 1990s (Sidley, 1999, p. 1308). The measurement of AIDS related mortality is also a complex task owing to incomplete death records and the failure of medical practitioners to certify AIDS as a cause of death (Whiteside et al., 2002). The scientific evidence of AIDS and the causes of AIDS are often fiercely debated within scientific circles, and between researchers and politicians.8

The public denial and secrecy of AIDS is a prominent feature of the South African political landscape, a drama in which science plays a leading role in both challenging and defending the evidence. Early in 2000, Thabo Mbeki, the President of South Africa, sought council from ‘AIDS dissidents’ who dispute ‘orthodox’ theories of the causal relationship between HIV and AIDS (Schneider, 2002).9

In 2001 the Department of Health publicly rejected the results of a study on AIDS mortality by the South African Medical Research Council (MRC). In a letter to the Sunday Times newspaper, the Minister of Health argued that AIDS could not be considered as the major cause of death in South Africa and accused the MRC of coordinating a ‘witch hunt’ against the South African President (Tshabalala-Msimang, Ngubane & Pahad, 2001).

High profile AIDS deaths of politicians were also denied. In 2002 press reports stated that Parks Mankabalanla the presidential spokesperson had died of AIDS. These allegations were denied but later it was revealed that he was ‘poisoned by anti-retrovirals’ suggesting that he had died of AIDS (Kindra, 2002).

In a document released by certain members of the African National Congress during 2002 entitled Castro Hlongwane, caravans, cats, geese, foot and mouth and statistics, the authors point out that AIDS is not simply a scientific, biomedical problem but is a threat to a new African-ist identity. The preface states that:

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

This discourse of denial resists biomedical models of risk that associate AIDS with the dangerous ‘anti-social other’ and that portrays people as vectors of disease, and as guilty bearers of misfortune rather than as people requiring compassion and support (Leap, 1995, p. 229). Targeting sex workers and other ‘at risk’ populations contributes towards the ‘othering’ of people infected by HIV/AIDS and the marginalisation of ‘risk groups’ (Farmer, 1992; Schoepf, 2001).

In KwaBomba, my field site, AIDS was also shrouded in secrecy and denial. Public reference was seldom made to AIDS directly, with the exception of rituals such as World AIDS Day ‘celebrations’. In funerals orators would state that the deceased had been ill for a long time but provided few additional details.

The public secrecy of AIDS caused confusion as people struggled to establish the cause of death. At the funeral of Norah Qibe, a 45-year-old woman, no mention was made of AIDS. Instead the cause of death was announced as ‘TB’. After the funeral a young man told me that HIV/AIDS was listed as the secondary cause of death on the death certificate. He remarked that this had shocked him as Norah was an older woman and she did not have many sexual affairs. Norah’s older sister later started a rumour that claimed that a neighbour had bewitched Norah. However, Norah’s younger relatives refuted these claims and argued that they were an attempt to deny that Norah had died of AIDS.

A young man from KwaBomba summed up the problem of denial and secrecy:

According to my view I do not see anyone who has AIDS in this village. Our problem is that we have seen people dying, but they are hiding. They are not saying that he or she was killed by AIDS, but that they are killed by this or that.

An elderly woman appealed for mandatory HIV testing at the local high school to reveal how many of the students were infected.

After taking the blood and the results come back they will know how many of the students at (the local high school) are HIV positive. It will make them scared because they won’t know who is HIV positive. If the boy proposes the girl she will be scared. She will think maybe it is him. Maybe he is HIV positive.

Avoidance of AIDS was evident in the way people talked about AIDS. AIDS was jokingly referred to as ‘OMO’ (a brand of washing powder with three letters), or a ‘house in Vereeniging, (spells out H – I – V). Others spoke of AIDS as
the ‘shameful disease’ or the ‘shy disease’. People living with HIV/AIDS were identified as ‘one of them’. Others simply avoided any reference to AIDS. A young woman complained that her boyfriend would turn off the television whenever an AIDS related programme was broadcast. An elderly woman suggested that the government should construct an ‘underground tunnel’ in the village to provide a secret meeting place for people with AIDS.

The silences around AIDS were difficult to sustain. The growth of funeral homes and the commonplace sight of multiple funeral processions brought home the reality of the epidemic. The sheer number of funerals held over the weekend created logistical problems and organisers struggled to ensure that events did not coincide. On a weekend in June, 2002, nine funerals were held in KwaBombha. Six of the deceased were suspected to have died from AIDS. As a friend remarked ‘now you can really see there is AIDS’.

My neighbours and friends had all heard of, or known someone, who had died of AIDS. Some had lost siblings, cousins, spouses, lovers and grandchildren. Informants could point out the homes in their neighbourhood that had experienced AIDS deaths. Multiple deaths within the same household were also relatively common. In one case a 40-year-old woman and her 19-year-old daughter both died of AIDS.

News of death — barring accidental death — was almost always accompanied by the speculation and suspicion of AIDS. It was said that it was impossible to die from an illness without speculations of AIDS being voiced. However, public secrecy prevailed. Thus although private suspicion of AIDS was extremely common, public denial of its existence was strong.

Secrecy, avoidance and denial of AIDS created barriers to my fieldwork. Young men were aware of the AIDS epidemic, but seldom provided detailed descriptions of AIDS deaths. Older men usually lacked even rudimentary awareness about AIDS. In contrast both young and old women were fairly knowledgeable about AIDS deaths.

Respondents exercised extreme caution when talking about cases of AIDS, nervous that I would publicise these details in the media. Some feared arrest if they identified people who had died of AIDS, a concern reminiscent of witchcraft accusations (Stadler, 1996).

Taking these limitations into account, I documented the details of forty seven deaths attributed to AIDS. Formal interviews were not an ideal setting for asking questions about AIDS deaths. Only those informants who knew me well were prepared to talk openly about their personal knowledge of AIDS deaths. I found it more productive to raise the topic in informal conversations with villagers with whom I was well acquainted. I also listened to local neighbourhood gossip and requested key informants to reconstruct conversations about AIDS. Where possible, AIDS deaths were explored from the perspective of more than one informant.

At one level the evidence of AIDS focused on the physical appearance of the deceased and their symptoms. The signs of AIDS were identified as thinning hair, reduced body mass, open sores, constant diarrhoea, advanced venereal disease, and a persistent and bad cough. People who were ill for long periods or who were frequently ill raised suspicions of AIDS. The death of a sexual partner, husband or wife, or a new born child also contributed to these suspicions. People who died at a young age were usually suspected of AIDS.

Suspicion of AIDS were also confirmed by knowledge of the person’s behaviour and character or heart (mbilo). Young women who socialised in drinking places with older men and were seen on the streets were believed to be susceptible to AIDS. Particular locales such as the shopping centres and urban centres were associated with HIV risk. Girls whose boyfriends were taxi drivers and teachers were thought to be HIV positive.

However, the evidence of AIDS was not unequivocal. Suspicion of AIDS were often questioned and even refuted. Informants admitted that they could not always be completely sure that AIDS was the cause of death. A 35-year-old, unmarried mother of two healthy children died from unknown causes. While her symptoms appeared to confirm AIDS, many of my informants expressed doubt as she was ‘respectable’ and not known to be someone who slept around.

Inaccurate biomedical knowledge and the similarities between the symptoms of AIDS and other illnesses contributed towards doubt and confusion regarding AIDS deaths. Conditions known as rixilana and tindzaka had similar symptoms to AIDS: weight loss, thinning hair, pale complexion, and fever and coughing. Rixilana afflicted young girls who had sex with older men. Tindzaka was caused by having sexual relations before the end of the period of mourning.

Healers distinguished between AIDS, tindzaka and rixilana. One healer claimed that AIDS caused a severe cough unlike tindzaka that was less severe. Another healer diagnosed AIDS from the colour of her patient’s faeces. Health care professionals spoke of the ‘face of AIDS’. A nurse in charge of voluntary counselling and testing at a government clinic detected AIDS by looking into a person’s eyes. The eyes revealed if they had been sexually active with many different partners.

Most suspected AIDS deaths took place between 1999 and 2003, the period during which AIDS is said to have arrived in the village. Women accounted for 62% of these deaths, and men for 38%. The mean ages of the women were 27.8 years, and their ages ranged between 17–50 years. The men were on average ten years older, with mean ages of 39, and their ages ranged between 20–65 years. Few (20%) of the women had access to an income; only three were formally employed. Six (20%) of the women were scholars. In contrast, many of the men (70%) had incomes. Most were in formal employment, notably as teachers, while others were employed locally with the Department of Public Works, and some were migrants.

These data reveal the occupational, age and gender dynamics of AIDS mortality. Younger, unemployed women and a smaller number of older wealthier men died from AIDS. AIDS was thus transmitted across age categories and affected both the affluent and the poor. However, the data do not reveal why these deaths were seen to be due to AIDS, nor do they indicate what these deaths meant in terms of local conceptualisations.
AIDS and witchcraft: Secrecy and desire

Appealing similarities can be drawn between AIDS discourses and another salient and widespread discourse, namely witchcraft. The relationship between AIDS and witchcraft has not gone unnoticed in recent anthropological writings. Yamba (1997) sees witchcraft as a way by which Zambians comprehended the epidemic in the absence of suitable biomedical explanations and the lack of a cure. He documents the resurgence of witch-finding as a logical response to the epidemic. Likewise Ashforth (2002) argues that in Soweto, South Africa, the current AIDS epidemic will become an ‘epidemic of witchcraft’. Elsewhere, traditional methods of dealing with witchcraft have been adapted to deal with the AIDS crisis. Probst (1999) documents the re-emergence of Mchape in Malawi. In the 1930s Mchape was a witch cleansing movement that sought to rid society of all witches. However, the Mchape movement of 1995 was directed at people who were infected with AIDS, professing to cure them.

The phenomenon of witchcraft in the lowveld has been well documented (Stadler, 1996; Niehaus, 2001). Lowveld villagers evoked witchcraft in the event of incomprehensible misfortune of a physical and mental nature. They referred to three forms of witchcraft: poisoning, magical medicine, and witch familiars. Witches’ methods of attack were usually surreptitious and invisible. The victims of witchcraft were transformed into zombies (xindhachani) and forced to work for the witch. Witches were motivated by their envy (‘jealousy’) of other villager’s fortune (Stadler, 1996, pp. 90–94). Accusations of witchcraft were often levelled at poorer, older men and women as they were most likely to experience feelings of jealousy and resentment toward the younger generation (Stadler, 1996).

It is tempting to seek an ethno-etiological link between witchcraft and AIDS. However, there was widespread agreement amongst my informants that witchcraft did not cause AIDS. People either died of witchcraft or of AIDS. Witches took advantage of the high mortality rate and ‘hid behind’ AIDS. Witches also struck at those who suffered from AIDS related illnesses to escape detection. However, witches could not send AIDS. Witchcraft was also used as an explanation for death to conceal AIDS deaths. A healer admitted that she told her AIDS patients that they were bewitched to spare them shock and shame.

Witchcraft is not simply a convenient explanation for AIDS. Instead I suggest that witchcraft provides a moral metaphor at the level of analogy for understanding the AIDS epidemic. I explore this analogy with regard to denial, secrecy and desire.

An interesting parallel can be drawn between official discourses on AIDS and witchcraft. In a similar manner as government denies the existence of AIDS, it denies the existence of witchcraft. Current legislation makes it illegal to impute or point a person as a witch.12 Likewise, the identity of those living with AIDS is protected by doctor–patient confidentiality. At the local level, denial of the AIDS epidemic was apparent in the secrecy surrounding funerals. The public naming of people living with AIDS was considered insulting and improper. Insinuations of AIDS were made but only privately and often in a joking manner.

Sex is often the subject matter of witchcraft beliefs. However, villagers did not make a literal comparison between the sexuality of witches and sexual behaviours and AIDS. Instead, I argue that secrecy and desire (sexual and material) are the core concerns of discourses of AIDS and witchcraft and provide the core substance of this analogy. Niehaus (1997) points out that witches could not be identified from their physical features. Witches assumed the form of familiars at night that remained hidden during the day. Witchcraft accusations were often based on circumstantial evidence: the sight of a baboon or a snake in a person’s yard, incriminating statements, a close relationship with well known witches and ‘excessive secrecy’ established the identity of witches (Niehaus, 1997, pp. 255–256). Witchcraft attacks were usually impossible to detect until these manifested as illness. Magical potions were concealed on foot paths and yard entrances to catch unsuspecting victims. Witches ate their victims invisibly while they slept and used dreams to send poison, and could pass unhindered through walls and underneath doors (Stadler, 1996).

Accounts about witchcraft were also concerned with the problem of unrestrained desire for wealth and sex. Witches were thought to be completely dominated by their desires: ‘Witches, like animals (…) do not merely succumb to their desires at times, but are completely dominated by their cravings for food, sex, money and revenge’ (Niehaus, 2001, p. 49). This is most cogently expressed in beliefs about witch familiars. Familiars such as the tokolotsi were often said to have hugely exaggerated sexual features and represent an ‘animal-like craving for uninhibited sexual expression’ (Niehaus, 2001, p. 46). The mamlambo, a snake-like familiar appears as a small fish or twig and later transforms into a large snake and an attractive woman or man. The mamlambo provided sexual gratification, wealth and financial success to those who acquired it, but was highly destructive because of its excessive and increasing demand for (human) blood. Niehaus (2001) argues that the mamlambo ‘objectifies the desire for money in a context of social and economic deprivation, and highlights the destructive social effects brought about by the unrestrained quest for wealth’ (p. 47). Men often acquired the mamlambo due to their lust for women. Women sought wealth and commodities. The following two cases illustrate these points.

A young man called Farius Ndlovu desired a beautiful wife, but was unsuccessful in his proposals to the women he met. When he worked in Johannesburg Farius came across an advert in the classifieds of the Ilanga (Zulu newspaper) that guaranteed him success with attractive women. He sent off R100 and received a parcel containing a small root and instructions. The root was to be placed in his pocket. When Farius saw the woman he desired he simply had to touch the root and speak to her. Farius was soon married to a beautiful woman who was light in complexion. One night, after being married for some years, Farius discovered a huge snake in the bathtub. He ran away calling to his wife to beware. To his surprise she emerged from the bathroom unscathed. Later, he recounted these events to his uncle and was told that his wife was a mamlambo, and had transformed into the snake.

NwaXuma was an elderly unemployed woman who
bartered cheap porcelain figurines in exchange for second hand clothes from Whites in Johannesburg. She then resold these clothes in Bushbuckridge. However, the clothes were usually in a poor condition and she struggled to sell them. In desperation NwaXuma visited an n’anga (traditional healer). The healer cut her wrists and mixed muthi (magical potion) into the incisions. That night NwaXuma left a bowl of fresh chicken blood in the yard. This ritual was intended to ‘trick’ her White customers into giving her their best items. Indeed, for a while NwaXuma’s business had prospered. However, her fortune soon began to dwindle and she was left worse off than before. Rumours circulated that she had a mamlambo. The familiar appeared in the form of a White man with long hair and a long beard, floating face down in a small dam next to her homestead. Neighbours alleged that the mamlambo had started to demand human blood, and NwaXuma had started to kill her neighbours and even her kinsfolk for their blood to satisfy its cravings. But NwaXuma was unable to rid herself of the mamlambo — ‘it was in her blood’.

As I noted above, HIV is a silent epidemic, only manifesting itself as AIDS towards the end. Many villagers were aware that people who are infected by HIV cannot be easily detected. Even the most beautiful and healthy looking individuals could carry the virus. Young men and women feared that they may unknowingly become infected by someone who had HIV through sexual as well as accidental contact with contaminated blood or other bodily fluids. People infected by HIV were also rumoured to surreptitiously and purposely infect others, so as ‘not to die alone’. The virus itself was described as being so small (xitsongwanwana) that it could permeate through the ‘tiny holes in condoms’. These statements attest to peoples’ perceptions of the power of HIV. After all, I was told thus far it had proven to be indestructible.

Other properties of AIDS mirrored witchcraft beliefs. HIV could catch a person unawares. A friend of mine once acquired a new mobile phone and new clothes with money he earned doing part time work. A young woman warned him not to linger on the village roads and footpaths. He suggested that this could mean that he was in danger of being bewitched because other villagers were envious of his good fortune. But he admitted that it that it could also be a warning about AIDS. He had had several proposals from women who had admired his new clothes and phone. Parents warned their daughters to avoid the street at night. Here they could be raped by men and possibly get AIDS. For other informants catching AIDS was a matter of bad luck; why else was it that some people appeared to be immune to the disease despite their behaviour? A group of construction workers refused to use condoms. One worker argued that none of his colleagues had ever become sick from AIDS even though they had unprotected sex.

Accounts of AIDS deaths implied a close association between secrecy, sex and AIDS. People who conducted secretive sexual liaisons risked infection by HIV. Women doubted the status of their husbands: ‘You don’t know what he does when he goes out there’ commented a young woman. Secret sex took place at night, in the bushes next to the road with strangers. These locations were anonymous and evaded the surveillance of parents and elders. A specific location was pointed out to me on the road that joined KwaBomba with a nearby town. Here young girls were known to wait after dark for men in cars. The men took them to a nearby motel where they rented rooms and purchased meat and beer for the girls. At one point these activities reached the notice of village elders and a local community radio station even broadcast complaints, warning motorists not to pick up girls at that location because the girls would ‘steal your car and give you diseases’.

As with witchcraft, narratives of AIDS drew a link between AIDS and sexual desire. The following two narratives reveal the symbolic resonances between accounts of AIDS and witchcraft, respectively.

A hairdresser from Bushbuckridge who works in the upmarket suburb of Rosebank, Johannesburg recounted the following story. A beautiful young woman had a relationship with an older man. He was kind and courteous and bought her fashionable clothes, took her to good restaurants and drove her around in his car. One weekend they visited his parents in a village of Lesotho. Upon arriving he ordered her to remain in a darkened hut and locked the door. He warned her to remain still and not to make any noise. Dutifully she waited in the dark. Suddenly she felt the presence of a creature inside the room that grabbed her breasts and sucked the blood from her body. Weakened and close to death she was delivered home and her parents were handed a suitcase full of money. ‘Your daughter is now dead’ said the man. ‘This money is for her funeral, take it and use it to buy her coffin.’

This case makes direct reference to witchcraft and specifically to witch familiar, the mamlambo. While it does not mention AIDS specifically, it resonates with similar accounts that do. In one such account an American tourist asked a woman who worked as a cleaner for a local game lodge to find him a prostitute. He promised to pay R2 500.00 for only one night. Loath to let the opportunity to make money pass by, she offered herself to the man. They had sex and the next day he gave her a suitcase full of money. On leaving he told her ‘You now have AIDS... take this money and use it to buy your coffin’. She was shocked, and told her family what had happened. She died several months later.

These accounts construct moral narratives about the pursuit of wealth and how this erodes sentiments of kinship and neighbourliness. Funerals and the rituals surrounding death were key events in village social life; in certain respects they are the core rituals in lowveld culture. Failure to regularly attend funerals risked being ‘buried alone’. Coffins were usually financed by the broader family or community, representing the unselfish act of sharing. Families who were too poor to afford coffins evoked pity and sympathy and sometimes neighbours and kin made voluntary donations to purchase a coffin. Even those with small incomes joined burial societies and schemes to provide for expensive and ostentatious coffins. Participation in burial societies was not only a question of financial contributions, but was a fundamentally social act necessitating attendance at members’ funerals and sharing in the preparation of the feast. In contradistinction, to buy one’s own coffin was a potent statement of independence and the rejection of kin-
ship, good neighbourliness and sentiments of reciprocity. This discussion has revealed the symbolic resonances between AIDS and witchcraft. Both were highly secretive and relied on circumstantial evidence and subjective interpretations. Both also attempted to deal with the perennial problem of untramelled desire and restraint. However, the types of individual who were ‘accused’ of AIDS were distinct from those who were accused of witchcraft. Accusations of witchcraft targeted the poor and often the elderly. In contrast, HIV affected the ‘rich of the poor’, the young, the attractive and the desirable.

The metaphorical similarities between witchcraft and AIDS have been noted elsewhere. Fordham (2001), remarks that in Thailand prostitutes are demonised and portrayed as the antithesis of ‘good women’ because of their ‘uncontrolled and rapacious sexuality’ (Fordham, 2001, p. 295). Like witches, prostitutes invert normal social behaviours and expectations: they were only seen at night, they appropriate male behaviours (such as drinking), yet they are able to conceal their true identities. Finally they are accused of destroying the moral and the physical foundations of society and of spreading AIDS (Fordham, 2001).

Kelly (1976) provides a fascinating discussion of witchcraft and sexual relations in New Guinea that has relevance to the current analysis. He argues that ‘(W)itchcraft and sexual relations occupy analogous structural positions within a larger conceptual system’ in which ‘life and death are complimentary and reciprocal aspects of the transmission of life-force’ (p. 51). A person’s life force is contained within a man’s semen, but is in limited supply. In terms of this conceptualisation women ‘who engage in excessive sexual relations’ are accused of witchcraft (p. 51). They wastefully and greedily take the life force of men. Likewise, male youth who engages in unsanctioned homosexual intercourse with his peers is like a witch, because he depletes others life force (semen) at their expense (Kelly, 1976, p. 50).

I argue that at an analogue level witchcraft beliefs provide a manner of conceptualising AIDS. However, I suggest that it would be simplistic to interpret this to infer that people living with HIV/AIDS are literally conceptualised as witches. Rather I follow Kelly’s (1976) lead who argues that ‘the analogical correspondence between acts of witchcraft and acts of sexual relations connotes a like relation between the characteristics of the (respective) actors’ (p. 5, my emphasis). The analogy is appropriate because of the distinct symbolic resonance between the two discourses, in terms of the denial and secrecy and the attributes of avarice. The following sections explore these leads in greater depth by looking first at women and then men who were identified as having died from AIDS.

Scratching the ground like a chicken: AIDS as a survival strategy

Many young women in KwaBomba entered into relationships with older men who provided them with gifts of commodities, groceries and cash. Women described these relationships as uku phanda, a Zulu phrase that means to ‘scratch the ground for food like a chicken’. Implicitly this involved trickery and pretence. As a young woman remarked: ‘we just pretend to love the man meanwhile we love his money’. Uku phanda was compared to ‘robbery’ (ku pirates) and to ‘pluck the feathers from a chicken’ (ku hiewa).

Informants drew a clear distinction between magosha (prostitution) and ku phanda (to survive). Whilst women readily admitted to uku phanda they strongly disagreed that they were magosha. They represented phanda as an entrepreneurial exercise, not very different to selling second hand clothes, cheap jewellery and beauty products, or joining pyramid schemes. These were often the only income generating activities for young women. These relationships involved more than sex: women often lived with and cooked and cleaned for their male lovers.

Women who did phanda received support and (albeit unspoken) encouragement from family members. Indeed, entire households were often totally dependant on the proceeds from uku phanda. Wojcicki (2002) made a similar observation of this distinction in Soweto and Hammanskraal. Hunter (2002, p. 108) also noted that in KwaZulu-Natal, ‘prostitutes’ were defined as outsiders who sold their bodies, while women chose their lovers.

Pinkie Sithole was a 29-year-old woman who lived in KwaBomba with her five sisters, her 6-year-old daughter and her mother. Pinkie’s father had never supported her and her mother was unemployed. Pinkie’s mother rented out rooms in a shack settlement close to the Carltonville mining hostels in the North West Province. In her early twenties Pinkie moved in with her mother. Although her mother helped Pinkie to find accommodation she was unable to support Pinkie financially. ‘Go out and find a man’ she said when Pinkie complained to her mother about the lack of food. Pinkie met a Zimbabwean man who drove a large four by four and provided her with the funds to start selling inexpensive jewellery. Although he was generous he suffered from extreme jealousy and once pistol whipped her in the face. Pinkie returned home to KwaBomba. Soon Pinkie met an elderly, former school headmaster who supported her well. She continued to have relationships with other men. Pinkie rationalised her cynical manipulation of these men as her only way of providing for herself and her daughter. She funded the construction of three additional rooms to her mother’s house and purchased an expensive sound system and several items of furniture. A neighbour remarked on Pinkie’s good fortune ‘She has hit the jackpot’.

Women such as Pinkie maintained rather than threatened household integrity and survival. Muecke (1992) observes, young Thai women who became ‘prostitutes’ were not viewed as problematic because through their activities they were able to fulfill the cultural expectations of their communities. Certainly, Pinkie and other women played an important role in building the household and contributed significantly towards household survival. However, other women who had fallen to AIDS demonstrated its dangers. It was well known that Pinkie’s mother’s sister (maki ntsongo) also had several lovers who had helped her to build a house, furnish it and support her. She died of AIDS in 2002 several months after one of her boyfriends had died. Her other lover, a Mozambiquan mine worker was also rumoured to be extremely ill.
A second category of women who were susceptible to AIDS were those who had many sexual partners. However, they did not use their relationships with men to survive, but for entertainment (ku jolla). They were criticised and labelled as an ngwadla, magosha, isifebe, and an ngwavava (loose woman, slut and prostitute). A young man remarked that the young girls who were seen hitch-hiking were not impoverished: ‘Just being in the car is good enough... a cold drink is a bonus. The girls don’t want anything. They just want pleasure.’ A young man alluded to the pursuit of pleasure in his account of his cousin’s death:

Now that she has passed away I can be sure it was AIDS because she was running. There was no reason for her to run; her father had plenty of money. She was just good looking. Men said ‘baby you are beautiful. I love you. I want you to be my wife’. So, she would feel happy and then she would go to them. Her boyfriends were many.

These themes emerge in the case of Elizabeth Mkhabela. Elizabeth was described as one of the most beautiful girls in the village and was sought after by many men. She died at 18 years in June 2002. At age 13 Elizabeth’s mother died and her father remarried. Elizabeth’s father bought food for his children but lived in a separate homestead with his second wife. Elizabeth lived with her two younger sisters (aged 15 and 13) and her older brother of 22 years. Elizabeth became sexually active around the time of her mother’s death. Joseph, a former boyfriend recalled: ‘It was early! I am one of her boyfriends. I think I was the first one’. However, Elizabeth soon broke off their relationship. Joseph remembered Elizabeth’s words: ‘My brother. Ah! I cannot go on having sex with you. I must try to get the one who is bigger than you. And then I will be very much fine because I need to satisfy myself’. Joseph recalled that Elizabeth had sex with six different men in a single week. Her lovers included two school teachers, a taxi driver, the local football coach, and two men from outside the village. Before she died Elizabeth was seen in the company of policemen. She was driven around in a police van, drinking beer.

In 2001 Elizabeth appeared ill. Her former school teacher recalled that her breasts appeared shrunken and she did not appear well. He suspected that she had had an abortion. In 2002 Elizabeth was incapacitated and remained at home. Her siblings looked after her as best they could. A neighbour recalled that she was constantly thirsty and begged for iced water. Elizabeth’s father took her to a local public hospital, but he was told that they could not help her. By now Elizabeth she was terminally ill and her body looked like a ‘tiny parcel’. Before her death her older brother tried to help her. He pushed her in a wheelchair ten kilometres down the main road to the nearest clinic. She died the same day.

The following is a reconstruction of a conversation between Elizabeth’s former boyfriend Joseph, and his friend Benson, about Elizabeth’s death. The dialogue illustrates how consensus was achieved that Elizabeth had died of AIDS.

Joseph: I was visiting my girlfriend. I met one boy. He told me Elizabeth is dead. He explained she was killed by AIDS. So I said ‘Why do you say that?’ He said ‘She was sick for a long time and her hair looked very thin and her body was thin’. I met another person. She told me that Elizabeth was dead. I asked why and she said Elizabeth was killed by AIDS. So I asked ‘why do you think that?’ That girl said that Elizabeth was a prostitute girl. She had been warned to stop prostitution but she never listened.

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

Elizabeth’s narrative highlights the danger of reckless and uncontrolled sexuality in contrast to women who used sex as a means for survival. The distinction between pleasure and survival sex is similar to the distinction between ‘consumer and survival sex’ that Hunter (2002) makes in his description of relationships in KwaZulu-Natal. The implications for HIV infection, are however the same. Both types of relationship made women vulnerable to HIV infection.

Both survival and commodity sex draw attention to the transactional nature of sexual relationships. However, the transfer of gifts and cash between sexual partners was not in and of itself problematic. Gift exchange was an integral aspect of romantic partnerships and culminated in the transfer of bridewealth (ndzobolo). Rather, to quote Weiss (1998, p. 24), women’s actions were particularly reprehensible due to their inability to ‘curb their desire for money and wealth’.

**Wealthy men and beautiful women**

A beautiful woman is a subtraction of money, a multiplication of enemies, a division of relatives and an addition of worry (Bumper sticker on a car in Bushbuckridge, January 2003).

As this passage laments, beautiful women are highly desirable, but troublesome. They cause disharmony in the family and deplete your income. However, men’s sexual behaviours were subject to the same critical scrutiny as women. Husbands were accused of wasting their incomes on ‘outside women’ who had fooled them into believing that they loved them. Men, particularly older and wealthy men, ‘go out there and get AIDS’ and then transmitted the disease to their wives. As a young married woman remarked, ‘Why should we women not do the same as we will get AIDS from our husbands anyway?’

The analysis of AIDS deaths in KwaBomba reveals three distinct categories of men to whom the spread of AIDS was attributed. These categories reflect the attributes of wealth, social status and mobility.

First, professional men such as school teachers were the wealthiest and most influential men in the village. They owned cars, built large houses and had disposable income for alcohol and luxury items and food. Teachers also occupied senior positions in church, were orators at weddings and funerals, and served as members in local development committees. Locals even gave the nick-name ‘teacher’ to a more exclusive brand of beer. However, teachers were ‘corrupt’ and used their positions to have sex with school girls.
and young women, and infected them with AIDS. Nationally, AIDS has had a disastrous impact on the teaching profession.\textsuperscript{16} My research indicated that three of the men who died of AIDS between 1999 and 2003 were teachers, and more were rumoured to be infected. A local physician once remarked that he found it surprising that most of his AIDS patients were the ‘educated ones’ such as teachers and policemen and not those ‘who are deep in the bush’.\textsuperscript{17}

Second, men who migrated to the cities had affairs and transmitted AIDS to their wives and girlfriends at home. They were accused of bringing HIV from the city to the countryside. Anyone who had visited the city was suspected of being infected. However, less was known of these cases as the men tended to become ill while away from home and only come home to die.

Third, labourers who worked on road and housing construction projects travelled extensively within Bushbuckridge. They were paid weekly and often had cash to spend on alcohol and on gifts for women. An informant suggested that the arrival of AIDS in KwaBomba could be traced back to 1996 when the main road that connects the village with a nearby town was still under construction. Road workers camped in tents next to the village and had sexual relationships with local women.

Men had varied types of sexual relationship. Younger, unmarried men had medium term relationships with cheri’s (girlfriends). They also had brief sexual encounters with ‘prostitutes’ they met in shebeens in exchange for beer or cold drinks. Unemployed men’s sexual exploits were however limited by their financial circumstances. Older, married and employed men had wives and occasionally a co-wife. They also had secret lovers who were prospective wives.

Spiegel (1991), reports that Basotho men who kept bonyatsi (mistresses) appealed to a tradition of polygamy to legitimise their extra marital affairs. Male informants in the lowveld made a similar claim, and argued that their ancestors had had many wives and that polygamy was part of their birth right. Men also drew a distinction between the respectability associated with marriage, and the desirability of unmarried sexual partners.

Unlike a wife, a mistress or ‘secret lover’ (xigangu) was expected to be sexually adventurous, and to provide a man with sexual satisfaction. One of my informants recalled that his mistress once surprised him by exposing her breasts to him in the dining room, before she had sex with him. In contrast he described his wife as dull and unadventurous. In their extramarital relationships men felt free to experiment with different ‘styles’ such as ‘dog style (from behind)’, ‘woman on top’ and ‘sheep style’ (standing up). A young man elaborated:

Even when we Blacks live with a wife in a house, the men have something they are hiding — a secret. They are afraid to do something especially in bed. So the mistress is free to do everything she likes to do. She will do different styles. Your wife will do it normally.

Men who were accused of spreading AIDS had excessive sexual appetites. Bennet Magagule, a young teacher described a male colleague, Derrick Gumede, as a notorious drunkard who ‘would fuck anyone who was available. He did not want an affair; he just wanted a fuck’. Derrick never used condoms and would drink in the shebeens until ten o’clock at night. One night Bennet and Derrick ‘got hold of two young girls’. My informant eventually stopped drinking with Derrick. Bennet recollected that he ‘almost died of liquor’. Derrick also had an affair with a 17-year-old girl with whom he had a child. Bennet suspected that Derrick had infected her with AIDS. Late in 2000 Derrick was admitted to hospital. He returned to teaching three months later. Bennet recalled that Derrick had recovered, but he ‘was pale, skin-ny and powerless. His hair was soft and fluffy. He was coughing a bit and struggled to talk’. Derrick explained that he had had TB but felt better. Three months later Derrick was dead. After the funeral, rumours circulated that Derrick had slept with a girl who had had an abortion and this had caused his death. Bennet commented: ‘This may be true, but the way he went around with girls it might be AIDS’.

Titos Mbowane a 40-year-old man who died of AIDS, was described as a ‘real womaniser’. Titos was an employee of the local Department of Works as a road team supervisor and a preacher in the Apostolic Zion Church. A neighbour described Titos’ illness and subsequent death as follows:

I first noticed he was sick in June 2002. He developed pimples on his face and on his hands and became really thin. He couldn’t play soccer anymore. He went in and out of hospital. Sometimes he became better but then became really ill.

Titos left behind four wives and fourteen children. Following his death, the two youngest wives returned to their parents’ homes. One of his other wives died of AIDS, and the other wife is severely ill. In addition, Titos had several mistresses. As his neighbour remarked, ‘if he had AIDS he gave it to many people’. At one point the local Child Protection Unit (CPU) even informed primary school pupils to beware of Titos. A member of the CPU told me that he was concerned that Titos had infected several school girls with HIV. Characters such as Titos epitomised villager’s fears and concerns for the safety of their children.

Men such as those described above were regarded as being unable to control their desire and pursuit of women. Their excessive sexualities spread HIV and caused AIDS. The capacity to control one’s sexual desires was extremely important in the construction of an adult male identity. Ideally, wanuna ntiyela (senior men) were able to display control through their ability to manage the household and women. This was distinct from junior males (majaha) who were impulsive, prone to fight, and multiple sexual partnerships. This concept was best expressed through dramatic form, particularly through dance. At the weekly muchongolo dance rival teams competed for a prize by displaying their dancing skills. While individual younger dancers were applauded for their prowess, the aesthetic of muchongolo lay in the ability of the team to display absolute uniformity in movement. Uniformity created a visual and aural demonstration of balance and order, restraint and harmony.

However, men’s narratives of masculine sexuality highlighted their lack of agency. Women could ‘confuse’ a man, causing him to lack reason and rational judgement. Betwell Swelane was one such a man who seemed incapable of asserting his authority over his wife. Betwell worked as a
miner in Barberton. His wife was thought to exercise excessive control over him. She had several boyfriends and controlled the household budget and gave him R50 pocket money. ‘What do you want from money — cold drink?’ she used to ask Betwell. ‘It is very cheap — only five rand. You can buy at least ten cold drinks with this money.’ Betwell was also forbidden to smoke or drink beer. Young men scorned men who were ‘controlled by women’. They suggested that Betwell’s wife had used dyisa (magical potion) to make him love her.

Men also spoke of the sensation of the ‘loss of control’ and ‘madness’ that accompanied sexual stimulation (Collins & Stadler, 2000, p. 329). This was articulated as the gradual thickening and flow of blood, stimulated by the sight of a beautiful woman. Women who used skin lightening agents and other beauty products or had large buttocks, breasts and thighs were described as particularly attractive.¹⁸ Men’s crude commentary drew attention to envisioned sexual dexterity: ‘She can tow a caravan!’ A young man joked that although some women were ‘horrible to look at’ and ‘ugly’, but when he saw them ‘it reports down there (in the groin). She possesses me’ (na tala: isiZulu).

Alcohol also contributed to loss of control. In their sexual biographies men admitted that they were often unable to control themselves while drunk, and slept with numerous younger women that they met at drinking houses. A young man, a post office employee, told me that after he had had several beers he would choose any young woman and have sex with her in the bushes. He would then return home in the early hours of the morning to have sex with his wife. The next morning he would recall what he had done and worry that he had not used a condom. Although he acknowledged that his behaviour placed him at risk of infection from HIV, he claimed to experience amnesia whenever he was inebriated.

Loss of control also featured in narratives of rape and bestiality. A 45-year-old man was rumoured to have raped his wife’s step daughter. This had taken place in his wife’s absence while she worked as a labourer on a local citrus estate. He was also arrested for allegedly raping a neighbour’s goat. Although neighbours participated in arresting the man they commented that he was simply unable to control himself during his wife’s long absences. Likewise a young man, who had just returned from an initiation lodge, raped his neighbour’s dog on a nearby building site. His friends explained that he was in a heightened state of sexual stimulation, and ‘really needed a cheri (girlfriend)’. Witnesses laughed as they described how he ‘romanced’ the animal, prior to penetration.

Some men who were unable to satisfy their sexual desires were suspected of using witchcraft. Theko Magagule, an old unmarried man was said to use his munjhonhela phansi,¹⁹ to have sex with unsuspecting female victims when pretending to be asleep at the shebeen. Local youth who discussed his behaviour suggested that he was too stingy to support a family. Theko was known to eat an entire chicken and only shared the least tasty pieces with his partner.

This discussion has drawn attention to discourses of excessive and uncontrollable masculine sexualities. Men drew attention to their perceived lack of agency in sexual decision making. Women likened men to ‘dogs’, unable to control their sexual desires. Ironically, relatively wealthy men were portrayed as disempowered and unable to exercise self control. As in discourses of witchcraft, wealth corrupted and eventually destroyed them.

Conclusions

Young women are often portrayed as highly vulnerable to HIV infection due to their inferior social and economic status, and shoulder the blame for the AIDS epidemic (Leclerc-Madlala, 2002). Women and AIDS are not only ‘linked constructions, they are really one construction. Woman is AIDS’ (Leclerc-Madlala, 2001, p. 43, original emphasis).

The material presented in this article has suggested a different interpretation that highlights the allocation of blame for AIDS at men. This is supported by the evidence of men, and notably relatively wealthy men, who have died from AIDS. Furthermore, AIDS was not related to women’s ritual pollution or ‘misfortune’. Instead, narratives constructed AIDS at an analogical level as witchcraft. AIDS and witchcraft referred to similar conceptual frameworks that dealt with the perennial problems of sexual secrecy, desire, greed. Narratives of AIDS and witchcraft thus seemed to be woven from the same cloth.

I suggest that the focus on young women’s vulnerability ignores and obscures the significant HIV risks that men face. My research in the lowveld revealed a link between relative affluence, power and mobility, masculine sexuality and AIDS. Although men certainly had material advantages over women, this did not protect them against becoming infected with HIV and dying of AIDS, and infecting women. On the contrary, power had a negative influence on men’s ability to protect themselves and their wives and families from AIDS. It appeared that the more educated, better skilled, higher income earners experienced increased susceptibility to AIDS.

These observations at the local level are supported by large scale epidemiological studies of HIV in South Africa. A survey of men employed in a large parastatal company revealed that HIV affected both workers and management (Colvin, Gouws, Kleinschmidt & Dlamini, 2000). A recent national HIV prevalence study suggested that wealthy as well as not so wealthy Africans had similar levels of risk to AIDS (Shisana, 2002, p. 62).

Marks (2002) draws similar conclusions as I do here, and points to the high numbers of South Africa’s educated and affluent elite who have been infected with HIV. She argues that ‘(H)igh-risk situations do not in themselves cause AIDS, even if they do explain its rapid spread. If they were causal, South Africa should have been amongst the first, not the last of the countries to suffer its ravages’ (Marks, 2002, p. 22, original emphasis).

These observations also call into question the value of seeking to economically empower women with the expectation that by doing so will decrease their risk of being infected by HIV. The increased autonomy, mobility and economic empowerment of women may not protect women against HIV. Indeed, this may increase women’s vulnerability to HIV.

Finally, the danger of disregarding those presumed to be
at low risk because of their economic status needs to be addressed through awareness and educational campaigns. For example, the 2002 Nelson Mandela/HSRC survey revealed that White South Africans had higher rates of HIV than had previously been anticipated (Shisana, 2002, p. 59), alerting us to the dangers of excluding and thus creating a false sense of security to 'low risk groups'. Educational campaigns that target men, notably the elite and educated require urgent implementation to address these issues.

Notes

1. Due to the sensitivity associated with AIDS research, the identity of the village and all personal names are pseudonyms. All local phrases are in XiTsonga unless otherwise indicated.

2. Relocation was due to the introduction of ‘betterment schemes’. Access to arable and grazing land was severely curtailed and residents were told to move from their homesteads into residential stands.

3. AIDS research in South Africa is characterised by rapid survey methods that have generated a huge body of data on the knowledge, attitudes and behaviours of specific populations in relation to AIDS. For a comprehensive review of surveys see Eaton and Flisher (2000). I agree with Bolton (1995) who states that by adopting the survey over the ethnography privileges ‘the etic over the emic’, ‘data quantity over quality’ and ‘reliability over validity’ (p. 298).

4. In Carltonville in the North West Province women had higher prevalence rates than men. Thirty per cent of men aged 35 and 50% of women aged 25 were HIV positive. Almost 35% of women between 14 and 24 years of age were infected with HIV compared to nine per cent of males in the same age band (Gilgen, Campbell, Williams, Taljaard & MacPhail, 2000). In Botswana for every HIV positive boy under the age of 14 there are two HIV positive girls of the same age. This rises to 1:3 in the group aged 15 to 29 before levelling out in the older age groups. In Zambia 14-year-old girls were three times more likely to be infected by HIV than boys of the same age. In Kenya boys aged 15 and 16 had zero HIV prevalence rates compared to 8% and 18% for girls aged 15 and 16 respectively (United Nations Development Program, 2000).

5. Employment levels in Bushbuckridge are estimated to be around 70% for men and 30% for women, although these figures may overestimate the extent of employment due to their inclusion of temporary and informal sector employment (Collinson & Wittenburg, 2001).


8. Gisselquist, Rothenberg, Potterat and Drucker (2002) argue that HIV infections in Africa due to unsafe medical procedures could account for between 20% and 40% of all infections. The HSRC survey of HIV in South Africa reported that almost 6% of children surveyed aged between two and 14 were infected with HIV. The authors concluded that ‘it remains unclear as to how these children could have been infected’, and speculated that needle stick, or sexual abuse may account for anomalous findings (Shisana, 2002, p. 63).

9. In an interview with the Washington Post, Thabo Mbeki, the president of South Africa, stated that he did not ‘know anybody who has died of AIDS’, effectively denying the existence of the epidemic in South Africa (Halfajee, 2003).

10. According to verbal autopsies of deaths that occurred between 1994 and 1995 in Bushbuckridge, AIDS was responsible for a dramatic reversal in mortality trends particularly amongst adults (Tollman, Khan, Garenne & Gear, 1999). Death from AIDS, tuberculosis and chronic diarrhoea increased from 15 to 33 cases amongst men and from five to 21 cases amongst women, between the first period (1992–1993) and the second period (1994–1995). These diseases mainly affected young adults and to a lesser extent, children (Tollman et al., 1999, p. 1095). At the national level, mortality from AIDS during 2001 is estimated to account for 40% of adult deaths and over half of those aged between 15 and 49 (Dorrington, Bourne, Bradshaw, Laubscher & Timaeus, 2001).

11. Three infants of unspecified gender and age have been excluded from the analysis.

12. I refer to the Suppression of Witchcraft Act No. 57.


14. This is remarkably similar to Weiss’ (1998) account of women who are seduced by the desire for money and goods, and are said to ‘buy their own graves’.

15. This metaphor was used to describe the practice of tricking men out of their money. Young women who hung around bar lounges and shebeens pretended to accept men’s sexual advances and then ran away.

16. A 2002 World Bank report revealed that 12% of teachers in South Africa were HIV positive (Cape Argus, 21 May 2002). Furthermore, the South African Democratic Trade Union reported that 40% of teachers had died in 2001; many from AIDS related illnesses (Cape Argus, 5 November 2001).

17. The same physician told me that he had recently conducted HIV testing at a local police station and found all eight officers tested HIV positive. I personally knew of several teachers who were ill with AIDS. In addition, local well known cases of AIDS included a local doctor and a chief.

18. This discourse recently received affirmation from Swazi royalty. The Swazi King Mswati II defended the annual reed parade of bare-breasted maidens against accusations that this ‘would lead to AIDS’, saying that African men were stimulated by the sight of bare thighs, not bare breasts.

19. The munjhonjhela phansi was described as a bird that hides itself in the grass as it runs, occasionally popping its head above the tall grass.

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