

# **Fragile yet unbreaking**

## **An ethnographic exploration into young people's entangled experiences of Traditional Healing and HIV/AIDS**

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## **PLAGIARISM DECLARATION**

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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## ABSTRACT

The following study is an ethnographic exploration into young people's entangled experiences of health and illness in relation to both HIV/AIDS and traditional forms of healing. The research employed a creative, didactic methodology based around a series of workshops conducted with two non-governmental organisations based in Grahamstown's peri-urban townships: The first, Siyapumelela, maintains a focus on youth and HIV/AIDS; the second, Sakhuluntu, is a cultural group aimed at keeping young people off the streets. The argument begins by challenging the dichotomous relationship that is maintained between Modern Scientific Medicine and traditional forms of healing, and calls for a dual standard system in which both epistemologies can be free to operate according to their own medical standards. The study explores young people's therapeutic environments and tracks, in particular, how young people talk about and represent HIV/AIDS. HIV/AIDS is discussed as a concept metaphor; a domain term that orients a person towards areas of shared exchange and meaning. It is clear that most young people have a well-informed biomedical understanding of HIV/AIDS, yet metaphorically, they see it as a dangerous and destructive force; an uncertain threat in the world. The research poses the question as to why young people continue to put themselves at risk of contracting HIV by exploring the social environments which many young people are subject to – environments that are often characterised by extreme social structural violence. The argument examines the nature of social structural violence as it plays itself out in the everyday lives of the participants and identifies the kinds of challenges that many of them face on a day-to-day basis. Due to fragmented avenues of support and conditions of domestic fluidity, many young people from structurally violent communities are left with feelings of vulnerability and insecurity. Alongside experiences of social and structural insecurity, young people also harbour a sense of spiritual insecurity that stems from the dissolution of the ancestral cult as a result of the historical, yet persisting, fragmentation and reorganisation of the African family unit. The research discusses a form of spirit possession known as *Amakhosi* that young people engage in in order to (re)gain a sense of security and protection from forces beyond their control.

**Keywords:** HIV/AIDS; traditional healing; Concept-Metaphor; social structural violence; Amakhosi spirit possession.

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*Stephen Pentz, 2011*

## **ABBREVIATIONS**

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Treatment
ARVs	Anti-retrovirals
CD4 cell	A cell in the immune system which is selectively attacked by the HI virus
CD4 count	The number of CD4 cells in a person's immune system
DNA	Deoxyribonucleic acid
H1N1	Strain of the influenza A virus, commonly known as Swine Flu
HSRC	Human Sciences Research Council
HIV	Human Immunodeficiency Virus
MSM	Modern Scientific Medicine
NGO	Non-Governmental Organisation
RDP	Reconstruction and Development Project
TAC	The Treatment Action Campaign
TAH	Traditional African Healer
THP	Traditional Health Practitioner
THPB	Traditional Health Practitioners Bill
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
VCT	Voluntary Counselling and HIV Testing

## GLOSSARY OF SOUTH AFRICAN TERMS

<i>Abathandazi</i> [pl.], <i>umthandazi</i> [s.] (isiZulu)	-	faith healer(s)
<i>Amagqirha</i> [pl.], <i>igqirha</i> [s.] (isiXhosa)	-	traditional African healer(s)/diviner healer(s).
<i>Amajoni umzimba</i> (isiZulu)	-	“soldiers of the body”.
<i>Amakhosi</i> [pl.] (isiZulu)	-	ancestral spirits.
<i>Amaprofethi</i> [pl.], <i>iprofethi</i> [s.] (isiXhosa)	-	prophet(s).
<i>Amawethu</i> [pl.] (isiXhosa)	-	our people/ancestors.
<i>Imbeleko</i> [s.] (isiXhosa)	-	a naming ceremony.
<i>In’ganga</i> [s.] (chiShona)	-	a diviner healer.
<i>Ingcibi</i> [s.] (isiXhosa)	-	a traditional surgeon.
<i>Isifo</i> [s.] (isiZulu/isiXhosa)	-	a disease that is manifest by somatic symptoms, to various forms of misfortune, and also to a state of vulnerability to misfortune and disease.
<i>Izangoma</i> [pl.], <i>isangoma</i> [s.] (isiZulu)	-	traditional African healer(s)/diviner healer(s).
<i>Izinyanga</i> [pl.], <i>inyanga</i> [s.] (isiZulu)	-	herbalist(s).
<i>Izizwe</i> [pl.] (isiXhosa)	-	bad medicines.
<i>Kwaito</i>	-	South African style of music, similar to hip-hop.
<i>Makoti</i> [s.] (isiZulu)	-	young bride.
<i>Oonomathotholo</i> [pl.] (isiXhosa)	-	voices of the ancestors, or <i>amakhosi</i> .
<i>Rhini</i>	-	another name for Grahamstown.
<i>Sakhuluntu</i> (isiXhosa)	-	“we are building”
<i>Shebeen</i>	-	an illegal, unlicensed bar.
<i>Siyapumelela</i> (isiXhosa)	-	“we are succeeding”

Township	-	also referred to as locations, townships are historically non-white neighbourhoods usually situated a distance from towns and cities.
<i>Ubuhlanti</i> [s.] (isiXhosa)	-	‘Kraal’, or round, outdoor encampment that is considered the seat of the ancestors.
<i>Ugawulayo</i> [s.] (isiXhosa)	-	the grim reaper.
<i>Uhlonipha</i> [s.] (isiZulu/isiXhosa)	-	respect.
<i>Ukufutha</i> (isiXhosa)	-	to inhale.
<i>Ukuthakatha</i> [s.] (isiZulu/isiXhosa)	-	witchcraft.
<i>Ukugana</i> [s.](isiZulu)	-	informal form of marriage.
<i>Umkhuhlane</i> [s.] (isiZulu/isiXhosa)	-	category of illnesses caused by natural phenomena.
<i>Umlungu</i> [s.] (isiZulu/isiXhosa)	-	a term used to describe white people.
<i>Umuthi</i> [s.] (isiZulu)	-	traditional medicine
Umuthi umthando (isiXhosa)	-	Love medicine
Vuk’unzenzele (isiXhosa)	-	“stand up and do it for yourself”

## LIST OF FIGURES

Figure 1.1.	Zapiro cartoon .....	4
Figure 1.2.	Map of Grahamstown .....	17
Figure 2.1.	The alien Zo from planet !Qi .....	26
Figure 2.2.	Lindiwe’s visual representation of HIV/AIDS .....	33
Figure 2.3.	Brenda’s visual representation of infected CD4 cells .....	34
Figure 3.1.	Character sketch one: Precious .....	46
Figure 3.2.	Character sketch two: Mustafar .....	50
Figure 5.1.	Thabo’s Body-Map .....	69

## LIST OF TABLES

Table 1: Results from “Step Across the Line” .....	39
Table 2: List of common challenges .....	43

# TABLE OF CONTENTS

PLAGIARISM DECLARATION .....	i
ABSTRACT .....	ii
ACKNOWLEDGEMENTS .....	iii
ABBREVIATIONS .....	iv
GLOSSARY OF SOUTH AFRICAN TERMS .....	v
LIST OF FIGURES .....	vii
LIST OF TABLES .....	vii
TABLE OF CONTENTS .....	viii
POEM .....	x
VIGNETTE ONE .....	xi
PREFACE .....	xii
<b>CHAPTER ONE: INTRODUCTION .....</b>	<b>1</b>
1.1. Entrenched Dichotomies: Problematising South Africa’s Pluralist Therapeutic Environment .....	1
1.2. Traditional Healing’s Contribution .....	5
1.3. Youth and HIV/AIDS .....	7
1.4. Key Questions .....	8
1.5. Initial Concerns .....	10
1.5.1. Discussing witchcraft .....	10
1.5.2. Researching vulnerable youth and HIV/AIDS .....	11
1.5.3. Differing notions of the body: expanded aetiologies .....	12
1.6. Field Site and Choice of Participants .....	14
1.6.1. Siyapumelela: “we are succeeding” .....	15
1.6.2. Sakhuluntu: “building our people” .....	16
1.7. Methodology .....	18
1.8. The Organisation of the Thesis and Progression of the Arguments .....	19
<b>CHAPTER TWO: ALIEN HOT SEAT .....</b>	<b>21</b>
VIGNETTE TWO .....	21
2.1. Methodological and Ethical Considerations .....	22

VIGNETTE THREE .....	24
2.2. Young People’s Therapeutic Environments .....	27
2.3. The semantics of HIV/AIDS .....	28
2.4. Representing HIV/AIDS .....	32
2.5. Chapter Conclusion .....	35
<b>CHAPTER THREE: CHARACTER SKETCHES .....</b>	<b>36</b>
VIGNETTE FOUR .....	36
3.1. A Multi-axial Understanding of Human Suffering .....	38
3.2. Gaining a Broader Perspective .....	40
3.2.1. The entangled axes of socio-economic status, gender, and ethnicity .....	40
3.2.2. Domestic fluidity and avenues of support .....	42
3.2.3. Challenges of the everyday – living with crime and violence .....	43
VIGNETTE FIVE .....	45
3.3. Character Sketches .....	47
3.3.1. Character sketch one: Precious .....	47
3.3.2. Character sketch two: Mustafar .....	50
3.4. Chapter Conclusion .....	52
<b>CHAPTER FOUR: RADIO WORKSHOPS .....</b>	<b>53</b>
VIGNETTE SIX .....	53
4.1. Introduction .....	54
4.2. Traditional Healing and HIV/AIDS .....	55
VIGNETTE SEVEN .....	58
4.3. <i>Amakhosi</i> Spirit Possession .....	59
4.4. Social, Structural, and Spiritual Insecurity .....	62
4.5. Chapter Conclusion .....	65
<b>CHAPTER FIVE: CONCLUSION .....</b>	<b>67</b>
VIGNETTE EIGHT .....	67
5.1. Fragile yet Unbreaking .....	70
<b>BIBLIOGRAPHY .....</b>	<b>72</b>

## **Fragile yet unbreaking**

It shouldn't be their burden  
to bear, the sins of our forefathers.  
An invisible weight heavy with remorse,  
For hope, a burning light remains.

To bear the sins of our forefathers  
without question, the heart waits  
for hope, a burning light remains  
carrying us through the storm.

Without question, the heart waits  
with trepidation; they *are* our steadfast saviours  
carrying us through the storm.  
Will their resilience ever falter?

With trepidation; *they* are our steadfast saviours.  
Fragile yet unbreaking,  
It is an imperfect comfort  
placed unwillingly on shoulders too young.

Fragile yet unbreaking,  
An invisible weight heavy with remorse  
placed unwillingly on shoulders too young.  
It shouldn't be their burden.

Stephen Pentz, February 2010

## Vignette One

I'm in Vuyo's one-roomed RDP<sup>1</sup> house, sitting on the end of his bed, crammed into the nearest corner of the room. Standing next to it is a shabby dressing-table with a cracked mirror. On the opposite wall there is a metal locker with posters of Steve Biko and Miriam Makeba – old sung heroes of 'the struggle' years. I recall Vuyo's proud mention of his activism in the fight against Apartheid. A pile of plastic garden-chairs is haphazardly stacked against the locker's side, and a few scattered pairs of gumboots lie amongst two large bongo-drums. The 'kitchen' floor in the far corner of the room is stained ash-black from the remnants of paraffin and coal. Looking around, the house has a transitory feel of impermanence.

While I'm waiting, the first of the children arrive. They're talking loudly and animatedly, until they notice me sitting on the bed. I'm greeted with silent, suspicious eyes. Nervously, I suspect what they must be thinking; "What is this *umlungu*<sup>2</sup> doing here?" I smile back at them reassuringly and pretend to busy myself by organising my things on the dressing-table.

The small, gloomy house fills up quickly. The kids soon lose interest in me and resume their lively talk, each seemingly competing with the other for the best story. In no time at all there are over thirty bodies in the cramped room, all boisterously vying for space. Vuyo shouts an authoritative command in *isiXhosa* and, with a criss-cross of arms, the kids form a circle. I join in and swop my place on the bed with the youngest of the children – the three and four year olds - who wait quietly and patiently while the routine announcements are made. Vuyo reminds the kids about the need for discipline and respect. His moralising project drones on in a voice of resigned habitude, and after a while, the kids start restlessly fidgeting with one another's hands. To bring the discussion to a close and perhaps to drive the point home, Vuyo leads the circle in the Lord's Prayer. The prayer is recited quickly in a rhythmic *isiXhosa*, voices raised in climax towards the end.

Now that the formalities are over, all attention is duly turned to me. Vuyo enthusiastically introduces me as a student from Cape Town who is studying *iAnthropology*. Naturally, I'm greeted with puzzled faces which clearly say, i-what? I take this as my cue, and begin ...



<sup>1</sup> RDP refers to the 'Reconstruction and Development Project' which aimed to build low-cost houses for the poor.

<sup>2</sup> *Umlungu* is the isiXhosa word for 'white person'.

## PREFACE

The project of Anthropology has never been a simple one to define (Eriksen & Nielsen 2001), not least when faced by an eager group of expectant children. And yet, being able to define the role of Anthropology in the post-colonial, post-apartheid moment remains an important preoccupation for contemporary South African Anthropology. This question was therefore maintained in the forefront of my mind upon entering the field along with the question as to what my personal intellectual and moral project has been in choosing to work with young people from disenfranchised communities. And so, having been placed on the spot on my very first day in the field and asked to elucidate what I was doing and to what end, I was challenged from the onset to think through these very fundamental issues.

Anthropology remains for me an act of translation – at times subtle and at others violent. More particularly, Anthropology seeks to “illuminate the chaos of the world by spinning it poetic ... [by] making the everyday fit into a technological lexicon” (Levine 2009: 1). It is through the technology of language that anthropologists navigate multiple registers and valences in describing the complex social milieux in which they work. However, it has long since been recognised that anthropologists are both enabled and limited by the constraints of language (Clifford & Marcus 1986). For one thing, the social situations or interactions witnessed in the field can, more often than not, appear incommensurate, paradoxical, or excessive, and difficult to describe within a linear temporality. It is for these reasons that I have chosen to work with the notion of entanglement in helping to draw together what is seemingly incommensurate.

Entanglement is a term which gestures towards “a relationship or set of social relationships that is complicated, ensnaring, in a tangle, but which also implies a human foldedness” (Nuttall 2009: 1). Human foldedness, or “the folded-together-ness of being” (Sanders 2002: 11) encompasses the interpenetration of multiple temporalities experienced in everyday life. The notion of entanglement not only “enables a complex temporality of past, present and future” (Nuttall 2009: 11) but also offers, in the South African context, “a rubric in terms of which we can begin to meet the challenge of the ‘after apartheid’” (*ibid*), especially because it allows one to find the points of intersection between seemingly disparate phenomena, paradigms, and discourses. In the context of the research which follows, the notion of entanglement is especially useful in exploring the particular relationship that exists between biomedicine and traditional healing. For one thing, it helps to collapse the dichotomous relationship that is maintained in Public Health discourse between what is considered

‘traditional’ and what is seen as ‘modern’. For another, it is useful in thinking through the ways in which traditional healing and biomedicine overlap and intertwine. The analysis that follows can therefore be understood as an exploration into young people’s entangled experiences of health and illness in the post-apartheid moment.

As for my personal moral and intellectual project in choosing to work with young people from disadvantaged communities, I have found the concept of fragility (see. Henderson 1999) useful in thinking through researching children and teenagers. There is no question that children’s social worlds are fragile<sup>3</sup> and therefore deserving of study. But herein lies the paradox: it is because children are seen as fragile that it is complicated to conduct research with them, but it is because of this fragility that more work with children needs to be done, especially in situations where children are subject to the conditions of social structural violence. Under such conditions, institutions of childhood can not only be seen as fragile but also fragmented, and it is through working with young people who are subject to social structural violences that one is able to uncover the varying valences – the layers of entanglement – that contribute towards their maintenance. As Henderson (1999: 25) points out, in the South African context, the notion of fragility is useful because it “suggests the shadow, or the traces, of apartheid state policies in the everyday lives of children”, which continue to impact how children’s senses of self develop, “for it is out of a social context characterised by discontinuity and flux that children’s senses of self emerge as multiple and variable” (*ibid.*). By working with individual children around questions of self (with an emphasis on personal conceptions of body, health and illness), I hope to draw attention to the discontinuities evident in their everyday lives. These discontinuities often contribute towards a general sense of vulnerability in the world – and in some instances an apathy for life – that lead young people to engage in dangerous, risk-taking behaviours. The question as to why this is so is crucial in thinking through the continued problem of the high HIV prevalence amongst young people in South Africa today.

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<sup>3</sup> It is important to remember that the notion of fragility does not necessarily suggest a lack of agency on the part of young people. On the contrary, more recent social theories around childhood have increasingly recognised children’s agency and role in society (see. Coles 1986; Hecht 1998; Rapport & Overing 2000; Stephens 1995). And in South Africa in particular, there has been a growing body of research recognising the agency of children in society (see. Barbarin & Richter 2001; Bray 2003; Henderson 1999; Jones 1993; Levine 1999; Ramphele 2002; Reynolds 1989/1991/1996; Swart-Kruger 2000).

# CHAPTER ONE

## Introduction

“The history of AIDS in South Africa constitutes a web of meaning that extends well beyond country borders and the disease itself. It recounts a political world order composed of both social configurations and symbolic arrangements, relations of knowledge and power, representations of the self and discourses of the other”.

(Fassin 2007: 275)

### 1.1 Entrenched Dichotomies: Problematising South Africa’s Pluralist Therapeutic Environment

Health care in South Africa is pluralistic in nature (leBeau 2003); people often access a number of healing systems in a “diverse therapeutic environment” (Wreford 2009: 37) both independently or in concert for a variety of reasons. In a pluralist health environment, in order for different healing systems to be mutually beneficial, it is essential to maintain a socio-cultural understanding of illness; from the subjective experience of illness to culturally specific aetiological explanations of affliction. This is particularly relevant in a country like South Africa where many people consult Traditional African Healers (TAHs) while at the same time accessing biomedical healthcare. It is therefore essential that a mutual, reciprocal relationship between the different healing systems is built and encouraged. All the more so in the context of the HIV/AIDS epidemic where conditions surrounding the understanding, perception and acceptance of the disease have been compounded by stigmatisation, social structural violence, and an historical climate of both denialism and a mistrust of biomedical interventions<sup>4</sup>. Concerted efforts have been made to encourage just such a relationship (see. Wreford 2005a, 2005b, 2008; Wreford *et al* 2008; Hippler 2006) but unfortunately there is an evident antipathy within Public Health discourse against traditional forms of healing, no less so in the context of HIV/AIDS (Wreford 2008). This antipathy has emerged out of a biased, dualistic positioning of biomedicine as superior to African healing systems, where biomedicine is often

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<sup>4</sup> An historical legacy of colonialism and apartheid in South Africa has resulted in enduring suspicions surrounding the motivations and efficacy of biomedical interventions and western medicine in general (see. Vaughan 1991; Niehaus & Jonsson 2005). This mistrust and suspicion has been further compounded by issues surrounding population control and sexually transmitted diseases (see. Jochelson 1999). For a full account of Mbeki’s denialism, see. Fassin (2007).

construed as ‘modern’ and ‘scientific’ and African healing as ‘traditional’<sup>5</sup> and ‘superstitious’. In the context of HIV/AIDS prevention and management, this disjunction has allowed blame to be placed on Traditional Health Practitioners (THPs)<sup>6</sup> who have, in the past, been accused of “spreading stories or encouraging denial and non-disclosure” (Wreford 2008: 2). What is important to remember is that in a pluralistic therapeutic environment, the relationship between Modern Scientific Medicine (MSM) and traditional forms of healing is complex and entangled. It is for such reasons that the professionalization of African traditional medicines has become an ever increasing project within the public health environment.

In discussions concerning the professionalization of African traditional medicines, it is necessary to remain critical of the adverse polarisation of biomedicine and traditional healing. What this dualistic positioning has essentially resulted in are questions of authenticity, authority and legitimacy. For one thing, as “biomedical protocols have emerged as the accepted mode of legitimising the value and marketability of traditional medicines” (Levine 2009: 4), traditional methods of verification and ways of knowing have been negated or simply overlooked. This is hardly surprising considering the difficulty one might have in trying to quantify and standardise practices that are based on dreaming, and the intangible presence of the ancestors. Fan and Holiday (2007: 455) challenge the ideology of science that lies behind the demand that all forms of traditional medicines be evaluated and reformed according to Modern Scientific Medicine and argue for a dual standard system in which both traditional medicines and MSM can be free to operate according to their own medical standards.

Part of the issue in discussing traditional forms of medicine in relation to MSM lies in the connotations associated with the word ‘traditional’. Practices that are seen as ‘traditional’ are often constructed within an “allochronic discourse” (Fabian 1983: 143); they are seen as existing outside

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<sup>5</sup> The notion of the ‘traditional’ when pitted against that of ‘science’ carries positivist connotations of ‘backwardness and ‘primitivism’ located in an evolutionary schemata (see. Rapport & Overing 2000: 322). This is a notion which continues to reinforce negative reactions to traditional medicine.

<sup>6</sup> ‘Traditional Health Practitioner’ (THP) is a blanket term used to refer to a collectivity of traditional African healers (TAHs) – *izangoma* (isiZulu) or *amagqirha* (isiXhosa), and *izinyanga* (isiZulu/isiXhosa). Freeman and Motsei (1992: 1183) explain these terms by situating them within three broad types of traditional healers: *izangoma/amagqirha* “are usually women who operate within a traditional religious supernatural context” (also known as diviner-healers); the second are the *izinyanga* who are usually men and who use “herbal and other medicinal preparations for treating disease” (*ibid.*); the third are faith healers (*abathandazi*) or prophets (*amaprofethi*) who integrate “Christian ritual and traditional practices” (*ibid.*). THP will be used when talking more generally about traditional African healers. When referring to specific types of healers, the exact term will be used.

of time, as coming from an indefinite past, as timeless and unchanging. However, cultural practices are never static but fluid and adaptable. Traditional forms of healing are entangled within multiple temporalities that bridge the challenges of modernity with resonances from the past. This is because traditional healing often has to deal with problems that exist between the living and the dead. As Haydon White (2004) demonstrates, the forces of conjecture and disjuncture, collusion and rupture that inscribe the relation of tradition to modernity are complex and variable. His exploration into one rural family's present day experiences of hardship and misfortune reveals how past injustices that were never righted continue to plague the living. Traditional forms of healing can therefore offer an epistemological challenge to notions of linear temporality.

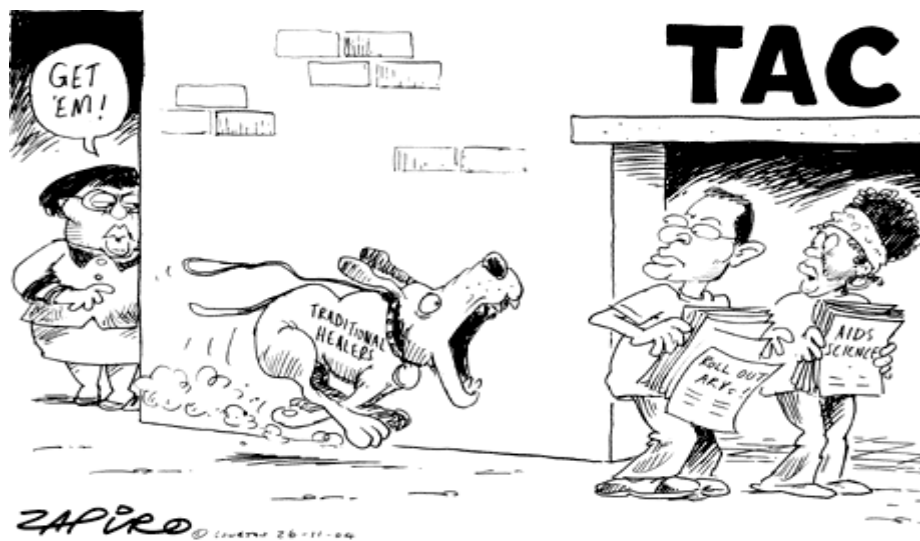
The politicisation of traditional healing in South Africa over recent decades has revealed how entrenched notions of what constitutes 'modern' versus 'traditional' forms of healing have had a devastating impact on public health responses to HIV/AIDS (Ndaki 2009). This dichotomisation has allowed for an 'us versus them' attitude to develop in the political sphere between African traditional medicines and Western science. The dissident position on the aetiology of AIDS held by former president Thabo Mbeki and supported by former health minister Manto Tshabalala-Msimang "collided headlong with orthodox scientific views, creating even more doubt, mistrust and suspicion between Western science and African traditional medicine" (Ndaki 2009: 145). Mbeki's position in supporting AIDS dissidents, and in questioning both AIDS statistics and the safety and efficacy of antiretroviral treatment (ART), has been portrayed as misguided, irrational and irresponsible. African traditional medicine has been held in collusion with Mbeki's seemingly irrational "political rationality", and has in turn been sharply contrasted with the orthodox scientific approach to HIV/AIDS advocated by the "rational", mainstream medical establishments, further driving divisions between the two systems of healing.

Given the current political climate surrounding recent discussions about the proposed implementation of a National Health Insurance (NHI) scheme for all South Africans (Van Heerver 2009), the state has had an opportunity to rethink its position on the professionalization of African traditional medicine. Already, a policy on African traditional medicine is in its final stages of drafting allowing for "the recognition, promotion, development, protection and affirmation of African Traditional Medicine and the African traditional healing system" (Mayeng 2009: 6)<sup>7</sup>. A

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<sup>7</sup> The South African Government made this commitment clear with the creation of the Traditional Health Practitioners Bill, which was gazetted in parliament in May 2005, and was designed to formalise the structure and organisation of

central aim of the draft policy on Traditional African Healing, unlike the Traditional Health Practitioners' Bill (THPB), is to encourage collaboration rather than competition between different healing systems. According to the proposed policy however, this can only be achieved once traditional African healing and medicines are legally recognised, regulated and institutionalised. Such regulation is an important step towards offering protection to both healers and their patients in ensuring the safety and efficacy of traditional pharmacopeia.



**Figure 1.1 – Zapiro Cartoon**

*The Zapiro cartoon<sup>8</sup> above accentuates how former president Thabo Mbeki's accusations against 'Big Pharma', scientists and AIDS activist groups such as the Treatment Action Campaign (TAC) on the basis that they "were complicit in a racist assault on African dignity" (Robins 2008a: 101) has helped entrench an attitude of 'us versus them' and discouraged potential collaboration between biomedicine and traditional healing.*

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traditional health practices (THPB, 2003). But as Wreford (2005a) points out, the Bill was designed to address biomedical anxieties about certification and training rather than creating opportunities for collaboration.

<sup>8</sup> Mails & Guardian Online, 26 November 2004, <http://www.mg.co.za/zapiro/fullcartoon/1555>

## 1.2 Traditional Healing's Contribution

Beyond biomedical healthcare institutions in South Africa, traditional health practitioners play a crucial role in offering healthcare to many South Africans. According to the Select Committee on Social Services (1998: 2), there are about 350,000 THPs who services between “60 – 80 % of their communities”. It is not possible to know the exact number of people who use THPs<sup>9</sup>, however, as a recent article in the Mail & Guardian online (Gerardy 2009) points out, the traditional medicines industry makes a huge contribution to the South Africa economy every year, suggesting a large consumer base; “used by about 27-million South Africans, the annual trade in traditional medicine was tipped in 2007 to be at least R2,9-billion (\$397-million) and sustaining some 130 000 jobs”.

Besides the economic contribution of the traditional medicines industry, THPs also offer avenues of social and psychological support. This is due to the holistic nature that traditional healing takes in mimicking the life cycle. THPs monitor and assist (through ritual as much as by offering advice and support) in key moments in people's lives – from courting to marriage; pre-conception, conception, pregnancy, and birth; mothering and fathering; naming and initiations; counselling and dealing with death and disease; to post death counselling – what Mayeng (2009: 2) refers to as the African healing cycle.

The fundamental premise of traditional African healing is different to that of biomedicine in that it seeks to answer the immediate questions “why me?, why now?” in order to uncover and treat the underlying causes of illness (Ashforth 2005; Wreford 2008). This approach differs from that of biomedicine which seeks to understand illness by treating symptoms of the physical body while not necessarily taking into account social or psychological factors. As Scheper-Hughes and Lock (1987: 8-9) explain, biomedicine is fundamentally driven by scientific principles which promote the mechanistic concept of ‘the Cartesian body’; a concept that fails to acknowledge the possibility of a “‘mindful’ causation’ of illness<sup>10</sup>. Traditional healing on the other hand views the human body as part of a “cyclical structure” (Wreford 2005a: 57), simultaneously considering the social, spiritual,

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<sup>9</sup> This is partly due to the secrecy surrounding traditional healing, but also due to issues of stigma, many people do not readily admit to using traditional healing. Furthermore, it is equally difficult to be precise about the number of THPs operating in South Africa. This is due to the fact that the industry has not yet been standardized, even though organised bodies representing THPs do exist. A further reason is the recent influx of new forms of traditional African healing originating from countries outside of South Africa. For many foreign Africans working in South Africa, traditional forms of healing offer an entry point into the economy.

<sup>10</sup> Of course psychotherapy and psychiatry are notable exceptions.

emotional, physical and non-material aspects of an individual (Ngubane 1992). In so doing, traditional healing attempts to go beyond the mere absence of disease when healing a patient. In this vein, traditional healing may make an invaluable contribution to the social nature of a disease like HIV in working through the disruptive effects of AIDS.

Traditional healing is characterised by a reverence for ancestral authority which is established through ties of clan and kinship. Treatment therefore, may involve “addressing, and if need be, altering, relationships, both material and spiritual” (Wreford 2005a: 57) within the domestic family unit. For many young people however, clan and kinship relations have become highly fragmented due to the vicissitudes of colonialism and apartheid; vicissitudes which have had a direct result on health and health practices. As Fiereman and Janzen (1992: 8) point out, some of the regularities that can be seen as a result of the political and economic changes in the lives of African people in the twentieth century severely affected the general state of health for many people; one of these regularities was the intentional “weakening of kinship-based support mechanisms” as a result of political and social control. African family units have not only been highly disrupted and fragmented as a result of the migrant labour system of the previous political regimes in South Africa (Bank 2002), but continue to be affected by the disproportionate effects of racialised capitalism (Robins 2008b).

As the ancestral cult is essentially “a cult of the domestic unit, the extended family” (Magubane 1998: 28), for many young people, the disruption of the domestic unit has meant an environment in which the African healing cycle is either fragmented or simply no longer exists. And besides the historical vicissitudes mentioned above, the disruption of the domestic unit and the extended family has continued due to the HIV/AIDS pandemic and rising social inequalities. This has left many young people either vulnerable and without the support of the institution of the family, or in some cases, responsible for maintaining and supporting their families. Young people are, in a sense, forced to look beyond the domestic unit for avenues of social, economic and psychological support. New, fluid forms of domesticity have emerged that do not simply challenge the basis of African traditional healing but also open up new possibilities to the role that traditional forms of healing could play in offering avenues of support to young people.

### 1.3 Youth<sup>11</sup> and HIV/AIDS

Despite the considerable work that has been done in dealing with the problems and potentials for collaborative efforts between biomedicine and traditional healers in South Africa, the place of youth within this polemic has not been fully considered<sup>12</sup>. This question becomes all the more relevant in the context of HIV/AIDS, considering how severely affected young people have been by the epidemic.

There are an estimated 10 million young people between the ages of 15 and 24 who are living with HIV worldwide; many of these people live in Sub-Saharan Africa (Chunyiswa & Odendal 2008). And of a population of approximately 46 million people in South Africa, 6 million people are HIV positive, “more than one in eight people” (Steinberg 2008: 2), with the epidemic “spreading at a rate of more than a thousand new infections a day” (*ibid*). More specifically, the Eastern Cape Province (where the research was conducted), is one of the poorest provinces in South Africa, and has the third highest number of people affected by HIV/AIDS in the country (667 000); 12% of the total population of people living with AIDS in South Africa as a whole (Dorrington *et al.* 2006). HIV/AIDS has undoubtedly had a massive effect on the lives of young people in this province.

In 2006, “over one million 18 – 25 year olds in South Africa were living with HIV” (Chunyiswa & Odendal 2008: 5). Furthermore, the National Youth Risk Behaviour Survey conducted in 2002, revealed that 41% of students from grades 8 to 11 claimed to be sexually active, of which 54% said they had had sex with multiple partners (*ibid*). As it is clear that sexually active youth are a high risk population group in contracting HIV<sup>13</sup>, more attention needs to be paid as to how this particular demographic accesses information and materials related to sex, sexuality and HIV/AIDS in general. Although recent statistics have revealed that “HIV levels have fallen by 25% among people aged 15 – 24” (UNAIDS Global Report 2010), young people still remain a high risk demographic. A number

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<sup>11</sup> By youth, I am referring to children, adolescents and young adults. I often use the term ‘young people’ to encompass this demographic.

<sup>12</sup> That is not to say that the question and agency of youth in relation to the HIV/AIDS epidemic has not been, or continues to be, a vital topic of inquiry (see for example Leclerk-Madlala 1997).

<sup>13</sup> Young people in South Africa are a high risk demographic in contracting HIV. This is evident from the report on causes of death by Statistics South Africa (2002: 22) which explained that between 1997 and 2001 there was a “pronounced” pattern of mortality from HIV and related diseases “amongst children and the reproductive and economically active population group (i.e., the population between ages 15-49)”.

of key questions start to emerge around the reasons as to why this is so, as well as the potential role that traditional healing might play in relation to the health care choices made by young people.

## 1.4 Key Questions

Broadly speaking, the following dissertation is an exploration into young people's entangled experiences of health and illness in post-Apartheid South Africa. More particularly, in looking more closely at young people's social worlds, it hopes to gain a better perspective of the kinds of relationships that young people have with both HIV/AIDS and traditional forms of healing<sup>14</sup>. One of the initial interests at the start of this research concerned the ways in which young people locate experiences of health and illness within the body and the kinds of connections that they make between 'traditional' and 'modern' notions of the body in relation to health and illness. To begin with, it was therefore important to first assess the therapeutic economies that young people access. Nguyen (2005: 126) describes a therapeutic economy as:

“the totality of therapeutic options in a given location, as well as the rationale underlying the patterns of resort by which these therapies are accessed. These therapeutic options comprise the practices, practitioners, and forms of knowledge that sufferers resort to in order to heal affliction”.

Furthermore, beyond therapeutic economies, individuals often rely on moral economies through which they are able to access “networks of obligation and reciprocity to negotiate access to therapeutic resources” (Nguyen 2005: 126). Bearing in mind the focus on HIV/AIDS and traditional healing, the initial questions of the study were:

- What do young people's health and illness environments look like?
- What kinds of relationships do young people have with both biomedical healthcare and traditional forms of healing?
- Do young people choose to consult THPs?
- If so, do they consult THPs about HIV/AIDS?
- If so, what might traditional healing have to offer young people in terms of understanding and coping with experiences of HIV/AIDS?

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<sup>14</sup> As a key focus of this study is the relationship that young people have with traditional forms of healing, the primary demographic of interest were young people with some connection to traditional healing or traditional African medicine. Most of the participants in this study were isiXhosa speaking adolescents from the Eastern Cape (see below, Section 1.6)

In working with traditional African health practices, a number of concerns arise. Firstly unlike the biomedical paradigm, African health practices contain elements of the spiritual alongside notions of deviancy, pollution and cleansing (Ngubane 1977) in understanding affliction, healing and cure. A traditional grammar that centres around witchcraft is readily employed in describing various kinds of affliction and misfortune. The methods of diagnosis used by traditional African healers, conventionally described in African studies, are linked to divination through communication with spiritual others, most notably the ancestors (Henderson 2005; Wreford 2005a). *Izangoma* or *Amagqirha* (healer-diviners), for example, appeal to the ancestors for help in diagnosing problems and prescribing remedies, and routinely check to see if illnesses are caused by their clients having violated cultural norms and traditions. As many cultural practices are “designed to preserve cultural institutions” (Freeman & Motsei 1992: 1186) the issue of flouting cultural norms brings to the fore questions of deviancy and blame. Furthermore, as HIV/AIDS is often linked to notions of sexual deviancy, a potential conflict may arise between traditional aetiologies and modern understandings of affliction and the ways in which illness is negotiated and described. From this, a new set of questions arise:

- How do young people talk about and represent HIV/AIDS?
- How do young people locate HIV within the body?
- Considering that many young people are continually juggling the demands of tradition and modernity, how do they negotiate entangled experiences of health and illness?
- What aetiological explanations do young people give for HIV? And do they connect HIV with explanations of witchcraft?

Henderson (2004: 43), in exploring the metamorphosis of individual suffering in the body in relation to HIV/AIDS, shows how the experience of bodily disintegration – “the falling away of the body” – is linked to social fault lines. The affliction of the body in connection to HIV/AIDS has powerful social resonances which are marked by “fraught relations of intimacy within family groupings” (Henderson 2004: 44). In the context of this research, many young people have had to (and some continue to) deal with their dying parents, or with members of their families who are severely afflicted by HIV/AIDS. The responsibilities of the households regularly fall on young, inexperienced hands, who have fragmented avenues of support within the immediate domestic unit, and often need to look elsewhere for support. Many young people’s social worlds are characterised by social structural violence, and as such, the structurally violent environments in which they live lack

fundamental institutional support structures. With these issues in minds, the research also sought to answer the following questions:

- How are young people's households constituted?
- What effect does social structural violence have on the lives of young people from structurally violent environments?
- What impact does social structural violence have on the health choices that young people make?
- How do experiences of social structural violence affect risk behaviour amongst young people?

## **1.5 Initial Concerns**

There are a number of concerns evident in choosing to research the relationship that young people might have with traditional healing, especially in the context of HIV/AIDS: the first is the difficulty of researching and discussing issues of witchcraft and traditional African spiritual practices as an 'outsider' (a white, English-speaking South African); the second concerns the particular dynamics involved when working with vulnerable children and adolescents; and the third is the sensitive nature of working with people affected by HIV/AIDS. Furthermore, one needs to consider how differing conceptions of health, illness and the body are expressed through language, as certain notions inherent in discourses of healing are not always commensurate from one language to the next, or from one medical framework to another. These issues are dealt with in more detail below:

### **1.5.1 – Discussing witchcraft**

As a white English-speaking South African, I was aware that my external identity markers (which are often markers of difference) might unintentionally carry a history of colonial prejudice<sup>15</sup>. These prejudices are all the more pronounced when asking critical questions about witchcraft and African spiritual practices. As Adam Ashforth (2005: xiii) reminds us, "throughout the history of colonialism, not only were European attitudes to African spirituality derogatory, but the colonial fascination with African witchcraft served to perpetuate stereotypes of African irrationality". The question of the perceived notion of a stereotyped African irrationality is still relevant in the present

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<sup>15</sup> In the context of this research, race and class were the most noticeable markers of difference. Even though a large part of the post-apartheid project in South Africa follows the Fanonian call to 'decolonize the mind' (Ngugi 1981), it is unfortunately difficult to escape such a strongly embodied marker of identity as race.

post-colonial moment<sup>16</sup>, as was evidenced by the initial reluctance by many of my research participants to talk about such things as witchcraft and traditional healing. Therefore when choosing to talk about such issues, I was conscious to avoid the impression that my interest in traditional healing was more than a mere “voyeuristic trifling with the exotic” (Ashforth 2005: xiii).

### **1.5.2 – Researching vulnerable youth and HIV/AIDS**

There are of course a number of ethical concerns to hold in mind when researching vulnerable youths, especially when talking about the body, sex and sexuality, and HIV/AIDS. At the same time, it is clear that young people have a lot to offer social theorising around questions of the body, health and illness (Reynolds 1996; Henderson 2006; Levine 1999 ). As Sharon Stephens (1995: 24) explains, children’s lived experiences can tell one a lot about what is going on in the world, for young people are “social actors in their own right, engaged in making sense of and recreating the social worlds they inherit”. Besides contributing to a particular social commentary, by examining how young people recreate their social worlds, one is also able to gauge valuable insights into their interpersonal experiences.

A number of issues arise when talking to young people about HIV/AIDS. Participants in my research for example, expressed that they felt constantly bombarded with information about HIV/AIDS – in schools, on television, on the radio – so much so that many of them were quite bored by the topic. The continual reinforcement of information about HIV prevention and treatment has resulted in many young people taking a prosaic attitude when talking about HIV/AIDS. Levine and Ross (2002: 89) describe this kind of attitude as “AIDS Information Fatigue Syndrome”, where although young people have a good general knowledge about HIV/AIDS transmission, they no longer pay attention to information concerning issues of HIV and AIDS. Levine and Ross (2002) found that among middle-income, educated students, many young people seemed to hold stereotyped notions that HIV/AIDS is a disease of the poor and not likely to affect them. AIDS Information Fatigue Syndrome is not however, exclusive to young people from middle income backgrounds. One of the challenges during my research was therefore to offer a space through which young people could talk about HIV/AIDS without the topic seeming mundane and banal.

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<sup>16</sup> In writing anthropologically, is important to bear in mind that the epistemological order in which Anthropology itself is invested – that of the Enlightenment – is centered on questions of rationality and modernity (Latour 1993). A new set of questions emerge concerning the role of the post-colonial university in rethinking how Anthropology is written.

A further problem arises when discussing issues of HIV/AIDS – that of talking about and situating individuals in relation to a disease. As Ross (2009) reminds us, in choosing to name an illness in relation to an individual, one is not only situating a person within a particular context surrounding that illness, but one might run the risk of reducing a person to a single category of health, or lack thereof, diminishing the person and the context of everyday life. And as Staiano (1992: 173) warns, in discussing the semiotics of illness, “we create categories of illness and are in turn victimized by them”. In asking question about HIV/AIDS, one needs to be careful not to diminish or reduce individuals to the disease; this is no easy task.

### 1.5.3 – Differing notions of the body: expanded aetiologies

Biomedicine has long since been criticized for localising disease to particular parts of the body without taking into account how extraneous variables – poverty for example – might be affecting an individual’s status of health (Scheper-Hughes & Lock 1987). This is not to say however that biomedicine does not recognise that some symptoms of disease, such as stress, can be socially produced. Nevertheless, the biomedical definition of disease, as a “disorder of structure or function in a human ... especially one that produces specific symptoms or that affects a specific part”. (Concise Oxford English Dictionary 2004: 410), encompasses this bias. In isiXhosa, the notion of disease is somewhat different. The word *isifo* is used, in much the same way that Ngubane (1977: 22) explains the same term in isiZulu, to mean “a disease that is manifest by somatic symptoms, to various forms of misfortune, and also to a state of vulnerability to misfortune and disease”<sup>17</sup>. According to traditional African notions of affliction, some diseases are seen as a result of natural causes, while others as a result of witchcraft.

A clear distinction is made in everyday understandings of health and illness between “natural” illnesses and “man-made” illnesses (Ashforth 2005; Ngubane 1977; Hunter 1936; Hammond-Tooke 1962). More specifically, in isiXhosa, any slight illness (*umkhuhlane*), such as a cold or headache is understood to be naturally caused (Hunter 1936: 272), whilst other illnesses may be understood as being “maliciously sent” (*ukuthakatha*) (Hammond-Tooke 1962: 264), either by someone out of spite or jealousy, or as a sign of warning from the ancestors. In the first instance, where *ukuthakatha* is associated with jealousy, witchcraft can be used against people who experience repeated success; material or otherwise. People who experience success might feel themselves vulnerable to the

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<sup>17</sup> URL 1: <http://www.xhosadictionary.com/search.php?igama=disease&stype=general&lang=XE>, last accessed, 5 November 2009

jealousy of neighbours or relatives, and might even take measures to protect themselves from potential acts of witchcraft. The theme of jealousy was often repeated by many of my informants when talking about issues of personal safety and security<sup>18</sup>. In the second instance, one's ancestors are seen as being able to make one vulnerable to disease and misfortune if they feel they have been neglected or wronged. This most often happens when a person does not fulfil the required rituals or sacrifices in their honour or remembrance. Such rituals are strongly linked to the African healing cycle (Mayeng 2009), and can be expensive to maintain, especially in the case of animal sacrifice. For example, when a child is born, a Xhosa family is expected to perform a ritual sacrifice of a goat in a naming ceremony known as *imbeleko*, in order to introduce the new born child to the ancestors in return for their recognition and protection. A similar ritual is performed in seeking protection for Xhosa boys who are about to undergo their initiation into manhood; a custom which is still strongly maintained. In cases where such rituals are not performed, a person may feel vulnerable to the potential wrath of their ancestors. Ashforth (2005: 128) describes this sense of vulnerability as spiritual insecurity.

There are a number of reasons why many of the rituals that form part of the African healing cycle are no longer performed today. First of all, many African people have adopted Christianity where such displays of ancestral worship are incommensurate with Christian beliefs. This is not to say that all forms of Christianity denounce African spirituality; in some denominations, traditional practices are maintained whilst in others, they are denounced as evil. Secondly, acts of ritual sacrifice are often expensive and poorer families are not always able to afford them. Nevertheless, families sometimes pool money together or save money over a period of time for the express purpose of fulfilling the necessary rituals. For boys who are expecting to undergo the initiation into manhood, this often means that they are forced to wait until the family can afford it. This can often lead to internal identity conflicts around issues of status where a 'boy' may have to wait into his twenties before he 'becomes a man'. Lastly, acts of sacrifice are often conducted by the head of a family, and due to the continued disintegration of the African domestic unit, family figureheads might not always be available to perform particular rituals, or in some cases may no longer be living.

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<sup>18</sup> The issue of insecurity is addressed in greater detail in Chapter Four.

## 1.6 Field Site and Choice of Participants

The research was conducted in and around Grahamstown, a small university town in the Eastern Cape Province of South Africa (see Figure 1.2). Typical of South African social geography, the town itself has an overwhelming white majority, whereas the surrounding areas and townships are predominantly non-white. The population of greater Grahamstown numbered 41,799 in 2003, of which 77.4% were Black, 11.8% Coloured, 10% White, and 0.7% Indian<sup>19</sup>, <sup>20</sup>.

Grahamstown is the seat of Rhodes University. As a result, many of the participants in the research had had some contact with university students, either through other research projects in which they had been involved, or through student volunteers who have helped out with the organisations in the study. The proximity of Rhodes University was one of the reasons for choosing Grahamstown as the site of this research. More importantly however, I wanted to work in a peri-urban landscape where Xhosa traditions were still visible, if not strongly maintained by many residents. Besides an already well-established Xhosa community in Grahamstown, since 1994 there has been a steady influx of economic migrants into Grahamstown from more rural areas in the former Transkei and Ciskei<sup>21</sup>. Many of these more recent residents have maintained their cultural traditions while living in Grahamstown. Walking around residential areas in the former black townships, one can still see *ubuhlanti*<sup>22</sup> proudly displayed in front of many houses, with the horns of animals sacrificed in ceremonies of ancestral worship.

A further reason for choosing to work in Grahamstown is that there are many non-governmental organisations (NGOs) operating in the town. Some of these NGOs have a focus on young people and it was easy to establish networks with people working in and around the town. After much consideration, I chose to work with two organisations: Siyapumelela and Sakhuluntu. The first, Siyapumelela has a focus on HIV/AIDS and the second, Sakhuluntu, a focus on youth. A detailed description follows on each organisation:

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<sup>19</sup> Here I follow the population classifications most commonly used in South African public discourse, and inherited as part of the apartheid legacy (see. West, in Boonzaier & Sharp 1988). These racial classifications – ‘White’, ‘Coloured’, ‘Indian’ and ‘African’ – are still maintained in current public discourse.

<sup>20</sup> URL 2: <http://www.info.gov.za>, last accessed 7 December 2009

<sup>21</sup> URL 3: <http://www.grahamstownhandbook.co.za>, and <http://www.grahamstown.co.za>, last accessed 7 December 2009

<sup>22</sup> An *ubuhlanti* is a kraal, usually circular, in the centre of which the horns of sacrificed animals are displayed. The ancestors are said to reside in this section of the homestead.

### 1.6.1 – Siyapumelela: “we are succeeding”

Siyapumelela is the youth program run by the Raphael Centre. The Raphael Centre is a Voluntary Counselling HIV Testing (VCT) centre and was especially founded for people living with AIDS. The Centre’s vision is one that shows a strong commitment to poor, disadvantaged communities in and around Grahamstown that have had little access to counselling and support for people living with or affected<sup>23</sup> by HIV. The Centre is “dedicated to combating the spread of HIV/AIDS and to improving access to support services required by those who are HIV positive or living with AIDS. The Raphael Centre uses Voluntary Counselling and HIV testing as a vehicle to implement this vision” and in so doing acts as a “refuge for those who feel alone”<sup>24</sup>. It provides a range of diverse HIV and AIDS services to approximately 700 people (*ibid*), through 7 main programs<sup>25</sup>. One of these programs is their youth program, Siyapumelela.

Siyapumelela – “we are succeeding” – offers a space for young people between the ages of 13 and 21 from poorer communities in and around Grahamstown to come together not simply to work through their respective experiences of HIV/AIDS in a safe and understanding environment, but more importantly to come together as young people with similar experiences of ‘being young’. The program to date has run a number of workshops and tours in which the participants have learned about HIV prevention and treatment, and which have allowed many of the participants to disclose sensitive and personal information to trained professionals or volunteers<sup>26</sup>. There are currently about 60 participants involved in the program; most participants are isiXhosa speakers from Grahamstown’s townships along with some Afrikaans speakers from Grahamstown’s formerly ‘coloured’ area (see. Figure 1.2 below)

The Raphael Centre is one of the more established and well-known HIV/AIDS counselling centres in Grahamstown, having being founded in 1999. It is well recognised in and around Grahamstown and has received wide acclaim for its dedication in the ‘fight’ against HIV. It is for these reasons that the

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<sup>23</sup> A distinction is made here between people *infected* and people *affected* by HIV. Many people who use the counselling services offered by the Raphael Centre are not necessarily infected but are in some way affected by HIV/AIDS.

<sup>24</sup> URL 4: <http://nml.ru.ac.za/ngo/raphael/>, or <http://raphaelcentre.co.za>, last accessed 3 December 2009

<sup>25</sup> Besides Siyapumelela, the other programs are: voluntary counselling and testing; training and education for people living with HIV/AIDS; prevention of mother to child transmission; access to treatment; food support; orphans and vulnerable children; and advocacy and volunteer work.

<sup>26</sup> Many of the volunteers are students from Rhodes University who have made a concerted commitment to the program and have developed positive and continued relationships with the participants

Raphael Centre was the first organisation I approached. Furthermore, the participants in the youth program had had experience working with students and researchers and were, as expected, extremely open and receptive to the workshops conducted (see Section 1.7 on Methodology).

### **1.6.2 – Sakhuluntu: “building our people”**

The Sakhuluntu Cultural Group, a small NGO, was established in 1998 by the current organiser, Vuyo Booie and was initially based in Fingo Village. The township neighbourhoods in which Sakhuluntu is currently active are those of Extension 8 and 9, which are both the more recently built and amongst the poorest residential areas in Grahamstown (see. Figure 1.2 below). The organisation operates out of the house in which Vuyo is currently living; a small RDP house belonging to Vuyo’s father. Unlike the more settled and established sections of Grahamstown’s formerly black townships, the newer extensions do not have the same history of established “intra-generational kinship and neighbourhood networks of support ... community and religious organisations, improved infrastructure such as paved roads and street lights. There are also no community halls<sup>27</sup>, cinemas, demarcated play areas, clean soccer fields, or safe public spaces in this section of the township” (Sakhuluntu Annual Report 2008/2009: 2). The residents of these newer sections include many newcomers, often economic migrants from more rural communities in the Eastern Cape, as well as the “poorest of the poor” – the most economically marginalised residents of Rhini<sup>28</sup>. As a result, one finds signs of both economic marginalisation and social neglect due to “unemployment, petty but violent crimes, the abuse of drugs and alcohol (increasingly so by youths), *shebeens*<sup>29</sup> and dusty and unsafe streets” (Sakhuluntu Annual Report 2008/2009: 2).

Sakhuluntu’s principal aim, as clarified in a flyer given out at a Heritage Day performance is “to help township youth stay away from crime, drugs, and alcohol by providing after-school activities to develop their creative potential”. This has been achieved by providing a space where young people between the ages of 4 and 20 can meet, and learn creative skills – dancing, singing, and drama – along side general life skills. One of the main reasons for choosing to work with the participants of Sakhuluntu was that many of the children and teenagers in the organisation were used to the performance space. As hoped, the participants responded extremely well to the nature of the

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<sup>27</sup> A community hall is currently under construction and Sakhuluntu hope to be able to use these new facilities in the near future

<sup>28</sup> Rhini is the isiXhosa name for Grahamstown

<sup>29</sup> A *shebeen* is an informal tavern most commonly located in ‘townships’. They are often illegal on account of not having a liquor license

workshops conducted for the research. They were open and receptive and not necessarily intimidated by the ‘theatrical’ element of the workshops. A second reason in choosing to work with Sakhuluntu was that unlike Siyapumelela, the participants from Sakhuluntu did not necessarily have access to information about HIV/AIDS outside of the school environment. The group offered a welcome contrast to Siyapumelela.

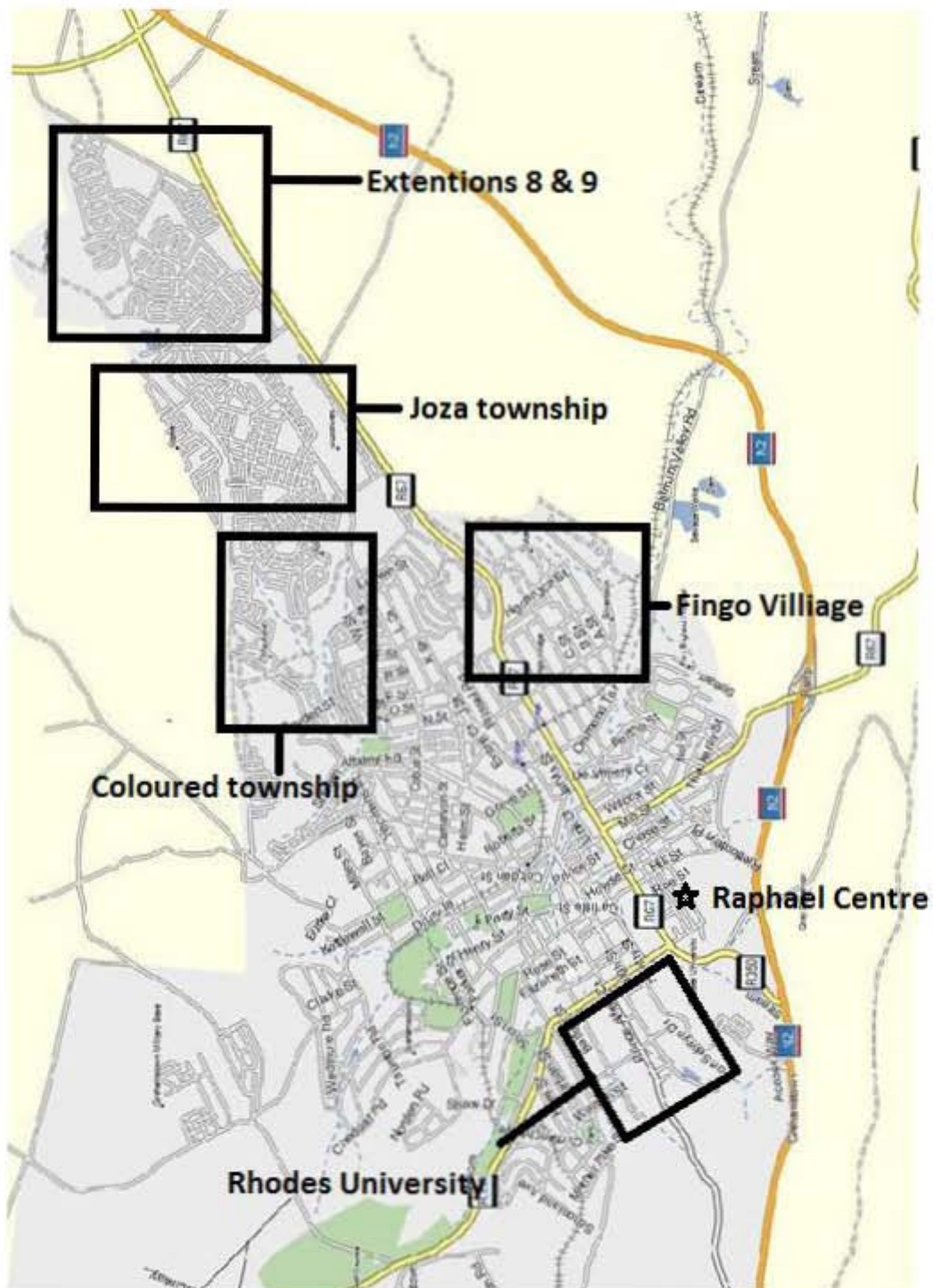


Figure 1.2 – Map of Grahamstown

## 1.7 Methodology

The research was conducted through a series of workshops with the two youth groups detailed above. The workshops took place over 6 consecutive weekends<sup>30</sup>, within the three months spent in the field. As the participants attended school during the week, the workshops were held on the weekends for between 2 to 4 hours at a time. During the week days that fell between the workshops, I worked with individual participants, following up on points of interest that arose during the workshops.

The two groups were variously comprised: in the first group, Siyapumelela, there were between 20 and 30 participants (from the ages of 13 to 21); in the second group, Sakhuluntu, the participants were on average much younger (from the ages of 7 to 15), and consisted of between 15 and 25 participants<sup>31</sup>. Most of the participants in Siyapumelela were isiXhosa speakers although there was a core group of Afrikaans speakers from the ‘coloured’<sup>32</sup> community. Nevertheless, almost all the participants in this group had a fair to good grasp of English and were readily able to express themselves in English. For this reason, English became the *lingua franca* during the workshops. As aforementioned, most of the participants in this group had worked with other students and researchers who had used English as the medium of instruction and almost all participants were comfortable talking in English. The second group however consisted solely of isiXhosa speakers, many of whom had a poor grasp of English. This was due to the fact that the participants in Sakhuluntu were both much younger and attended poorer schools which conduct most classes in isiXhosa. Fortunately, I was able to engage two translators at any one time when working with Sakhuluntu who helped ease the flow of the workshops.

Both organisations expressed that their own agendas needed to be maintained during the research process. As Siyapumelela’s principle aim is to offer a space in which young people can talk through

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<sup>30</sup> It was not possible to work with a fixed group of people from Siyapumelela despite my express concern that it could prove problematic to have participants join part way through the research process. Nevertheless, I was able to secure a key group of people who were present at all the workshops. There were about 15 main participant-informants in this core group. It would often happen that participants would be called away on weekends due to personal engagements. On a few occasions, some of the participants were absent due to the fact that they were attending a funeral.

<sup>31</sup> Like the first group, the participants from Sakhuluntu could not always be relied upon to partake in the workshops. Nevertheless, a core group of about 10 participants attended all the workshops.

<sup>32</sup> As mentioned in footnote 16, the racial categories inherited from the Apartheid legacy still circulate in current public discourse. The racial category ‘coloured’ refers to people of mixed race, who in South Africa constitute a defined community with a shared cultural heritage of slavery and oppression.

any problems in their lives (be they related to HIV or not), the organisers were excited that the proposed research could offer different ways in which the participants might choose to talk about their lives. For Sakhuluntu, the workshops were seen as an interesting way to offer information and educate the participants about HIV/AIDS.

Due to the sensitive nature of the questions posed in the research – questions pertaining not only to HIV, but also to issues of subjectivity, the body, health and illness – the methodology employed in the workshops sought to uncover the issues at hand in a non-intrusive, didactic and self-reflexive manner. The workshops offered the participants a variety of ways in which they could talk about and talk through their life histories, allowing them a sense of autonomy within the research process. As one of the co-ordinators of Siyapumelela explained, far too often researchers come into poor communities and conduct research that is both extractive and invasive. The workshops were therefore intentionally didactic in that they offered the participants a means through which they could talk and learn more about HIV/AIDS as well as themselves.

## **1.8 The Organisation of the Thesis and Progression of the Arguments**

The research is presented around a series of Vignettes which describe various interactions that occurred both during the workshop sessions and whilst in the field. The term ‘Vignette’ alludes not only to some of the theatre techniques that informed the central methodology during the workshop process, but also to the nature of writing subjectivities and the ethnographic impetus of trying to capture one’s informants as “people living on the page” (Biehl 2005: 19). The Vignettes are therefore intended to give the reader both an indication of how various creative methodologies were employed during the research, as well as how the participants responded to the workshop sessions. Important themes that emerged during each workshop are discussed around the fundamental research question concerning the nature of young peoples’ entangled experiences of health and illness in relation to both HIV/AIDS and traditional healing.

The second chapter begins with a broader discussion on the methodological and ethical considerations central to the research process. The Vignettes in this chapter are snippets from the first workshop session and they are included for two reasons: firstly, to give the reader a clearer view of how the methodology unfolded during the research process; and secondly to reveal how young people talk about and understand both their therapeutic environments and HIV/AIDS. A detailed discussion follows on the semantics of HIV/AIDS, and the nature of young people’s discourse

around health and illness issues. This is substantiated with reference to a series of exercises where the participants visually represented their understandings of words like HIV/AIDS, CD4 cell, and ARVs.

The third chapter is primarily concerned with the relationship between health and illness and the environments that young people come from; environments that are characterised by the conditions of social structural violence. A noticeable feature of structurally violent communities is a high level of illness, largely due to conditions of poverty (Farmer 1996). A further feature is the lack of adequate health-care facilities, resulting in many people accessing an extended therapeutic environment consisting of alternative forms of healing. The chapter therefore looks at how social structural violence plays out in the participants' lives and relates the common challenges that they face to their experiences of well-being, or lack thereof. The chapter concludes with a discussion based around a series of character sketches that were created in order to act as a means through which the participants could relay their personal experiences. In so doing, the character sketches draw attention to how the conditions of social structural violence affect the participants' lives and their experiences of health and illness. The characters sketches also offered an opportunity to begin to examine how the participants relate to traditional forms of healing.

The fourth chapter, entitled radio workshops, looks at the kinds of relationships that young people have with traditional forms of healing. Using a methodology derived from the work of Tobias Hecht (1998), the chapter examines two main topics that were discussed during a series of radio interviews conducted by the participants themselves. The first of these topics involves the relationship that traditional healing has with HIV/AIDS. The second, looks at the nature of *amakhosi* spirit possession which is often necessitated by strong feelings of vulnerability. The discussion therefore examines three types of insecurity – social, structural, and spiritual – that variously contribute to this overall sense of vulnerability.

The concluding chapter draws the argument to a close by relating the notion of unbreaking fragility through the body-map of one participant, Thabo. The discussion around Thabo's body-map highlights one of the central themes that is discussed throughout the thesis – the consequences of fragmented avenues of support - and draws the discussion to a close through his personal narrative.

## CHAPTER TWO

### Alien Hot Seat

#### Vignette Two

We're seated in a circle on hard plastic chairs in a draughty community hall. The twenty or so teenagers look relieved to be relaxing a little after a mornings worth of games and activities. We're waiting for a special guest to arrive, and when she does, the participants meet her with mixed reactions. Some scream theatrically and pretend to run away whilst others burst out laughing at the extraordinary sight before them. Our guest is an alien named Zo from the planet !Qi. She has a long translucent face and wide, oblong eyes. As the participants already know, Zo has come from far away to seek their advice about a recent pandemic affecting her planet in the hope of finding out as much as possible about an unknown disease.

After the initial shock of meeting an alien for the first time, we all settle down and duly welcomed Zo to address us. She stands in front of the group and explains her situation:

“I'm going all over the galaxy to find what is making my people sick”, she explains. “Do you want to see what my planet !Qi looks like?”

There is a general murmur of agreement from the assembled group. Zo opens a large book with a number of drawings showing variously coloured dwellings. Some of the kids giggle at the pictures, others shout in amazement at the strange buildings. While Zo is putting her book of pictures away, one of the more outspoken boys in the group asks her why he isn't wearing any shoes.

“Shoes? What are these things ... shoes?”, Zo asks looking confused.

“You put them on your feet”, explains one of the research assistants.

“It's what I'm wearing now”, continues the boy, pointing to his shoes.

“What do you do with these shoes”, Zo asks, still looking rather befuddled.

“Walking. Just like this”, says the boy while demonstrating how one walks in shoes.

“I walk just fine without these things, what do you call them?” Zo asks again.

“Shoes!”, replies the group in unison.

“Shoes. It's a funny name isn't it?” Zo remarks.

“You're a funny creature”, replies one of the research assistants to everyone's general amusement.

## 2.1 Methodological and Ethical Considerations

When working with children and teenagers, it is important to create a platform through which they are able to easily and comfortably express themselves. This was a key motivating factor in creating the workshop series that formed the central methodology in my research. As is clear from the example given in Vignette Two, the participants were encouraged to engage with the research process on their own terms. Each workshop was aimed at opening up different points of discussion in ways that were interesting and accessible. Central to this particular methodology was the belief that it is essential to recognise the agency that young people hold, and especially the agency of children (Morrow & Richards 1996) within the research process, as it is unethical to coerce one's participants into joining any given research activity. As a result, the concept of informed consent was carefully explained and reinforced by continually reminding the participants of their choice to take part in the activities presented. Additionally, consent forms were given out in both English and isiXhosa in order to inform the participants' guardians about the proposed research.

In keeping with official Anthropological ethical guidelines, it is important when conducting research to “consult actively with the affected individuals or group(s), with the goal of establishing a working relationship that can be beneficial to all parties involved”<sup>33</sup>. The workshop series was therefore constructed around both my needs as a researcher as well as the particular projects of the organisations involved in the study.

The nature of the workshops allowed Participant-Observation in the true sense of the term; at times I would participate in some of the planned activities and for particularly pertinent activities, I was able to unobtrusively observe while the research assistants took charge. The term Participant-Observation is in itself oxymoronic. As Hecht (1998: 6) explains, “participation implies being a part of the events one is studying; observation implies detachment, even invisibility”. It is with this in mind that the workshops were constructed to allow myself ample space for both activities. At times this proved successful, but at others it was difficult to achieve. This was mainly due to my position within the research environment which was inevitably one of authority. Nevertheless, as many of the activities were created to allow the participants to engage in an imaginative space (through theatre games, drawing and painting, and so on) on their own terms, they were encouraged to suspend their disbelief and, in most cases were happy to ‘play along’.

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<sup>33</sup> See. American Anthropological Association's Code of Ethics: <http://www.aaanet.org/issues/policyadvocacy/upload/AAA-Ethics-Code-2009.pdf>, last accessed 15 February 2010.

Vignette Two is taken from the combined transcript and field notes from the first workshop conducted with the participants from Siyapumelela. The workshop drew on Augusto Boal's (1985: 122) "poetics of the oppressed", in using a theatre technique called 'hot seating'. The principle aim of 'hot seating' is to create an object of deference – in this case an alien – onto which the participants project their experiences of the world. During the workshop, the participants were active in creating the character Zo through a series of conceptualisation exercises. Zo was introduced to the participants as someone who had a serious problem and was in need of advice. She<sup>34</sup> was invited to take centre stage – 'the hot seat' so to speak – and to explain her problem to the group. The participants were encouraged to reflect on Zo's problem and offer her what help they could.

The problem that Zo presented – that of her mother's illness – was meant to encourage the participants to reveal what they knew about HIV/AIDS. I was interested to know how the participants would respond to Zo's cry for help, considering that the symptoms affecting Zo's mother mimicked the opportunistic infections commonly found in AIDS patients. The 'hot seating' technique was useful here for a number of reasons. Firstly, as has already been mentioned, young people often feel bombarded with information about HIV/AIDS. This has resulted in "AIDS Information Fatigue Syndrome" (Levine & Ross 2002:89) where young people are bored of talking about HIV/AIDS related issues. Zo's situation offered an interesting platform through which the participants were in some ways compelled to talk about HIV/AIDS. Secondly, as Zo is a creature who knows very little about how people live on planet earth, she was able to ask seemingly innocent questions about the participants' lives, such as the configurations of their households (see. Vignette Three). These are questions that are often hard to ask. And thirdly, as one of the main aims of the first workshop was to garner an understanding of the participants' health and illness discourse, Zo's innocent questioning about their health and illness practices further allowed for this.

The 'hot seating' workshop was repeated with the children from Sakhuluntu, revealing similar patterns. These are illustrated in Vignette Three (below) which, along with my field notes, was taken from a transcription translated from isiXhosa:

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<sup>34</sup> One of the main reasons for using an alien in this exercise was to create a neutral canvass onto which the participants could project their experiences. However, it was not possible to escape certain characteristics such as gender.

### **Vignette Three**

Zo is seated on a chair in Vuyo's house with a large group of children sitting on the floor facing her. She has just finished describing what the houses look like on her planet – enormous bright beams of coloured light. She was interested to know if any of the kids lived in similar looking houses. Everyone agreed that their houses looked quite different. When Zo asked if they all lived together as did the people on her planet, she was quite surprised to find out that everyone lived in different houses. Some of the children lived with their parents, others with their aunts or uncles, brothers or sisters, and some with their grandparents. Most of the kids houses were a lot smaller than Zo's but like the houses on Zo's planet, there were often quite a lot of people living in one house together.

The children seem quite fascinated by Zo. They listen intently as she explains why she has come to talk to them. Zo talks about her sick mother and describes what is wrong with her. Her description closely fits many of the opportunistic infections associated with AIDS. Zo also explains that on her planet, when someone gets ill, they are taken to see the medicine man who creates different kinds of medicines; some you have to drink, others you have to inhale. She asks the children if they have a similar kind of medicine man in their community.

“Yes”, replies a young girl of eight. “She is called a Sangoma”.

Some of the children giggle at the mention of a Sangoma. Zo just nods her head contemplatively.

Then she asks,

“Where do you go when you're sick?”

“The clinic, hospital”, chorus the children.

“And what do they do at this hospital, clinic?” Zo asks.

“They give you medicine”, reply the kids, in almost perfect unison.

Zo looks intrigued, and enquires “What kind of medicine?”

“Pills and things”, reply some of the children.

“And what does this medicine look like?”, continues Zo.

“You get different types; some green, some yellow, some white”, explains one of the boys.

“And you can drink some medicine and sometimes you get pills”.

“And you can get Panado”, explains a small girl with long braids.

Zo tries the word out for the first time, “Panado? What's Panado?”

“You take a Panado if you have a headache”, explains one of the research assistants.

“Ok, I see”, says Zo, looking satisfied.

“Do you not have headaches on your planet?”, continues the research assistant.

“No”, replies Zo. “Our heads are very good on our planet”.

Some of the children laugh at this remark.

“ But I came to your planet because my mother is very sick”, Zo reminds us. “She is very thin and vomits all the time and now she has sores growing around her mouth. This is a new illness on our planet and I thought I could get some help from you”.

“Is it not a headache?”, enquires the research assistant again.

“No, it’s not a headache”, says Zo looking around worriedly. “I don’t know what it’s called”.

“What do you guys think it is?” asks the researcher, addressing the seated children.

“Swine-flu”, ventures one of the boys.

“What’s swine flu?” asks Zo.

“It’s the sickness of the pigs”, explains the boy. “H1N1”

“Zo, do you have pigs on your planet?” asks the researcher.

“No”, replies Zo, “we don’t have pigs”.

“So do you think it can be swine flu then?” continues the researcher.

“No, it can’t be a headache and it definitely can’t be swine-flu” replies Zo. “Don’t you `guys have an illness like this on your planet?”, she asks imploringly. “People who have this illness cough all the time and they need to go to the toilet a lot, and vomit and get very thin. My mother is very thin”.

One of the older girls puts up her hand. “Maybe it’s HIV”, she says.

“What’s HIV?” asks Zo.

“It’s *Ugawulayo*<sup>35</sup>”, explains the girl.

“What is *Ugawulayo*?”, enquires Zo.

“It makes them sick like your mother” explains another of the kids.

“What do you do when someone has HIV?”, Zo asks optimistically.

“You get them ARVs”, says one of the boys.

“ARVs.”, repeats the research assistant for Zo’s benefit. “Do you know about ARVs?”, she asks, addressing Zo.

Zo shakes her head, “What are ARVs?”

“They are pills that make you less sick”, replies the boy.

“Oh ok, I see”, says Zo, looking pleased.



**Figure 2.1 – The alien Zo from planet !Qi**

<sup>35</sup> *Ugawulayo* translates as ‘the reaper’.

## 2.2 Young People's Therapeutic Environments

Vignette Three – an excerpt from the first workshop – reveals how the ‘hot seating’ technique was employed to gain a better understanding of the participants’ therapeutic environments as well as how well-informed the participants were about HIV/AIDS related issues. It is clear that many of the participants have a strong awareness of their therapeutic environments; most of them are both aware of, and knowledgeable about, different kinds of illnesses and illness episodes within their communities. The mention of Swine Flu (H1N1) is a case in point<sup>36</sup> – the fact that the participants were able to recognise the symptoms of Swine Flu as being similar to those of AIDS (coughing, headaches, fatigue, sore throats) indicates the level of their awareness. Moreover, when talking about issues of health and illness, the participants were quick to describe biomedical healthcare institutions as their first resort; the most common place that is accessed is the local clinic. Besides the fact that the township clinics in Grahamstown are often overcrowded and understaffed, they are still the most accessible and affordable. Not surprisingly, the clinic has come to represent a complex symbolic space within township life: For many, it is the only means of medical support beyond the immediate moral economy of the extended domestic unit and is therefore considered a place of refuge and support; for others, the clinic is seen as synonymous with HIV/AIDS due to the fact that many people use it to get ART. In some conversations, the mention that someone ‘goes to the clinic’ was meant euphemistically to indicate that that person was HIV positive. Unfortunately, because the clinic is often under pressure to accommodate many people, it is not always able to offer the much needed psycho-social support that comes with experiences of illness, especially HIV/AIDS. NGOs such as the Raphael Centre that take on these needs are therefore indispensable.

Beyond biomedical healthcare it is possible to see from the participants response to Zo’s description of traditional healing that many of them are aware of how traditional healing operates, although they are sometimes embarrassed to talk about it. This embarrassment could be partly due to the inherent secrecy that surrounds many traditional forms of healing, but also because of the perception that traditional healing is out-dated and used mainly by older generations. Often, the participants would respond to the mention of traditional healing with derision, especially in relation to the use of biomedicine. Many of the participants explained that in the modern world, ‘western’ medicine is much more effective than traditional African medicine in dealing with disease. However, because ‘western’ medicine is not able to deal with issues such as witchcraft, or other problems connected to

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<sup>36</sup> While the research was being conducted, there was an outbreak of Swine Flu (H1N1) in Grahamstown (see. Meintjies 2009).

the African healing cycle, traditional healing is still an important necessity. This issue was clarified in the follow-up discussions concerning Zo's situations: First of all, the participants explained that due to the fact that Zo was not amaXhosa, a traditional healer could not help her; second of all, because Zo needed help treating HIV/AIDS, it is better for her to go to the clinic or to consult a western doctor.

A further feature that was clear from the discussion with Zo was that both groups had a firm understanding of HIV/AIDS; how HIV is contracted, how to effect prevention, and how it may be bio-medically treated. This was not surprising from the participants from Siyapumelela due to the organisations focus on HIV/AIDS. The children from Sakhuluntu, however, were on the whole a lot younger and would primarily have had access to information about HIV/AIDS through school. Nevertheless, they were equally as well-informed about HIV/AIDS. This observation is in keeping with research amongst young South Africans which has revealed that in general, young people are well-informed about issues relating to HIV/AIDS, as well as other STIs, including both prevention and treatment options (James *et al* 2007). However, as James *et al* (2007: 267) explain, there still remains a large gap between awareness and behaviour, and despite having a clear knowledge of STDs and STIs, young people continue to put themselves at risk. The question as to why this might be so is dealt with in the discussion that follows, first by exploring the semantics of HIV/AIDS. It is important to pay attention to the ways in which HIV/AIDS is talked about and named, especially when considering African language speakers, because "naming in African languages is always significant, with most given names having a meaning" (Dowling 2004: 1). The second part of the discussion therefore looks at how the participants both talk about and visually represent words such as HIV, CD4 and ARV. By examining the kinds of connections that young people make in talking about HIV/AIDS, the discussion attempts to think through the kinds of problems that may be contributing to the fact that many young people, from structurally violent communities, continue to put themselves at risk of contracting HIV and other STDs.

### **2.3 The semantics of HIV/AIDS**

First of all, it is important from the start to consider the semantics of the acronyms HIV and AIDS. For one thing, these two acronyms are often used interchangeably, even by health care professionals. I noticed that many of the participants would regularly mix the terms HIV and AIDS when talking about HIV/AIDS. What this indicates is not necessarily a carelessness around naming and labelling, but an attitude of generalisation. Two questions emerge from this observation: why is it that people

generalise the acronymic phrases HIV and AIDS? And what have these acronyms come to represent in young people's everyday lives?

In answer to the first question, Nguyen (2005: 126) explains that HIV and AIDS have come to encompass “a heterogeneous and uneven congerie of practices and techniques, present and active in everyday life, to produce particular kinds of subjects and forms of life”. Seemingly disparate phenomena such as “condom demonstrations, CD4 counts, sexual empowerment, retroviral genotyping, an ethic of sexual responsibility, and compliance with complex drug regimes” (*ibid*) have all become entangled together into a remarkably stable and simultaneously homogenous global formation encompassed in one term, HIV/AIDS. The acronyms HIV and AIDS have come to represent a number of socially contextual concepts, and like many aspects of health and illness discourse, are often metaphorically produced (Sontag 1977). In this light, one could perhaps best describe HIV/AIDS as a “concept-metaphor” (Moore 2004).

Concept-metaphors may be understood as “domain terms that orient us towards areas of shared exchange” (Moore 2004: 73). Words such as ‘global’, ‘gender’, ‘body’ and ‘mind’ are used as “a kind of conceptual shorthand” (*ibid.*) in representations of complex social phenomena. In a sense, concept-metaphors reduce people's lived experiences on a local scale into neat categories so that they might be better understood in relation to global formations and processes. This has resulted in what Arthur Kleinman (1987) has termed ‘category fallacies’; invidious distinctions that serve to separate invariably linked social phenomena such as poverty, disease, and social structural violence. This, in turn, results in social worlds being divided into ‘suitable’ categories – political, cultural, economic – and so on<sup>37</sup>. Although anthropologists have long since recognised the porous nature of such socially defined categories and have been critical of the structural functionalist model of dividing lived realities into static institutions (Eriksen & Nielsen 2001), these categorisations continue to bear a direct result on the kinds of discourses that emerge around describing large-scale social suffering.

Large-scale suffering that leads to individual suffering is always structured by historically given (and often economically driven) processes and forces that conspire, as Farmer (1996: 263) explains, “to constrain agency”. As Mbeki's rejection of ARVs attests (Fassin 2007), this is inherently a political

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<sup>37</sup> Such category fallacies are a direct result of a particular historicity implicit within the Western epistemological order, and they offer a challenge to an Anthropology that is trying to re-imagine the post colonial university.

process. Useful here is Foucault's (1961) critical reflection on the nature of political discourse which reveals that in every society the production of discourse is intentionally controlled, selected, organized and redistributed according to a certain number of procedures. Foucault describes how specific prohibitions are placed on individuals through the external delimitations that allow for the privileged or exclusive rights to speak of and for a particular subject. These 'privileged or exclusive rights' are determined by those considered 'experts' in the representation of others, favouring a particular set of discourses that might constrain the agency of those who would attempt to move beyond them<sup>38</sup>. In this light, one can see how public health discourse around HIV/AIDS favours particular modalities of knowing that bear a direct influence on how HIV and AIDS are spoken about, understood and invariably treated.

Also useful to this discussion is Trouillot's (2004: 230) notion of "substantive universals", which are not dissimilar to concept-metaphors. Words that are central to public health discourse around HIV/AIDS – such as 'compliance', 'progress', 'modernity' and even 'health' – are imbued with social and cultural significance and are differently understood and expressed at the local and global level. Like concept-metaphors, such universals have no one fixed meaning yet they are used to describe the world in homogenous terms. What we find here are examples of catachresis; words that are not always used correctly or in the same way. Or inversely, words that are used differently by different people. Such differences emerge because substantive universals, like concept-metaphors, are words embedded within particular historical and cultural contexts. If one thinks of the word 'progress' for example, colonial discourses encompassing an evolutionary schemata spring to mind. Implicit within this evolutionary schemata of 'progress' are notions of primordial sexuality which allow Africans to appear more sexed than other people (Susser 2009). And if one takes the notion of progress in terms of public health interventions around HIV/AIDS prevention and treatment in Africa, it is possible to see how such notions of progress might affect models of prevention and treatment. Furthermore, local responses to HIV/AIDS continue to be measured against Western models of success. What Anthropology can bring to witness in such situations is precisely how people on the ground understand and appropriate concept-metaphors, and how assumptions implicit within substantive universals might affect how public health efforts are implemented. In seeking to demonstrate the value of the local, anthropologists are able to show that "the relationship between an

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<sup>38</sup> This is not to say that such discourses cannot be re-imagined or contested. However, it seems pertinent to remember that the political is an evasive construct which inescapably permeates all aspects of social organisation, informing the way one is able to speak of social processes.

imaginary or hypothetical construct and a concrete set of processes and connections in the world is important to ordinary individuals” (Moore 2004: 74).

Turning to the second question concerning the meanings that HIV and AIDS hold for young people in South Africa, it is necessary to further consider the linguistic features of these acronyms. For one thing, the words ‘HIV’ and ‘AIDS’ are semantically void in African languages. This is because African languages are agglutinative – words are broken up syllabically – and unlike inflectional languages such as English, African languages cannot easily form acronyms. HIV therefore has no direct translation from its acronymic form into a language like isiXhosa. Neither do words such as AIDS, ARV or CD4 cell. What often emerges in place of these acronyms are a collection of metaphors; some that are positive and work to better explain the concepts implicit within these acronyms, and others that are debasing and destructive. In Medical Anthropology, metaphorical language is understood as representing how people think about, relate to, and make sense of illness by giving a disease a name that belongs to something else (Sontag 1977). As Susan DiGiacomo (1992: 117) explains, “we can experience anything at all only through and by means of culturally constructed and socially reproduced structures of metaphor and meaning”. In this way, metaphors embody local subjectivities and ways of knowing as expressed through culturally specific language. For example, in isiXhosa, CD4 cells are referred to as *amajoni umzimba*, or ‘the soldiers of the body’, as they are the cells which maintain the integrity of the immune system. When describing how ARVs work, health care professionals will often explain that ARVs help to reinforce the ‘soldiers’ so that they can have a better chance of ‘fighting’ the virus. Military metaphors in this instance might work to bolster a person’s confidence in dealing with ART.

HIV/AIDS in South Africa, however, is no stranger to the potentially destructive nature of negative metaphors (Dowling 2004). The children from Sakhuluntu, for example, referred to HIV as *ugawulayo*, or ‘the reaper’, indicating how HIV is seen as a death sentence. This kind of despondent attitude arises primarily from the fact that HIV is, at present, an incurable disease. Yet unlike other chronic illnesses, the socio-sexual nature of HIV has an inherent connection to danger and pollution (Henderson 2004), and is associated with social and sexual deviancy; HIV/AIDS therefore demands a moral explanation (Sontag 1991). In order to see the kinds of connections that the participants make with concept-metaphors like HIV/AIDS, a series of exercises were conducted in which the participants were asked to visually represent words like CD4, ARV and HIV. Maria Weiss (1997: 460) employed a similar methodology in which her informants would first draw their associations,

assumptions and connections relating to HIV/AIDS, Cancer, and Heart disease, and use their drawings to talk through their understandings of these illnesses. In this way, she was able to identify recurrent themes and underlying patterns linked to representations of illness. The discussion that follows below looks at some of the patterns that emerged from the participants' drawings concerning their understandings of HIV/AIDS:

## **2.4 Representing HIV/AIDS**

In many of the visual representations of HIV/AIDS, the participants painted recognisable, 'universal' symbols such as the red AIDS ribbon and the red cross associated with both foreign aid and biomedical healthcare institutions. These symbols are indicative of how HIV/AIDS, as a concept-metaphor, makes universal claims to the ways in which HIV/AIDS is perceived, experienced and understood. For example, the recurrent use of the colour red is significant due to its intrinsic connection to the colour of blood. This indicates that, despite representations of HIV/AIDS being constructed as universal and "beyond culture" (Weiss 1997: 457), the symbolic space within which HIV/AIDS is represented has implicit links to a biomedical aetiology. Furthermore, the colour red is also associated with danger, and considering that to be HIV positive "is to be revealed as a member of a certain "risk group"" (Weiss 1997: 457), the associations that may be made about certain "risk groups" could be linked to perceptions of moral and social deviancy. Some of the participants included short sentences next to the images of the red AIDS ribbon to indicate who they understood these "risk groups" to be; they wrote sentences such as "HIV is for poor people" and "HIV is for Blacks only". What is evident from these associations is that, in South Africa, due to a history of racialised capitalism and the resultant conditions of social structural violence, factors of socio-economic status and ethnicity continue to impact young people's understandings and experiences of HIV/AIDS. This point is explored more thoroughly in Chapter Three.

Some of the participants painted metaphoric imagery in explaining their feelings towards HIV/AIDS. Anele (21), for example, painted a fire to show the devastating effects that HIV/AIDS can have on a person's life. Anele explained that like HIV, a fire is red, dangerous and holds the potential to destroy a person's life. The themes of the dangerous and destructive nature of HIV/AIDS recurred in a number of the participants pictures. Lindiwe's (16) representation of HIV/AIDS, in figure 2.2 below, presents HIV/AIDS as both the colour red and a destructive force in the world:



**Figure 2.2 – Lindiwe’s visual representation of HIV/AIDS**

Figure 2.2. shows a picture of “a dark cloud hanging over the world”. Next to a crying face with the words “the new face of dead [death]”, Lindiwe has written that because HIV cannot be cured, “it will destroy our people”. Such feelings of hopelessness that surround young people’s discourse about HIV/AIDS reveal a despondency towards the value of life, which may well explain the attitude of carelessness that many young people take concerning HIV prevention. Similar to Freud’s (1924) notion of Thanatos – or death drive – the seeming hopelessness that surrounds subjective experiences of HIV/AIDS, compounded with the conditions of social structural violence, might lead young people to engage in risky behaviours.

Despite the achievements that HIV/AIDS education has had in drawing awareness to the nature of HIV/AIDS and promoting prevention and abstinence, there still remains a large discrepancy in young people’s actualised behaviour. This points to the urgent need for HIV/AIDS and sex-education to be reoriented towards crucial behavioural change. However, as Brandt (1998, cited in Marks 2002: 22) explains, behaviours are “subject to complex forces, internal psychologies and external pressures, all of which are not subject to immediate modification ... Sexuality is subject to a number of powerful influences ... many more powerful than even the risk of disease and death”. It is therefore necessary to look at the kinds of “external pressures” affecting young people’s behaviours if behavioural change is to be realised. James *et al* (2007: 264) found, for example, a strong impetus for

“addressing gender discrepancies and promoting skills for communication through planned intervention programs”. Organisations such as Siyapumelela and Sakhuluntu, which are sensitive to the many challenges faced by young people from structurally violent communities, are essential to affecting this kind of change. According to Lindiwe, the candles that are dotted around her picture are a reference to the hope that HIV/AIDS originations, such as Siyapumelela offer young people today.

Some of the participants represented HIV/AIDS from a heavily biomedical point of view. In Figure 2.3 below, Brenda (17) has drawn how she imagines infected CD 4 cells to look. The red dots within the balloon-like cells represent the HI virus multiplying within the CD4 cell. The image favoured here is clearly biological, with the tails of the cells resembling DNA strands. In the centre of the picture Brenda has drawn an explosion to show how HIV erupts in the body and destroys the immune system. In the corner of the picture, she has written, “HIV is a symbol of danger”. Once again, the language of danger and destruction is evident from such representations of HIV/AIDS. As Brenda explained, the explosion in the centre of her picture shows how HIV/AIDS reaches out and affects everything around it. Like an explosion, people can be caught unaware and never recover from the shock.



**Figure 2.3 – Brenda’s visual representation of infected CD4 cells**

Brenda also drew the way she understood ARVs to work within the body. In the image above, one can see how the explosion in the centre is contained within a green, squiggly box. These squiggly lines show how ARVs contain infected CD4 cells. However, because ARVs are not able to cure HIV but merely control it, some infected cells – although not as distinct – have escaped the box. ARVs are spoken about as offering a level of control over a situation that is already out of a person's hands. The notion of control may bring a level of order to feelings of vulnerability and instability.

## **2.5 Chapter Conclusion**

The first workshop drew attention to the fact that many of the participants have a keen awareness of their therapeutic environments. Equally, as biomedical healthcare is normally their first point of recourse, the participants demonstrated a clear and well-informed biomedical understanding of HIV/AIDS. However, because there is an evident gap in young people's awareness about HIV/AIDS and their actuated behaviour, it is important to look at how young people talk about and represent words such as HIV, CD4, and ARV, in order to gain a better understanding of kinds of discourses operating in their lives. The politics of representation is complex and variable and calls into question the ways in which entangled relations of power construct universal responses to epidemics like HIV/AIDS. By looking at HIV/AIDS as a concept-metaphor, the politicisation inherent in representations of HIV/AIDS becomes more transparent.

The fact that many of the participants described HIV/AIDS as a violent, destructive force that permeates multiple aspects of their lives, may help in understanding the reckless, self-destructive and potentially violent behaviours that many young people engage in. As behaviours can be linked to the social environments which produce them, it is important to look more closely at the social conditions that may contribute to their maintenance. In so doing, it is possible to grasp a clearer view of young people's experiences and responses to issues of health and illness. The chapter that follows therefore examines the relationship between health and illness and the environments that the young people in this study come from; environments that can be characterised by the conditions of social structural violence.

## CHAPTER THREE

### Character Sketches

#### Vignette Four

A long blue ribbon has been stretched across Vuyo's house, dividing it neatly in two. The participants stand on the one side of the ribbon, the researchers on the other. We are playing a game called 'Step Across the Line'. I have been asking the children a series of questions to find out more about them. The last question I asked was whether or not anyone liked eating chocolate. The response was unanimous. Everyone stepped across the line in agreement with the statement. But now, the questions start to get a little more serious.

'Step across the line if you have been to the clinic recently', I ask.

Nomphelo translates my questions into isiXhosa just to make sure everyone understands. To my surprise, all the participants step across the line. I'm not sure if this means that they themselves have been sick, or if they have had to accompany someone in their family to the clinic.

I try to narrow down the possibilities and say, 'Step across the line if you have been sick within the last two months'.

Once again, there is a shuffle of feet and almost all the children step across the line. Only two of the eighteen participants remain behind. I remind the children to acknowledge those standing with them and to return to other side of the line.

'Step across the line if you have been to a traditional healer', I ask expectantly. I'm worried that the children might be embarrassed to comply with my request. Once again I'm surprised when ten of the participants step across the line.

My interest peaked, I tweak the question a little by asking, 'Step across the line if you trust traditional healers'

This time, twelve of the participants step across the line. I thank them, and ask them to return. The kids seem to be enjoying the game despite the strange questions I have been asking. I decide to change my focus a little bit, and ask the children to step across the line if they have ever been to a wedding. Fifteen pairs of feet step over the ribbon.

‘Step across the line if you have been to a funeral’, I ask soon afterwards.

Once again, it is heart-wrenching to see everyone steps across the line.

As the game continues, a clear picture starts to emerge around the everyday lives of these children. Many of them live with care-givers other than their parents. A disturbing majority of them have been victims of some form of abuse. And on a day to day basis, many of them go hungry.

One of the younger boys had told me earlier that he is a constant victim of bullying at school. The older boys keep stealing his lunch or his pocket money, and most recently he had his phone stolen. He never reported the theft to the teachers for fear of being beaten up. With this in mind I ask the children to step across the line if they have had something stolen from them. My question is met with confused faces. Some kids step across the line while others hesitate, not quite sure what to do. I tell everyone to return across the line so that I may frame the question better in a different way. Nompelo tells me that some of the children weren’t sure if I wanted to know if they had stolen something or if they had had something stolen from them.

This time, I rephrase the question, ‘If you have stolen something, step across the line’.

A handful of children step across the line.

‘What about bread or sugar?’, asks one of the boys. Some of the children laugh at this question dismissively.

‘Yes’, I say. ‘Even bread and sugar’

Once again, to my surprise, all the children step across the line.



### 3.1 A Multi-axial Understanding of Human Suffering

The game ‘Step Across the Line’, described in Vignette Four, was useful in revealing the kinds of day-to-day challenges faced by many children from structurally violent environments. As social structural violence contributes variously to human suffering, subjective experiences of suffering are often difficult to measure and describe. Paul Farmer (1996: 274 original emphasis) suggests that in trying to understand how social structural violence impacts individual experiences of suffering, it is important to keep to both a *geographically broad* and *historically broad* analysis. Anthropology is well situated to this task in that anthropological analysis is able to draw together the relationships that exist between the local and the global as well as remaining cognisant of the ways in which historical factors continue to shape present day experiences. Through a paradigm of entanglement, one is able to see how multiple temporalities intersect time and space (Mbembe 2001), and how numerous factors may contribute to the texture of human suffering. Farmer suggests that any analysis of social structural violence should therefore take into account the multiple axes of gender, ethnicity, and socio-economic status, as these factors variously influence the ways in which human suffering is contextually experienced. A multi-axial model of analysis that simultaneously draws together these social ‘axes’ is “imperative in efforts to discern a political economy of brutality” (Farmer 1996: 274), that invariably impacts individual experiences of health and illness. Steven Robins (2008: unpublished) concurs in reminding us that in the context of everyday experiences of health and illness the “historical experiences of colonialism, apartheid and racialised capitalism continue to shape the objective realities and subjective experiences of disease and everyday social life in contemporary South Africa”.

The discussion that follows looks at the roles that gender, ethnicity and socio-economic status play in contributing to the everyday challenges faced by many young people so as to gain a broader perspective as to how such factors influence young people’s experiences of health and illness. As the texture of affliction is best felt “in the gritty details of biography” (Farmer 1996: 261), the discussion draws on personal narratives that emerged during the second workshop, for it is through personal narrative that one is able to see how social delimitations of gender, race, and class differ according to individual circumstance. Along with these personal narratives, the first part of the discussion also draws on some of the games and exercises from the second workshop which helped to identify the kinds of everyday challenges experienced by the participants. The second part of the discussion looks at devised character sketches which show how these challenges affect the participants’ health and illness environments.

**Table 1 – Results from “Step Across the Line”**

	<b>Siyapumelela</b> (20 participants)	<b>Sakhuluntu</b> (18 participants)
<i>Step across the line if you:</i>		
enjoy school	9	17
watch T.V	All	15
have a dog	6	7
use mixit	8	/
use facebook	7	/
have a girl/boyfriend	9	1
go to church	8	8
want to go to university	19	All
have been to a wedding	13	15
have been to a funeral	15	All
live with one parent	7	1
live with both parents	4	6
live with an aunt/uncle/brother/sister/grandparent	8	10
have been a victim of abuse	7	17
have used drugs	5	/
have smoked a cigarette	6	3
have been a victim of crime	8	15
have stolen something	/	All
have been to the clinic recently	11	All
have been ill in the last two months	/	16
have been to a traditional healer	2	10
trust a traditional healer	/	12
use traditional medicine	9	/
know someone with HIV/AIDS	12	9
have lost someone to HIV/AIDS	7	3

## **3.2 Gaining a Broader Perspective**

Table 1, above, is a summary of some of the more pertinent responses to the statements made during the game ‘Step across the line’. The statements were divided into four sub-sections: the first giving an indication of both the participants personal circumstances and socio-economic standing; the second looking at the constitution of their households; the third exploring their experiences of crime and criminality; and the last examining their health choices and medical environments. Although the responses gave only a general indication of the participants’ situations, the patterns that emerged pointed to the seriousness of certain issues, and directed what was later followed up on. From these initial observations, a number of preliminary conclusion could be drawn about many of the participants’ social circumstances. The first three of these circumstances are dealt with in the sub-sections below (3.2.1 to 3.2.3). The fourth, which looks at the participants health choices and medical environments, is explored in greater detail in relation to the character sketches discussed in section 3.4.

### **3.2.1 The entangled axes of socio-economic status, gender, and ethnicity**

It is important to bear in mind that, for the most part, post-apartheid South Africa has experienced “liberation under neoliberal conditions” (Comaroff & Comaroff 2000: 292). Although poverty alleviation has been a constant project of the post-apartheid government, millions of disenfranchised people continue to live in dire conditions. A constant battle has to be fought for the delivery of basic social services such as adequate sanitation and health-care, access to electricity and running water and improved educational facilities (Brooks 2009).

As is the case with many poor South Africans from impoverished communities, the environments in which they live are structurally violent. Structurally violent environments are not simply marked by an underdeveloped social infrastructure and a lack of access to resources, but also by factors of race and class. As most poor South Africans are non-white South Africans, the axis of race<sup>39</sup> remains an important consideration in discussions of social structural violence. The vestiges of apartheid social engineering are structurally evident in today’s townships, and widespread poverty is a constant reality for those who are subject to such conditions. A lack of adequate access to social resources results in increased levels of poverty which in turn bears a direct influence on experiences of health

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<sup>39</sup> Race remains a constant preoccupation in the South African political landscape. Ironically, the very categories which divided South Africans along racial lines are often reinforced in efforts to deal with economic disparity. Due to the history of racial capitalism in South Africa, the axis of race is visible along economic lines.

and illness. As Farmer (1996: 276) points out, for non-white South Africans, “the proximate cause of increased rates of morbidity and mortality is lack of access to resources: poverty remains the primary cause of the prevalence of many diseases and widespread hunger and malnutrition among black South Africans”.

Besides the socio-economic conditions typical to structurally violent environments, the axis of gender also affects the way social suffering is individually experienced and (re)produced. Historically, black South African men were removed from rural economies and inserted into a capitalist system as migrant labourers. As a result, the ‘traditional’ African family unit became highly fragmented<sup>40</sup>. Bozzoli (1987) argues that the rupture of the African family unit helped reproduce pre-colonial forms of gender inequality. In post-apartheid South Africa, despite a political environment supportive of gender and sexual rights there are still “deeply embedded ideas and practices that reproduce gender and sexual inequality” (Robins 2008: 145). What one finds is that *poor* women tend to bear the brunt of the excesses of structural violence, often in the forms of domestic abuse and rape. Tellingly, the highest risk demographic of contracting HIV/AIDS are poor, black women; not because of their ethnicity but because poverty is the primary and determining condition in their lives (Ward 1993). Furthermore, women who are subject to abuse are often stigmatised, even within their own families. A personal anecdote about the influence of HIV/AIDS in one of the participant’s life clearly brings this point to the fore:

*“There was a friend of mine who was living with her mother. But the problem, she was raped on her way to school. The doctor find out she was HIV/AIDS. After that, her mother started to treat her like a dog and the whole family was separating everything in the house, e.g. dishes, clothes etc.*

*They were discriminating her because she was raped and get HIV/AIDS. Her life was miserable but she end up killing herself. That’s my dear friend’s story. Sometimes when I think about it, it hurts me inside”.*

(Anonymous)

Such anecdotes reveal how the excesses of social structural violence are a constant burden for many poor, young South Africans. It is therefore essential, when considering young peoples’ experiences

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<sup>40</sup> The influence of Christianity also played a hand in reimagining traditional domestic structures and cementing the notion of the nuclear family unit.

of health and illness, to bear in mind the entangled conditions of socio-economic insecurity as a result of racialised capitalism, gender inequality and racism. As Farmer (1999: 14) reminds us, “poverty and racism increases the likelihood of dire outcomes among the sick by restricting access to effective therapy”. For many young people, access to health care is often directed by parents, guardians or care-givers. Under socially violent conditions, where domestic units are highly disrupted or fragmented, young peoples’ experiences of health and illness are undoubtedly affected. This point is considered in further detail below:

### **3.2.2 Domestic fluidity and avenues of support**

Many of the participants’ household arrangements can best be described as being diverse, fluid, and unresolved. Domestic fluidity is a regular feature of many poorer households in structurally violent environments such as the townships in which the participants live. This is partially due to the dissolution of the African family unit and the contributing legacy of racialised capitalism and circular male-migration (Robins 2008). The continual changes in the political economy of domesticity may also be attributed to rising social inequalities, structural unemployment and reduced marital rates (Spiegel 1996 *et al*; Reynolds 2000; Hunter 2006).

Such a varied constitution of household arrangements is significant in understanding the kinds of support structures evident in young peoples’ lives. As Richter (2004: 2) explains, “as a result of migration and death, family members, including dependent children, often move in and out of households”. Care-givers change along with circumstance, and in many situations, children and adolescents end up living with aged relatives. In some cases, this may lead to emotional distress “due to the mutual dependency that often exists between adult and child” (Richter 2004: 2). Households are often reliant on social grants and pension funds in order to sustain themselves, and in many cases, children and adolescents need to find other ways of contributing to the maintenance of the household. In situations where parents or grand-parents are ill, young people are the most immediate avenues of support within the household. During the workshop sessions, there were times when some of the participants were not able to attend as they were needed at home to look after sick relatives. Due to the fluidity of many households, for many young people, avenues of support are tenuous and inconsistent. The lack of domestic stability can be an extreme emotional strain, particularly for young children, bearing a direct result on young peoples’ health.

South Africa has also seen an increase in child-headed homes as a result of HIV/AIDS. Child-headed homes most often form “when there is a teenage girl who can provide care for younger children”

(Richter 2004: 2) and as a result, girls are more likely to drop out of school. Henderson’s (2009) ethnographic study amongst young girls in rural KwaZulu-Natal is a case in point. She found that in the context of HIV/AIDS and the subsequent diminishing of kinship networks, young girls sought informal ‘marriages’ (*ukugana*) in order to offer themselves future familial security. As Henderson (2009: 5) explains, *ukugana* constituted “a publicly negotiated relationship between a boy and a girl where a girl came to live in a boy’s homestead, taking on many of the attributes of a *makoti* (young bride)”. Girls would be expected to assume gendered roles within the homestead at the expense of their formal education. For many girls, the low standards of education in the region were unlikely to help them secure future employment in wider society and *ukugana* seemed to offer a more reliable network of security.

Due to the high level of disruption within many domestic units and the subsequent fragility of avenues of support, young people from structurally violent environments are often face with a variety of everyday challenges. These are discussed more fully below:

### 3.2.3 Challenges of the everyday – living with crime and violence

During a series of games and exercises in the second workshop, both groups of participants established a list of issues that they felt were the greatest challenges affecting themselves as young people. The lists, in Table 2 below, class these issues in order of seriousness:

**Table 2: List of common challenges**

<b>Siyapumelela</b>	<b>Sakhuluntu</b>
1. Crime	1. Bullying
2. HIV/AIDS	2. Abuse
3. Teenage pregnancy	3. Poverty
4. Peer pressure	4. Crime
5. Abuse <sup>41</sup> (Rape)	5. HIV/AIDS
6. Suicide	6. Drugs
7. Poverty	7. Pollution
8. Pollution	8. Intimidation

<sup>41</sup> In the discussion, it was agreed upon that abuse could refer to physical, emotional, sexual (rape), and substance abuse.

Classing the issues in order of seriousness was done primarily to facilitate discussion, yet it is interesting to note that the older participants from Siyapumelela placed crime as the most serious issue affecting their day-to-day lives, whilst the younger children from Sakhuluntu expressed that bullying at schools affected them most. In many regards, bullying in township schools often involves petty crimes, as Mbongeni's story below illustrates:

*“At my school the boys are bullying us. They take our money and buy cigarettes. And there is a boy who take my phone but I did not go to the police because it was not an expensive phone. But now he want some money to me to buy some cigarettes and I don't have any money for him. He use drugs. He fought with the school principal”*

(Mbongeni, 13)

Instances of crime (both violent and petty), intimidation, alcohol and drug abuse in South African schools is common place. As a 2008 survey of township schools in Kwa-Zulu Natal revealed, for example, “there were 11 murders, 280 rapes and more than 2,500 violent assaults in its schools [and] a further 3,000 cases of drug possession” (McDougall 2009). There have also been instances of teachers being threatened, and in some cases murdered by pupils (*ibid.*). In many of the follow-up discussions that were conducted with the participants from both groups, the issues of violence against teachers and school principles was often brought up. Learners have little confidence in the authoritative structures at their schools as teachers, who are regularly threatened, are too afraid to act on incidences of crime<sup>42</sup>.

Some of the participants explained that young people get involved in crime in order to support their drug habits. Unsurprisingly, drug abuse in Grahamstown's schools is commonplace, and many teenagers drop out of school as a result. Anele tells a story close to his heart that illustrates the point:

*“There was a boy who was never get the education. But the boy have 2 parents. The parents, they get everything. One day the boy meet some friends. They start to smoke because they saw other people smoke. The boy go to other place because he want to prove that I can take something not belonging to me. But now the boy was in jail”*

(Anele, 21)

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<sup>42</sup> It was during these discussion that I first heard about *amakhosi* spirit possession (see Chapter 4, Section 4.3). Many of the participants talked about how *amakhosi* spirits were used to threaten and intimidate both teachers and learners.

From the discussions that followed with the teenagers from Siyapumelela, it seems that drug use is more common amongst boys than girls. Peer pressure was often the cause of teenagers taking up smoking (most often marijuana) as it was seen as a cool thing to do. Some of the girls expressed that drug abuse often lead to violent forms of assault in and around school. Many of them expressed that they worried about attending school as girls have been raped on the way to and from school, and in some cases even at school. Violence in schools is often gang related and as a result, is not often reported for fear of further assaults from other gang members. Ayanda told the story of how he got a tattoo on his arm when he was fourteen as a sign of inclusion into a gang:

*“In my right hand side I have a tattoo. I do because all my bad company was having it. It is not professional, it is just a tattoo. But I grow up now , I regret myself because now I am hating it. Some people can judge and think I am a gangster or a criminal because it is a sign of prisoners and with this tattoo you can’t work in Government places, and some schools and universities can’t allow you with that tattoo”.*

(Ayanda, 16)

The relationship between gangsterism and social structural violence is evident. In situations where social avenues of support have been fragmented, or disrupted due to conditions of poverty, gangs offer young people both security, albeit tenuous, and support. It is therefore not surprising that experiences of crime and criminality are so prevalent in many young peoples’ lives.

### **Vignette Five**

A group of five participants are busy presenting the first of the characters to a seated crowd of teenagers. Two of them are holding up the life-size drawing of a smiling girl named Precious. In the picture, she is dressed very smartly in jeans and a floral blouse. The group’s spokes person dutifully gives a synopsis of Precious’s life.

“Precious is from England and she came to South Africa to study”, explains the spokes person.

“She is 19 years old and has a family with five people: her mother, her father, two sisters and one brother. Her favourite music is R&B. The thing she doesn’t like is to hear people gossip”.

There is a murmur of agreement from the assembled crowd.

“This one time”, continues the spokes person, “she met a guy at a party and they started chatting. She didn’t hmm hmm him when the guy tried to pull the moves. So the guy said, “I’m gonna show you who I am. I am a man”, and then he forced her”.

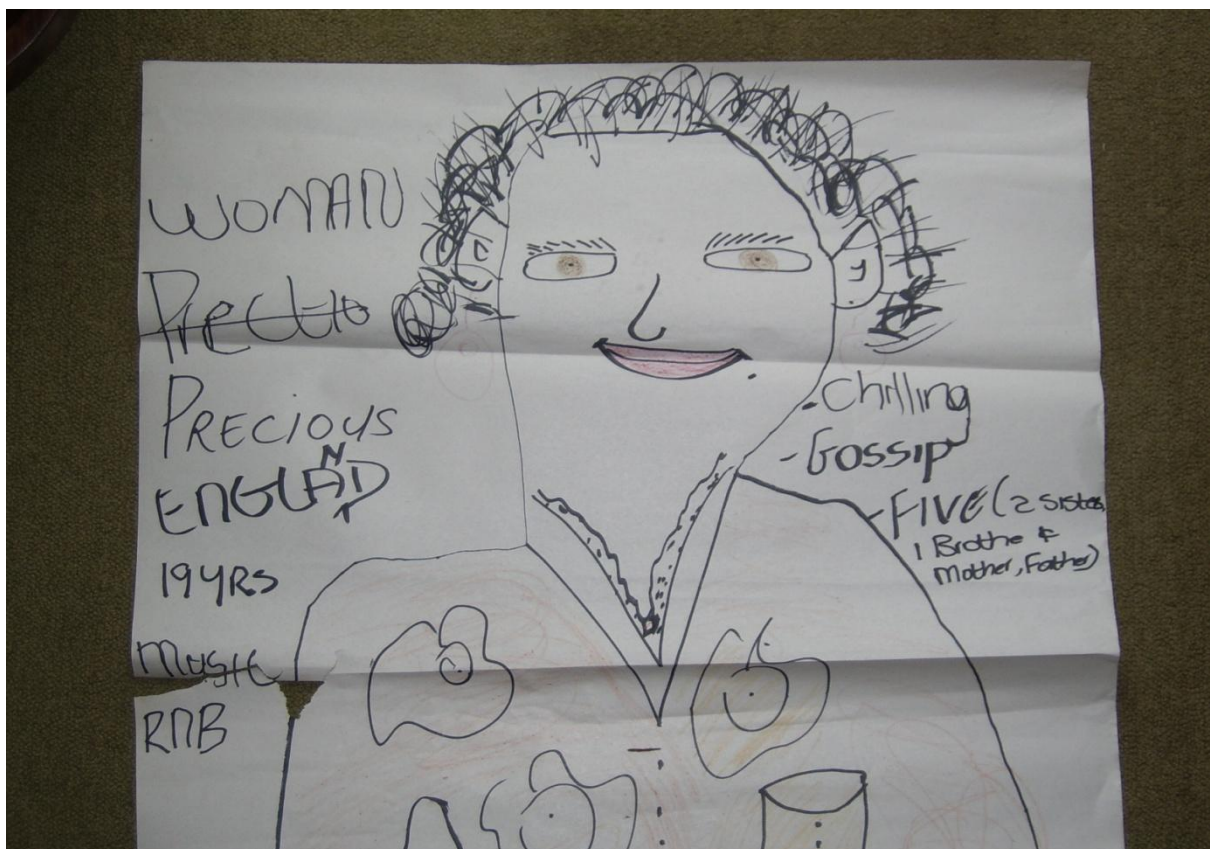
Some of the participants gasp at this remark.

“Now she is HIV positive and got pregnant”, concludes the spokes person. “But she didn’t keep the baby”.

After we finish hearing Precious’s story, I open the floor to the participants to ask what questions they might have about Precious. One person asks if she is still studying.

“No”, explains one of the group members. “She doesn’t have enough money and she is sick”.

“Why doesn’t she keep the baby?”, remarks one of the girls jokingly. “Then she can have some money from the social grant”.



**Figure 3.1 – Character sketch one: Precious**

### 3.3 Character Sketches

As Vignette Five indicates, the character sketches were useful in gaining a broader perspective as to how the conditions of social structural violence impact both the everyday lives of the participants and their responses to issues of health and illness. The characters themselves primarily allowed for a space of projection through which the participants were able to tell their own stories by responding to a set of clearly devised questions. The process of creating the character sketches was two-fold. To begin with, the initial characters reflected archetypical notions of a person in good health; this was done in order to gauge the participants' understanding of a healthy individual. From this, the characters were personalised by implicitly encouraging the participants to project their experiences of the world by relating to their characters.

Once the characters had been created, the participants were asked to work individually to answer some personal questions about their character which related to both HIV/AIDS and traditional healing (although the link between the two was not enforced). This was done in two ways: for Siyapumelela, each participant was given a questionnaire and asked to write answers to two questions by themselves<sup>43</sup>; for Sakhuluntu, small groups worked with a research assistant who encouraged individuals to respond to different questions about their characters. The discussion which follows below looks in more detail at two of these characters – Precious from Siyapumelela and Mustafar from Sakhuluntu – and examines some of the personal responses from the questionnaire:

#### 3.3.1 – Character sketch one: Precious

The first exercise in creating the character sketches was based on gaining an idea as to what the participants understood a healthy person to be. Precious was initially described as a well-off foreigner (from England) of non distinct race, from a stable family. Both her parents were alive and she had enough money to study at university. Considering that many of the participants have had contact with students from Rhodes University, it is not surprising that they might associate a healthy person as being a student from a middle class background. The fact that both Precious's parents are alive, points to the association between a stable family and a healthy life.

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<sup>43</sup> The two questions were as follows:

1. One person in your character's family is HIV positive. Tell this person's story.
2. Has your character ever been to a traditional healer (*sangoma*)? If yes, tell this story. If no, explain why not.

Along with the two questions above, the groups from Sakhuluntu were also asked to explain where their characters go when they are ill.

However, when questions were asked that mimicked the participants personal circumstances, the picture changed dramatically. Precious was raped at a party and infected with HIV. She fell pregnant and decided to abort the baby. Because she was ill, she no longer had money to continue her studies. One of the participants jokingly suggested that Precious should have kept the baby so that she could have received some money from a child support grant. Although there are perceptions that teenagers intentionally fall pregnant in order to secure a child support grant (Monare 2007), a report by the HSRC found this to be highly unlikely (Makiwane & Udjo 2006: 11). Precious's dramatic shift in circumstances however, highlights the impact that social circumstances have on individual experiences of social suffering. Below are two of the personal responses from the first question of the questionnaire that further drives this point home:

**1. One person in Precious's family is HIV positive. Tell their story**

*"It is her. Everything went wrong because of a simple rape and everyone blamed her because she wanted it, she deserved it. It had been coming. But now if one look at her, now you would never imagine her broken, alone, confused, and suffering. She started to believe that there is life after HIV and it is not the end of the world"*

(Brenda, 17)

*"A family member is HIV positive and this character goes to see if her cousin is doing well. She is very ill and has been to hospital for a few times. She is getting sick all the time. She [Precious] must pay the hospital bills cos the family don't have money"*

(Anonymous)

In the first response, rape is treated as something "simple" and common place. Precious is blamed for provoking the situation and therefore "deserved it". This not only highlights the fact that women often bear the brunt of the excesses of structural violence in the form of abuse, but that such forms of abuse are seemingly commonplace. Despite this, Brenda explained that Precious was able to find a new lease on life and come to the realisation that "there is life after HIV" thanks to the social support of organisations such as Siyapumelela. In the second response, Precious's cousin is HIV positive. Because she is sick and her family doesn't have money, Precious has to pay the hospital fees. What this indicates is that under conditions of poverty, many people rely on moral economies where individuals often need to "call on networks of obligation and reciprocity to negotiate access to therapeutic resources" (Nguyen 2005: 126).

A further aim in using character sketches was to begin to see what kinds of relationships young people have with traditional forms of healing, and whether or not any connection is made between traditional medicine and HIV/AIDS. The responses to the second question of the questionnaire, below, indicated a mixed reaction:

**2. Has Precious ever been to a traditional healer? If yes, tell her story. If no, explain why not.**

*Yes, because they were trying to help her. The sangoma gave her a white chicken so that she can drink the blood. And she drink it but she was not better at all because they were trying to help and they made some traditional medicine. But those medicines didn't help. At that time there was not ARVs”*

(Simpfiwe, 15)

*“She has been to a traditional healer because she had a sore part and her parents believed it was witchcraft’s work. They took her to a sangoma and the sangoma shook some old bones at first, and poured them on an old leopard skin, and said a neighbour has been jealous of her because she was running her own business. She did some witchcraft for her to die but luckily she survive”*

(Lindiwe, 16)

*“No, because she treated the virus well while it started, and his [Precious’s] CD4 count is still high and good”*

(Sandile, 17)

*“No, because she does not believe much in traditional healing. She is a Christian and she believes that God is a creator of everything”*

(Thabo, 20)

The first three response give a preliminary indication of the kinds of relationships that young people have with traditional medicine. In the first two responses, it is clear that the participants are aware of the ways in which traditional healing operate. In the third response, even though the participant said that Precious hadn’t been to a traditional healer, this is because her CD4 count is high and she has not yet fallen ill. People sometimes turn to traditional healing when other forms of healing don’t

seem to be working. It is only in the last response that the participant rejects traditional healing on the grounds that it is not commensurate with Christianity.

The first response also indicates that people used traditional medicines because ARVs were not available. When this point was followed up on, a number of the participants explained that, in general, only old people consult traditional healers concerning AIDS related symptoms because they don't know much about HIV. Young people, however, make a clear distinction between when it is appropriate to use traditional medicines, and when to access biomedical health care. Traditional healers are normally consulted when someone suspects the involvement of witchcraft, or in connection with the African healing cycle. According to the participants, HIV is seen as a 'modern' disease and is not associated with witchcraft. Young people's uses of traditional healing are discussed more thoroughly in Chapter Four.

### 3.3.2 – Character sketch two: Mustafar

Below is a picture of Mustafar. He is thirteen years old and lives in Extension Seven with both his parents, his five brothers and one sister:

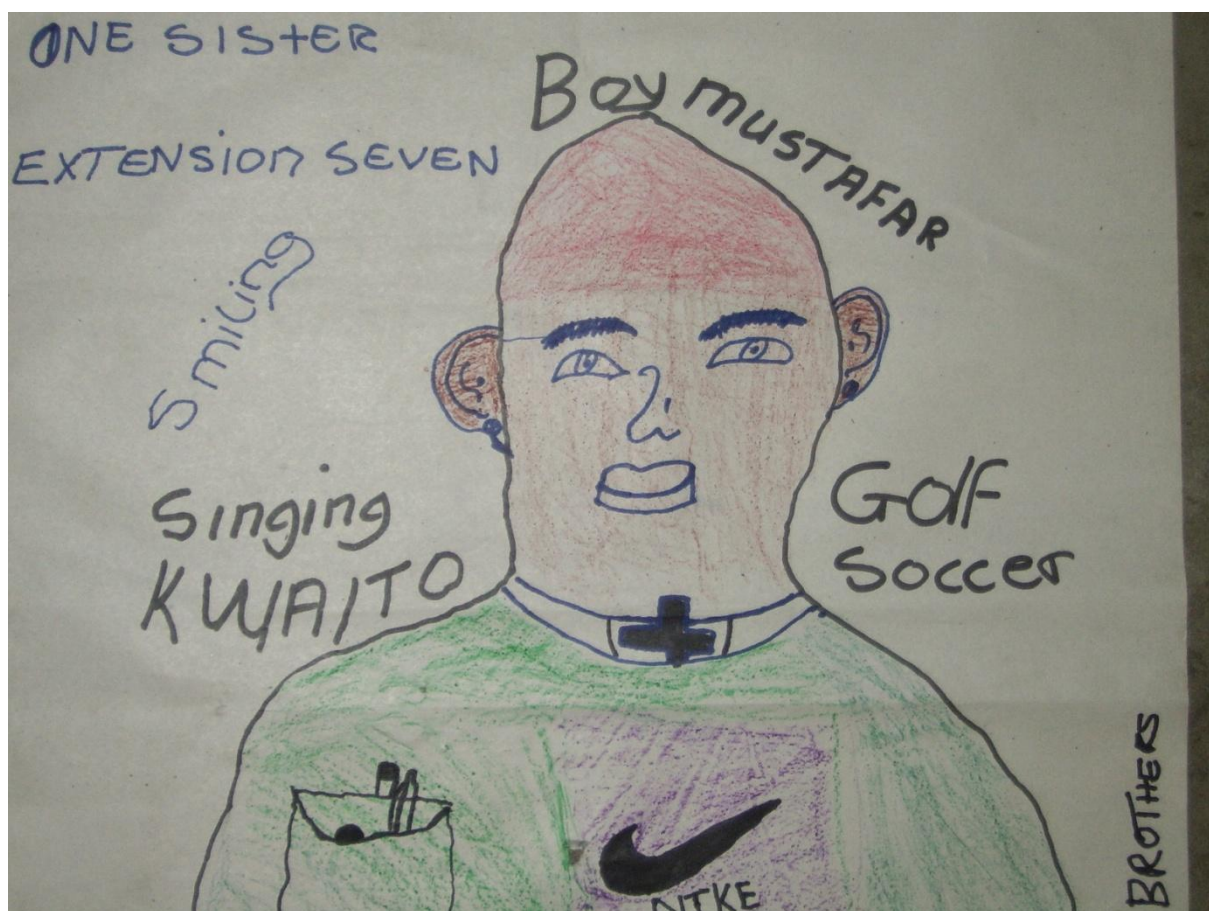


Figure 3.2 – Character sketch two: Mustafar

The participants who created Mustafar were all boys between the ages of twelve and thirteen. Like Mustafar, they enjoy listening to *kwaito*<sup>44</sup> and playing soccer, but none of them like golf. Sometimes Mustafar is happy, but not always. As one of the participants from this group explained, when Mustafar passes school he feels happy and smiles, but when he is hungry because there is not food in the house, he feels sad. The healthy Mustafar has much in common with Precious. He wears expensive branded clothing like Nike, and works hard to do well at school. His family is also secure and stable.

Mustafar's therapeutic environment is similar to that of many young people his age. As the participants explained, when he gets sick, "he goes to the clinic to get help. He goes with his mother. He has to stand in a queue for a long time. The nurse helps him and gives him injections and pills". Waiting in the queue is something to be expected when one goes to the clinic due to constant demand on the clinic's facilities. When the participants are ill, they seldom see a doctor; normally, they are referred to a nurse who dishes out medication. Besides accessing the clinic however, Mustafar has also been to a traditional healer. According to Mustafar, this is what happens when a patient consults a *sangoma*:

*When a person has a problem, the sangoma throws the bones and tells the patient what is wrong with him by reading the bones. He also tells the patient what to do to get better and gives him herbs and medicines. Once he gets better he pays the sangoma".*

What Mustafar's description reveals is that many of the participants have had some experience of traditional healing and are able to identify some of the ways in which traditional healers work. What was clear from the discussion that centred around Mustafar is that many of the participants access a diverse therapeutic economy depending on the nature of the affliction and the discretion of their care-givers. Furthermore, the participants made a clear distinction between when to consult a traditional healer and when to go to the clinic. When it was discovered that someone in Mustafar's family was HIV positive, the participants explained that a *sangoma* would not be able to help, and that this person had to go to the clinic to get ARVs. During the discussion, the participants were asked to explain which person in Mustafar's family was HIV positive and what their situation was. This is what was said:

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<sup>44</sup> *Kwaito* is a style of music similar to hip-hop that emerged in the early 1990s.

*“His sister, Bongiswa is a prostitute because they are poor and their parents are dead. She hitchhiked from someone who wanted to have sex as payment for the lift, and this is how she got HIV. She is ugly now because of lesions and she always coughs. She is the only girl in a family of five brothers. They don't have any money because their parents are dead. She has four of her own kids from two different fathers, and all the children are infected with HIV, except for the eldest child. Her children will also have to be prostitutes”.*

From Mustafar's story, one can once again see how experiences of illness are strongly aligned with the conditions of social structural violence. His story is marked by vectors of inequality and difference that paint a bleak picture of a poor boy from an unstable background. The axes of gender and socio-economic status are brought to the fore through Mustafar's sister, Bongiswa, who has had to rely on prostitution in order to support her family. The fragmentation of the domestic unit and the unbreaking cycle of violence is accentuated by the fact that three of Bongiswa's children are HIV positive and are destined to mimic their mother's situation by becoming prostitutes themselves. Mustafar's story, like Precious's, is indicative of the kinds of challenges that young people from structurally violent communities are often faced with.

### **3.4 Chapter Conclusion**

Many of the participants social worlds can be described as violent, fragile, unstable and fragmented. The axes of socio-economic status, gender, and ethnicity continue to shape both their therapeutic environments, as well as their experiences of health and illness. As a result, young people access a diverse therapeutic economy depending on the nature of affliction and the discretion of their caregivers. However, due to the domestic fluidity indicative of many of their households, young people are often left with fragile avenues of support and care, and feelings of vulnerability. It is also clear that many of the participants have an understanding of how traditional healing operates often as a result of direct experience. Furthermore, in relation to HIV/AIDS, all the participants strongly opposed the use of traditional healing in favour of biomedical intervention. The question therefore remains as to why young people consult THPs. Considering the often fragmented nature of their support structures, a further question remains as to how young people cope with everyday adversities along with the feelings of vulnerability and social dis-ease that these conditions produce. These questions are examined in the chapter which follows.

## CHAPTER FOUR

### Radio Workshops

#### Vignette Six

We have come to the end of the workshop and the Siyapumelela coordinator – Nola – is making her routine announcements for the day. Nola has been planning an exciting end of year tour to Cape Town. For many of the participants, this will not only be their first visit of the Western Cape but the first time they'll be leaving Grahamstown. The trip is being partly sponsored by the Makana Municipality and the participants have been invited by the Mayor of Grahamstown to attend a lunch where the money will be handed over.

Nola asks in a loud voice if everyone still has their Siyapumelela t-shirts from the previous year. Her question rebounds off the walls in the echoing hall. So too does the almost unanimous 'yes'.

“No, Auntie Nola. No, I don't have a t-shirt anymore”, shouts Thabo, trying to get her attention.

“Why not?”, asks Nola. “What did you do with it?”

“I had to burn it”, replies Thabo matter-of-factly

“Me too”, adds Sandile quickly.

This strange statement seems to need no explanation for the rest of the teenagers in the room, but Nola isn't so easily placated.

“Why did you burn it?” she asks shortly.

“We had to burn our clothes from when we were children before we went to the bush”, Thabo explains. “Now that we are men, we can't wear children's clothes”.

This seems to bring the issue to an abrupt close. Nola accedes to this statement and makes a note to get more t-shirts.

## 4.1 Introduction

Vignette Six illustrates the central focus of this chapter – the ways in which young people engage with cultural practices and the relationships that are maintained with traditional forms of healing as a result. As is clear from the above situation, many young people in South Africa have to juggle ‘traditional’ practices and the demands of modernity in ways that are sometimes paradoxical or incommensurate. The symbolic act of ritual renewal and reconstitution in the burning of one’s childhood clothes, for example, marks a challenge to the logics of modernity. As Ngwane (2004: 180) explains, Xhosa initiation rites allow for the “birthing of social subjects”, in the social reproduction of masculine identities. Male initiation rituals are often a “particularly spectacular display of the economic implications of producing new male subjects” (Ngwane 2004: 185), as families are subject to a number of economic constraints<sup>45</sup>; the cost of the circumcision surgery<sup>46</sup>, the costs of living during the seclusion period, refurbishing young men with new clothes and bedding, and the lavish public displays of ‘spilling’ the household’s wealth once boys return from ‘the bush’ as men, to mention but a few. The huge economic and social investment placed on young people in these ways may be a difficult burden to bear. It is not only that young people become socially legitimated sexualised subjects through such rituals, but they are also subject to traditional notions of the body, sex and sexuality, and genders norms.

In order to find out on what level my participants engage with cultural practices (such as the initiation ritual mentioned above) and the ways in which traditional forms of healing enter into their lives, I chose to use a particular methodology based on Tobias Hecht’s (1998) work with street children in Northeast Brazil. Hecht gave tape recorders to street children to play around with and invent radio workshops. The children interviewed each other, imitating voices they had heard on the radio, and asked questions that Hecht would either have had difficulty asking, or would simply not have thought of. What Hecht (1998: 9) noted was that when the children were given the opportunity to record their voices, they “tended to view the tape recorder not with suspicion but as a means of making themselves heard, of telling stories they rarely if ever had the chance to recount”. As a result,

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<sup>45</sup> For a full account of the economic implications of Xhosa initiation rituals see. Mhlahlo (2009)

<sup>46</sup> The parents of the participants from Siyapumelela who had undergone the male circumcision ritual insisted on providing their children with their own clean, sterilized blades for the act of circumcision. This points to is an awareness of the potential danger of contracting HIV from other young men if the same ritual blade is used by the *ingcibi* (surgeon) on all the initiates. For a full account of the risks involved during circumcision rituals, see. Meissner & Buso (2007).

the children used the tape recorder “as a means of projecting their voices to other audiences” (*ibid.*). The aim behind using a radio workshop methodology was therefore twofold; it allowed my participants a chance to ask their own questions around key points of interest in this study as well as offering them an opportunity to listen to and reflect on what their peers had to say about the issues discussed.

Two main topics of interest were brought up during the radio workshops: the relationship between traditional healing and HIV/AIDS; and *amakhosi* spirit possession. In the first topic, both the relationship that young people have with traditional forms of healing and the role they see traditional healing playing in relation to HIV/AIDS prevention, management and treatment are brought to the fore. In the second topic, the nature of *amakhosi* spirit possession and the recent upsurge of *amakhosi* ‘gangs’ are discussed. As a report in the *Grocott’s Mail* (28 October 2008) – Grahamstown’s local newspaper – describes, *amakhosi* spirit possession involves imparting ‘power’ to young people “through the use of herbs for protection against bullies, negative spirits and the like” (Sibiya 2008). Although descriptions of *amakhosi* spirits are variable, they are primarily invoked as a means of offering protection; protection from both malevolent occult forces and the dangers encountered in everyday life. As this points to an overriding sense of insecurity in young people’s social circumstances, the discussion that follows examines three kinds of insecurities in relation to the conditions of social structural violence: social insecurity, structural insecurity, and spiritual insecurity. Bearing in mind the notion of entanglement, it is possible to see how the conditions that produce various forms of insecurity, alongside experience of health and illness and traditional forms of healing, “interpenetrate one another, and envelop one another” (Mbembe 2001: 14).

## **4.2 Traditional Healing and HIV/AIDS**

The question around the relationship between young people’s perceptions and experiences of traditional healing and HIV/AIDS arose from the character sketches created in the previous workshop (see. Chapter 3). Although it was clear that many of the participants were aware of how traditional healing operated, the radio workshops helped to uncover how young people locate HIV/AIDS in relation to traditional medicine. During the radio workshops, the participants expressed that, due to the HI virus being at present incurable, traditional healing should not be used to treat people. On the contrary, all the participants felt that biomedical treatment is the safest and most effective way to deal with HIV/AIDS. This is clear from Joseph’s response below:

*“HIV is a very dangerous disease that cannot be cured and ... when you are HIV positive né, you cannot go to a traditional healer to help you. Because HIV cannot be cured, you must go to a doctor for the treatment”.*

(Joseph, 15)

Although the participants felt strongly that biomedicine, and ARV treatment in particular, is the best form of treatment for HIV, they were aware that some people choose to use traditional medicines to treat AIDS related symptoms, such as headaches and stomach pains. But, as Thabo expressed, “only old people use those medicines because nowadays you can just take a panado”. Most of the participants have a strong aversion to the use of traditional medicine as they see it as ineffective or even dangerous. In relation to HIV/AIDS some of the participants mentioned that, in the past, healers have made false claims of being able to cure HIV. As Richter (2003: 11) notes, there has been a number of cases of traditional healers “claiming to have a cure for AIDS or submitting their patients to dangerous or ineffective treatments”, resulting not only in further tensions between biomedicine and traditional healing but also creating an evident mistrust in the efficacy of traditional medicines. Many young people are unsurprisingly sceptical of claims made by traditional healers, as Themba’s example below indicates:

*“Some of the traditional healers they say if like you have a small penis, he or she can give you umuthi so that your penis can be like, can be strong and what what. So I can say they’re doing it for money, some of them ja”.*

(Themba, 16)

Some of the participants believe that traditional healing is evil and dangerous, mostly due to the inherent connection between traditional healing and witchcraft, as well as traditional healing’s incommensurability with certain Christian beliefs. Despite this attitude, none of the participants felt that witchcraft could be responsible for causing HIV/AIDS; they were very clear on the biomedical aetiology of the virus. This is mainly because the discourse surrounding traditional healing makes a clear distinction between illnesses that result from malevolent occult forces (*ithakathi*) and illnesses that are caused by natural phenomena (*umkhuhlane*). HIV/AIDS is seen as a ‘modern’ disease and therefore belonging to the latter category. Themba also had the following to say as to why he believes traditional medicines are ineffective in treating HIV/AIDS:

*“Traditional healers, they give you umuthi (herbal medicine) that you have to ufutha (inhale) ... Then HIV you don’t have to ufutha ... you have to swallow iARVs and iARV will go straight to immune system”.*

(Themba, 16)

In essence, Themba’s explanation involves the nature of aetiological understandings of illness. In cases where illness is understood to be the work of malevolent forces, inhaling the medicine is both symbolic and transformative. The preparation and ritual involved in administering traditional medicines takes more time and social investment, whereas swallowing pills is more direct and immediate. As HIV/AIDS is understood primarily in biomedical terms and is seen as a ‘modern’ affliction, swallowing medicines is therefore considered more effective.

It is important to bear in mind that the binary that is constructed around things that are considered ‘traditional’ and things that are seen as ‘modern’ has deep seated roots within a particular historical teleology. As Mbembe (2001: 12) explains, the reclamation of a ‘traditional’ African identity was part of the emancipatory project of postcolonial African states, which sought to recreate an identity based on the ‘memory’ of an Africa “deemed past and misunderstood” (*ibid.*). As a result, the twin projects of emancipation and assimilation engendered a tension in the African subject at once trying to strike a balance “between his/her total identification with ‘traditional’ African life, and his/her merging with, and subsequent loss in, modernity” (*ibid.*). This tension was due to the very project of modernity itself, which relied on “the eradication of ‘non-Western’ cultural difference in the name of the ‘enlightenment’” (Ashforth 2005: 117). It is clear that the conflict surrounding things deemed ‘of the past’ and things deemed ‘of modernity’ still surfaces in health and illness discourse.

A further finding from the radio workshops was that young people most often choose to consult THPs around issues related to the African healing cycle. Traditional medicines are seen as useful in procuring luck concerning up-coming challenges, such as finding or securing a job, or even doing well at school and passing exams. Traditional healing is also associated with gaining protection from potential dangers, such as a boy’s initiation into manhood, or protection against the jealousy of neighbours or relatives. Traditional medicines are sometimes used concerning matters of the heart. *Umuthi umthando* (love medicine) can be used to secure oneself a lover or a potential partner. This practice, however, was spoken about in jest, and allusions were made to it being something done by people in the rural areas.

Due to the alignment of traditional healing with the African healing cycle, consulting THPs often involves a number of people, usually from within the same kinship network. Most participants pointed out that they would not personally choose to consult a THP or use traditional medicines unless under their parents' duress. Conversely, THPs do not normally treat children or teenagers without the permission or acknowledgment of their parents (Sibiya 2008). One traditional healer explained that due to the recent upsurge in *amakhosi* spirit possession, as many as five or more teenagers visit him every week to vanquish *amakhosi* spirits. In these situations, some of the teenagers request that their parents/guardians are not informed as they might be punished for getting involved in *amakhosi* gangs. The nature of *amakhosi* spirit possession is discussed in more detail in the section which follows:

### **Vignette Seven**

I'm seated on a long, wooden bench waiting patiently to speak to a well-known *sangoma* named John. From where I sit, I can discern the musty smell of dried herbs from the neatly organised pharmacopeia hidden behind the counter. In the rafters above, a variety of animal skins and other non-distinct items hang from the dark ceiling. Next to me, two elderly men are chatting in hushed voices in a guttural Setswana. This would normally have struck me as odd considering that we are in the heart of the Eastern Cape, however, I know from a previous meeting that John is originally from Botswana. John trained as an *in'ganga*<sup>47</sup> in Zimbabwe back in 1973, after which he travelled to what was then the Eastern Transvaal to practice in his trade. He later moved to Grahamstown and opened his current practice called *Vuk'unzenzele*; this translates from isiXhosa as 'Stand up and do it for yourself' – a slogan often used by former president Thabo Mbeki.

“If you trained in Zimbabwe, how can you work as a *sangoma*?”, I asked him naively the first time we met.

“The healing systems are very similar”, he told me. “I have learnt to work with the Xhosa traditions”.

I have made an appointment to talk to John about the issue of *amakhosi* spirit possession that many of the participants brought up in the radio workshops.

“Are *sangomas* responsible for giving these spirits to teenagers?”, I ask him

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<sup>47</sup> The word *in'ganga* is Shona for 'traditional healer' and is the equivalent of *isangoma*.

“No, not at all”, he replies indignantly. “We are the ones who have to fix this problem. It is these *ikhosis* (false healers) who tell the boys to drink this powder – *izizwe* – and it makes their stomach’s grumble. This causes the sensation of *amakhosi*”.

“And what are these *amakhosi* spirits?”, I ask expectantly.

“They are like demons”, he explains. “They are angry and that is why they give people extra strength. But they are not *amawethu* (our people/ancestors). They come from somewhere else. Us *sangomas* are against these things”.

John tells me that *amakhosi* spirit possession is not a recent thing, but something that has been around for generations. Young men could use these spirits if they needed both strength and protection in times of war. Young people today, however, are drawn to *amakhosi* spirits not only because they can offer a person protection, but because they are seen as dangerous and unpredictable. They seem to think it is a cool thing to do, but because they are not properly prepared, they are not able to control the spirits. It is left to trained *sangomas* like John to fix the problem and vanquish these spirits.

### 4.3 *Amakhosi* Spirit Possession

*“Several township schools in Nelson Mandela Bay say they have been hit by a storm of unruly and violent pupils who believe they are invincible after paying sangomas to contaminate them with “evil powers””.*

*(The Herald, 2 December 2008)*

These opening lines from an article entitled “Chaos as Pupils Buy Powers to Become Invincible”, reveal the violent nature of *amakhosi* spirit possession. In Grahamstown, a similar report in the *Grocott’s Mail* (28 October 2008), described *amakhosi* spirit possession as a “new fad” (Sibiya 2008) where ‘possessed’ students had been wreaking havoc in classrooms by threatening their teachers or acting out in displays of violence. During the radio workshops, many of the participants were very vocal about the issue of violence in schools as a result of *amakhosi* gangs, who invoke *amakhosi* spirits to fight each other during recess. As one student from a prominent township school in Grahamstown explained, when someone invokes *amakhosi* spirits, “their voices change, they

speak different languages, their eyes turn red and they become very aggressive” (Sibiya 2008). These radical displays of aggression are an evident challenge to social institutions, like schools, that seem to be failing many students. In recent years, social unrest over the delivery of basic social services has been a regular feature within the lives of people from structurally violent communities, no less so in many schools, with teachers striking for weeks on end during the last academic year (Parker & Pillay 2010). What the various newspaper reports on *amakhosi* spirit possession seem to show is that young people access *amakhosi* spirits possession as a means of venting both their frustrations over the inefficacy of the schooling system and their lack of agency over the situation.

Interestingly, the word *amakhosi* comes from isiZulu and means ‘ancestral spirits’ (Ngubane 1977). The isiXhosa equivalent of this word is *oonomathotholo*, which can be translated as ‘voices’ (Sibiya 2008). It is significant for a number of reasons that isiXhosa speakers would choose an isiZulu term to describe this particular phenomenon: Firstly, there is a history of antagonism between the Zulu and the Xhosa people, and due to the negative, and potentially dangerous attributes inherent in *amakhosi* spirit possession, it is not surprising that these ‘bad’ spirits are thought to come from elsewhere; Secondly, many forms of African traditional healing attribute power to the culturally distant (Rekdal 1999)<sup>48</sup> where foreign spirits are often perceived as being both more powerful and more dangerous. As a result of these spirits coming from elsewhere, when under the influence of an *amakhosi* spirit, a person is able to speak in different languages. In so doing, impetus is given to the mysterious and foreign nature of these spirits.

In Vignette Seven, above, John blames false healers for encouraging young people to engage in *amakhosi* spirit possession. During the same interview, he explained that these charlatan healers had not been fully trained and were administering *amakhosi* spirits because they were poor and in need of money; it can cost between R150 and R300 for the entire ritual. John was explicitly clear that true healers would never subject young people to these spirits, and that the people who have been doing so are damaging the reputation of traditional healing<sup>49</sup>. The article in *The Herald* (2 December 2008) on *amakhosi* spirit possession supported this claim in explaining that “herbalists and not sangomas are seen as responsible for transferring Amakhosi ... Sangomas are called by ancestors and are not

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<sup>48</sup> South Africa has recently seen an influx of foreign African healers from other African countries into the informal health-care sector. This could be due to the perception that medicines from the culturally distant are more powerful.

<sup>49</sup> One of the participants mentioned during the radio interview that his school had organised for a *sangoma* to address the learners and discourage them from engaging with *amakhosi* spirit possession.

allowed to administer medicine without the knowledge of family members. However, herbalists learn how to use medicine to do evil things and are not called by the ancestors” (Matomela 2008).

During the radio workshops there were a variety of descriptions explaining how *amakhosi* spirits are invoked. From these descriptions, a general picture can be formed. To begin with, a person has to provide a white chicken and a bottle of strong alcohol, such as gin, for the ritual. The ‘herbalist’ invokes the spirits by offering the chicken as a sacrifice. He<sup>50</sup> then gives the recipient of the spirit a powder to drink, inviting the spirit into the person’s stomach. John called this powder *izizwe*, or ‘bad medicines’. The powder creates a sensation within the recipients stomach that indicates that the spirit has entered. Once the spirit has been ingested, the recipient has to drink a strong alcohol to calm the spirit. One participant described *amakhosi* spirits as “animals” which “reside in the stomach”, and have to be placated with strong alcohol or they could act out against the recipient. After the spirit has been invoked, the recipient becomes subject to a number of taboos: Firstly, he/she cannot drink any other alcohol other than what the spirit demands – this is usually a specific brand of gin or beer (such as Smirnoff or Castle mixed-stout); Secondly, the recipient may not eat pork or chillies. These taboos are kept in order to control and appease the spirit. In some cases, a recipient may receive more than one *amakhosi* spirit. Some of the participants explained that the more spirits one has, the stronger one may become, particularly when one is involved in a fight. This is how Lukhanyo explained it:

*“People who have them (amakhosi spirits) say that if you fight with someone, they take your side. Maybe you have 56 amakhosi and you give a person one punch, that person will get 56 punches”.*

(Lukhanyo, 18)

Teenage boys seem to be attracted to the physical power gained from *amakhosi* spirits because it makes them appear more dangerous in a fight. Furthermore, the alcohol that is given to the *amakhosi* spirits is intended to add to the spirits’ strength and power. As Sandile explained:

*“... I once saw them drinking iSmirnoff Gin and they drink iCastle milk-stout also, yes. I don’t know for what good reason but they say they make them strong. You see, when they drink those stuff they say that they don’t get drunk, only the things get drunk ...”*

(Sandile, 17)

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<sup>50</sup> In all cases, the initiator was described as a man.

A person that invites *amakhosi* spirits into their bodies is usually initiated into an existing gang. These gangs distinguish each other by wearing coloured beads around their necks. Such gangs offer both a sense of solidarity as well as protection from potential violence. Thabo elaborates on this point below:

*“It’s like a group né, they wear the same colour, and the other group wears the same colour. And when they get together there are some groups, they are against each other”*

(Thabo, 20)

The question remains as to why so many young people feel that it is necessary to gain protection from spirits that can be potentially dangerous. Lukhanyo’s view as to why *amakhosi* spirits are so popular sheds some light on the matter:

*“Amakhosi is not like a negative thing. To us it is a positive thing. It’s who we are ... Amakhosi are there to protect you against iwitchcraft and all that stuff”*

(Lukhanyo, 18)

Lukhanyo’s attitude towards the protective nature of *amakhosi* spirits points to an overriding sense of vulnerability to the adversities of everyday life, as well as the subsequent need for protection against intangible forces beyond an individual’s control. The discussion which follows below examines the roots of these feelings of vulnerability by looking at three kinds of insecurities wrought by both historical factors and the consequent demands of modernity; these are social, structural and spiritual insecurity.

#### **4.4. Social, Structural, and Spiritual Insecurity**

As has already been discussed (see. Chapter Three), Apartheid social engineering ensured the dissolution of the traditional African domestic unit; a feature that has continued through to the present, although for a number of different reasons (see. Hunter 2006). More particularly, in considering the axis of gender, as it was men who were coerced into migrating to urban areas in search of work, traditional structures of patriarchy were internationally destabilised, leading to a “weakening of kinship-based support mechanisms” (Fiereman and Janzen 1992: 8) which in turn reduced the possibility of organised resistance. Unto the present, as a result of migrant labour and forced removals, men continue to be “disempowered, unemployed, and uprooted – especially in

relation to their families and their children” (Ramphela & Richter 2006: 73). The disruption that was caused due to the re-organisation of the domestic unit, both as a result of Apartheid social engineering and the demands of modernity, has therefore had long lasting implications for the construction of masculine identities. Moreover, as these identities have traditionally been aligned with the responsibility of maintaining the African healing cycle, the consequences of the social insecurity caused by the fragmentation of the domestic unit have further resulted in a sense of spiritual insecurity. These feelings of spiritual insecurity stem mainly from the realisation that, as men were drawn away from the everyday affairs of the domestic unit, they were unable to fulfil their ritual responsibilities in maintaining the ancestral cult. This sense of fragility surrounding the ancestral cult, along with the cross-generational trauma of Apartheid, continues to affect young people’s sense of identity to this day. As Judith Lewis-Herman (1992: 51) reminds us:

*“Traumatic events ... breach the attachment of family, friendship, love, and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim’s faith in a natural or divine order and cast the victim into a state of existential crisis”.*

What traumatic events, such as Apartheid, call into question are basic human relationships. Like many experiences of trauma, Apartheid has damaged relational life in the ways it has affected “the systems of attachment and meaning that link individual and community” (Lewis-Herman 1992: 51). Within Xhosa communities, as this link has been traditionally mediated through the ancestral cult, an individual could secure the blessings of the ancestors and affirm their identity within the larger community by appeasing the ancestors at various moments within the African healing system. However, due to the fragmentation of the ‘traditional’ African domestic unit, many of the traditions integral to the maintenance of the ancestral cult within the African healing cycle have ceased to be possible. As Ashforth (2005: 128) explains:

*“custodians of African tradition have long been both too few and too many: too few because many families have been unable to reproduce the traditions of their ancestors; too many because few communities have formed around a shared sense of local cultural continuity”*

Despite the fact that many cultural practices have had to be abandoned, young people are sensitive to the belief that their ancestors – “the primary source of spiritual security” (Ashforth 2005: 128) within the domestic unit – might harbour anger and resentment against them for not being properly

acknowledged. Coupled with the continued traumas that have resulted from a turbulent history, the feeling that the ancestors have withdrawn their protection has led to an overwhelming sense of vulnerability and spiritual insecurity. As Janoff-Bulman (1985, cited in Lewis-Herman 1992: 51) explains, the sense of abandonment and vulnerability that result from traumatic events can destroy an individual's "fundamental assumptions about the safety of the world, the positive value of the self, and the meaningful order of creation". *Amakhosi* spirits seem to offer a sense of protection against occult forces, such as witchcraft, as well as the anger of the ancestors, as Thabo's explanation of *amakhosi* attests:

**R:** What does *amakhosi* mean?

**T:** Um, the ancestors.

**R:** But aren't the ancestors good?

**T:** Ja, the ancestors are good but there are some, some of the ancestors that are not good that can kill people.

**R:** Kill people! Why?

**T:** It's because of, of the anger. You see, my ancestors want to protect me but they can't, and if I have the *amakhosi* then no one will touch me or hurt me.

An interesting connection can be drawn between the sense of control gained over the potentially negative influence of the ancestors as a result of the protection offered by *amakhosi* spirits and the loss of control of the individual due to the need to placate *amakhosi* spirits by drinking strong alcoholic beverages, such as gin. Much of the violence associated with *amakhosi* spirit possession can be attributed to the recipients loss of inhibition; this is explained away as the *amakhosi* spirit's anger. This anger is often directed against authoritative structures or social circumstances seemingly beyond the control of the individual. What seems evident from these inferred displays of anger is that many young people feel helpless against the conditions produced by social structural violence. The forms of social and structural insecurity endemic to structurally violent environments contribute to young people's feelings of vulnerability to forces beyond their control.

A further dimension that needs to be considered is the role that *amakhosi* spirit possession plays in the (re)forming of masculine identities. In many ways, because *amakhosi* spirit possession is almost

always the exclusive domain of teenage boys<sup>51</sup>, it may be seen as a means of recapturing or (re)constructing a particular kind of masculinity. In the Xhosa tradition, a clear distinction is made between ‘boys’ and ‘men’<sup>52</sup>. A person is only considered a man after he has successfully completed a number of initiation rituals into manhood and has been reincorporated into his community (Mahlhlo 2009: 51). Once a man, a person is treated with respect – *uhlonipha* – and given an elevated status in society<sup>53</sup>. *Amakhosi* spirits are able to do much the same in that they give boys an increased sense of prestige due to the physical power they impart on the recipient. Furthermore, because *amakhosi* spirits are seen as dangerous and unpredictable, they engender a sense of fear and respect. Teenagers are drawn to *amakhosi* for the very reason that through the fear associated with *amakhosi* spirits, they are offered a greater sense of security. Furthermore, as there are many expenses involved in undergoing the manhood initiation rituals, boys sometimes have to wait until their mid-twenties before their families are able to afford to ‘send them to the bush’. The inscribed identities associated with *amakhosi* spirit possession might therefore be appealing to older teenage boys who have not yet been through their initiation into manhood.

## 4.5 Chapter Conclusion

The radio-workshops were useful in revealing the kinds of relationships that young people maintain with traditional forms of healing. Young people most often consult traditional healers around issues relating to the African healing cycle – gaining protection for up-coming initiation rituals; getting luck for finding future employment; or using ‘love medicines’ for matters of the heart – for example. Young people also consult traditional healers for situations where witchcraft is suspected; most often in cases of suspected jealousy. However, many of the participants expressed that they would not

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<sup>51</sup> For the most part, it seems that girls choose to remain on the periphery of *amakhosi* spirit possession, sometimes aligning themselves with certain *amakhosi* gangs. Although some of the participants mentioned during the radio-workshops that girls could partake in *amakhosi* spirit possession, I did not succeed in finding any girls who had actually done so.

<sup>52</sup> This distinction between ‘boys’ and ‘men’ is so heavily maintained that during a discussion with a social worker who worked with prisoners in Grahamstown, I was told of an inmate who, upon entering prison, had not yet undergone the manhood initiation rituals, and for all his time in prison, he was treated like a boy. Finally, at the age of seventy, after being released from prison, he chose to undergo the manhood initiation rituals in order to be considered a man.

<sup>53</sup> All the participants were acutely aware of the notion of *uhlonipha* (respect). During one of the workshop sessions, some of the participants who had recently undergone the initiation rituals into manhood chose to group themselves together on the grounds that they could no longer associate with ‘boys’. This caused feelings of tension between the two groups because, despite many of the participants being close in age, the group of men felt they were not being properly respected by the other participants.

choose to consult a traditional healer for issues relating to ‘natural causes’, such as headaches or colds. Furthermore, all the participants were extremely vocal about not consulting a traditional healer around issues relating to HIV/AIDS. This is mainly due to the strongly biomedical understanding that they hold around the causes of HIV/AIDS.

Young people also come into contact with traditional forms of healing when dealing with the issue of *amakhosi* spirit possession; usually when trying to rid themselves of *amakhosi* spirits. *Amakhosi* spirit possession seems to act as a means of bridging the divide between the demands of modernity and the excesses of social structural violence, and the feelings of insecurity and vulnerability that result from the dissolution of African spirituality linked to the ancestral cult. Furthermore, what *amakhosi* spirit possession exposes is the fragility of the social support structures available to young people in dealing with complex challenges faced day to day.

# CHAPTER FIVE

## Conclusion

### Vignette Eight

Thabo and I are sitting in a small room in the community library. On the floor in front of us is his life-size body-map showing two overlapping images of himself; what we have come to talk about as the 'Blue Thabo' and the 'Red Thabo'. In the one image, the 'Blue Thabo' is a visual representation of his experiences as a younger self. The juxtaposed 'Red Thabo', on the other hand, is a closer reading of his current self, embodying at once both his hopes and ambitions, and feelings of anger and frustration.

We begin our discussion by examining the younger 'Blue Thabo'. I point at the image on the floor and ask him, rather vaguely, to tell me more about his painting:

"The blue picture is when I was at school, and I wasn't much mature", he explains. "I felt a bit shiny and I was feeling ..."

"... shiny or shy?", I ask him, thinking I've misheard.

"Shiny", he clarifies. "I was like ok, I'm on the top and everyone's looking at me. I used to go to church and I was more inspired in church. I used to preach at um, at them, at school ..."

"... and your face here? What is that expression?", I ask him pointing at a grimace that looks both mischievous and worried.

"Oh, except the face", he says. "The facial expression was when I heard about my father. He didn't even support me. He never did something, nothing, nothing much for me. And I was like, ok, angry".

"Why is that?", I ask him gently. "Was your father always working?"

"Ja, he was working. He was a soldier. I was like, ok, why can't he support a child of his own? I was kinda feeling um, blue, if I can say that".

The two of us laugh at the irony of this statement but at the same time, we recognise it's embedded truth. Thabo's father lives in Bloemfontein and he rarely gets to see him. His mother was his primary guardian until she died a few years ago. He has been living with his aunt ever since.

After some discussion, I asked him to tell me about the Red Thabo.

“*Eish*, I was much growing”, he says. “I was feeling much more mature because the red colour is stronger. I’m running *né*, I’m running to my future”.

“Are you running away?”, I ask.

“No”, he says shortly. “I’m running *to*. Like, I’m searching, I’m searching more about my future. Ja”.

We talk for a while about his aspirations and hopes for the future. Like many young people his age, he is hopeful and ambitious, but uncertain about what the future holds. I direct the discussion back to the painting by commenting on the look of determination that the Red Thabo has on his face.

“Tell me more about your facial expression here?”, I say.

“My facial expression?”, he says, taking some time to think about it. “I was angry. I was angry ‘cos people, ‘cos most of the people didn’t want to tell me the truth. When uh, when my mother died because of the HIV, I locked myself on my room until Auntie Nola came to me and asked me how do I feel. And I told her, this is how I feel, and I don’t think I’ll be able to live too far. I thought I also had HIV”.

“Why was that?”, I ask.

“Um, ‘cos my mother had HIV”, he explains. “And I had the mentality that ok, if my mother died of HIV, so do I. I have the HIV! Until Nola came to me and asked me about that and she told me to go to get tested. And I was like, ok let me take a chance, let me try ... After that I was ok. But before I was angry to everyone”.

“I can see that from your expression”, I remark.

“And on this one”, Thabo says, speaking more freely and pointing to a picture of a whip lying beside the red body, “although my mother was doing everything to me and like beating me, I learnt more from being beaten. I learnt what is wrong and right. I learnt how to differentiate between the right thing and the wrong thing. Most of the time now I’m missing my mother through that”, he says. “I’m missing being beaten about wrong things that I’ve done and I’m doing. It’s like, ja, I miss her”.



**Figure 5.1 – Thabo's Body-Map**

## 5.1 Fragile yet unbreaking

The idea of using body-maps as a means through which personal narratives and life histories could be told was based on a project run with the *Bambanani*<sup>54</sup> Woman's Group from Khayelitsha<sup>55</sup>, where body-mapping helped a group of women affected by HIV/AIDS to “sketch out, paint in and put into words their memories and their stories” (Morgan *et al.* 2003: 8). The body-maps that the participants in this study created were used as a means of returning to, drawing together and consolidating many of the themes that emerged during the workshop process. They acted both as a means through which the participants could relay personal details about their social circumstances, as well as a platform from which questions about their social worlds could be asked. What was clear from many of the participants' stories was that their social worlds are fragile and tenuous, and tainted by the shadow of Apartheid social engineering in ways that are sometimes subtle but more often violent. Through their body-maps, it was possible to see how, as Maria Weiss (1997: 457) explains, “social paradigms are articulated through bodies”. The cyclic vestiges of social structural violence are a recurrent and unbreaking reality for many young people from structurally violent environments. Moreover, it is from just such environments, characterised by discontinuity and flux, that young people's senses of self emerges as multiple, yet fragile. As Rutherford (1990: 20) reminds us, “identity marks the conjuncture of our past with the social, cultural and economic relations we live in. Each individual is the synthesis not only of existing relations but of the history of these relations”.

The notion of unbreaking fragility gestures towards the consequences that result from fragmented avenues of support and the conditions of social structural violence. For many young people, the domestic unit is fluid and fragile; a situation which continues due to conditions of poverty and the affects of HIV/AIDS. The dissolution of the African family unit and the dislocation of the ancestral cult as a result of fragmented domesticity has led to an unnamed feeling of social and spiritual insecurity that plagues young people's senses of well-being. Thabo's story is just one case in point, yet it highlights the fragility, instability and fragmented-nature of the institutions of support that young people often need to rely on. The feelings of anger and abandonment that Thabo has towards his father, for example, is indicative of the consequences of domestic fluidity and the resultant sense of vulnerability; of being alone and without guidance in the world. As Thabo explains in Vignette Eight, he would rather be given direction from his mother, albeit through violent means, than to have no guidance at all.

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<sup>54</sup> *Bambanani* means ‘to help or support each other’ (Morgan *et al.* 2003: 183).

<sup>55</sup> Khayelitsha is a high-density informal settlement adjoining Cape Town

As a result of fragmented avenues of support, young people's therapeutic environments tend to be varied and diverse. Although biomedical health-care is favoured when dealing with illness episodes, traditional practices and non-western notions of the body, affliction and cure are sometimes accessed in trying to deal with the excesses of social structural violence. *Amakhosi* spirit possession is a case in point, in that it reveals the ways in which feelings of social and spiritual insecurity are embodied and addressed. Moreover, *amakhosi* spirit possession inadvertently challenges the dichotomous positioning of Modern Scientific Medicine in relation to traditional forms of healing, and enables the notion of an entangled temporality in understanding people's health and illness choices. Subjective experiences of HIV/AIDS, for example, cannot solely be described and understood in linear terms, but should rather be thought of as fluid, folded-together and layered. Viewing HIV/AIDS as a concept-metaphor is therefore useful in that it draws attention to the political economy of health and illness.

Despite the fragility indicative of so many young people's social worlds, there remains a promising, unfaltering resilience to the challenges that many young people regularly face. It is important to examine young people's social worlds because, despite the fact that the vestiges of Apartheid shouldn't be their burden to bear, many young people have little choice but to deal with its resultant consequences. And although many of them do so with an engaged, positive attitude, this remains an imperfect comfort placed unwillingly on shoulders too young.

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